TEXAS HIV/STD PREVENTION PLAN 2011

The Texas HIV/STD Prevention Community Planning Group (TxCPG)

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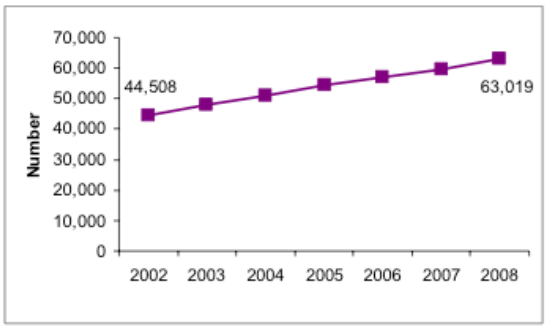
TEXAS HIV/STD PREVENTION PLAN

EXECUTIVE SUMMARY

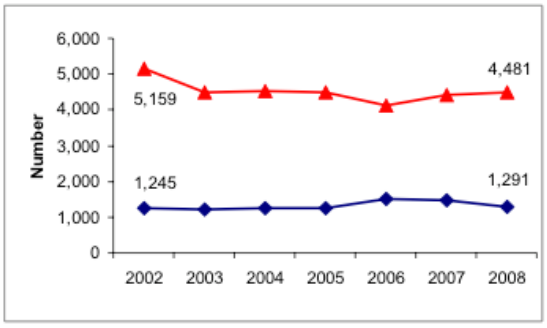
The HIV epidemic in Texas has reached a crossroads. Advances in treatment now allow persons with HIV to live longer, healthier lives, but the number of people living with HIV in Texas continues to rise. By the end of 2009, more than 65,000 Texans were living with HIV.

Since 2003, approximately 4,200 Texans have been diagnosed with HIV each year. The fact that the number of new HIV infections has held steady in recent years is testament to the effectiveness of existing prevention activities. However, in order to move from maintaining the status quo to making progress in reducing the human misery and financial burden of HIV, we must do more to optimize and extend HIV prevention in Texas.

Number of People Living with HIV/AIDS, Texas 2002-2008[1]



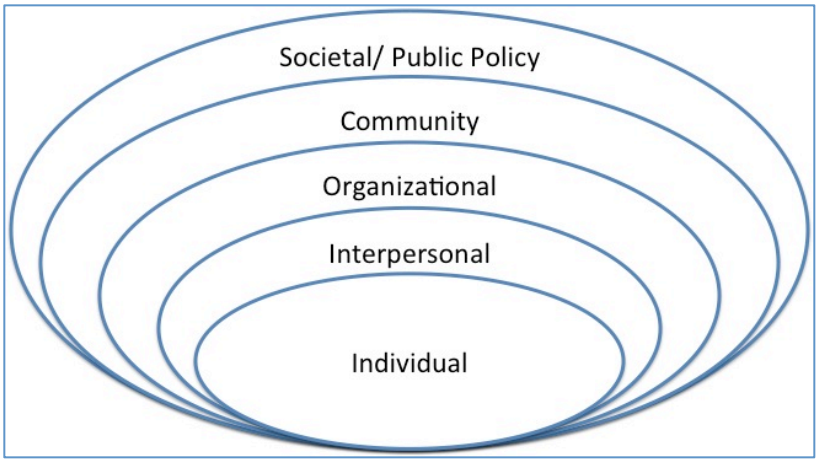
Number of New Diagnoses of HIV Disease and Deaths, Texas 2002-2008[1]



The Texas HIV/STD Prevention Plan has been developed by the Texas HIV/STD Prevention Community Planning Group (TxCPG) to guide the development of a comprehensive, coordinated approach to HIV/STD prevention activities across the state. While the ultimate power to prevent HIV and other STDs lies in individual behavior changes, these behaviors are influenced by a wide array of factors that have not been sufficiently addressed by existing prevention activities. This plan is designed to move prevention strategy toward an expanded focus that embeds HIV/STD prevention at all levels of society.

[1] Texas Department of State Health Services. (2010). Texas integrated epidemiologic profile for HIV/AIDS prevention and services planning. Austin, TX

The plan's approach to prevention is guided by the socio-ecological framework[2]. This framework acknowledges that an individual's decisions and behaviors result from interactions taking place at the interpersonal, organizational, community, societal, and/or structural/policy levels. Interactions at all of these levels have the potential to influence individual behaviors. Using the socio-ecological framework as a tool to identify and analyze factors influencing behavior can highlight new opportunities for prevention.



HIV disproportionately affects some of the most marginalized segments of society. The disease exacts a particularly heavy toll on gay/bisexual men and Black men and women. Over 60% of all new cases in Texas are a result of sex between men. Approximately 1 in 92 Black Texans is living with HIV, compared to 1 in 421 White Texans and 1 in 426 Latino Texans. Risk behaviors do not fully tell the story of HIV. Poverty, social/sexual networks, unequal access to health care, racism, homelessness, homophobia, stigma, and other factors contribute to the continued spread of HIV.

In order to effectively use limited funding, the plan outlines nine priority populations for HIV prevention. TxCPG selected and ranked populations based on Centers for Disease Control and Prevention (CDC) guidance and the disproportionate impact of HIV on these populations as demonstrated by DSHS epidemiological data. Priority populations include:

- HIV-positive individuals, particularly undiagnosed individuals
- Black gay men and other Black men who have sex with men
- All gay men and other men who have sex with men
- Black high-risk heterosexual women
- Injection drug users

[2] Richard L, Potvin L, Kishchuk N, Prlic H, Green LW. (1996). Assessment of the integration of the ecological approach in health promotion programs. American Journal of Health Promotion 10(4): 318-328.

- Black high-risk heterosexual men
- Latino high-risk heterosexual men and women
- Youth, ages 13 to 24
- Special populations, including transgender individuals, partners of HIV-positive individuals, homeless individuals, incarcerated and recently released individuals, sex workers, individuals with an STD and/or Hepatitis C diagnosis, individuals with mental health issues, and individuals with substance abuse issues.

Chapter 6 of the plan outlines a set of universal strategies that form the bedrock of HIV/STD prevention in Texas. These include expanded testing, linkage to care, treatment access, condom access, and public health follow-up. The universal strategies are applicable across priority populations.

The plan also contains Action Briefs for issue areas in which effective HIV/STD prevention is especially critical. TxCPG used the socio-ecological framework to develop Action Briefs with multi-level recommendations for the following areas of concern:

- Criminal Justice
- Education (Kindergarten through 12th Grade)
- Mental Health
- Substance Use
- Stigma
- Advocacy and Policy
- Healthcare
- Faith-based Communities

This list of issue areas is not exhaustive. Extending the reach of prevention will require engagement across an ever-expanding range of areas that may vary from community to community.

In the past, HIV prevention community planning in Texas focused on matching evidence-based interventions (EBIs) to priority populations. This plan significantly expands the potential reach of prevention activities by considering all levels within the socio-ecological framework. While the plan does not abandon the matching of EBIs to priority populations, it acknowledges that the prevention toolbox must be expanded to address the vast majority of persons at risk for HIV and other STDs who will not be reached by resource-intensive, person-to-person interventions.

Accordingly, this plan identifies seven crosscutting objectives that must be addressed to advance HIV/STD prevention in Texas:

1) **Reduce undiagnosed HIV and STD infections.** One in three HIV-positive Texans is diagnosed with AIDS within one year of their first HIV diagnosis—an alarming indication that Texans are testing too late. Ensuring that all persons living with HIV and other STDs learn their status early in the course of infection is the first step to

connecting them to clinical care, prevention, and supportive services. In addition, HIV-positive persons who know their status are more likely to make behavior changes that reduce the likelihood of further disease transmission[3].

2) **Ensure availability of prompt HIV/STD treatment upon diagnosis.** A large-scale international clinical study sponsored by the National Institute of Allergy and Infectious Diseases found that treating HIV-positive persons with combination antiretroviral therapy decreased transmission to sex partners by 96%[4]. Early HIV treatment also improves long-term health outcomes for HIV-positive persons.

3) **Promote behavior change among high-risk populations.** This includes expanding community-wide access to and acceptability of basic prevention tools, such as condoms and clean needles, as well as building a sense of individual and shared responsibility for lowering community viral loads.

4) **Increase the urgency and priority of HIV prevention.** A 2011 Kaiser Family Foundation public opinion survey found that only four in ten survey respondents reported seeing, hearing, or reading about the HIV epidemic in the past year, down from seven in ten respondents in 2004. The number of survey respondents who say they have been tested for HIV in the past 12 months—one in five—has remained flat since 1997[5]. Increasing top-level awareness of and willingness to adopt proven prevention strategies is a critical step in mounting an effective community response to HIV.

5) **Build a comprehensive, coordinated approach to prevention.** Scaling up HIV/STD prevention in Texas will require increased flexibility to leverage both traditional and non-traditional public health resources. Robust partnerships across administrative boundaries are needed to address the wide range of individual and social factors that drive HIV and STD transmission.

6) **Create a shared understanding of who is at risk for HIV and other STDs.** While anyone can become infected with HIV and other STDs, not everyone has an equal chance of becoming infected. Prevention activities in Texas must focus on the

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[3] Marks G, Crepaz, N, Senterfitt JW, Janssen, R. (2005). Meta-Analysis of High-Risk Sexual Behavior in Persons Aware and Unaware They are Infected With HIV in the United States: Implications for HIV Prevention Programs. JAIDS Journal of Acquired Immune Deficiency Syndromes 39(4): 446-453.

[4]National Institute of Allergy and Infectious Diseases. (2011). Treating HIV-infected People with Antiretrovirals Protects Partners from Infection (Press release). Retrieved from http://www.niaid.nih.gov/news/newsreleases/2011/pages/hptn052.aspx.

[5] The Henry J. Kaiser Family Foundation. (2011). HIV/AIDS at 30: A Public Opinion Perspective (A Report based on the Kaiser Family Foundation's 2011 Survey of Americans on HIV/AIDS). Retrieved from http://www.kff.org/kaiserpolls/8186.cfm.

populations in which HIV and STDs are most prevalent, particularly gay and bisexual men and Black men and women.

7) **Use the socio-ecological framework to design scalable, cost-effective prevention strategies.** Like the National HIV/AIDS Strategy, this plan endorses a multi-pronged approach to HIV/STD prevention. The socio-ecological framework supports the development, implementation, and evaluation of a combination of individual, community, cultural, institutional, and environmental strategies for HIV/STD prevention.

Implementing these strategies will require those on the front lines of HIV/STD prevention in Texas to recalibrate their approaches to fighting disease. Barriers to prevention will have to be overcome and new partnerships cultivated. Most importantly, our collective investment in prevention must be leveraged in a manner that has the greatest possible impact on turning the tide of HIV and STD in Texas.

INTRODUCTION TO THE TEXAS HIV/STD PREVENTION PLAN

Big State, Big Population, Big Responsibility:

A Big Response to HIV/STD for All Texans

Like the HIV epidemic itself, the Texas HIV/STD Prevention Plan is a call for us to reexamine our assumptions about our relationships. While traditional prevention plans have focused on matching specific interventions to populations at increased risk for HIV/STD, this plan expands the prevention landscape by examining the socio-ecological context in which HIV and STD occur in order to find new opportunities to stop infections.

The plan represents years of individual- and group-level discussion among Texas HIV/STD Prevention Community Planning Group (TxCPG) members, Texas Department of State Health Services (DSHS) staff, and many others around the state who have a committed role, passion, or driving interest in seeing HIV/STD infections dramatically decrease throughout Texas.

From 2002 to 2009, the number of Texans living with HIV/AIDS increased by 39%. While we are heartened that the number of new infections has remained relatively stable in recent years, this situation is neither acceptable nor sustainable. In order to decrease the number of new infections, Texas must implement a wide array of innovative, enhanced prevention activities for the populations most at risk and ensure that those infected with HIV and other STDs receive the care they need.

TxCPG used the socio-ecological framework to develop this plan. This framework recognizes that an individual's behavior takes place in the context of his/her social and physical environment. Using this framework highlights the need for prevention activities to take place across the many levels of social and physical environments.

With almost one quarter of HIV-positive persons unaware of their infection, more must be done to reduce undiagnosed infections. Accessible opportunities for routine HIV testing must be created, sustained, and enhanced across Texas, particularly in communities at increased risk for HIV infection.

The primary goal of the plan is to provide the building blocks of a coordinated and comprehensive statewide HIV/STD prevention strategy. The plan is intended to be multi-functional and useful to administrators, community-based organizations, clinicians, health department officials, and anyone else with an abiding interest in HIV/STD prevention. We hope that the plan will resonate beyond the HIV/STD specialists to all parts of the state's infrastructure that influence health: parents, teachers, doctors, nurses, faith leaders,

elected officials, community leaders, and anyone else with a willingness to take action to bring about the end of this epidemic.

About TxCPG:

> *TxCPG is the community entity that shares responsibility with DSHS for the development of the Texas HIV/STD Prevention Plan.*

The vision of the TxCPG:

> *A comprehensive and coordinated approach to HIV/STD prevention in Texas.*

The mission of the HIV/STD Prevention Plan:

> *Provide direction to a broad array of stakeholders on all effective and necessary HIV/STD prevention efforts in Texas.*

Purpose of the HIV/STD Prevention Plan

The plan's purpose is to drive an ongoing collaborative process that:

- Assesses the present and future extent, distribution, and impact of the HIV/AIDS and STD epidemics among at-risk populations
- Inventories existing community resources for HIV and STD prevention
- Identifies unmet HIV and STD prevention needs within at-risk populations
- Uses all existing data and information to identify effective interventions and specific strategies to deliver HIV and STD prevention services
- Defines the potential impact of specific strategies for HIV/STD prevention
- Prioritizes HIV and STD prevention needs for at-risk populations
- Evaluates the effectiveness of the planning process
- Provides information about issues related to HIV/STD prevention programming, as requested by DSHS

In developing a plan for enhanced HIV/STD prevention, TxCPG started with the question, "What would a world where HIV infections are increasingly rare look like?" This question

led the group's planning process beyond the traditional HIV prevention infrastructure to focus on new nodes of opportunity where limited community resources can be maximized to have the greatest impact on reversing the direction of the epidemic.

An example of TxCPG's expanded vision of prevention can be found in the Action Briefs, located in Chapter 4. Although this list is not exhaustive, the briefs address HIV prevention related to the following topic areas:

- Advocacy and Policy
- Stigma
- Healthcare
- Criminal Justice
- Mental Health
- Substance Use
- Education (Kindergarten through 12th Grade)
- Faith-based Communities

The Action Briefs were developed using the socio-ecological framework to address specific social determinants that have been persistent barriers to expanding HIV prevention[1, 2]. Each Action Brief recommends individual, organizational, and community-level actions that TxCPG has determined will have the greatest impact on preventing HIV and STDs in Texas. While many of the recommendations contained in the Action Briefs may not be new or startling, we believe they represent a fresh approach because previously unrelated socio-ecological levels are now linked together under the banner of prevention. The Action Briefs are our concrete attempt at making HIV/STD prevention more accessible, broad-based, and effective.

The optimism of launching a plan with such broad goals is based on many social, legal, and biomedical measures that have been successfully implemented over the last five years. The National Alliance of State and Territorial AIDS Directors' Prevention Policy Agenda and HIV Prevention Blueprint, as well as the White House's National HIV/AIDS Strategy provide an implementation structure for many of the elements identified in the plan. In addition to satisfying its Centers for Disease Control and Prevention (CDC) mandate, TxCPG hopes the plan will catalyze discussions at the local and community levels to foster strategic, collaborative prevention activities.

There are additional reasons to be optimistic about the prospects for new approaches to HIV/STD prevention in Texas. Significant progress in reducing the transmission of HIV from mother to child indicates broad-based support for prevention among Texans. Legislation using nothing less than the full authority of the law to prevent the birth of HIV-infected infants has had a powerful effect on the prevention landscape. Legislative action on needle exchange continues to resurface each session, each time with a greater, more

broad-based understanding that letting this health threat proceed unabated is unacceptable.

In the words of award-winning epidemiologist William Foege, we are "pursing the last mile in HIV prevention" from a variety of socio-ecological perspectives. If we are to succeed in prevention, we can no longer accept a structural environment where HIV is ignored and instead is an ongoing private tragedy.

When pulled together, all the parts of the plan may renew the collective energy needed to get Texas to the place where it needs to be. We hope this will lead to a healthier place with more HIV-positive Texans receiving the care they need, more Texans aware of their HIV/STD status, and more Texans—both HIV-positive and HIV-negative—taking an active role in ending the human misery brought about by this disease.

STD Prevention

TxCPG understands the importance of effective STD prevention. The vast majority of HIV infections in Texas are transmitted sexually. Additionally, TxCPG acknowledges linkages in STD morbidity to HIV infection. TxCPG understands there are (1) indirect linkages to individuals with a previous STD-positive diagnosis and the likelihood of having a future HIV-positive diagnosis and (2) increases in HIV/STD co-infection. Because HIV shares many of the same behavioral risk factors as other STDs, STD prevention and treatment services are critical front-line strategies that prevent new HIV infections.

Though TxCPG has not enumerated steps to address STD morbidity specifically, we are brainstorming ways in which community-based organizations, community stakeholders, and other interested parties can incorporate STD prevention into their application of the HIV prevention efforts explained in the plan. The goal of TxCPG is to, in addition to incorporating STD prevention into the local application of the plan, continue recruitment of members with a particular emphasis on STD prevention. In doing so, TxCPG will solicit the expertise of STD prevention professionals, other TxCPG members, DSHS personnel, and other stakeholders.

References

1. Richard, L., et al., *Assessment of the integration of the ecological approach in health promotion programs.* American Journal of Health Promotion, 1996. **10**(4): p. 318-328.
2. Kok, G., et al., *The ecological approach in health promotion programs: A decade later.* American Journal of Health Promotion, 2008. **22**(6): p. 437-442.

TEXAS HIV EPIDEMIOLOGICAL PROFILE AT A GLANCE[1]

As of December 31, 2009, more than 108,134 HIV cases had been reported in Texas since the beginning of the epidemic. Of these cases, 42,916 are known to be deceased. In 2009 there were a total of 66,126 Texans known to be living with HIV in Texas, 65,884 of whom were adults and adolescents. This is a 39% increase from 2003.

New HIV/AIDS diagnoses and deaths have been relatively stable from 2003–2009. Increases of about 6% each year in the number of persons living with HIV/AIDS (PLWHA) reflects survival due to the use of antiretroviral medicines and preventative therapies for opportunistic infections.

- Over 78% of PLWHA are male.
- Men who have sex with men (MSM)[2] account for 54% of PLWHA.
- Injection Drug Users (IDU) account for 15% of PLWHA.
- High-Risk Heterosexuals (HRH) comprise 23% of PLWHA.
- New diagnoses in MSM represent more than 60% of the new cases each year.
- Between 2003 and 2009, new diagnoses among persons age 13–24 showed a 66% increase.
- The highest rate for both males and females was in persons age 25 – 34.

RACE/ETHNICITY

- HIV/AIDS among Whites was concentrated in MSM. To a slightly lesser extent, the same is true among Hispanics[3].
- The Black[4] population has the largest proportion of cases, with a rate in 2009 over four times the rate in the White population and nearly five times the rate in the Hispanic population.
- HIV/AIDS among Blacks was more widely distributed across mode of exposure, reflecting the broader scope and impact of HIV/AIDS in the Black community, although MSM still is the main mode of infection for Black males.
- Rates of new diagnoses of HIV show a 3.5:1 ratio of male to female. However, while the ratio of male to female cases among Whites and Hispanics is about 6:1 and 5.5:1, respectively, the male to female ratio is only 2:1 in Blacks.
- The rate of new diagnoses in Black females was 2.6 times higher than the rates observed among White males, 1.6 times as high as Hispanic males, and about 9 and 15 times higher than the rates in Hispanic and White females, respectively. This demonstrates how HIV disproportionately effects the Black population.

GEOGRAPHY

- In 2009, over half of PLWHA in Texas were in the Houston and Dallas Eligible Metropolitan Areas (EMA)[5].
- Austin, Fort Worth and San Antonio Transitional Grant Areas (TGA) each had 6–7% of the total number of living cases, as did the Texas-Mexico border counties, East Texas, and the Texas Department of Criminal Justice, respectively.
- In Houston and East Texas, the largest number of PLWHA was among Black persons.
- In the San Antonio and US-Mexico border areas, the largest numbers were in Hispanic persons; in the other areas, the largest numbers of PLWHA were among White persons.

CONCURRENT DIAGNOSIS

- From 2005 through 2008, over one third of all new diagnoses in Texas received an AIDS diagnosis within one year of their HIV diagnosis.
- More males than females received HIV and AIDS diagnosis within one year.
- The Hispanic population had a larger proportion of concurrent diagnoses (43%) than the White (31%) or Black (30%) populations.

It is in response to the specifics of this epidemic that TxCPG has developed the HIV/STD Prevention Plan.

A copy of the complete *2010 Texas Integrated Epidemiologic Profile For HIV/AIDS Prevention And Services Planning* can be found at http://www.dshs.state.tx.us/hivstd/reports/default.shtm

UNITED STATES HIV EPIDEMIC AT A GLANCE

The Centers for Disease Control and Prevention (CDC) estimates more than one million individuals in the United States are living with HIV. One out of five of these individuals do not know they are HIV positive. The trends seen in Texas can be found in the national epidemiology.

Like Texas, the number of PLWHA in the US continues to increase. The annual number of new HIV infections has remained stable. New infections are estimated at 56,300 per year.

Across the United States, groups most affected by HIV reflect those identified in Texas.

GAY, BISEXUAL, AND OTHER MEN WHO HAVE SEX WITH MEN (MSM)

- MSM account for more than half (53%) of all new infections in the US.
- MSM make up 48% of PLWHA in the US.
- The rate of new HIV diagnoses among MSM is more than 44 times that of other men and more than 40 times that of women.
- White MSM account for the largest number of new HIV infections of any group in the US, followed by Black MSM.
- MSM is the only risk group in the US where HIV infections have been increasing since 1990.

INJECTION DRUG USERS

IDU represent 12% of the annual new HIV infections and 19% of PLWHA.

RACE/ETHNICITY

The Black population carries the most severe burden of HIV in the US. They represent 12% of the US population but account for almost half (46%) of the HIV in the US. They account for 45% of new infections each year.

The rate of new HIV infections among Black men is six times as high as that of White men and three times as high as Hispanics. As in Texas, Black women are disproportionately affected. Black women in the US have an incidence rate that is nearly 15 times that of White women and is four times the rate of Hispanic women.

Hispanics account for 16% of the US population; 17% of PLWHA; and 17% of new infections.

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[1] Texas Department of State Health Services. (2010). Texas integrated epidemiologic profile for HIV/AIDS prevention and services planning. Austin, TX

[2] Throughout this document we use the terms “gay and bisexual men,” “gay men,” and "men who have sex with men (MSM)" interchangeably, and we intend these terms to be inclusive of all men who have sex with men (MSM), even those who do not identify as gay or bisexual.

[3] Throughout this document we use the terms “Latino” and “Hispanic” interchangeably.

[4] Throughout this document we use the terms “Black” and “African-American” interchangeably, and we intend these terms to be inclusive of all individuals from the African Diaspora who identify as Black and/or African-American.

[5] U.S. Department of Health and Human Services Health Resources and Services Administration. (n.d.). A living history: The Ryan White HIV/AIDS program. Retrieved October 14, 2011, from http://hab.hrsa.gov/livinghistory/programs/index.htm

COMMUNITY PLANNING AND THE NATIONAL HIV/AIDS STRATEGY

[1, 2]

"The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination."

-National HIV/AIDS Strategy Vision Statement, 2010

OVERVIEW

In July 2010, President Barack Obama released the first-ever National HIV/AIDS Strategy for the United States. The strategy was developed over a year and a half in consultation with medical experts, social scientists, HIV prevention and care providers, and advocates from across the country. The TxCPG community co-chair and other members provided testimony at the National Strategy community discussion held in Houston in October 2009.

While the National Strategy uses slightly different language and organizational principles than this plan, the two approaches are largely supportive of each other. The four primary goals of the National Strategy are:

1) Reduce the number of people who become infected with HIV

2) Increase access to care and optimizing health outcomes for people living with HIV

3) Reduce HIV-related health disparities

4) Create a more cohesive and coordinated response to HIV at all levels

While anyone can become infected with HIV, not every person or group has an equal chance of becoming infected. The National Strategy seeks to refocus prevention activities in populations where HIV is most prevalent, including gay and bisexual men, Black men and women, Latino men and women, and substance users, particularly those using injection drugs. Similarly, TxCPG's identification of priority populations will focus HIV prevention efforts on the populations in Texas that are most affected by the epidemic.

Many individuals in populations at increased risk for HIV infection may not be engaging in higher-risk behaviors than others, but they can still be more likely to acquire HIV infection because of the sheer number of HIV-positive persons in their communities and social networks. Preventing HIV at the community level requires a sustained effort to build beyond individual-level interventions to cultivate a physical, economic, and social environment that supports the reduction of community viral load at multiple levels.

The National Strategy promotes a multifaceted approach to HIV prevention. Similarly, the socio-ecological framework, used by TxCPG to develop the prevention plan, supports the development, implementation, and evaluation of a combination of individual, community and structural/environmental strategies for HIV prevention.

Both the National Strategy and the Texas HIV/STD Prevention Plan prioritize prevention interventions that are cost-efficient, produce sustainable outcomes, and have the greatest impact.

The National Strategy identifies expanded HIV testing as a key strategy to identify HIV-positive persons who do not know their status. To this end, TxCPG supports the Texas Department of State Health Services' (DSHS) expanded HIV testing initiative and encourages community-level providers to develop prevention strategies that support and coordinate with expanded testing initiatives at the local level. People who receive a diagnosis of HIV infection need to be connected to and maintained in appropriate clinical care, prevention, and supportive services.

In accordance with the Centers for Disease Control and Prevention (CDC) community planning guidance, persons living with HIV/AIDS are the highest-ranked priority population in the Texas HIV/STD Prevention Plan. The socio-ecological framework enables the development of a strategy for persons living with HIV that addresses their prevention needs at the individual, community, and structural/environmental levels. This includes, but is not limited to, the following services outlined in the National Strategy:

1) Health department partner services to assist with notifying recent sex and drug-using partners of the need to get tested for HIV

2) Access to behavioral and biomedical interventions that have been shown to sustainably reduce the probability of transmitting HIV to others and reduce acquisition of other STDs

3) Screening for, and linkage to, other appropriate medical and social services, including drug treatment, family planning, housing, and mental health services

In addition, TxCPG is exploring the feasibility and effectiveness of using emerging biomedical strategies to prevent new HIV infections. Emerging biomedical strategies identified in the National Strategy include:

1) Pre-exposure prophylaxis (PrEP), the use of antiretroviral therapy by high-risk uninfected populations, such as by HIV-negative individuals in committed relationships with HIV-positive individuals.

2) Potential prevention strategies known as "test and treat" or "test, treat and link to care" to determine whether a community-wide HIV testing program with an offer of immediate treatment can decrease the overall rate of new HIV infections in that community.

TxCPG has only begun investigation of the role of biomedical interventions for the state prevention plan. The effectiveness of these emerging interventions will be maximized if combined and coordinated with existing HIV prevention strategies, including behavior change and structural interventions. As new information emerges in the coming years, the socio-ecological framework supports the seamless integration of biomedical interventions into the Texas HIV/STD Prevention Plan.

ENHANCED COMPREHENSIVE HIV PREVENTION PLANNING/ 12 CITIES PROJECT

In September 2010, the CDC responded to the National Strategy with the release of the Enhanced Comprehensive HIV Prevention Planning (ECHPP) funding opportunity. ECHPP is a leading-edge component of the U.S. Department of Health and Human Services' "12 Cities Project," which supports and accelerates comprehensive planning and cross-agency response in the 12 U.S. jurisdictions that bear the highest HIV/AIDS burden in the country, including Houston and Dallas.

Funded through the Affordable Care Act's Prevention and Public Health Fund, ECHPP is designed to facilitate the testing and evaluation of new approaches to integrate planning, monitoring, and delivering HIV prevention, care, and treatment services. Prevention strategies identified through ECHPP should coordinate and maximize existing community resources. ECHPP strategies must also align with the National Strategy.

In Phase I of ECHPP, each jurisdictional area is working to develop and implement a more focused HIV prevention plan. The project period for Phase I of ECHPP is one year. Much like the TxCPG's planning process, the ECHPP plans are intended to address gaps in the scope and reach of HIV prevention interventions and strategies among priority populations on multiple socio-ecological levels. A total of 14 required and 10 recommended intervention activities are to be used to identify the best mix of strategies to reduce the number of new HIV infections for each jurisdiction.

REQUIRED ECHPP INTERVENTION ACTIVITIES

1. Routine, opt-out screening for HIV in clinical settings
2. HIV testing in non-clinical settings to identify undiagnosed HIV infection
3. Condom distribution targeting HIV-positive persons and persons at highest risk of acquiring HIV infection
4. Provision of Post-Exposure Prophylaxis (PEP) to populations at greatest risk
5. Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment

6. Implement linkage to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care

7. Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons

8. Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons

9. Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons

10. Implement STD screening according to current guidelines for HIV-positive persons

11. Implement prevention of perinatal transmission for HIV-positive persons

12. Implement ongoing partner services for HIV-positive persons

13. Behavioral risk screening followed by risk-reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV

14. Implement linkage to other medical and social services for HIV-positive persons

RECOMMENDED ECHPP INTERVENTION ACTIVITIES

1. Condom distribution for the general population

2. HIV and sexual health communication or social marketing campaigns targeted to relevant audiences

3. Clinic-wide or provider-delivered evidence-based HIV prevention interventions for HIV-positive patients and patients at highest risk of acquiring HIV

4. Community interventions that reduce HIV risk

5. Behavioral risk screening followed by individual- and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV; particularly those in an HIV-serodiscordant relationship

6. Integrated hepatitis, TB, and STD testing, partner services, vaccination, and treatment for HIV-infected persons, HIV-negative persons at highest risk of acquiring HIV, and injection drug users according to existing guidelines

7. Targeted use of HIV and STD surveillance data to prioritize risk reduction counseling and partner services for persons with previously diagnosed HIV infection with a new STD diagnosis and persons with a previous STD diagnosis who receive a new STD diagnosis

8. For HIV-negative persons at highest risk of acquiring HIV, broadened linkages to and provision of services for social factors impacting HIV incidence such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and others

9. Brief alcohol screening and interventions for HIV-positive persons and HIV-negative persons at highest risk of acquiring HIV

10. Community mobilization to create environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among their family, friends, and neighbors

In Phase II of ECHPP, a subset of the jurisdictions funded under Phase I will be selected, through a competitive process, to further implement their ECHPP activities over a two-year project period.

ECHPP IN HOUSTON AND DALLAS

The CDC is funding two Texas jurisdictions—Houston and Dallas—to conduct Phase I ECHPP activities. The City of Houston Health and Human Services Department is funded directly by CDC to conduct ECHPP for the Houston area. The DSHS HIV/STD Prevention and Care Branch is funded to partner with Dallas County Health and Human Services and other community-based stakeholders to conduct ECHPP in the Dallas area. DSHS released the Dallas ECHPP plan in April 2011. TxCPG strongly encourages providers serving the Houston and Dallas areas to become familiar with local ECHPP plans and to tailor their service delivery strategies accordingly.

ECHPP AND COMMUNITY PLANNING

According to the CDC, ECHPP should serve as a more focused, results-oriented supplement to the jurisdiction's existing Comprehensive HIV Prevention Plan. ECHPP should address gaps in scope, reach of HIV prevention interventions and strategies among relevant populations, and coordination of HIV prevention, care and treatment services as it complements, but does not negate, the agreed-upon HIV Prevention Comprehensive Plans for community planning. ECHPP should strengthen and refocus the jurisdiction's current efforts to significantly reduce the number of new HIV infections and increase access to and use of HIV care and treatment. TxCPG supports ECHPP-funded efforts to optimize the provision of HIV prevention, care, and treatment in Houston and Dallas, particularly as they relate to underserved priority populations in those areas.

THE NATIONAL STRATEGY, ECHPP, AND COLLABORATION AMONG DSHS PROGRAMS

Both the National Strategy and ECHPP emphasize the coordination of HIV/STD programs across the federal government and among federal agencies and state, territorial, tribal, and local governments. Collaboration among programs within DSHS must be enhanced to achieve an effective response to these initiatives. In particular, new ways of collecting and sharing data need to be investigated to demonstrate collective statewide efforts in reducing new infections, increasing access to care, and reducing HIV-related health disparities.

A NEW DIRECTION

These efforts have changed the direction of HIV prevention. TxCPG was prepared to respond to the change in direction because they had already moved from focusing on individual intervdentions to a more environmental community change model.

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3.1 A MULTI-LEVEL APPROACH TO HIV PREVENTION

TxCPG members came to realize the need for a broad, inclusive approach to HIV prevention after they fully explored the purpose of an HIV prevention plan as well as the audience for a plan. Throughout the community planning cycle, members explored the issues surrounding HIV prevention. In the beginning, TxCPG sought to complete the statement, "We will not be successful in our efforts in HIV/STD prevention if we do not address _____." Members recognized in the community planning process the many societal issues that affect prevention and the prevention opportunities before them.

Broadening the approach to HIV prevention means additional opportunities, arenas, and prevention partners. TxCPG members believe that the plan should provide guidance for audiences well beyond the traditional prevention providers and consumers and that, ideally, it will inform prevention policy and practice at many levels. Additionally, members agree that the plan should address broader issues that affect the spread of HIV/STD, including culture, substance use, mental health, education, and policy, among others. After two years of focusing on prioritizing populations and evidence-based individual and group interventions, TxCPG revisited the need to address broader issues and audiences, and the "All Things Considered" Committee (ATC) was created. They focused on the socio-ecological approach.

THE SOCIO-ECOLOGICAL APPROACH

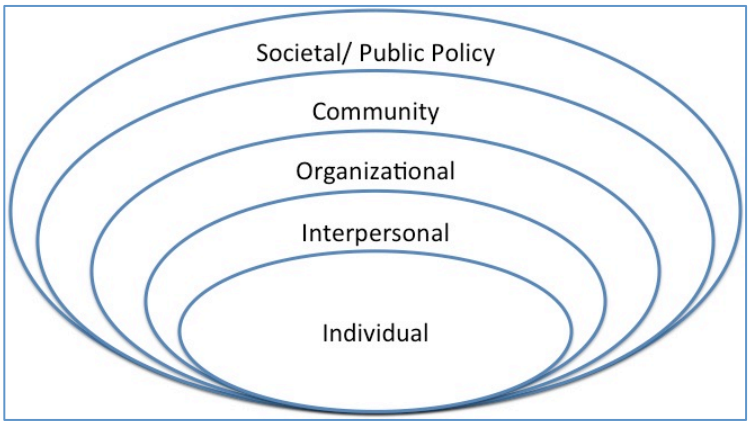
Texans are provided many opportunities to maintain and improve their health—sidewalks for strolling, food labels to inform choices, policies to protect minors, education about safety, and medical screening for the early identification of health needs. TxCPG seeks to extend health opportunities to include social and sexual health so that Texans can more easily make healthy choices involving HIV and STD.

Traditionally, HIV prevention has focused on individual and interpersonal approaches to behavior change; high-risk individuals attend counseling or groups. While individual and group-level interventions have been quite effective, behavior occurs within a context. Significantly, while behaviors have remained much the same, the context for HIV has shifted throughout the epidemic, creating a need for innovative approaches.

The socio-ecological approach [1, 2] recognizes that an individual's decisions and behaviors result from interactions with his/her social and physical surroundings. For example, an individual's condom-using behavior can be influenced by peers and family (social surroundings), as well as access to and availability of condoms (physical surroundings). The socio-ecological framework suggests that a person is situated within multiple levels of interaction and interdependence: the interpersonal, organizational, community, and societal and/or structural/policy levels. The basic multi-level embedded oval in

Figure 1 was the basis for ongoing conversations about how to address HIV prevention. The model, as elaborated by Poundstone and colleagues [3], comprises Figure 2 at the end of this section. Moving beyond individual characteristics, behaviors, and cognitive factors, higher order factors—including social and sexual networks, access to condoms, testing, and treatment, inclusivity policies, social and cultural norms, residential segregation, stigma and discrimination, legal structures, and the policy environment—are seen as key to HIV prevention.

FIGURE 1. BASIC SOCIO-ECOLOGICAL FRAMEWORK



According to the socio-ecological framework, interventions will be most effective when they target multiple levels to support behavior change. Individuals experience the socio-ecological model not so much as "levels," but rather as encounters with individuals, groups and systems. When creating a comprehensive, coordinated approach to HIV prevention, the socio-ecological approach highlights opportunities for providers and communities to create points of prevention in which individuals "bump into" HIV prevention as they live their lives.

Key to creating effective interventions is addressing the social factors that influence behavior and health[4]. Determinants occur at all levels of the socio-ecological framework, and analysis of the determinants of a risk behavior within a particular population can point to the levels on which change must occur. For example, a person who engages in unprotected sex may do so because of his beliefs related to condom use (individual level), the power dynamics within the relationship (interpersonal level), a lack of available condoms (organizational level), norms for condom use in his social network and community (community level), and policies that do not allow for condom distribution in schools or prisons (structural/policy level). Figure 2 includes a number of the determinants of HIV risk behavior that should be considered. Usually interventions are needed at multiple environmental levels, as well as at the individual level. Fortunately, small changes in the environment can lead to larger behavioral changes in the population.

While changing an organization or system may seem daunting, facilitating change actually means working with individuals within the organizations or systems. After the need for

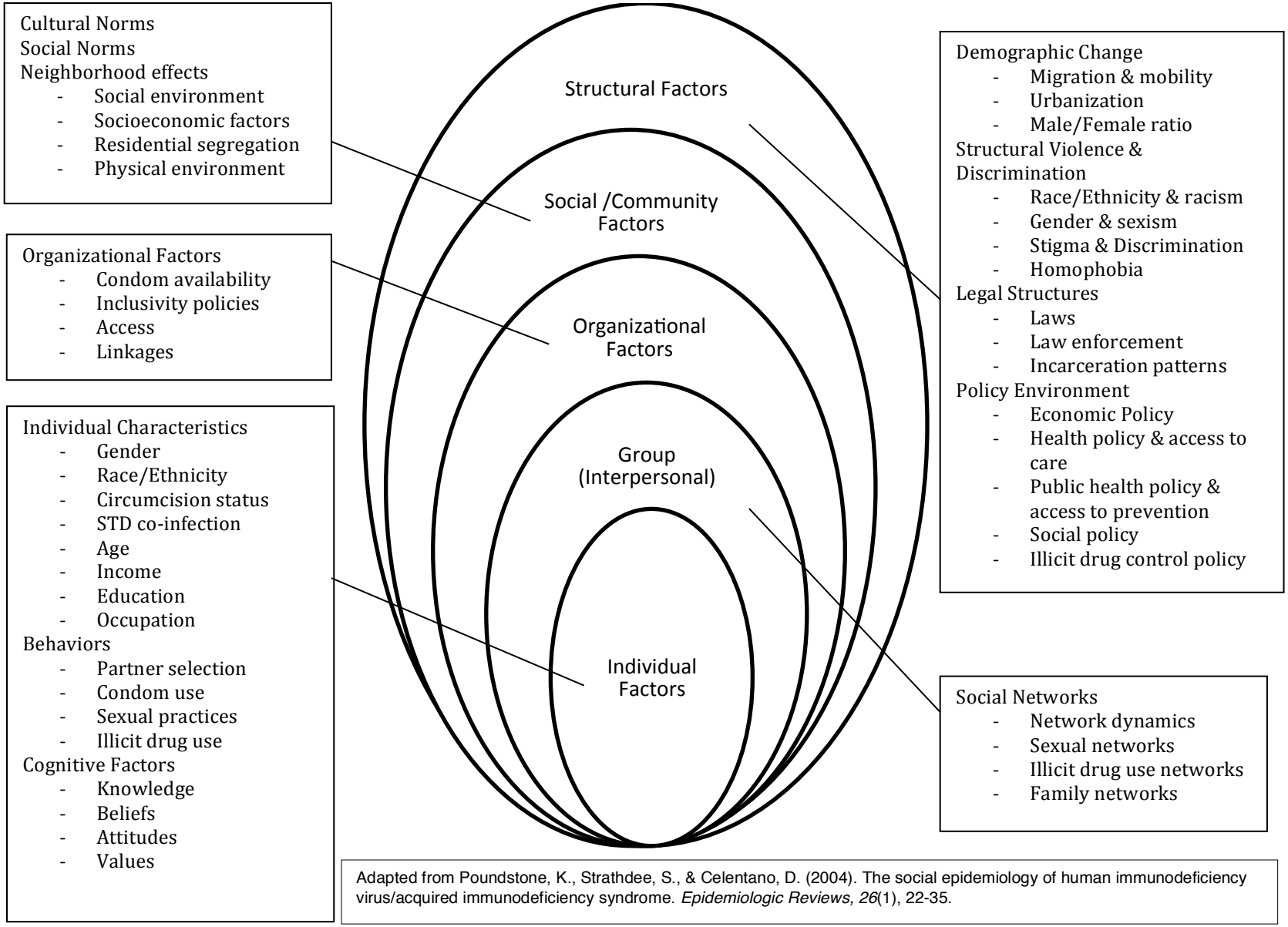
environmental change has been determined, the next steps are to identify who holds the keys to making the environmental change and to convince that person or group of the value of the proposed change. For example, changing policies requires advocating for policy change with elected officials or individuals who are in charge of a system.

Table 1, at the end of this section, illuminates the socio-ecological model, showing strategies or pathways used at each level to improve the health of individuals, and an HIV/AIDS prevention example for each strategy. The strategies clearly show that environmental interventions at all levels can be carried out with the intention of HIV prevention among individuals in the population.

"…The exciting work, to me, became those socio-ecological issues. While the work of the other committees was professionally completed and spurred healthy debate, the socio-ecological issues generated the WOW energy." – TxCPG Member

The introduction of the socio-ecological model provided a framework for the ATC to explore important issues that had been identified. Through the lens of the socio-ecological model, the ATC was able to look at the context for HIV risk behavior. The focus moved beyond individual- and group-level Evidence-Based Interventions (EBIs) to interventions at higher levels. By directing attention to environmental levels, TxCPG will reach more people at different levels of influence, and thus increase the impact of HIV prevention in Texas. At the same time, TxCPG will not abandon individual- and group-level interventions, but views these interventions as requiring environmental changes to facilitate and support the intended behavioral impacts.

FIGURE 2. SOCIO-ECOLOGICAL MODEL OF HIV PREVENTION



Adapted from Poundstone, K., Strathdee, S., & Celentano, D. (2004). The social epidemiology of human immunodeficiency virus/acquired immunodeficiency syndrome. *Epidemiologic Reviews, 26*(1), 22-35.

TABLE 1. A SOCIO-ECOLOGICAL APPROACH TO HIV PREVENTION

Ecological Level	Strategy	Description	Example
Individual	Program → individual	Strategies aimed at building individuals' competencies, knowledge, beliefs, attitudes, or values	A Data- and Evidence-Based Intervention such as Sista A campaign aimed at increasing knowledge
	Program → (individual – individual)	Establishment of relationships among individuals to have them share ways to restore or promote their own health	Out Youth provides activities and a place to promote supportive relationships among gay youth
Interpersonal	Program → (groups) → individual	Strategies aimed at modifying the individual's interpersonal environment (other people and small groups who regularly interact with the individual)	PFLAG supports parents to provide a safe and loving environment for their lesbian and gay youth
	Program → (groups-groups) → individual	Establishment of relationships among members of the individual's interpersonal environment to have them share ways to restore or promote individuals' health	Establishing support groups of partners of HIV+ women
Organizational	Program→ organization→ individual	Organizational change programs aiming to modify health-compromising aspects of an organization Training programs to increase health-promotion-relevant competencies of important actors in organizations Creation of a new organization	Working with school districts to establish policies related to discussion of harm-reduction approaches A training program aimed at increasing health care providers skills in talking about HIV
	Program → (organization-organization) →	Establishment of relationships between organizations devoted to (or interested in) a	Establishing an HIV prevention coalition in a city

Ecological Level	Strategy	Description	Example
	individual	specific health issue	
Community	Program → community → individual	Training programs to increase health-promotion-relevant competencies of a community's representatives	Training hospital administrators, medical directors, and laboratory heads to carry out routine testing in health care (e.g., TestTexas)
	Program →(community-community) → individual	Establishment of relationships between communities to promote health	Developing a coalition between communities to share resources to promote HIV prevention
Public policy	Program → political system → individual	Programs aimed at influencing political representatives to make policy change on a health-related issue	Lobbying to get routine testing for HIV in health care facilities mandated
	Program → (political system-political system) → individual	Establishment of relationships between political systems with the objective of improving the health of a given targeted population	State and local governments work together to increase funding for HIV programs

Adapted from Quinn LA, Thompson SJ, Ott MK. Application of the social ecological model in folic acid public health initiatives. *Journal of Obstetric, Gynecologic, & Neonatal Nursing.* 2005;34(6):672-681.

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3.2 APPLICATION OF THE SOCIO-ECOLOGICAL FRAMEWORK: ACTION BRIEFS

The ATC categorized the wide-ranging themes identified throughout the planning processes, and explored recommendations at each level of the socio-ecological model. After extensive consideration and the recognition that there are many relevant topics, the committee selected the following subject areas to analyze through the lens of the socio-ecological model. These areas cut across all priority populations and others affected by HIV/AIDS.

- Advocacy and Policy
- Stigma
- Healthcare
- Criminal Justice
- Mental Health
- Substance Use
- Education (Kindergarten through 12th Grade)
- Faith-based Communities

Over the course of several meetings, the ATC committee discussed recommendations in each topic area at every level of the socio-ecological model, and the entire TxCPG participated in a subsequent exercise to complete the recommendations.

The final product of this research and analysis is the following Action Briefs. The briefs enable users of the plan to find TxCPG recommendations on their subject of interest. Each brief recommends actions for specific stakeholders and the anticipated benefits of taking action. TxCPG recognizes that the settings and topics covered by the Action Briefs are not exhaustive and have been discussed only as they relate to Texas. This process helped TxCPG and DSHS envision prevention on a national level, which was later described in the National Strategy.

ACTION BRIEF: ADVOCACY AND POLICY

Texas HIV/STD Prevention Community Planning Group (TxCPG)

Changing the behavior of the individual often means changing the context in which the behavior occurs. This Action Brief contains individual, organizational, and community-level recommendations related to policy that TxCPG has determined will have the greatest impact on preventing HIV/STD in Texas. This list may serve as a springboard for identifying other potential actions.

HIV/STD Prevention efforts in Texas will be more successful if state, community, and organizational policies support interventions and environments that facilitate HIV/STD risk-reduction behaviors.

Policy has consequences that affect the spread of HIV/STD. For instance, routine opt-out prenatal HIV screening and subsequent anti-retroviral therapy for women has dramatically decreased the number of infected babies born to HIV-positive women[1]. To achieve comparable success, TxCPG supports advocacy at every level to advance policies and laws that have proven effectiveness for HIV/STD prevention.

RECOMMENDATIONS

Advocate for age-appropriate, accurate, and effective health education from childhood through adulthood.

TxCPG encourages HIV/STD stakeholders to work together with schools, treatment centers, correctional facilities, and other organizations to advocate for education impacting HIV/STD risk behaviors. Providing information about HIV/STD, sexuality, and substance use may reduce risk behaviors, number of sexual partners, and STD infections. Common characteristics of effective programs include clear goals focused on STD and/or pregnancy prevention, specific discussions of risk behaviors related to the goals, and attention to multiple behavioral determinants associated with the risk behaviors of interest[2].

Support and develop public policies associated with safer sexual and drug using practices.

TxCPG encourages HIV/STD stakeholders to support and advocate for policies such as those that recognize relationships for same-sex couples, prohibit hate crimes, and permit needle exchange. Such policies may reduce stigma, which is associated with risky behaviors[3]. Needle exchange programs have been found to be associated with lower levels of sero-prevalence in cities[4] and lower levels of repeat needle use[5].

Solicit the support of political leaders for HIV/STD prevention, as outlined in the National HIV/AIDS Strategy[6].

TxCPG recommends that HIV/STD stakeholders seek commitments for program funding from current lawmakers and elect HIV/STD prevention advocates at all levels of government. Strong advocates for HIV/STD prevention may lead efforts to address the causes and consequences of HIV infection through the funding of appropriate program initiatives.

Support policies of collaboration among all stakeholders capable of contributing to prevention efforts.

TxCPG encourages state and local governmental agencies, the legal and law enforcement community, and service-oriented HIV/AIDS groups and planning bodies to collaborate on HIV/STD prevention activities. A comprehensive, coordinated approach to prevention, as outlined in the National HIV/AIDS Strategy, will require cooperation in both planning and service delivery. Collaborative planning and execution of programming could lead to more efficient and effective use of HIV/STD prevention resources.

Support community and media HIV awareness and testing events.

Large events, such as Hip Hop 4 HIV, World AIDS Day, and the various National HIV/AIDS awareness days provide opportunities to educate the public about HIV/STD issues. TxCPG encourages media coverage of these events, of HIV/STD issues in general, and of community HIV/STD prevention activities. Hip Hop 4 HIV in Houston alone resulted in over 15,000 tests being given in one year[7].

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ACTION BRIEF: STIGMA

Texas HIV/STD Prevention Community Planning Group (TxCPG)

Changing the behavior of the individual often means changing the context in which the behavior occurs. This Action Brief contains individual, organizational, and community-level recommendations related to stigma that TxCPG has determined will have the greatest impact on preventing HIV/STD in Texas. This list may serve as a springboard for identifying other potential actions.

HIV/STD prevention will be more successful if stigma is ended for high-risk individuals at their schools, where they play or work, and where they receive medical care.

Stigma has been associated with depression, risk behavior, delays in HIV testing, failure to access services, failure to begin and maintain treatment, and hate crimes and other violence, all of which are related to HIV transmission and health[1]. Stigma is "an undesired differentness"[2] that reduces the bearer "in our minds from a whole and usual person to a tainted, discounted one"[2] and results in social exclusion[3]. Four types of stigma have been identified: public stigma (prejudice), self-stigma (e.g., internalized homophobia), stigma-by-association (from friends, health care providers, caregivers), and institutional stigma (legitimization of stigma by government and other social institutions and ideologies)[4]. Stigma is a social and cultural phenomenon that upholds the existing social order[5]. Racism, sexism, and poverty facilitate stigmatization[6].

Recommendations:

Implement anti-bullying programs and comprehensive health education in Texas schools.
Ignoring or stigmatizing LGBT youth can contribute to homophobic attitudes and a hostile school environment. Ninety-two percent of LGBT middle and high school students report often hearing homophobic remarks from students and/or staff; 84% are verbally harassed because of their sexual orientation; and 64% feel unsafe at school[7]. TxCPG calls upon school districts to adopt well-evaluated sexuality curricula and ensure that LGBT youth are in a safe environment. Sexual orientation is rarely discussed in most curricula used in Texas[8].

Repeal laws and policies that contribute to stigma and discrimination.
Many laws directly contribute to the stigmatization and discrimination of at-risk groups, thereby contributing to the harassment and status loss of HIV/STD-infected people and the populations that are at greatest risk for becoming infected[5]. For example, TxCPG recommends that state representatives follow the lead of the federal government, which

lifted the ban on needle exchange programs in 2009[9]. Involvement in advocacy by stigmatized communities and others related to them is empowering and reduces public stigma, self-stigma, and stigma-by-association[4].

Decrease public stigma related to HIV and STDs.
TxCPG recommends that the Centers for Disease Control and Prevention (CDC), the Texas Department of State Health Services (DSHS), and HIV/AIDS and LGBT organizations provide multi-level (individual, interpersonal, community, and policy) and multi-faceted interventions that address the range of stigmatizing conditions related to HIV (including homosexuality, IV drug use, promiscuity, and commercial sex work). Examples of environmental-level strategies include care and support, social marketing, mass media, policy development, legal interventions, and rights-based approaches[6]. Mass media and social marketing campaigns can be conducted using local role models and spokespersons from the at-risk population.

Reduce stigmatizing processes in government, health care, religious institutions, the judicial and criminal justice systems, and education.
TxCPG calls upon elected officials, health care providers, leaders in faith communities, law-enforcement officials, and education officials to provide a welcoming environment for all individuals, regardless of their sexual orientation, gender identity, sexual promiscuity, HIV status, and other common targets of stigma. Stigma and discrimination are perpetuated in all of our institutions, though advances have been made in recent years, particularly through judicial and policy interventions[5].

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ACTION BRIEF: HEALTHCARE

Texas HIV/STD Prevention Community Planning Group (TxCPG)

Changing the behavior of the individual often means changing the context in which the behavior occurs. This Action Brief contains individual, organizational, and community-level recommendations related to healthcare that TxCPG has determined will have the greatest impact on preventing HIV/STD in Texas. This list may serve as a springboard for identifying other potential actions.

HIV/STD Prevention efforts in Texas will be more successful if infections are detected early and treatment is offered promptly in the course of an HIV/STD infection.

Advances in medical care enable people with HIV to stay healthy and survive longer than ever before. Linking people with HIV and other STDs to care and treatment early in the course of infection helps ensure the best possible treatment outcome and helps prevent the further spread of disease.

RECOMMENDATIONS

Educate individuals at increased risk for HIV infection on the importance of getting tested regularly.
TxCPG encourages HIV/STD agencies to work together with public and private healthcare providers to ensure that high-risk clients and patients understand the importance of testing for HIV at least annually. In social networks with elevated rates of HIV, each risk behavior has a higher probability of transmitting HIV. Regular testing can help identify new cases of HIV and other STDs sooner, providing timely linkage to care and opportunities to prevent the further spread of HIV and other STDs. All other adults and adolescents ages 13-64 should be encouraged to test for HIV at least once in their lifetime and whenever their individual HIV-related risk behavior changes[1].

Reduce the number of HIV-positive persons in Texas diagnosed with AIDS within one year of their initial HIV diagnosis.
TxCPG encourages local HIV/STD agencies to work with public and private healthcare providers to reduce the number of late HIV diagnoses across the state through routine and targeted testing. Texas Department of State Health Services (DSHS) surveillance data show that one in three Texans with HIV receive an AIDS diagnosis within one year of their HIV diagnosis[2]. This means many Texans are infected for many years without the knowledge that triggers behavior change, and without the treatment that could lower viral load and reduce transmission.

Reduce community viral load by ensuring prompt, coordinated treatment for HIV-positive persons upon diagnosis.
TxCPG recommends that HIV/STD healthcare stakeholders improve interventions designed to promptly get newly diagnosed HIV-positive persons into care, as a means of reducing community viral load in Texas. Community viral load is the average viral load of HIV positive persons in a specific population. Reduced community viral load has been associated with a reduction in the number of newly reported HIV cases[3]. Persons living with HIV are less likely to transmit the infection to others if they are on effective treatment that lowers the amount of the virus in their systems.

Educate HIV-positive individuals and associated providers on the importance of remaining in care.
TxCPG recommends that HIV/STD stakeholders in Texas work together to educate HIV-positive individuals and medical and social service providers about the importance of remaining in care. Consistency of care for HIV-positive persons is essential to slowing the progression of HIV, maintaining treatment adherence, and reducing the likelihood of antiretroviral resistance. Educational efforts should be coupled with active engagement by local service providers and coordinated inter-agency communication to help ensure availability of comprehensive medical, behavioral, biomedical, and structural services for HIV-positive individuals.

Provide technical assistance to healthcare providers on the logistics of implementing a routine HIV testing program.
TxCPG encourages HIV/STD stakeholders in Texas to work with DSHS, local health departments, hospitals, private health care providers, and health-related professional associations to extend the adoption of Centers for Disease Control and Prevention (CDC) recommendations for routine testing in medical settings across the state. Technical assistance, such as screening costs, reimbursement, and benefits of early diagnosis will ensure the effective implementation of routine testing.

Ensure continuity of care for HIV-positive persons newly released from incarceration.
TxCPG encourages the Texas Department of Criminal Justice and county jails to work with DSHS, local health departments, and community-based HIV/STD agencies to provide seamless access to health and associated social services for the newly released. Appropriate intake and discharge planning is essential to ensuring that benefits of antiretroviral treatment are not lost in the transition from incarceration to Texas communities[4].

Reduce stigma and discrimination in healthcare settings.
TxCPG encourages Texas healthcare providers and policymakers to make tangible investments in the reduction of stigma and discrimination against persons living with HIV and their respective communities at the individual, organizational, and social policy levels. The World Health Organization cites fear of stigma and discrimination as the main reason

why people are reluctant to test for HIV, disclose status, or take antiretroviral medications[5]. This reluctance to access care contributes to the expansion of the HIV epidemic in Texas through missed opportunities for early diagnosis and prevention of secondary transmission.

Expand STD intervention efforts in high morbidity areas.
TxCPG encourages Texas health providers to expand STD testing and treatment in high morbidity areas by adopting expedited partner therapy (EPT) for partners of patients with gonorrhea and/or chlamydia and encouraging clients to use local health department partner services programs in HIV and early syphilis cases. Both clinical and behavioral outcomes of the available studies indicate that EPT is a useful option to facilitate partner management among heterosexual men and women with chlamydia or gonorrhea[6]. Enhanced coordination between public and private health providers is critical to stemming the transmission of STDs.

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ACTION BRIEF: CRIMINAL JUSTICE

Texas HIV/STD Prevention Community Planning Group (TxCPG)

Changing the behavior of the individual often means changing the context in which the behavior occurs. This Action Brief contains individual, organizational, and community-level recommendations related to criminal justice that TxCPG has determined will have the greatest impact on preventing HIV/STD in Texas. This list may serve as a springboard for identifying other potential actions.

HIV/STD Prevention efforts in Texas will be more successful if offenders have access to needed care and services and the opportunity to successfully transition from incarceration to the community.

Correctional health is public health with the potential to reach many people. The Texas Department of Criminal Justice (TDCJ) houses, on average, over 160,000 inmates[1]. Every year, TDCJ receives over 70,000 offenders and releases over 70,000 ex-offenders into communities all across the state[1]. The HIV rate is fifteen times higher among TDCJ offenders than the general population in Texas[2]. The correctional systems offer potential for HIV prevention. In order to reduce HIV/STD transmission inside and outside of correctional facilities, TxCPG supports improvements at every level in the systems of prevention and care on both the inside and outside.

RECOMMENDATIONS

Empower correctional staff to effectively interact with HIV-positive offenders.
TxCPG encourages TDCJ to provide ongoing training of correctional staff to reduce the stigma of HIV-positive offenders and increase staff HIV-related competencies. While incarcerated, stigma can deter offenders from getting tested, as they wish to avoid the possibility of testing positive and having their status known by others[3]. Similarly, offenders may avoid seeking information about HIV prevention because it may raise suspicion about engagement in forbidden activities (such as sex and drug use)[3].

Expand access to substance abuse treatment and mental health care in all correctional facilities.
TxCPG encourages elected officials, TDCJ, and other stakeholders to ensure that substance abuse treatment and mental health care programs are available in all correctional facilities. According to the Bureau of Justice Statistics (BJS) and the National Center on Addiction and Substance Abuse (CASA), an estimated 60% to 83% of incarcerated individuals have used drugs, compared to the general U.S. population (40%)[4]. In order to reduce the revolving door between incarceration and the community, offenders need effective mental health

care and substance abuse treatment while incarcerated. TxCPG also supports the continued improvement of systems that provide linkages to care from incarceration to the community.

Provide health care and support services to incarcerated HIV-positive individuals.
TxCPG encourages elected officials, TDCJ, and other stakeholders to ensure the provision of medical care and support services to HIV-positive individuals in state correctional facilities. When offenders living with HIV are released, prison HIV issues become community HIV issues. About 8% of HIV-infected persons are incarcerated, and about 25% of all the people in the United States who have HIV/AIDS pass through a correctional facility in a year[5, 6].

Provide prevention education in state jails and prisons.
TxCPG encourages elected officials, TDCJ, and other stakeholders to ensure that HIV/STD prevention education is provided to incarcerated individuals. In addition to condom distribution and peer education, prevention education includes encouraging HIV-positive individuals to avoid re-infection, avoid infecting others, and guard against contracting additional STDs. In spite of rules in correctional facilities, offenders engage in high-risk behaviors while incarcerated, and research suggests that, upon release, these individuals may be more likely to engage in risky behaviors[3]. Correctional facilities provide an ideal opportunity to reach individuals who may otherwise be disconnected from health systems[3]. Providing prevention education to offenders is in the interest of public health.

Increase educational and job opportunities for ex-offenders returning to the community.
TxCPG calls for state and local officials, community-based organizations, and other stakeholders to provide incentives and support to agencies and businesses that provide job training, employment, education, or housing assistance to recently released individuals. On average, TDCJ offenders have an educational achievement level of 7th grade[1]. The unemployment rate among this population is estimated to be between 20% and 40%[7]. Without the opportunity to gain legal employment, ex-offenders are more likely to seek illegal sources of income, and may well be re-incarcerated[7]. Strategies to assist in securing employment for ex-offenders include expansion of federal bonding programs, which offer tax credits to employers, and increasing the number of community-based agencies that facilitate the hiring process by assisting the employer and the ex-offender[7]. Providing more support to ex-offenders upon release will have a direct effect on reducing behaviors that put them at risk for recidivism and high-risk behaviors.

Increase family involvement for ex-offenders.
TxCPG encourages community-based organizations, faith-based organizations, and other stakeholders to develop programs that help families support ex-offenders who return home. Research indicates that family involvement is instrumental in preventing recidivism, and when families have access to support services, the rates of physical and mental health problems, drug use, and re-incarceration are reduced[8]. In 1996, the United States

Commission on Human Rights stated, “Prisoners are the community. They came from the community, they return to it. Protection of prisoners is protection of our communities.”[6]

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ACTION BRIEF: MENTAL HEALTH

Texas HIV/STD Prevention Community Planning Group (TxCPG)

Changing the behavior of the individual often means changing the context in which the behavior occurs. This Action Brief contains individual, organizational, and community-level recommendations related to mental health that TxCPG has determined will have the greatest impact on preventing HIV/STD in Texas. This list may serve as a springboard for identifying other potential actions.

HIV/STD prevention efforts in Texas will be more successful if mental health issues are addressed for both HIV-negative and positive individuals. The decision to engage in risky sexual or drug behavior is often linked to mental health issues and past experiences of abuse and trauma. People with HIV are more likely to experience mental health problems than people in the general population. Mental health issues may also interfere with an individual's engagement in diagnosis and treatment[1].

RECOMMENDATIONS

Provide or secure broad-based ongoing training on mental health issues for HIV workers and HIV issues for mental health workers.
Prevention staff members do not need to be experts on mental health; however, training on common signs and symptoms will help staff recognize when to refer to a mental health resource. Similarly, specialized training on how to elicit a sexual history and information on sexual risk taking is also needed for mental health workers [2]. Training would also help all staff maintain ethical boundaries.

Institute the use of validated screening tools for mental health issues.
This recommendation pertains specifically to staff members who work with clients over time, such as Comprehensive Risk Counseling and Services (CRCS). Knowledge of how to use tools for common mental health issues, such as depression and anxiety, can help HIV prevention workers know when to refer and may assist in understanding issues driving client risk behavior. Early detection of mental health issues would likely offset the cost of increased medical costs that often occur as a result of mental health issues[1]. In particular, both mental health and HIV workers should learn to screen for interpersonal violence among gay and bisexual men[3].

Implement HIV risk-reduction programs in mental health settings.
Small-group HIV prevention interventions in mental health settings have been effective in reducing sexual risk behaviors[4].

Create and implement a policy on harm to self and others.
Prevention staff may interact with clients in differing states of psychological distress. Each agency needs a policy and ongoing training on the correct steps to take in situations in which staff suspect impending client self-harm or harm to others.

Establish relationships with mental health professionals or agencies.
Identifying referral resources for clients needing support and assistance with a mental health issue is important for modifying risk behaviors. Keeping in mind the resources of the target population, agencies need to establish systems with local mental health professionals.

Implement intervention components that promote pride in cultural background.
Positive self-image and resilience are important to the whole health of the individual. Agencies need to include this type of prevention interventions.

Facilitate social support for Persons Living with HIV and AIDS (PLWHA).
Social support positively impacts mental health for PLWHA[5]. Communities can support drop-in centers or open houses where individuals can meet each other and provide support.

Individualize risk-reduction plans.
Condom access is an important structural intervention; however, risk-reduction plans must be individualized. A risk-reduction plan focusing on condom use may not be appropriate for persons with undiagnosed underlying mental health issues.

Support positive messages about gay men.
Homophobia is a culture-wide phenomenon and agencies should combat stigma wherever they find it. The extent to which an individual internalizes harmful messages can heighten marginalization and translate into increased levels of mental health problems and risk for HIV/STD[6].

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ACTION BRIEF: SUBSTANCE USE

Texas HIV/STD Prevention Community Planning Group (TxCPG)

Changing the behavior of the individual often means changing the context in which the behavior occurs. This Action Brief contains individual, organizational, and community-level recommendations related to substance abuse that TxCPG has determined will have the greatest impact on preventing HIV/STD in Texas. This list may serve as a springboard for identifying other potential actions.

HIV/STD prevention efforts will be more successful in Texas if HIV prevention services are integrated with substance abuse prevention and treatment programs. A range of conditions occur among drug users; for those with HIV infection, psychiatric disorders and drug and alcohol use may have adverse effects on the use of health services, may increase unsafe sexual behaviors and needle sharing behaviors, and may complicate adherence to medical regimens, such as antiretroviral therapy[1-5].

The 2007-2008 National Surveys on Drug Use and Health estimated that 6.3% of the Texas population age 12 and older had used an illicit drug in the past month, and 2.7% of Texans were dependent on or abused an illicit drug in the past year. With the population of Texas estimated to be 25,373,947 in 2010, that would mean 687,634 Texans were affected by drug use in the past year—yet only a small fraction enter treatment[6, 7]. Prevention programs have demonstrated effectiveness since they have been crafted specifically to target prevention factors and risk factors[8].

RECOMMENDATIONS

Support routine HIV screening for substance users.
TxCPG encourages substance abuse prevention and treatment services to adopt routine HIV screening and plan for the identification of HIV-positive individuals. Federal agencies recommend that HIV prevention services be integrated into substance abuse treatment programs. The National Institute on Drug Abuse core principles of effective drug treatment indicate that treatment programs should assess for HIV/AIDS. At the 2009 National Prevention Conference in Atlanta, Georgia, delegates from Substance Abuse and Mental Health Services Administration (SAMHSA) and from the Centers for Disease Control and Prevention (CDC) discussed efforts to better integrate services for drug users. Efforts include routine HIV screening for substance users and the Center for Substance Abuse Treatment's requirement that its grantees test a minimum of 80% of their clients for HIV[9].

Support community-based outreach to reduce substance abuse and relapse.
TxCPG supports capacity-building and working with community-based stakeholders to reduce substance abuse. Community-based outreach is an effective strategy for reaching and influencing drug-using populations. A significant proportion of drug users in community-based outreach interventions enter drug treatment, stop, or reduce their frequency of use[10]. In addition, community-based organizations play an active role and become strong advocates in improving their community's quality of health.

Integrate HIV prevention intervention with substance abuse treatment.
HIV infection from substance use remains among the three most frequent modes of transmission of HIV disease[11]. In Texas, 13% of new infections in 2007 resulted from injecting drug use. Drug sharing and sexual networks frequently overlap[12]; for a proportion of female intravenous drug users, for example, trading sex for drugs or money has been found to be associated independently with HIV infection[13]. Substance abuse treatment and HIV prevention intervention have effectively helped individuals to reduce transmission behaviors upon HIV diagnosis, and share needles and syringes primarily within restricted social networks[14].

Support linkages among agencies for seamless care for the HIV-positive individual.
Substance abuse treatment programs are a unique aspect of the health care system and a critical point of access to health care and adherence to treatment for HIV-positive substance abusers[15]. Procedures for discharge planning must consider an HIV-positive diagnosis and linkages to care. There is wide recognition of the tangible benefits of integrating services for substance use, mental health, and primary care[16]. Integration of services for individuals with co-morbidities benefits patients, medical and mental health providers, addiction clinicians, and society at large. Patients receive improved care, providers are better equipped to formulate different diagnoses, and costs are contained by avoiding duplication of services[17]. Moreover, the benefits of integrating services may be particularly important now that HIV is a chronic illness with which co-morbid psychiatric conditions are common[4].

Provide HIV prevention education to health care personnel.
Health personnel may need additional training and resources to provide support to substance abuse clients at particular milestones in the disease progression: 1) the decision to be tested and waiting for results; 2) receiving results; 3) developing the first symptoms of HIV disease; 4) being diagnosed with AIDS [18-20].

View substance abuse treatment clinics as an opportunity to influence HIV prevention behaviors of individuals.
Over the past 20 years, research has demonstrated positive associations between substance abuse treatment, reductions in those behaviors that lead to HIV transmission, and increased protection from HIV infection. In short, those in substance abuse treatment programs are more likely to avoid infection than those who are not[21-23]. HIV testing and counseling tailored to substance use and HIV in this setting will provide increased protection for clients.

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ACTION BRIEF: EDUCATION (KINDERGARTEN THROUGH 12TH GRADE)

Texas HIV/STD Prevention Community Planning Group (TxCPG)

Changing the behavior of the individual often means changing the context in which the behavior occurs. This Action Brief contains individual, organizational, and community-level recommendations related to education (K–12) that TxCPG has determined will have the greatest impact on preventing HIV/STD in Texas. This list may serve as a springboard for identifying other potential actions.

HIV/STD prevention efforts in Texas will be more successful if HIV/STD prevention knowledge and skills are imparted to teachers, parents, caregivers, and youth.

Educating youth about health and human sexual development is an important part of the responsibility of parents and teachers. School-based comprehensive sexuality education can add to the education of young people. Parents and teachers need information, tools, opportunities, and support from a system that encourages open, honest discussion[1].

RECOMMENDATIONS

Recognize and provide science-based, age-appropriate health education as an integral part of overall child development.
Health education curricula can teach youth to make healthy choices in many aspects of their lives, including drug and alcohol avoidance, proper nutrition, exercise, and how to create healthy relationships and prevent pregnancy, STDs, and HIV infection[2].

Work with School Health Advisory Councils (SHACs) to create and implement age-appropriate, sequential sexual health education programs, and early intervention and prevention strategies that can be supported by local families and community stakeholders[3].
Appropriate sexuality education can give young people the opportunity to receive information, examine their values, and learn relationship skills that will enable them to resist becoming sexually active before they are ready; prevent unprotected sexual intercourse; avoid exposure to STDs and HIV; and help young people become responsible, sexually healthy adults.

Provide educators with relevant, up-to-date, and science-based information about HIV prevention.
TxCPG calls upon the Centers for Disease Control and Prevention (CDC), the Texas Department of State Health Services, the Texas Education Agency, AIDS service organizations, LGBT organizations, and education officials to provide training and disseminate relevant, accurate, and up-to-date information to Texas educators. According to the CDC, only 40% of the lead health educators in Texas received professional development during the two years prior to being surveyed on HIV prevention[4]. Educators need access to current research, accurate information, resources, and skills training. If we do not properly equip our educators, HIV/STD prevention and education will not be successful.

Strengthen the capacity of parents and caregivers by providing up-to-date and accurate information related to sexuality education and HIV prevention.
Young people who talk with their parents about sexuality are more likely to delay having sex and more likely to make healthier decisions about sexual behavior and risk-taking[5]. Yet most parents do not believe they are the most influential source of information. Despite having the best intentions and opportunities, parents may be infrequent and inadequate sexuality educators for their children. The reasons may include lack of information, parental inhibitions, communication misunderstandings, procrastination, and lack of knowledge. When a community provides resources, parent support groups, parental lifestyle education, and sexuality education, this can increase parental confidence and strengthen their ability to initiate important HIV prevention conversations [6-10].

Create advocacy, policy, and research resources for parents, caregivers, and educators.
Being an effective advocate requires skills, access to information, and support. TxCPG recommends that resources, support groups, and training are developed for advocacy concerning effective sexuality education.

Create school communities that minimize bullying behaviors and violence.
TxCPG recommends linkages between organizations and schools to foster school communities that support sexual minority students. TxCPG supports the Texas Education Agency's website on resources to stop bullying for youth, parents, caregivers, and legislators: http://www.tea.state.tx.us/index2.aspx?id=2822#bullying.

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ACTION BRIEF: FAITH-BASED COMMUNITIES

Texas HIV/STD Prevention Community Planning Group (TxCPG)

Changing the behavior of the individual often means changing the context in which the behavior occurs. This Action Brief contains individual, organizational, and community-level recommendations related to faith-based communities that the TxCPG has determined will have the greatest impact on preventing HIV and STDs in Texas. HIV/STD prevention efforts will be more successful in partnership with faith-based communities.

Faith-based institutions have long played a central role in the lives of many Texans[1]. Public health research has shown that "improving the health of a community involves activating local organizations, groups, and individuals to cause changes in behavior or in rules or policies that influence health."[1] Faith-based communities are in many ways ideal for HIV prevention efforts, as they feature strong social networks, trust in leadership, and a history of collaborating with public health workers[1, 2]. TxCPG encourages the involvement of faith-based communities in HIV/STD prevention in Texas.

RECOMMENDATIONS

Provide factual health information to faith communities.

TxCPG calls for public health workers and members of the faith community to work together to provide factual health information in faith-based communities. TxCPG suggests that local faith communities locate resources and initiatives, such as those funded by the Centers for Disease Control and Prevention [2, 3] that offer HIV/STD education and training for faith leaders. In Texas, no provider specifically offers capacity-building assistance to faith-based communities or provides capacity-building assistance to organizations working with faith based organizations.

Reduce stigma.

TxCPG encourages faith leaders and communities to use teachable moments, like the National Week of Prayer for the Healing of AIDS, to spread awareness and reduce stigma[4]. "AIDS-related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS. They can result in being shunned by family, peers and the wider community; poor treatment in healthcare and education settings; an erosion of rights; psychological damage; and can negatively affect the success of HIV testing and treatment."[5] TxCPG calls for leaders of faith communities to encourage compassion towards all people living with HIV/STDs or those

who put themselves at risk for acquiring HIV/STDs. Faith leaders can, for example, highlight theological reasons for compassion, or they can lead by example by talking openly about relevant prevention issues[2, 4]. By a leader simply framing the problem as *our* problem, the issue becomes one of community health rather than individual morality.

Increase collaboration between faith communities and public health entities.

TxCPG encourages faith communities and public health stakeholders to collaborate on prevention efforts. Faith-based health activities typically involve health screening, health promotion, disease prevention events, and risk-reduction programs[1].

Encourage congregations to test regularly for HIV/STDs and to proactively seek treatment when necessary.

Faith-based communities can empower a community by, for example, communicating the importance of testing and treatment as a way to lower its community viral load (the average viral load of HIV-positive persons in a specific population), which has been shown to decrease HIV transmission in that population[6]. Persons living with HIV are less likely to transmit the infection to others if they are on effective treatment that lowers the amount of the virus in their systems. Public health workers from local health departments, clinics, AIDS service organizations, or the Centers for Disease Control and Prevention can provide faith communities with HIV/STD awareness information, including the rates of HIV in their communities, and access to HIV/STD testing and treatment.

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3.3 CROSS-CUTTING PREVENTION STRATEGIES

The Texas HIV/STD Prevention Community Planning Group (TxCPG) and the Texas Department of State Health Services (DSHS) have identified six cross-cutting prevention strategies that apply across all priority populations. These strategies form the foundation of HIV/STD prevention in Texas. Each strategy works towards achieving the Texas HIV/STD Prevention Plan objectives:

- Reduce undiagnosed HIV and STD infections
- Ensure availability of prompt HIV/STD treatment upon diagnosis
- Promote behavior change among high-risk populations
- Increase the urgency and priority of HIV prevention

EXPANDED AND TARGETED HIV TESTING

In 2006, the Centers for Disease Control and Prevention (CDC) recommended screening patients ages 13 – 64 years for HIV infection in health care settings that have a prevalence of undiagnosed infection greater than or equal to 0.1%. Subsequent to release of the screening recommendations, the CDC initiated funding for Expanded HIV Testing through 25 health departments to facilitate HIV screening and increase diagnosis of HIV infection. This effort was focused in areas that have populations that are disproportionately affected by HIV, especially non-Hispanic Blacks. Another critical aspect to this effort is linking identified HIV-positive individuals to medical care, treatment including Highly Active Antiretroviral Therapy (HAART), and access to prevention services as soon after HIV infection as possible[1].

The strategy is to create an atmosphere where HIV testing is a routine part of medical care and access points are available throughout a community. Access points include emergency departments, inpatient medical units, urgent care clinics, STD clinics, correctional health facilities, substance abuse treatment centers, tuberculosis clinics, community health centers, and community-based organizations[1].

LINKAGE TO CARE AND TREATMENT

On May 12, 2011, the National Institute of Allergy and Infectious Disease issued a press release. The clinical trial known as HPTN 052 ended early and findings were issued. An independent data and safety monitoring board (DSMB) found a clear relationship

between the use of antiretroviral medication by an HIV-positive individual with a relatively health immune system and a substantial reduction of transmission to their partners. These results are the first to indicate that treating an HIV-infected individual can reduce risk of sexual transmission of HIV to an uninfected partner. These findings leave little doubt that treatment is critical in preventing HIV transmission[2]. Therefore, a crucial prevention strategy is ensuring newly diagnosed individuals are linked to medical care and enrolled in treatment. Furthermore, this gives cause for both HIV prevention and HIV care organizations to seek out those individuals who know they are HIV-positive and have never received treatment or have dropped out of HIV treatment.

The strategy is to engage and maintain HIV-positive individuals in treatment. There are various models of engagement. Ryan White services support maintenance in care through the use of support services, such as medical and social service case management; early intervention services; and transportation and medication assistance programs. In the end, the relationships with the health care provider, social and family support, and positive outcomes to medication therapy strengthen an individual's desire to stay in treatment[3].

ACCESS TO CONDOMS

Condoms, whether male or female, allow individuals to reduce their risk of HIV and STD. When used consistently and properly, condoms are highly effective[4]. The strategy is to increase promotion of male and female condoms, increase distribution, and ensure access to condoms. Condom promotion should take place across multiple levels of intervention.

The strategy is to ensure access to both male and female condoms throughout communities. More importantly, identified priority populations and other high-risk groups need targeted, substantially increased distribution, promotion, and access efforts[5].

ACCESS TO CLEAN NEEDLES

Like condoms, access to clean needles reduces the transmission of bloodborne disease and can effectively avert transmission of HIV[6]. The sharing of contaminated syringes is the principal mode of transmission among injection drug users (IDU). The primary reason for sharing is a lack of legal access to new, uncontaminated needles[7]. Studies have shown that offering an alternative to needle-sharing within an IDU community can help contain the transmission and acquisition of HIV. There is clear evidence that syringe exchange programs (SEP) have reduced HIV transmission rates among IDU in areas where they have been established[8]. The World Health Organization released a

2004 report reviewing the effectiveness of needle exchange programs in many countries. This report examined whether or not these exchange programs promoted or prolonged illicit drug use. The results provided convincing evidence that needle exchange programs significantly reduce HIV infection *with no evidence that drug use is encouraged*[9]. Decreases in needle-sharing by IDU and in needle stick injuries among first responders have been documented following the implementation of SEP[10].

SEP is a proven public health intervention that interrupts the transmission of disease. Removing legal barriers to obtaining clean needles significantly reduces the number of new cases of HIV and viral hepatitis[10]. IDU are likely to be poor and uninsured or underinsured, so their medical costs are disproportionately borne by the state and local indigent care systems. As such, these systems would greatly benefit from averted infections.

In Texas, efforts to pass legislation for an SEP have consistently met resistance.

PARTNER SERVICES AND PUBLIC HEALTH FOLLOW-UP

Disease intervention and partner services are core public health activities. The goal of partner services is to notify sex and needle-sharing partners of infected persons and other high-risk individuals of a possible exposure and to offer them testing and linkage to treatment as needed. Investment in public health follow-up and partner services protects communities by intervening in disease spread; promoting knowledge of status; facilitating entry into care; and providing opportunities to lower risk. These activities require coordination of state, regional, and local resources. They are particularly reliant on personnel resources at the local and regional level. Disease surveillance and specialized testing to identify recently acquired HIV infection is critical. Paired with robust partner services, this approach increases the potential of intervening before the disease is spread[11].

The strategy is to ensure community support for partner services and public health follow-up. It is important to bring culturally sensitive and competent information to communities, which may view these strategies as intrusive. Special sensitivity is needed with populations that already experience marginalization.

PERINATAL CARE

Texas has adopted universal opt-out screening for pregnant women; this requires that all pregnant women in Texas be screened for HIV[12]. Screening should occur after a woman is notified that HIV screening is recommended for all pregnant patients and that she will receive an HIV test as part of the routine panel of prenatal tests unless she

declines. No women should be tested without her knowledge and if the initial test is declined, this decision should be documented in the medical record. Women who decline the test should be encouraged to test at the subsequent prenatal care visit[13].

For patients who agree to HIV testing, a verbal notification for the HIV testing should be documented in the medical records. Prior to testing, pregnant women should receive written information that includes an explanation of HIV infection, a description of intervention that can reduce HIV transmission from mother to infant, and an explanation of positive and negative test results. Because the initial test is to promote informed and timely therapeutic intervention by health care providers for patients that test positive, the first test should take place during the first visit to a health care provider. A second HIV test for all pregnant women during the third trimester takes place during the 32^{nd} – 36^{th} week of gestation.

Finally, for those patients who have no evidence of an HIV test, labor and delivery facilities will test the patient and make results available within six hours. All women who have positive confirmatory HIV test results at delivery should be counseled regarding test results and referred to a specialist who can provide further HIV care. Appropriate antiretroviral prophylaxis should be recommended to women on the basis of positive screening test result without waiting for results of a confirmatory test, unless the patient has been previously identified to have a false-positive test or advised otherwise by an HIV specialist. Infant testing takes place less than two hours after the time of birth when the mother's HIV status is unknown or confirmed HIV-positive. Antiretroviral medication can be offered to an HIV-exposed infant within 12 hours after birth.

HIV testing for pregnant women in Texas has proved to be a successful strategy.

COMMUNITY MOBILIZATION

The goal of community mobilization is to affect behavior and bring about social change. Community mobilization involves planned actions meant to reach key segments of the community. The community mobilization process is a dynamic process[14]. It can foster collective power and sustained engagement with communities, and provides an opportunity to build social networks and social capital. Community mobilization works to engage the whole community, facilitates a process of social change, provides repeated exposure to ideas, uses a human rights framework, and promotes community ownership[15].

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4.1a POPULATION AND ASSESSMENT PROCESS

The priority populations for the plan were identified through a process driven by epidemiological evidence and enhanced by other approaches and tools used by the Populations and Assessment Committee. Early in the process, the committee decided to consider at-risk populations statewide, while deepening its understanding of the local trends and emerging issues in order to encourage appropriate, local responses to the HIV epidemic.

Over the course of several meetings, committee members received epidemiological information through presentations and documents, independently reviewed rates and trends in infections, and prioritized populations. They compared and discussed lists, made preliminary prioritized lists, and generated questions about the populations they identified. Committee members came to the committee knowledgeable about the at-risk populations, and their skills were enhanced by additional training in understanding data and conducting field observations and "reports from the field."

The processes of the committee were supported by the University of Texas at Austin HIV Research Team. As the committee developed questions about the different populations, the university research team gathered information to help the committee make its decisions. Information was generated through a variety of processes, such as:

- Literature reviews
- Interviews with key informants and individuals familiar with the research or population of interest
- Focus groups with members of the population of interest
- Field notes from events attended by the at-risk populations

These efforts assisted the committee in further identifying conditions, barriers, and issues that contribute to risk for the prioritized population in local communities.

The selected priority populations include eight main categories, plus a "special populations" category. Ranking is based on epidemiological evidence and need for testing and outreach—*not* the importance of individuals within these populations. Populations were ranked according to rates of infection, number of infected, and risk factors leading to infection. The "special populations" category contains descriptions of additional populations and social conditions that contribute to HIV transmission and acquisition. These "special populations" are not ranked by priority of population or urgency of the social condition.

4.1b PRIORITY POPULATION OVERVIEW

The following descriptions provide a brief overview of the TxCPG-identified priority populations. A more in-depth description of each population can be found in the appendix.

1. HIV-POSITIVE INDIVIDUALS

The Centers for Disease Control and Prevention (CDC) Community Planning guidelines require that community planning groups prioritize persons living with HIV/AIDS (PLWHA) above all other at-risk populations. PLWHA participating in high-risk behaviors may transmit the virus to others. Particularly at risk for transmission of the virus are newly diagnosed individuals, newly infected, or individuals who are not aware of their HIV status. Intervention with all PLWHA to reduce high-risk behaviors can slow the spread of the disease.

Undiagnosed HIV drives new infections through transmission. The CDC indicates that one in five infections is undiagnosed[1]. Once an individual is infected with HIV, five to ten years often pass without symptoms. If HIV status is unknown, an individual is more likely to transmit the disease to others, resulting in missed opportunities for prevention of new HIV infections. Moreover, early diagnosis among HIV-infected individuals allows for early medical intervention, including life-sustaining treatment and opportunity for behavior change. In Texas, from 2003 to 2007, over one quarter of all newly diagnosed individuals received an AIDS diagnosis within one month of their HIV diagnosis. One third of all newly diagnosed individuals received HIV and AIDS diagnoses within one year. This demonstrates that a substantial proportion of current PLWHA were not diagnosed until late in the progression of HIV disease[2].

Community viral load, also know as *viral burden*, is the amount of the HIV virus within a particular community or sexual network, which means the risk associated with similar sexual practices increases as community viral load increases[3]. If the sexual network has an HIV- or other STD-infected person within it, factors such as density of the network (i.e. the number of individuals and the frequency of sexual contacts among various members) and how connected the infected person is to the rest of the network impact the “pool” of infection in the sexual network[4]. Sexual networks may be small, consisting of people who live in the same geographic area, or they can be very large, consisting of sub-communities within entire cities.

Knowledge of status for individuals with HIV is crucial, as intervention and treatment among HIV-positive individuals is critical to stopping the HIV epidemic.

2. BLACK GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN (MSM)

Experiences that exacerbate risk for Black MSM include racism, homophobia, socio-economic disadvantage, dense sexual networks (characterized by small size and high frequency of overlapping sexual partners), high rates of STDs, high rates of incarceration, sexual identity issues, and a lack of HIV testing and knowledge of status[5].

Evidence suggests that Black MSM are the racial/ethnic group of MSM most likely to report bisexual behaviors, and least likely to identify as gay[5]. However, sexual identification and disclosure are not predictive of high-risk behavior. Differences in risk behavior have not been shown to explain the disparity of HIV in Black MSM in comparison to their White and Latino peers[5, 6].

Black MSM tend to have denser sexual networks than other racial/ethnic groups of MSM, as Black MSM are most likely to have same-race partners[7]. However, their number of sexual partners is no greater or less than other racial/ethnic groups of MSM[5]. Young Black MSM are more likely to have partners that are 10 or more years older than they are, and these partners are more likely to expose them to HIV/STD due to potentially longer sexual histories[7]. Additionally, Black MSM have higher rates of other STDs, making them more vulnerable to HIV infection[5]. Studies show that Black MSM are least likely to know their HIV status in comparison to other racial/ethnic groups of MSM[5].

Comparatively few evidence-based interventions exist for Black MSM[8]. Lack of cultural competency has been cited as a barrier to reaching this population[9]. Black MSM may be less likely to approach traditional AIDS service organizations due to perceived stigma of both homosexuality and HIV in their communities. Interventions must be adapted to address the totality of the Black MSM experience[10].

Black gay, bisexual, and same-gender-loving men face the largest burden of HIV/AIDS in the United States and in Texas. Research continues to investigate why this disparity exists[5]. Several studies have discredited the idea that a higher frequency of risk behaviors explains the disparity, as most scientific research shows comparable or fewer risk behaviors by Blacks in comparison to Whites and Latinos[5, 10].

Finally, over half of persons living with HIV/AIDS (PLWHA) in Texas are in the Dallas and Houston areas[2]. In both areas, Black males have some of the highest rates of HIV infection in the state: One in 27 Black men in Houston ages 35 to 44, and 1 in 32 Black men in Dallas ages 35 to 44 were living with HIV in 2007. That same year, 60% of all new cases were Black MSM[2].

The profound numbers in both incidence and prevalence of HIV/AIDS among Black MSM in Texas clearly demonstrate why this population is considered a priority.

3. ALL GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN

Specifically, MSM are at risk for HIV through unprotected anal intercourse (UAI) with an HIV-positive partner. However, for the MSM population in particular, HIV/AIDS is a life-long event. Among MSM, the probability of exposure to HIV remains high from adolescence to adulthood due to high HIV prevalence among MSM, especially in urban communities. Both Houston and Dallas have an HIV prevalence of 26%[11]. HIV risk is associated with many other issues, such as dating, sex, love, substance use, homophobia, racism, and poverty[12, 13]. Age may be a risk factor for particular cohorts of MSM. Data analyses show that Latino MSM tend to seroconvert before the age of 30, while White MSM tend to seroconvert after the age of 30[2].

In Texas, new diagnoses have remained steady in most age cohorts of MSM and have increased in groups such as younger MSM of color and White men in their 30s and 40s. Studies indicate that the increase in new diagnoses from 2002 to 2007 is related to four phenomena:

- "Safe sex fatigue"
- HIV treatment optimism
- Facilitated access to sex partners via the internet
- Crystal methamphetamine use[14]

MSM continue to bear the largest burden of the HIV/AIDS epidemic in Texas. Regardless of race/ethnicity and geography, MSM throughout Texas are vulnerable to HIV infection. Additionally, gay men and other MSM face a syndemic of health issues, of which HIV is only one. Other relevant health issues that exacerbate the risk of contracting HIV are high rates of STDs and high rates of depression and substance use among MSM[15-17]. Victimization has also been found to predict future HIV seroconversion[18, 19].

4. BLACK HIGH-RISK HETEROSEXUAL FEMALES

Although Blacks represent only 12% of the total population in Texas, the Black population comprises 38% of PLWHA. The particular risk for Black females is unprotected vaginal or anal intercourse with an HIV-positive male partner. In comparison with other racial and ethnic groups of females, Black females have rates 8 to 14 times higher than rates in Hispanic and White females[2].

A number of biological and social factors increase Black heterosexual women's vulnerability to HIV. During penile-vaginal sex, women are biologically more susceptible to HIV infection due to a greater exposure of tissue that may be penetrated by HIV, unlike the skin of the penis. Higher rates of STDs in Black communities in comparison to other racial/ethnic communities also increase the risk of HIV transmission[20].

Black communities are disproportionately affected by high rates of HIV and other STDs. The likelihood of being exposed to an infected person is much higher for Black women and

men than it is for people living in other communities[21]. High rates of transmission of HIV within Black communities will likely continue due to the density of sexual networks and presence of other STDs. Effective intervention is necessary.

5. INJECTION DRUG USERS

For habitual IDUs, sharing drugs and equipment is a significant and frequent activity*. Of all risk behaviors, this activity carries the highest probability of transmission of HIV.*

For IDUs, the risk of arrest and drug withdrawal are greater concerns than the chance of HIV infection[22]. In the face of limited treatment availability and without a change in needle exchange policy, this population's vulnerability to HIV infection will continue.

IDUs are a marginalized group. They often live on the streets, in shelters, or in rundown housing. They spend time evading law enforcement, and are often refused health and social services due to their drug use. For some IDUs, meeting basic needs is difficult enough that preventing disease or seeking help for treatment for their addiction or HIV seem beyond reach[22].

The injection of infected blood through the sharing of injection equipment is responsible for rapid spread of HIV among IDUs. The importance of social relationships and the reality of where injecting drugs takes place is often obscured. The context of drug use includes the setting, characteristics of local IDU networks, languages, norms, values, rituals, and rules. This subculture and its interaction with larger societal structures, including law enforcement practices and official drug policy, may have the greatest significance for determining and ultimately changing the concrete behaviors responsible for the spread of HIV within the population of IDU[23].

The single most significant measure of HIV prevention for an IDU is to have personal injection equipment to carry all the time. However, possession of such equipment can be reason for harassment and even arrest. Paraphernalia laws criminalize the possession of needles, syringes, and other injecting utensils, creating an atmosphere of fear of prosecution and social stigma[23].

6. BLACK HIGH-RISK HETEROSEXUAL MEN

Black heterosexual males are a priority population due to their disproportionate burden of HIV/AIDS cases. Many Black men are out of care[2], and bringing these men into care may greatly decrease HIV transmission. Black men face a variety of health disparities, and effective work on one health issue may lead to improvements in overall health outcomes.

Black men face a number of health concerns, of which HIV/AIDS is only one. Other factors, such as high rates of depression, substance use, and other STDs in Black communities, increase the ease with which HIV is transmitted in this community[24].

Black men tend to have significant barriers to overcome in order to access health care, including insurance, employment, and education. Once these barriers are surmounted, Black men are likely to experience discrimination in these settings[24]. Black men in Texas are less likely to complete high school than White men, putting them at a disadvantage in seeking steady employment[25]. Lack of employment often leads to precarious personal circumstances, complicating caring for one's health.

Incarceration particularly disadvantages Black men[24]. A history of incarceration greatly reduces one's ability to achieve full-time employment and complicates maintaining a full-time job once employed. The stigma attached to incarceration creates barriers to resources that inmates need, post-incarceration, to prevent them from re-offending. These resources include but are not limited to regular and stable employment, education, treatment, and family-related services. These post-incarceration services are important because, without them, former inmates may find themselves in secondary labor markets trying to earn livable wages to support themselves and their families[24, 26].

Incarceration also makes it harder to maintain intimate relationships with partners, at times resulting in concurrent partnerships (multiple partners at the same time). Concurrent partnership patterns expose more individuals to HIV/STD than serial monogamous coupling patterns[25].

For Black men, there are many sexual implications to meeting cultural expectations for masculinity. Higher HIV/STD rates can be linked back to these perceived norms, such as a having a high number of female partners, having sex without a condom, and fathering numerous children[27].

The stigma of HIV in Black communities leads to fear of rejection from sexual partners, families, and religious communities, all of which can silence Black men regarding their HIV status and complicate effective HIV prevention[9].

7. HIGH-RISK HETEROSEXUAL HISPANICS

Of all persons living with HIV/AIDS in Texas in 2007, 24.8% were classified as Hispanic[2]. Like the Black population in Texas, Hispanics tend to have less access to health care, insurance, employment, and education, and are likely to experience discrimination in these settings[2, 28]. The current political climate surrounding immigration and the rights of Hispanic communities may impede the undocumented portion of the Hispanic population from seeking health care services[29].

Like the Black population, the Hispanic population tends to seroconvert at earlier ages than their White counterparts[2]. Hispanics represent a young, growing population in Texas whose sexual health is a concern. Hispanic youth have increasingly high pregnancy rates, an indicator for risky sexual practices[30].

Traditionally, in Hispanic families, the topic of sexuality is not discussed[31]. This lack of discussion between parents and children impedes access to needed information about HIV/STD and pregnancy prevention. Silence about sexuality impacts Hispanic women's ability to initiate a conversation about sex with a male partner, as doing so implies promiscuity.

Machismo in Hispanic culture has sexual implications for both men and women[32]. Hispanic men may prove masculinity through quantity of sexual conquests, unprotected sex, and having the power to make decisions in sexual relationships.

The relationship of acculturation and health risk behavior differs among Latinos depending on country of origin and socio-economic status before immigration. It is hypothesized that, despite social, economic, cultural and linguistic disadvantages faced by new Latino immigrants, they tend to have better health outcomes than their US-born counterparts. As Latino immigrants acculturate to the US host culture, they have worse health and mental health outcomes. This is known as the Hispanic Health paradox, which is found to be especially true of Mexican-origin immigrants. This paradox is not found in Puerto Ricans, Cubans, and Central Americans. There are two attributable factors to the Hispanic Health Paradox. First, immigration to a new country is a considerable, difficult undertaking in which healthier persons are more likely to be successful. Second, Latino culture tends to be a close-knit familial structure with traditional family standards, which may act as protection and insulate the individuals. Deterioration of that culture by time and influence of US culture results in worse health outcomes[33].

8. YOUTH, AGES 13 TO 24 YEARS

Youth are at a stage that will shape the balance of their lives. When adolescents are impulsive and experimenting with new experiences, they increase their risk of STD infection. Emotional challenges, including depression and stress, can likewise increase the chance that adolescents will engage in high-risk behaviors. Fortunately, a stable, close, and communicative family (in which sex can be discussed) may serve as a preventive factor for adolescents who might otherwise engage in high-risk sexual behaviors[34].

Texas youth show higher levels of risk behaviors than youth in other states. Texas has a high teen birth rate, high rates of STDs and HIV in youth, and limited access to school-based comprehensive sexual health education that teaches protective practices. Among youth, MSM of color contract HIV at rates much higher than their peers[35].

Many youth conduct their daily activities in venues where HIV/STD prevention education can be easily implemented. Universities, schools, and religious organizations have regular contact with the young people in their communities. The youth at risk for HIV today are the adults at risk for HIV tomorrow. Early intervention with this population may benefit society through reduced disease burden and human suffering for many years to come.

9. SPECIAL POPULATIONS:

a. Transgender Individuals
b. Partners of HIV-positive individuals
c. Homeless individuals
d. Incarcerated and recently released individuals
e. Sex workers
f. Individuals with a STD/Hepatitis C diagnosis
g. Individuals with mental health issues
h. Individuals with substance abuse issues

The special populations experience many barriers to optimal health, differentiating their risk from other populations that may not have the same quantity of confounding factors. Stable employment, access to housing, access to culturally competent and affordable medical care, and fair treatment from the judicial system are often elusive for these populations.

Patterns of risk factors and conditions often operate synergistically, meaning that, together, they increase the risk of HIV far beyond the effects of one risk condition alone[36]. For example, persons with an STD diagnosis have a greater biological vulnerability for contracting HIV through sores and high concentrations of white blood cells at infection sites[37]. Homeless persons have limited access to medical care and health insurance coverage and may live for a long time unaware of an HIV or STD infection, or without treatment. Research shows transgender individuals, particularly youth, who experience rejection by their families are more likely to become homeless, experience sexual abuse, and engage in unprotected commercial sex, all exacerbating their vulnerability to HIV infection[38]. Incarcerated individuals may not have access to barrier methods for sexual intercourse or access to needed health care, such as treatment and testing. Additionally, incarcerated individuals experience difficulty in gaining employment after release. Sex professionals who work on the streets may risk incarceration by carrying condoms on their person, often considered proof of their profession from law enforcement authorities. These patterns of instability in employment, housing, and family life impact an individual's ability to safeguard their health, leading to a number of negative health outcomes that increase their risk for HIV[39].

The committee supports more research and outreach/testing in these populations.

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4.2 EXISTING INDIVIDUAL- AND GROUP-LEVEL INTERVENTIONS

OVERVIEW OF PROCESS TO REVIEW INTERVENTIONS

The intervention review process was comprised of two components:

1. Members of the Intervention Review Committee (IRC) of the Texas HIV/STD Community Planning Group (TxCPG) reviewed intervention program materials over the course of two quarterly meetings. Committee members completed written review tools individually while discussing the interventions with other committee members in either of two small groups (four to eight members each). The University of Texas at Austin HIV Research Team compiled the individual review results into summaries. In subsequent quarterly meetings, the IRC reviewed and offered revisions to the summaries and presented other promising prevention activities that could be effective for "special priority populations" for which few, if any, evidence-based programs had been designed.

2. Texas Department of State Health Services (DSHS) staff members who had experience with evidence-based interventions currently or previously funded by DSHS formed an Internal Review Panel (IRP). Teams of two to four IRP members met over the course of three months to review the implementation of evidence-based interventions (EBIs). In the summer and fall of 2010, IRP members also reviewed two counseling programs: Critical Risk and Counseling Services (CRCS) and Protocol-Based Counseling (PBC). As in the case of the above review process, panel members completed written evaluation tools while discussing the intervention with fellow group members. The university research team compiled summaries of each intervention review and provided them to IRP members for feedback.

A more detailed description of the review process is provided in the appendix.

OVERVIEW OF REVIEW OF INTERVENTION PRODUCTS

The following documents were revised continuously between September 2010 and May 2011 by members of the university research team in consultation with participants in the review process. In all, 37 EBIs were reviewed (17 reviewed by each group and 3 interventions reviewed by both groups). The process yielded several documents, which appear in the appendix:

- A matrix that contains a brief description and rating of each of the thirty-seven interventions
- A summary of each of the intervention reviews
- A glossary of terms relevant to HIV prevention
- A summary of implementation reviewers' comments on intervention evaluation

- A summary of implementation reviewers' comments on technical assistance (TA) and training
- A list of priority populations identified by TxCPG matched with the interventions that were designed for those populations. The interventions are linked to the review summaries.

The following prevention program materials were reviewed.

- Becoming A Responsible Teen
- Be Proud, Be Responsible
- CLEAR
- Connect
- D-Up!
- Enhancing Motivation
- Focus on Youth
- Healthy Living Project
- Modelo de Intervención Psicomédica
- Nia
- Project START
- Safe in the City
- Shield
- SiHLE
- Sister to Sister
- Street Smart
- Turning Point
- Video Doctor
- Wall Talk
- WiLLOW

Implementation aspects of the following prevention activities were reviewed.

- Becoming A Responsible Teen
- Brother to Brother
- Community Promise
- Comprehensive Risk Counseling Services (CRCS)
- Doing Something Different
- Enhancing Motivation
- Healthy Relationships
- Hot, Healthy, & Keeping it Up
- Intensive AIDS Education (formerly RHAP)
- Many Men, Many Voices
- Mpowerment
- Partners in Prevention – MSM
- Partners in Prevention – Women's Edition
- Popular Opinion Leader
- Protocol Based Counseling
- RAPP
- Safety Counts
- SISTA
- Sniffer
- Turning Point
- VOICES/VOCES
- WiLLOW

4.3 PRIORITY POPULATIONS WITH MATCHING INTERVENTIONS

Behavioral change interventions provide tools for changing risk behaviors and/or factors that shape risk behaviors. The following list of evidence-based interventions matched to priority populations includes those interventions reviewed in the preparation of the Texas HIV/STD Prevention Plan. More recently evaluated interventions, as well as those currently under development, are not included here. Prevention partners are encouraged to study existing interventions and consider the possibilities of adapting old or creating new interventions to achieve the best fit between risk population needs and prevention partner resources.

TABLE 1. PRIORITY POPULATIONS WITH MATCHING INTERVENTIONS, 2010

Intervention	*HIV Positive*	*Black Gay Men & Black MSM*	*All Gay Men & MSM*	*Black Females*	*Injecting Drug Users*	*Black Heterosexual Males*	*Heterosexual Latinos*	*Youth Ages 13-24*	*Special Populations*	*Universal Intervention*
CLEAR	**X**									**X**
WiLLOW	**X**			**X**						
Healthy Living Project	**X**									
Healthy Relationships	**X**									
SHIELD (Drug users)	**X**			**X**	**X**	**X**	**X**			
Brother to Brother		**X**								
D-Up		**X**								
Many Men, Many Voices (3MV)		**X**	**X**							
Popular Opinion Leader		**X**	**X**						**Sex Workers**	**X**
PIP MSM			**X**							
Mpowerment			**X**							
CONNECT				**X**		**X**	**X**			

Intervention	*HIV Positive*	*Black Gay Men & Black MSM*	*All Gay Men & MSM*	*Black Females*	*Injecting Drug Users*	*Black Heterosexual Males*	*Heterosexual Latinos*	*Youth Ages 13-24*	*Special Populations*	*Universal Intervention*
Doing Something Different				**X**		**X**				
Enhancing Motivation				**X**						
PIP-WE				**X**			**X(Females)**			
RAPP				**X**			**X(Females)**			
Safe in the City				**X**		**X**	**X**			
SiHLE				**X**				**X**		
SISTA				**X**						
Sister to Sister				**X**						
VOICES/VOCES				**X**		**X**	**X**			
Modelo de Intervención Psicomédica (MIP)					**X (Latino)**					
Safety Counts (Active Drug Users)					**X**					**X**
Sniffer					**X**					
Nia						**X**				
BART								**X**		

Intervention	*HIV Positive*	*Black Gay Men & Black MSM*	*All Gay Men & MSM*	*Black Females*	*Injecting Drug Users*	*Black Heterosexual Males*	*Heterosexual Latinos*	*Youth Ages 13-24*	*Special Populations*	*Universal Intervention*
Be Proud, Be Responsible								**X**		
Focus on Youth								**X**		
Project AIM								**X**		
Street Smart (Youth)								**X**	**Homeless Youth**	
Project Start									**Incarcerated – Soon to be released**	
Intensive AIDS Education (Male Youth)									**Incarcerated**	
Wall Talk									**Incarcerated**	
Community PROMISE									**Sex Workers**	

Additional HIV/STD Strategies/Interventions

- CRCS*
- CTR (PBC)*
- Respect
- Linkage to Care
- Peer-led Models
- Structural Interventions
- Community Mobilization /Engagement
- Social Networking Strategies
- Social Marketing
- Social Media
- Outreach – Internet/Community
- Routine Screening – HIV/STD

Interventions identified for universal implementation among prioritized populations

- CLEAR
- Community PROMISE*
- Popular Opinion Leader*
- Safety Counts – Active Drug Users*

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*Reviewed by Texas Department of State Health Services Intervention Review Panel

4.4 HIV/STD PREVENTION AND TREATMENT RESOURCES IN TEXAS

INTRODUCTION TO THE RESOURCE INFORMATION ON HIV, AIDS, STD, AND HEPATITIS

Each year, the Texas Department of State Health Services (DSHS) compiles an inventory of resources dedicated to the prevention and treatment of HIV, AIDS, STD, and Hepatitis. Although every attempt is made to report the most recent information, the tables are at best a "snapshot," a record of reported resources, and not all local resources have been captured in this information. The Intervention Review Committee of TxCPG worked with DSHS to compile local information. Any contribution to this information would be greatly appreciated and can be sent to Rosa Laura Valdez at rosa.valdez@dshs.state.tx.us.

FEDERAL, STATE AND LOCAL FUNDS SPENT ON HIV PREVENTION AND CARE

This section contains a compilation of federal, state, and local money spent on HIV prevention and care services. A concerted effort is made to obtain all major funding streams that provided support for HIV prevention and treatment. While efforts were made to identify these funds, the following is a list of concerns identified while looking at the HIV funding landscape:

- Although general health, women's health, and family planning programs provide access to HIV prevention services, these are not easily separated from their integrated services.
- More thorough canvassing of local health departments is required to obtain local funding information.
- Medicare, Veterans Administration expenditures, and non-Medicaid indigent care efforts are not captured here.
- This summary does not include state and federal resources associated with inpatient hospitalizations. Sources of data on inpatient billings are not segregated by source of payment.

TABLE 1. SUMMARY OF HIV/AIDS PREVENTION AND TREATMENT RESOURCES

Type of Funds	Service Description	Amount
HIV/AIDS Treatment and Care Services	This amount includes federal and state funding for outpatient medical and support services, including Medicaid. It does not reflect local funds devoted to indigent care, inpatient care, care paid for by Veterans' Administration or Medicare, or care delivered in correctional settings.	**$284,215,493**
HIV/AIDS Prevention	This amount includes federal and state funding through a variety of delivery mechanisms at the state and local level.	**$60,885,257**
Total		**$345,100,750**

FUNDING RESOURCES FOR HIV/AIDS CARE AND TREATMENT SERVICES IN TEXAS

Table 2 summarizes major federal and state funding streams for HIV care and treatment. All figures represent 12-month periods, but the actual months covered vary from source to source as detailed in the footnotes. Table 2 also shows the source of funds, a description of services provided by the funds, and reported annualized amounts. Immediately following the table are full descriptions of the different programs providing HIV/AIDS care and treatment services in Texas.

TABLE 2. FUNDING RESOURCES FOR HIV/AIDS CARE AND TREATMENT IN TEXAS

Type of Funds	**Service Description**	**Amount**
Ryan White Program (Part A through F) (Federal)[1]	Provides medical and supportive services for persons with HIV including the AIDS Drug Assistance Program (ADAP); also includes program administrative figures.	$150,165,202
Medicaid (Federal and State) [2]	Provides outpatient medical services and HIV-related drugs from Medicaid programs.	$73,973,999
State Appropriated Funds (State) [3]	Provides direct medical and supportive services for persons with HIV; includes funds for drugs purchased through the ADAP.	$40,830,281
Housing Opportunities for People with AIDS (HOPWA) (Federal) [4]	Provides tenant-based and emergency housing assistance for persons living with HIV/AIDS and their families. These funds go to the state and directly to local communities.	$17,896,011
Substance Abuse and Mental Health Service Agency (SAMHSA) (Federal) [5]	Direct to community-based organizations. Provides case management services for HIV-positive individuals. Some portion of these funds is also spent on testing	$1,350,000
Total		**$284,215,493**

[1] Federal Fiscal Year 2010 data was the most current information available from the HRSA website for total Ryan White funding. Health Resources and Services Administration (HRSA) publishes finalized annual costs two years behind the current year. http://granteefind.hrsa.gov/searchbystate.aspx?select=TX&index=51&year=2010. Retrieved May 5, 2010.
[2] Outpatient Medicaid data compiled for unmet need and Women Infant Children & Youth (WICY) reports for Federal Fiscal Year 2010.
[3] DSHS general revenue expenditures for State Fiscal Year 2010. Le, H., personal communication, July 27, 2011.
[4] Housing and Urban Development (HUD) website reported data of Housing Opportunities for People with AIDS (HOPWA) funds allocated as of Federal Fiscal Year 2010.http://www.hud.gov/offices/cpd/about/budget/budget09/index.cfm Retrieved May 6, 2010.
[5] Substance Abuse and Mental Health Services Administration (SAMSHA) website reported the most current data available from funds allocated in State Fiscal Year 2010. http://www.samhsa.gov/Statesummaries/detail/2010/TX.aspx Retrieved June 21, 2011.

RYAN WHITE PROGRAM

The Ryan White Program (authorized by the HIV/AIDS Treatment Modernization Act of 2006) provides funding for medical and supportive services to PLWHA. The majority of these monies require that at least 75% of funds be spent on core medical services. Part A funds go to metropolitan areas that meet certain thresholds of reported AIDS cases. Part B funds go to the state (through DSHS) to provide medical and support services for persons living with or affected by HIV and AIDS. Part B also provides funds for the AIDS Drugs Assistance Program, which provides HIV medications to low income Texans with no or inadequate insurance. Part C grants go directly to clinics and support HIV clinical early intervention services. Part D grants go directly to local communities to provide family-centered treatment and support services for women, infants, children, and youth. Part F grants fund Special Projects of National Significance, AIDS Education Training Centers, dental programs, and the Minority AIDS Initiative (MAI). Note: Budget amounts in this category have not changed from last year.

MEDICAID

Medicaid is the state and federal cooperative venture that provides medical coverage to eligible needy persons. Medicaid primarily serves low-income families, non-disabled children, related caretakers or dependent children, pregnant women, elderly, and people with disabilities.

STATE REVENUE FOR DIRECT CLIENT HIV CARE AND TREATMENT SERVICES

State Revenue funds are distributed through DSHS to local communities for medical care and services such as transportation, case management, food, and housing. These funds also purchase medications through ADAP to provide HIV medications to low-income Texans with inadequate or no insurance.

HOUSING OPPORTUNITY FOR PERSONS WITH AIDS (HOPWA)

The HOPWA program provides housing assistance and supportive services to income-eligible PLWHA and their families. The purpose of this program is to establish or better maintain a stable living environment in decent, safe, and sanitary housing, to reduce the risk of homelessness, and to improve access to healthcare and support services.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

SAMHSA provides Texas with funding to provide case management services for PLWHA at substance abuse treatment facilities.

FUNDING RESOURCES FOR HIV PREVENTION IN TEXAS

The following table summarizes the major state and federal funding streams for HIV and STD prevention. All figures represent 12-month periods, but the actual months covered vary from source to source, as detailed in the footnotes. This does not reflect local expenditures on prevention. The table shows the source of funds, types of services provided by the funds, and the reported annualized amounts.

TABLE 3. FUNDING RESOURCES FOR HIV PREVENTION IN TEXAS

Service Description	Amount	
Centers for Disease Control and Prevention (CDC) Cooperative Agreements (Federal)[6]	Provides counseling, testing and referral, partner services, and evidence-based risk-reduction interventions primarily for those at high risk. Supports limited routine HIV testing in medical care settings. Funding comes through DSHS and City of Houston and directly to local agencies.	$32,103,070
Houston/Harris County (Local)	Local funds from the City of Houston and Harris County to provide HIV prevention activities.	$1,501,310
CDC (portion of Comprehensive STD Prevention Systems)[7]	Provides public health follow-up for the purpose of rapidly locating and referring high-risk individuals to medical examination, treatment (treatment), counseling and risk reduction.	$6,698,238
State Appropriated Funds [8]	Provides counseling, testing and referral, partner services and evidence-based risk-reduction interventions primarily for those at high risk. Supports limited routine HIV testing in medical care settings. Funding comes through DSHS HIV/TB/STD and MHSA.	$4,536,884
SAMHSA funds (Federal) [9]	Provides counseling, testing and referral, outreach and education, integrated substance abuse, HIV and Hepatitis prevention efforts. Funding comes from SAMHSA directly to local agencies.	$7,047,662
SAMHSA (State) pass-through funds[10]	Provides counseling, testing and referral, education, and case management. Funding comes through DSHS and directly to local agencies.	$7,998,093
Title X Integration Project for HIV (Federal) [11]	Provides for integration of HIV testing for adults, adolescents and pregnant women in family planning clinics. Funding comes through DSHS.	$1,000,000
Total		**$60,885,257**

[6] Federal Fiscal year 2010 grant awards to DSHS for Texas HIV Prevention Services. Direct funded monies to CBOs, HIV Prevention Projects; Expanded Testing Grant; Enhanced Comprehensive HIV Prevention Planning and Implementation for MSA [Dallas]; PCSI; STD Training Centers; HIV Prevention Training Centers; HIV/SIDS Surveillance; Enhanced Perinatal HIV/AIDS Surveillance; Medical Management Project; and NHBS and the Funding Summary for Houston Department of Health and Human Services (HIV Prevention; Expanded Testing Grant; Enhanced Comprehensive HIV Prevention Planning and Implementation for MSA [Houston]; STD/HIV Prevention; Routine Testing; and Community Development).
[7] DSHS federal grant awards for Federal Fiscal Year 2010 for STD including HIV prevention services (STD Prevention Program Fund, STD/HIV Prevention Training Fund, and the HIV Training Fund). Notice of grant award amended. Aulds, S., personal communication, August 17, 2011.
[8] DSHS general revenue expenditures for State Fiscal Year 2010. Includes GR expended from substance abuse programs and HIV/STD programs. Le, H., personal communication, July 27, 2011. Gallego, S., personal communication, August 17, 2011.
[9] Substance Abuse and Mental Health Services Administration (SAMHSA) website reported the most current data available from funds allocated in State Fiscal Year 2010 (http://www.samhsa.gov/Statesummaries/detail/2010/TX.aspx) Retrieved June 21, 2011.
[10] Source of data: DSHS federal funds from SAMHSA Block Grant reports based on the State Fiscal Year 2012 and used for HIV prevention services. Gallego, S., personal communication, August 10, 2011.

HIV prevention in Texas is primarily focused on testing, brief individual counseling and behavioral interventions with evidence of effectiveness in reducing HIV risk behaviors. These behavioral interventions are delivered to individuals, in groups or communities. The interventions are designed to modify knowledge, attitudes, beliefs, self-efficacy and emotional well-being, while reducing risk-taking behaviors.[12]

PARTNER SERVICES

Partner services are essential public health activities. CDC has identified partner services as one of the Eleven Elements of Successful Prevention Programs. Based on statewide guidelines, the highest priority for partner services is for early syphilis cases and newly identified HIV-positive cases. Next in priority are HIV positives with continued high-risk behavior and latent syphilis cases of unknown duration. The lowest priority is given to gonorrhea and chlamydia prevention.

Partner services begin when the disease intervention specialist (DIS) receives a report of an infected client through the public health surveillance system. The DIS locates and notifies the infected individual of his/her health status. The DIS then conducts partner elicitation, refers the patient to additional medical and social services, provides counseling on methods to reduce the risk of acquiring or transmitting STDs and HIV in the future, and conducts partner notification. Through field investigation, the DIS locates and refers named partners for examination, treatment, and/or counseling. This cycle continues with identification of each infected partner.

DSHS funds disease intervention activities through its regional programs and through contracts with local health departments. In FY 2010, eight city and county health departments received funds to carry out these duties in Texas. Those departments are Austin/Travis County Health and Human Services Department, Corpus Christi-Nueces County Public Health District, City of El Paso Department of Public Health, Tarrant County Public Health, Galveston County Health District, San Antonio Metropolitan Health District, Houston Department of Health and Human Services, and Dallas County Department of Health and Human Services (Table 4)[13].

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[11] Title X HIV Integration Spreadsheet itemizing federal funds expended on HIV prevention services for the federal fiscal year 2009. Nelson, A., Preventive and Primary Care Unit, personal communication, June 28, 2011.
[12] Texas Department of State Health Services. (2006) *HIV/STD Program Annual Report 2006*. Austin, Texas
[13] Base funding amount awarded to these local health departments in FY 2010 contracts.

TABLE 4. LOCAL HEALTH DEPARTMENTS FUNDED TO CONDUCT PARTNER SERVICES

Name of Contractor	FY 2011 Contract Total
Dallas County	$1,438,213
Houston	$1,594,701
Tarrant County	$334,203
Austin/Travis County	$196,502
San Antonio Metro	$407,806
Corpus Christi	$39,923
El Paso	$92,160
Galveston	$114,968
TOTAL	**$4,218,476**

FUNDING RESOURCES FOR HEPATITIS PREVENTION AND TREATMENT SERVICES

The Hepatitis Prevention and Treatment information has been included in the resource discussion because many of these resources have implications for HIV/AIDS and STD prevention and treatment and care services. Risk factors for transmission and acquisition are shared among the diseases. Table 4 provides a summary of estimated federal, local, and state funds currently appropriated, awarded, and/or spent on Hepatitis prevention and care services in Texas. It does not include Medicare or Veterans Administration expenditures, nor does it include full accounting for local funds for outpatient care. It does not include expenditures made in correctional facilities, as these were not possible to disaggregate from all healthcare expenditures made in these facilities. The Medicaid amount reported this year is higher due to more precise coding for viral Hepatitis services.

TABLE 5. SUMMARY OF HEPATITIS PREVENTION AND TREATMENT RESOURCES IN TEXAS

Type of Funds	Service Description	Amount
Hepatitis Treatment and Care Services	Hepatitis Medicaid expenditures for outpatient care and outpatient hospital expenditures.	**$28,062,347**
Hepatitis Prevention	CDC funding for viral Hepatitis coordination given to DSHS and the City of Houston. Local funds from the City of Houston. SAMHSA funding for Hepatitis prevention services. The majority of these funds (over $3 million) are not dedicated solely to Hepatitis prevention; they support integrated substance abuse, HIV and Hepatitis prevention efforts. They are included here rather than in HIV funding because they are almost the only funding with a grant focus that includes Hepatitis prevention. CDC funding for Hepatitis A and B immunizations.	**$4,351,532**
Total		**$32,413,879**

FUNDING RESOURCES FOR HEPATITIS CARE AND TREATMENT SERVICES

There is fragmented information on how individuals receive their care for chronic Hepatitis unless they are Medicaid recipients. The true extent of caring for those individuals with acute or chronic viral Hepatitis is an area that needs further study.

TABLE 6. FUNDING RESOURCES FOR HEPATITIS-RELATED CARE AND TREATMENT IN TEXAS

Type of Funds	Service Description	Amount
Medicaid (Federal and State) [14]	Provides outpatient medical services and Hepatitis-related drugs from Medicaid programs.	**$28,062,437**

Most people infected as adults recover fully from Hepatitis B, even if their signs and symptoms are severe. Hepatitis B-infected persons should be evaluated by a physician for liver disease. Treatment of chronic Hepatitis includes use of antiviral medication including interferon, lamivudine, entecavir, telbivudine and Adefovir dipivoxil. Liver transplant is also an option if liver damage is severe.[15] Further study is needed of the health service delivery systems throughout Texas to understand how services are provided to individuals living with chronic viral Hepatitis.

FUNDING RESOURCES FOR HEPATITIS PREVENTION

TABLE 7. FUNDING RESOURCES FOR HEPATITIS PREVENTION IN TEXAS

Type of Funds	Service Description	Amount
CDC (Federal) [16] [17]	Funds support viral Hepatitis coordination activities at state and local level. Funds go to DSHS.	$90,541
	Funds support viral Hepatitis coordination activities at state and local level. Funds go to the City of Houston.	$87,485
SAMHSA[18] (Federal)	These funds are not dedicated solely to Hepatitis prevention; they support integrated substance abuse, HIV and Hepatitis prevention efforts. They are included here rather than in HIV funding because they are almost the only funding with a grant focus that includes Hepatitis prevention. Funds support outreach and educational activities and testing, counseling, and referral services. Funds go directly to local communities.	$2,035,337

[14] The Medicaid products that are included in this number are: STAR+PLUS, STAR, FFS-PCCM, Vendor Drug and CHIP. Prepared by the HHSC, July 8, 2011.
[15] Texas Department of State Health Services. *The ABC's of Viral Hepatitis*. Retrieved July 1, 2008 from http://www.dshs.state.tx.us/idcu/disease/Hepatitis/resources/hepabc.pdf
[16] NGA from the CDC for 2011. Issue date May 2, 2011.
[17] Reported by the City of Houston Health and Human Resources for FY 2010. Brickham T., personal communication, August 18, 2011.
[18] Substance Abuse and Mental Health Services Administration (SAMSHA) website reported the most current data available from funds allocated in state fiscal year 2010 (http://www.samhsa.gov/Statesummaries/detail/2010/TX.aspx) Retrieved June 21, 2011.

Type of Funds	Service Description	Amount
CDC[19] (Federal)	These funds include adult Hepatitis B and Hepatitis A/B vaccine administered through DSHS immunization sites.	$2,138,169
Total		**$4,351,532**

PREVENTION EFFORTS FOR HAV

Texas students in pre-kindergarten and childcare facilities are required to have Hepatitis A (HAV) immunizations in all counties. In 40 Texas counties, kindergarten through third grade, students are required to have the HAV vaccine for school entry. DSHS provides the HAV vaccine for adults through DSHS Health Service Regions, local health departments, Texas Youth Commission State School, and other providers. DSHS' effort to provide HAV vaccine through regional health departments, local health departments, and other agencies is part of a safety net of vaccines for adults at high risk, uninsured, or underinsured.[20]

HBV VACCINATION OF CHILDREN

Vaccination is the best method of preventing Hepatitis B infection. DSHS operates the Texas Vaccines for Children (TVFC) Program through participation in the Federal Vaccines for Children Program (VFC) initiated through the Omnibus Reconciliation Act of 1993. Currently, over 6000 providers are enrolled in the program. Vaccine is provided to enrolled TVFC providers at no cost. The provider may not charge for the vaccine itself but is permitted to charge a reasonable administration fee. HBV is a required immunization for a student prior to entry, attendance, or transfer to a child-care facility or public or private elementary or secondary school in Texas. The three-dose vaccination series for HBV is recommended at birth, one month, and after six months. If the mother has HBV, HBV immune globulin (HBIG) is also administered with the vaccine.[21]

ADULT HBV VACCINATION

Hepatitis B can be spread through unprotected sex, sharing syringes, having contact with blood or open sores, sharing razors, toothbrushes and washcloths, and using unsterilized needles in body piercing/tattoos. Although school-age children are required to be vaccinated, adults are not unless they are in health-related courses with direct patient contact in institutions of higher education. The highest rate of disease occurs in those 20-49 years old. The Hepatitis B vaccination is recommended for all adults in the following settings: STD treatment facilities, HIV testing and treatment facilities, facilities providing drug abuse treatment and prevention services, healthcare settings targeting services to IDUs or MSM, correctional facilities, end-stage renal disease programs and facilities for

[19] Reported from DSHS Immunization Program for FY 2009 (1/1/09 – 12/31/09), June 11, 2010.
[20] Texas Department of State Health Services. (2008). *Adult and Adolescent Immunization Information*. Retrieved July 1, 2008 from http://www.dshs.state.tx.us/immunize/adult.shtm
[21] Texas Department of State Health Services. (2007). Texas Vaccines for Children Fact Sheet. Retrieved July 1, 2008 from http://www.dshs.state.tx.us/immunize/tvfc/default.shtm.

chronic hemodialysis patients, and institutions and nonresidential daycare facilitates for persons with developmental disabilities.[23]

Some students enrolled in higher education are required to either complete a three-dose series of Hepatitis B vaccine or show evidence of immunity prior to the start of direct patient care. This applies to all medical interns, residents, fellows, nursing students, and others who are being trained in medical schools, hospitals, and health science centers and students attending two-year and four-year colleges whose course work involves direct patient contact regardless of the number of courses taken, number of hours taken and student classification. Vaccination must occur prior to any direct patient contact that may be part of the course of study. Also, students enrolled in schools of veterinary medicine whose coursework involves direct contact with animals or animal remains must receive a complete series of HBV vaccine prior to contact. HBV vaccine is available through local health departments as part of a safety net for students who are uninsured or underinsured.

Effective August 27, 2007, public clinics in Texas provide HBV vaccine as part of the adult safety net for uninsured and underinsured adults. The local health department is also responsible for planning and implementing efforts to increase awareness of adult immunization recommendations. Local health departments collaborate with DSHS health service regional staff and provide information and education on adult vaccination and vaccine preventable diseases to healthcare providers and the general public. They act as health subject matter experts for providers regarding vaccination schedules, high-risk groups, recommendations and disease prevention. Additionally, the local health departments often collaborate with community organizations, healthcare facilities, local employers and others to identify populations and individuals who need immunizations.

The DSHS Refugee Health Screening Program (RHSP) operates primarily with funds from the Office of Refugee and Resettlement in the U.S. Department of Health and Human Services Administration for Children and Families. The program supports local health departments in principal refugee resettlement areas with resources to provide health assessments to newly arrived official refugees. The program encourages screening and treatment for tuberculosis, immunization status, intestinal parasites, HBV, as well as identification, education and referral for other health problems. Three major settlement areas are Houston, Dallas and Fort Worth. Combined, these areas receive about 85% of all refugee arrivals to Texas. Smaller numbers of refugees also settle and are served in local programs in areas such as Amarillo, Austin, Abilene and San Antonio.

PERINATAL HBV

Texas law requires that providers and hospitals screen all pregnant women for HBsAG at their first prenatal visit and at delivery. Perinatal HBV infections and all positive HBsAg mothers must be reported to DSHS[24] .

[23] Centers for Disease Control and Prevention. (2007) *Hepatitis B: Fact Sheet*. Retrieved July 1, 2008 from http://www.cdc.gov/ncidod/diseases/Hepatitis/b/fact.htm

CDC estimates that up to 1,200 children are born to HBsAg-positive women every year in Texas. The goal of DSHS' Perinatal Hepatitis B Prevention Program (PHBPP) is to identify these women so that newborns can be treated at the time of birth. The program ensures that infants of any HBsAg-positive pregnant women receive HBV immune globulin (HBIG) and the HBV vaccine at birth and subsequently complete the HBV vaccine services and serological testing. Ninety percent of babies born to a positive mother will become chronic carriers of the disease if they do not receive this treatment at birth. Finally, the program identifies the mother's contacts and household members to provide immunization, serological testing, and education services as needed.

PREVENTION EFFORTS FOR HCV

There is no vaccine for HCV infection. Prevention efforts rely on risk assessment, HCV testing, referrals to treatment for those with HCV, and health education. Persons at risk for HCV may also participate in HIV prevention programming designed to reduce health risks associated with injection drug use. Grants provided through SAMHSA directly to communities throughout Texas focus on prevention of blood-borne diseases such as Hepatitis and HIV. These grants support a wide variety of prevention services that range from health education or outreach services to prevention skills-building in substance abuse treatment facilities. SAMHSA funds prevention services through block grants received by the DSHS Community Mental Health and Substance Abuse Program. These funds promote prevention of HIV and other communicable disease with particular focus on Hepatitis and especially HCV.

DSHS supports limited and highly targeted HCV testing through 11 HIV testing contractors. Programs are selected based on the number of injection drug users identified through their HIV testing efforts. These programs use a counseling protocol that includes assessment of HCV risk. When warranted, HCV testing is offered. Each program must establish referral networks for HCV assessment and treatment, HBV and HAV immunization, drug and alcohol treatment, and substance use counseling. Availability of treatment varies and is often dependent on the local indigent healthcare system. Those who are not eligible for indigent care or who have no access to such care may go without treatment for chronic HCV. However, even if care is problematic, individuals with HCV can benefit from health education. Benefits include factors that can aggravate the effects of HCV infection and increase the chances of developing liver disease, and counseling to support adoption of behaviors that reduce the risk of transmitting Hepatitis to others.

In the appendix, there is a comprehensive look at the HIV prevention services as identified by the TxCPG and DSHS staff. This inventory of the prevention programs is arranged by specific region. These regions are identified as follows: Ryan White identified EMA or TGA, counties in which residents naturally migrate to urban hubs, the Texas-Mexico border, and

[24] Texas Administrative Code Title 25, Part 1 Chapter 97, subchapter A, § 97.135 and 97.3

the Texas-Louisiana border, and Panhandle and Permian-Basin. The HIV prevention program identified regions using the ECHPP criteria for Required HIV Prevention Activities, as well as intervention strategies.

5.1 THE FUTURE OF HIV PREVENTION

No single intervention will effectively address the spread of HIV, but rather a combination of interventions and strategies will help reduce the transmission and acquisition of HIV and other STDs[1]. Therefore, the future of HIV prevention is in the creation of combined, multilayered prevention activities. Combinations should include biomedical, behavioral, and structural intervention strategies. This calls for a comprehensive and coordinated approach to the future of HIV/STD prevention.

Two significant events occurred in 2010 that affected the future of HIV prevention and began to facilitate the implementation of a coordinated approach to prevention. First, in July 2010, the National HIV/AIDS Strategy and the accompanying Federal Implementation Plan were released. Second, the Centers for Disease Control and Prevention (CDC) responded to the Federal Implementation Plan with the RFA-PS10-1081, Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS (ECHPP), also known as the "12 Cities Project." It is important to be familiar with the National Strategy, the federal response, and the implications for future HIV prevention resources and the populations at greatest risk for HIV.

ECHPP IN TEXAS

The goal for ECHPP, like the National Strategy, is to reduce HIV risk and incidence in the targeted MSA[2]. ECHPP will be conducted in two phases. Phase I is a one-year project period during which grantees develop focused plans for the targeted MSA and begin implementation of their plans. Phase II is a two-year project period in which grantees further implement their ECHHP. ECHPP has great influence on future HIV/STD prevention programs.

NEXT STEPS FOR HOUSTON, DALLAS, AND THE REST OF TEXAS

ECHPP is significant to Texas because it gives Dallas and Houston the opportunity to develop a more comprehensive, results-oriented supplement to the state's Comprehensive HIV Prevention Plan and to address gaps in scope, reach of HIV prevention interventions, and strategies among relevant populations. The coordination of HIV prevention, care, and treatment services is central to the ECHPP project. Prevention can be extended and enhanced through ECHPP.

The National Strategy and the 12 Cities Project emphasize the following priority populations:

- Gay men and other MSM
- Transgender persons
- African Americans
- Latino persons
- Substance users

These identified populations have been priority populations in Texas for over 10 years. Local communities and service providers in Texas have responded to their local epidemic and address the populations most affected by HIV in their communities. Similarly, TxCPG has responded to the state epidemic, and the priority populations identified by TxCPG reflect the populations identified in the National Strategy and ECHPP. The Texas HIV/STD Prevention Community Planning Group (TxCPG) and the Texas Department of State Health Services (DSHS) will continue to identify those populations that experience high rates of disease. Based on the current community resources, intervention efforts should follow the epidemic and the populations identified.

Facilitating a comprehensive, coordinated response

Texas is working to align its prevention strategies with the National Strategy. Texas will continue to include interventions that address the following:

- Science-based programs and strategies that
  - Reduce HIV diagnosis
  - Increase access to care
  - Reduce HIV-related disparities

Texas will strive to ensure the following:

- HIV prevention program outcomes are sustainable and have a long-lasting effect (greater than one year)
- HIV prevention programs are scalable to produce desired outcomes across communities
- HIV prevention programs are cost-efficient

Texas will facilitate the implementation of HIV prevention programming in the framework provided by the National Strategy. It will work to facilitate the appropriate mixture of intervention and public health strategies that best suit local communities, including working with communities to ensure prevention activities for *Required*, *Recommended for Consideration*, and *Innovative* local activities as indicated in the 12 Cities Project guidelines.

Required HIV Prevention Activities include:

- Routine opt-out screening for HIV in clinical settings
- HIV testing in non-clinical settings to identify undiagnosed HIV infection
- Condom distribution
- Provision of post-exposure prophylaxis to populations at greatest risk
- Efforts to change existing structure, policies, and regulations that are barriers to creating an environment optimal for HIV prevention

Perhaps the most significant strategy within the required interventions is prevention for people living with HIV. Texas is committed to providing prevention programming for individuals living with HIV. This programming includes biomedical, behavioral, and structural intervention strategies. Such strategies include:

- Condom distribution across the general population
- HIV and sexual health communication or social marketing campaigns
- HIV prevention intervention for HIV-positive patients
- Community interventions that reduce HIV risk
- Behavioral risk screening and interventions to address those behaviors across multiple levels for high-risk individuals
- Integrated activities for HIV-positive individuals and HIV-negative individuals at highest risk, including: hepatitis, tuberculosis, and STD testing; partner services; vaccination; and treatment
- Targeted use of HIV and STD surveillance data to prioritize risk-reduction counseling and partner services for persons previously diagnosed with HIV infection or with a new STD diagnosis
- Broadened linkages to services for social factors that influence HIV incidence, such as mental health, substance abuse, housing, safety, domestic violence, corrections, legal protections, and income generation

Program Collaboration and Service Integration (PCSI)

Texas has had an integrated HIV/STD program for 24 years. Momentum toward collaboration and integration continues. Texas is committed to the integration of prevention services related to HIV/STD, viral hepatitis, and tuberculosis.

Program collaboration and service integration is crucial to the extent to which these diseases are synergistically interacting epidemics, or "syndemics." The risk of acquiring any of these diseases is associated with similar behaviors and environmental conditions, and they have reciprocal or interdependent effects. As a result, certain populations are at elevated risk for multiple diseases and need the appropriate screening for HIV, viral hepatitis, syphilis, tuberculosis, and immunization services.

[3]

It is essential for the DSHS, TxCPG, and other prevention partners throughout the state to develop an understanding of the direction of HIV prevention[2]. Every prevention partner is called to embrace all possibilities for prevention across multiple levels of intervention as described in the socio-ecological framework. The HIV/STD prevention program will address:

- Epidemic concentration and prioritization of these areas
- Current economic realities
- Responsible stewardship of public funds
- Multilayered determinants for HIV transmission
- The use of viable and cost-effective biomedical strategies
- Program collaboration and service integration
- Multilayered approaches to reducing HIV infection
- Coordination of HIV resources
- Linkage to medical care for HIV-positive individuals

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5.2 CARRYING FORWARD THE LENS OF THE SOCIO-ECOLOGICAL MODEL

The Texas HIV/STD Prevention Community Planning Group (TxCPG) is committed to moving the prevention agenda in Texas beyond the individual level.

These recommendations are designed to be used by persons working in these different contexts, prevention organizations, advocacy groups, and health departments. We call upon the state health department to shift its prevention resources to include environmental-level interventions in its own work and in its funding of community-based organizations, universities, and local health departments. We call upon community-based organizations to include social network, community, and policy work as part of their agendas.

Acting upon the Findings

TxCPG will reorganize our committee structure to better accomplish these goals. We will analyze the feasibility and impact of the list of recommendations from the action briefs and from earlier deliberations and recommend priorities for action. TxCPG, based on these recommendations, will decide its priorities for the development of environmental-level interventions. These interventions may be developed by TxCPG, the state health department, or other entities.

Interventions for Higher Socio-Ecological Levels

We propose the use of the Intervention Mapping process[1] to guide the development of interventions directed toward the priority environmental changes selected by TxCPG. The first step is to develop an understanding of the context of the environmental change, including identifying the decision-maker(s) who can make the change, the determinants of the decision-maker(s) related to the change, and the methods to address those determinants.

The second step is to develop an intervention plan and materials based on this analysis. For example, if the change is passage of legislation to allow syringe exchange, the decision-makers are state legislators. Determinants of their behavior to be addressed might include a positive attitude toward public health, beliefs that syringe exchange will reduce the risk of HIV, that legal syringe exchange will not increase the use of IV drugs, and that their support of this legislation would not affect their re-election or standing in their political party. Methods to change these determinants would include provision of scientific research that supports needle exchange, persuasive communication, advocacy, and lobbying. The intervention might be an advocacy plan that includes convening of advocates/stakeholders; development of an advocacy agenda and research briefs; and mobilization of constituents to persuasively address the determinants of legislators' support of syringe exchange.

Biomedical Interventions/Emerging Technologies

The National Association of State and Territorial AIDS Directors (NASTAD) recently reported on the following to TxCPG[2]:

- Effective services that are not widely practiced, including non-occupational post-exposure prophylaxis (PEP) and routine testing in healthcare settings.
- Potentially effective services, including male circumcision

- Not yet realized options, including
    - Vaccination
    - Use of antiretrovirals as prevention (pre-exposure prophylaxis and microbicides)
    - Test and treat (early identification and linkage to care)
    - Reduction of community viral load

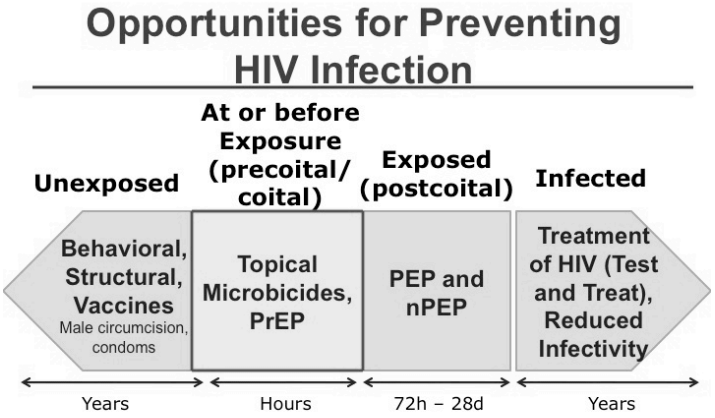
The implications for programming in Texas were discussed. These biomedical interventions work best if combined with other prevention strategies, including behavior change and structural interventions. The use of the new female condom for HIV prevention was also considered by the group.

TxCPG has only begun investigation of the role of biomedical interventions and emerging technologies for the prevention plan. The ATC Committee will place this topic on its agenda and consider a structure to address these prevention innovations, perhaps through a healthcare committee.

Summary of HIV Prevention Opportunities by Disease Course

TxCPG endorses a toolkit for HIV prevention that includes a mix of interventions. The model suggested by Cohen and colleagues[3] (see below) provides a guide for understanding the relationship among interventions. Future steps of TxCPG include developing recommendations for the mix of prevention interventions for persons at different stages of HIV infection (unexposed, at or before exposure, exposed, and infected). Persons living with HIV are a priority population in this prevention plan, but the full array of biomedical interventions has not been considered at this time.

FIGURE 1. OPPORTUNITIES FOR PREVENTING HIV INFECTION.



Source: M. Cohen, et. al. *J. Clin. Invest.* 118:4, 2008

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5.3 INTERVENTIONS – NEXT STEPS

REVIEW OF RELEVANT INTERVENTION IMPLEMENTATION ISSUES

In the creation of this plan, the Texas HIV/STD Prevention Community Planning Group (TxCPG) Intervention Committee reviewed existing interventions, paying specific attention to the provided intervention materials and the needs for implementation. In essence, they initiated a conversation among people who are familiar with the interventions or materials and people who are interested in applying the intervention. This review represented a point in time.

Since the initial review process, new intervention types have been added to the Centers for Disease Control and Prevention (CDC) lists of interventions, including: Best-Evidence, Promising, and Good-Evidence Medication Adherence Interventions. Anticipating that potential implementers of new interventions will be interested in learning more about relevant implementation considerations, TxCPG recommends these new interventions be reviewed. Interventions implemented for the first time through Texas Department of State Health Services (DSHS) funding will be reviewed by the Implementation Review Panel of DSHS consultants and trainers.

PROMOTING AND EVALUATING NEW INTERVENTIONS

Some prevention partners in Texas are creating new interventions that may also effectively prevent new HIV infections. These "homegrown" interventions are based on the principles of behavior and environmental change that are familiar to HIV/STD prevention workers, but they may be combined and/or implemented in new ways that reflect the best possible fit between prevention partners and their environments. The Interventions Committee plans to become familiar with the development of homegrown interventions and will review some of these new interventions in 2012. The committee plans to solicit presentations from DSHS consultants and prevention partners engaged in the homegrown intervention development process.

The population-intervention match list, found in the appendix of this plan, identifies several populations for which no interventions have been reviewed:

- Transgendered individuals
- Partners of HIV-positive individuals
- People with an STD or Hepatitis C diagnosis
- People with mental health issues

The Interventions Committee will examine these apparent gaps in programming and make recommendations to TxCPG as a whole.

UNDERSTANDING THE PREVENTION PARTNER–CLIENT RELATIONSHIP

A variety of sources emphasize the power of an enduring relationship between prevention partners and their clients. A discussion of this topic will be facilitated by the University of Texas at Austin HIV Research Team in 2012.

COMPLIANCE WITH THE NATIONAL HIV/AIDS STRATEGY

TxCPG will explore the implications of the National HIV/AIDS Strategy. We will summarize our findings in a series of recommendations to prevention partners. These findings will address the following topics:

- The coordination of comprehensive, multi-level programming among prevention partners and across communities
- The inclusion of biomedical advances in the general prevention repertoire
- The targeting of prevention activities toward high-risk populations and/or high-prevalence locales

MOVING FORWARD

The prevention landscape is changing rapidly in response to funding priorities and evolving understanding of how best to reduce HIV transmission. The Intervention Review Committee will stay abreast of changes in prevention activities and provide Texas prevention partners with the best available information on effective prevention options.

5.4 EVALUATION OF HIV/STD PREVENTION COMMUNITY PLANNING

The evaluation of HIV/STD prevention community planning is based on guidance from the Centers for Disease Control and Prevention (CDC)[1]. Required activities for evaluating progress on goals and objectives include:

- Conducting an annual Community Planning Group membership survey
- Describing priority populations
- Describing the accompanying set of prevention/intervention activities
- Assessing the linkages between the Texas HIV/STD Comprehensive Prevention Plan and the CDC funding application, as well as the linkages between the plan and funded interventions.

The plan is a strategic effort to unite health department programing with community values and to ensure that community input is reflected in programming. Monitoring and evaluation of the HIV/STD prevention community planning is a shared responsibility of the Texas Department of State Health Services (DSHS) and the Texas HIV/STD Prevention Community Planning Group (TxCPG). DSHS has the ultimate responsibility in reporting the monitoring and evaluation activities to the CDC.

The following goals and objectives provided the framework for measuring TxCPG's progress throughout the planning cycle.

Goal One: TxCPG supports broad-based community participation in HIV/STD prevention planning, evidenced by the following:

- Open recruitment process for CPG membership
- Efforts to recruit key professional expertise that represents a diversity of populations most at risk for HIV/STD infection and reflects the characteristics of local communities
- Fostering a community process that encourages inclusion and parity among community planning members

(Also see Appendix: Membership summary and matrix.)

Goal Two: TxCPG identified priority HIV/STD prevention needs and created a set of priority populations (see Appendix: Populations Narratives) and interventions for each identified target population, evidenced by the following:

- Conducted an evidence-based process to determine the highest priority, population-specific prevention needs in Texas.
- Ensured that prioritized target populations are based on the epidemiologic profile (See Appendix: Epidemiological Profile and Populations Narratives).

- Ensured that prevention activities for identified priority populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance and acceptability (See Appendix: Intervention Review).

Goal Three: TxCPG planning ensures that HIV/STD prevention resources target priority populations and interventions identified in the Texas HIV/STD Prevention Plan, as evidenced by the following:

- Demonstrates a direct relationship between the Texas HIV/STD Prevention Plan and the DSHS application for federal HIV prevention funding. (See Appendix: 2010 Letter of Concurrence)
- Demonstrates a direct relationship between the Texas HIV/STD Prevention Plan and funded interventions.

EVALUATION OF THE PLAN DIRECTION

The plan represents an expanded way of thinking about HIV/STD prevention. It allows for multiple stakeholder involvement, evidence-based practices and theory-based homegrown interventions, and environmental and structural changes that support HIV/STD prevention.

The Plan is not evaluable as a whole; rather, it serves to guide programs and approaches, each of which operates in its own way and addresses different populations. Some strategies will be emergent and will be designed to be responsive to the epidemic, the population needs, and the community resources. TxCPG seeks to seize new opportunities in HIV prevention.

TxCPG proposes a strategic approach to evaluation that relies on:

- Inclusion of various stakeholders. For example, enlisting program implementers or community planners to identify what they hope to learn from an intervention.
- Studies of major issues. For example, TxCPG could decide to learn more about the influence of stigma in health care arenas or identify paths to prevention for transgender individuals.
- Targeted studies exploring emergent questions.
- Capacity-building for evaluation. For example, develop local- and program-level monitoring and evaluation skills and capacity.
- Exploration of evaluation approaches relevant to community and intervention development. For example, participatory action, empowerment, or developmental evaluation.

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5.5 ACKNOWLEDGEMENTS

Many people contributed to the development of the Texas HIV/STD Prevention Plan.

Thanks to TxCPG leaders past and present, especially Jamie Schield, who has led TxCPG since it inception and selflessly agreed to remain Community-Elected Co-Chair through the writing of this plan. Thanks to Tony Schmitt, State-Appointed Co-Chair from 2007 to 2009, and Greg Beets, who took over as State-Appointed Co-Chair in 2009 and brought with him a wealth of experience that contributed greatly to the writing of this plan.

A very special thanks goes to Jeffery Green who volunteered to serve as editor for this plan.

Special thanks to the Editorial Board Members. These individuals work closely in the development, writing, and reading of the plan documents.

The Editorial Board:

- Jamie Schield
- Greg Beets
- Jeffery Green
- Aurelio Rodriguez
- Susan Rokes
- Manuel Sanchez
- Nike Lukan
- Elnora “Nonie” Mendias
- Charles Whitehead

TxCPG members have made themselves available to address the challenges and opportunities offered by HIV/STD prevention. These members were asked to look at prevention through a new lens of the socio-ecological framework. We offer many thanks to the members for their diligence, creativity, and tenacity in their efforts to address HIV/STD prevention.

TxCPG Members:

- Floyd Anthony
- Stan Baker
- Greg Beets – State-Appointed Co-Chair
- Tracee Belzle
- Anna Danciger
- Eddie DeRoulet
- Alex Fisher
- Jeffery Green – Interventions Committee Chair

- Christopher Hamilton
- Gloria Hawkins
- Mariama Janneh
- Amy Leonard
- Nike Lukan – "All Things Considered" Committee Vice-Chair
- Jenny McFarlane
- Jai Makokha
- Elnora "Nonie" Mendias
- Tony Ramos
- Sylvia Alonzo Rawlings – Membership Committee Chair
- Aurelio Rodriguez – Population and Assessment Committee Chair
- Susan Rokes – Community Co-Chair-Elect, "All Things Considered" Committee Chair
- Manuel Sanchez
- Jamie Schield – Community-Elected Co-Chair
- Lorenzo Sias, Jr.
- Sybil Schroeder
- Felton Stevens
- Ricky Waite – Population and Assessment Committee Vice-Chair
- Charles Whitehead
- Claudella Wright – Membership Committee Vice-Chair

It is important to acknowledge the efforts of past members of TxCPG, who helped unify the Texas HIV/STD Prevention Community Planning Group. They too contributed greatly to development of the plan. These members had the foresight to recognize the need for a different approach to HIV/STD prevention.

Thank you to Marilyn Gordon and the staff at Innovation Event Management for working to ensure TxCPG members have accommodations and get to and from their quarterly meetings.

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University of Texas at Austin HIV Research Team members, past and present:

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- Shanna Dickey-Brown
- Nell H Gottlieb
- Karol Kaye Harris
- Todd Harvey

- Jessica R. Jarvis
- Ken Ripperger-Suhler

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POPULATION NARRATIVES

HIV prevention requires intervention across the levels of the socio-ecological framework. The heaviest prevention burden falls on people living with HIV/AIDS (PLWHA), and the Texas HIV/STD Prevention Community Planning Group (TxCPG) and the Texas Department of State Health Services (DSHS) have designated PLWHA as the population of highest priority for prevention activities. The first priority for PLWHA and their communities is to create an atmosphere where "prevention with positives" can take place. Education about decreasing HIV transmission and preventing the acquisition of new strains of HIV and other STDs is paramount. Moreover, prevention activities must address PLWHA who are unaware of their positive status. HIV prevention strategies for PLWHA require a combination of strategies. You will find some of those strategies listed below and throughout this prevention plan[1].

- Linking to HIV care, treatment, and prevention services for those testing positive and not currently in care
- Interventions or strategies promoting retention in or re-engagement in care
- Policies and procedures that will lead to the provision of antiretroviral treatment
- Intervention or strategies promoting adherence to antiretroviral medication
- STD screening according to treatment guidelines
- Prevention of perinatal transmission
- Ongoing partner services and public health follow-up
- Behavioral risk screening followed by risk-reduction intervention for HIV-positive persons
- Linkage to other medical and social services

TxCPG and DSHS recognize that PLWHA are found in all of the identified priority populations and beyond. Therefore, within each of the priority populations, it is necessary to address the prevention needs of PLWHA. The narratives provide a brief overview of each priority population and the special populations. These narratives are designed to answer the following questions regarding the priority populations.

- Who?
- What places the population at risk?
- How is the population's risk different?

- Why is it a priority population?

TxCPG and DSHS hope that these narratives provide an understanding of the priority populations and prompt continuing exploration.

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Population and Assessment Committee timeline of activities

The Population and Assessment Committee (PAC) decides on a schedule of tasks to complete for populations prioritization. The PAC determines how to create the priority populations list and what elements it will include.	May 2009	Each PAC member submits a Priority Populations list via TxCPG website. Included with the list is rationale for each priority population. Population lists are reviewed by PAC members and discussed via website.	July 2009	PAC members review Population Narratives and discuss participant observations. They discuss how to use these resources in the prioritization process.	After January 2010
April 2009	The PAC members review the Epidemiological Profile provided by DSHS and submit questions via TxCPG website.	June 2009	PAC members review Epidemiological information and literature reviews to inform the process of prioritizing populations.	January 2010	The PAC presents the Priority Populations to the Interventions Committee and answers questions related to the prioritization process. The PAC disbands to assist in the overall plan development.

Texas HIV/STD Prevention Community Planning Group (TxCPG)

Priority Populations

1. HIV-POSITIVE INDIVIDUALS

Who are HIV-positive individuals in Texas?

The number of Texans living with HIV/AIDS (66,126) has increased about 30% over the past five years[1]. The number of new HIV/AIDS cases diagnosed is approximately 4,200 each year. However, the number of deaths among the infected (approximately 1,300 per year) offsets this increase. An increase in survival, not an increase in new diagnoses, is what is reflected in the increase in overall number of persons living with HIV/AIDS (PLWHA). Both deaths and new diagnoses have been stable for the past five years[1].

The number and rates of PLWHA has increased substantially for both sexes and across all races and ethnicities, except for those less than 13 years old. The Black population has the largest proportion of cases. Although Blacks represent only 11% of the population in Texas, they represent 43% of the HIV/AIDS cases. The rate of Black PLWHA in 2007 was four times the rate of White PLWHA (36.2%) and about five times the rate of Hispanic PLWHA (24.8%). PLWHA cases between the sexes remain the same, with over three quarters (78.1%) of the living cases among males. The majority of the cases are among gay men and other men who have sex with men (MSM)[1].

There is a shift past the age of 45 in the age distribution among PLWHA, reflecting the survival of the PLWHA population. In the past five years, because of effective prenatal and perinatal treatments that significantly reduce the risk of transmission of HIV from infected mothers to their newborns, the number of children living with HIV/AIDS has decreased by 25%[1].

What places HIV-positive individuals at risk?

Due to advances in antiretroviral therapy, PLWHA are enjoying better health and longer life. These benefits may place some PLWHA at risk for acquiring additional STDs and for transmitting HIV to their uninfected partners. Many HIV-positive persons require intervention(s) to help them reduce risk[2].

Prevention for HIV-positive persons is unique. Programs must address clinical, mental health, and social support needs and build skills to prevent HIV transmission to current and future partners. Specific areas of discussion, such as the stigma of disease and other social factors, disclosure, and responsibility, are critical for any prevention intervention for HIV-positive individuals[2].

How is their risk different?

Most HIV-positive persons are concerned about not infecting others, and they take steps to prevent transmission[3]. However, a significant percentage of HIV-positive persons

struggle with prevention. From 20% to 50% of HIV-positive persons report unprotected sex with partners who are HIV-negative or whose status they do not know[3].

For many HIV-positive individuals, the same structural, interpersonal, and behavioral challenges that put them at risk for HIV persist beyond their diagnosis and play a role in their struggle to prevent HIV transmission.

Why are they a priority population?

The Centers for Disease Control and Prevention (CDC) Community Planning guidelines require that community planning groups prioritize PLWHA above all other at-risk populations. PLWHA participating in high-risk behaviors may transmit the virus to others. Particularly at risk for transmission of the virus are newly diagnosed individuals, newly infected, or individuals who are not aware of their HIV status. Intervention with all PLWHA to reduce high-risk behaviors can slow the spread of the disease[4].

Undiagnosed HIV drives new infections through transmission. The CDC indicates that one in five infections is undiagnosed[5]. Once an individual is infected with HIV, five to ten years often pass without symptoms. If HIV status is unknown, an individual is more likely to transmit the disease to others, resulting in missed opportunities for prevention of new HIV infections. Moreover, early diagnosis among HIV-infected individuals allows for early medical intervention, including life-sustaining treatment and opportunities for behavior change. In Texas, from 2003 to 2007, over one quarter of all newly diagnosed individuals received an AIDS diagnosis within one month of their HIV diagnosis. One third of all newly diagnosed individuals received HIV and AIDS diagnoses within one year. This demonstrates that a substantial proportion of current PLWHA were not diagnosed until late in the progression of HIV disease[1].

Community viral load, also know as *viral burden*, is the amount of the HIV virus within a particular community or sexual network, which means the risk associated with similar sexual practices increases as community viral load increases[6]. If the sexual network has an HIV- or other STI-infected person within it, factors such as density of the network (i.e. the number of individuals and the frequency of sexual contacts among various members), and how connected the infected person is to the rest of the network, impact the "pool" of infection in their sexual network[7]. Sexual networks may be small, consisting of people who live in the same geographic area, or they can be very large, consisting of sub-communities within entire cities.

Knowledge of status for individuals with HIV is crucial, as intervention and treatment among HIV-positive individuals is critical to stopping the HIV epidemic.

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2. BLACK GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN (BLACK MSM)

Who are Black MSM in Texas?

Black MSM refers to Black gay men, men who have sex with men (MSM), same-gender loving men, bisexual men, and Black men of other sexual identities. They represent many ethnic and cultural groups, have diverse religious backgrounds, and speak many languages. This diverse group includes, but is not limited to, Afro-Cuban, Caribbean, Brazilian, and African men[1]. These men are at risk for contracting HIV through unprotected anal intercourse with an HIV-positive partner. In 2009, MSM accounted for 60% of all new cases of HIV in Texas[2]. Black MSM may have rates of HIV and STDs two to three times higher than other racial/ethnic groups of MSM in Texas[3]. Black MSM tend to contract HIV at younger ages than their White and Latino counterparts, with almost one quarter of new diagnoses among Black MSM between 2002 and 2007 occurring among individuals age 13 to 24. The majority of Black MSM living with HIV/AIDS reside in urban areas in Texas, particularly the Houston and Dallas metropolitan areas[2].

What puts Black MSM at risk?

Experiences that exacerbate risk for Black MSM include racism, homophobia, socio-economic disadvantage, dense sexual networks (characterized by small size and high frequency of overlapping sexual partners), high rates of STDs, high rates of incarceration, sexual identity issues, and a lack of HIV testing and knowledge of status[4].

Evidence suggests that Black MSM are the racial/ethnic group of MSM most likely to report bisexual behaviors, and least likely to identify as gay[4]. However, sexual identification and disclosure are not predictive of high-risk behavior. Differences in risk behavior have not been shown to explain the disparity of HIV in Black MSM in comparison to their White and Latino peers[4, 5].

Black MSM tend to have denser sexual networks than other racial/ethnic groups of MSM, as Black MSM are most likely to have same-race partners[6]. However, their number of sexual partners is no greater or less than other racial/ethnic groups of MSM[4]. Young Black MSM are more likely to have partners that are 10 or more years older than they are, and these partners are more likely to expose them to HIV/STD due to potentially longer sexual histories[6]. Additionally, Black MSM have higher rates of other STDs, making them more vulnerable to HIV infection[4]. Studies show that Black MSM are least likely to know their HIV status in comparison to other racial/ethnic groups of MSM[4].

Comparatively few evidence-based interventions exist for Black MSM[7]. Lack of cultural competency has been cited as a barrier to reaching this population[8]. Black MSM may be less likely to approach traditional AIDS service organizations due to perceived stigma of both homosexuality and HIV in their communities. Interventions must be adapted to address the totality of the Black MSM experience[9].

How is their risk different?

Black MSM face both racism and homophobia in their daily lives[9]. Racism in the United States impedes access to economic and social resources and has been associated with negative health outcomes. Another issue is that higher rates of incarceration of Black men disrupt communities and relationships. Anecdotal evidence suggests same-sex activity exists in prison settings; however, there are no conclusions that it is more or less likely than outside of correctional settings.

Research in Texas finds that stigma is the largest barrier for Black MSM to get an HIV test[10]. Men fear being shunned by their families or friends and are afraid to tell anyone they are HIV-positive. Overall, the response to perceived homophobia is another explanation. Although all racial/ethnic communities score equally on measures of negative attitudes toward homosexuality, Black MSM tend to perceive a greater degree of homophobia in their communities than other racial/ethnic groups of MSM[11]. Specifically, the Black church has not taken a leadership role in fighting stigma associated with HIV/AIDS or homosexuality. At worst, the Black church fuels homophobia, further isolating these men from a venue traditionally seen as a buffer from social oppression in their communities[12].

Why are they a priority population?

Black gay, bisexual, and same-gender-loving men face the largest burden of HIV/AIDS in the United States and in Texas. Research continues to investigate why this disparity exists[4]. Several studies have discredited the idea that a higher frequency of risk behaviors explains the disparity, as most scientific research shows comparable or fewer risk behaviors by Blacks in comparison to Whites and Latinos[4, 9].

Finally, over half of persons living with HIV/AIDS (PLWHA) in Texas are in the Dallas and Houston areas[2]. In both areas, Black males have some of the highest rates of HIV infection in the state: 1 in 27 Black men in Houston ages 35 to 44, and 1 in 32 Black men in Dallas ages 35 to 44 were living with HIV in 2007. That same year, 60% of all new cases were Black MSM[2].

The profound numbers in both incidence and prevalence of HIV/AIDS among Black MSM in Texas clearly demonstrates why this population is considered a priority.

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Texas HIV/STD Prevention Community Planning Group (TxCPG)

Priority Populations

3. MEN WHO HAVE SEX WITH MEN (MSM)

Who are MSM in Texas?

MSM refers to men of all ages, ethnicities, racial groups, and sexual identities who have sex with men. This brief does not specifically address Black MSM, who are addressed in a separate priority population brief. However, some information provided in this brief includes Black MSM. In 2007, MSM of all races and ethnicities represented 52% of all new cases[1]. The overwhelming majority of infections among White males and Hispanic males were MSM, 80% and 68%, respectively[1]. For other racial/ethnic categories, MSM made up 81% of new diagnoses[1]. Prevalence rates are not calculated for MSM; however, the acknowledged small proportion of MSM among the overall population and the high proportion of PLWHA from this category reveals the alarming prevalence of HIV/AIDS among these men[1].

Men who have sex with men are not a homogeneous group. Most men who have sex with men identify as gay, though others identify as bisexual, heterosexual, or refuse any identity label, regardless of behaviors[2]. Geographic location, age, and race/ethnicity influence how these men live their lives. Urban communities often have access to larger social and sexual networks of gay men and other MSM as well as commercial establishments catering specifically to their needs. Rural communities may not have access to networks of gay men and other MSM or to commercial establishments; therefore, MSM may be less likely to disclose their sexual behaviors and/or sexual identity in comparison to their urban counterparts[3].

What places MSM at risk?

Specifically, MSM are at risk for HIV through unprotected anal intercourse (UAI) with an HIV-positive partner. However, for the MSM population in particular, HIV/AIDS is a life-long issue. Among MSM, the probability of exposure to HIV remains high from adolescence to adulthood due to high HIV prevalence among MSM, especially in urban communities. Both Houston and Dallas have an HIV prevalence of 26%[4]. HIV risk is associated with many other issues, such as dating, sex, love, substance use, homophobia, racism, and poverty[5, 6]. Age may be a risk factor for particular cohorts of MSM. Data analyses show that Latino MSM tend to seroconvert before the age of 30, while White MSM tend to seroconvert after the age of 30[1].

In Texas, new diagnoses have remained steady in most age cohorts of MSM and have increased in groups such as younger MSM of color and White men in their 30s and 40s. Studies indicate that the increase in new diagnoses from 2002 to 2007 is related to four phenomena:

- "Safe sex fatigue"
- HIV treatment optimism
- Facilitated access to sex partners via the internet
- Crystal methamphetamine use[7]

How is their risk different?

HIV continues to carry stigma in the gay community, complicating conversations about HIV status and sex[8]. Community awareness of HIV and the urgency to prevent the spread of HIV is no longer prominent in gay communities since the onset of Highly Active Antiretroviral Therapy (HAART)[9, 10]. The long-standing prevalence of HIV among MSM can make men feel HIV infection is inevitable. Messages that center on 100% consistent condom use have ignored the mental and emotional aspects of relationships and connection. In fact, relationships are a pertinent context in which HIV transmission occurs[11].

Recent studies associate the rise in HIV infections among MSM with the phenomenon of finding sexual partners on the internet[12]. Although the internet has not been found to increase episodes of UAI, it has been found to increase the number of sexual encounters[13]. Additionally, research suggests that the internet has facilitated the creation of high-risk sexual networks of men[14].

Alcohol and drug use is more prevalent among MSM than among heterosexuals[15], though use is decreasing with most types of drugs except amphetamines[6]. Methamphetamine use among gay men and other MSM is approximately 10 times higher than in the general population, and highly associated with HIV risk behaviors[16]. Young MSM use methamphetamine more than adult MSM (21% and 12%, respectively)[7, 17]. Methamphetamine users are more likely than other substance users to report having receptive anal sex while under the influence, performing unintended behaviors such as not using a condom, and being encouraged to use drugs by a sexual partner[17, 18].

Texas data indicates that substance use is a major factor in the local MSM HIV epidemic. The majority of HIV/AIDS cases involving unprotected sex among MSM in Texas involved drug use during sex (64.8%). The three main drugs used with sex were alcohol (58%), marijuana (28%), and cocaine or crack (19%)[1].

In Texas, migration patterns of gay men and other MSM change the risks men encounter. Many rural men may migrate temporarily or permanently to urban centers that offer an organized gay community[19]. These migration patterns remove rural men from their traditional sources of social support, and they must adapt to their new urban settings. Migration may occur again upon the onset of illness associated with HIV, as urban-dwelling men return to their rural communities, encountering communities ill-equipped for their health and social needs[20].

Hispanic MSM live throughout Texas, but their risks may vary according to location. HIV/AIDS transmission rates have remained highest among MSM in all areas of Texas, including the United States-Mexico border. The border itself creates unique issues that must be considered when doing HIV prevention, such as international relationships, non-identifying MSM, and the number of people crossing the border in a particular area. Regardless of location in Texas, Hispanic MSM tend to test late in the progression of HIV[21].

Hispanic MSM have diverse needs. According to the Centers for Disease Control and Prevention (CDC), among Hispanics, those born in the United States account for most new infections (34%), followed by those born in Puerto Rico and Mexico (17% each)[22]. Studies have identified *sexual silence*, *machismo*, and *familismo* (family loyalty) as features of Hispanic cultures which may be protective or harmful to the health of Hispanic MSM[23]. *Sexual silence* prohibits MSM from talking about their sexual identity, providing an environment that may lead to low self-esteem and personal shame, while inhibiting conversations within families about sexuality and sexual health. *Machismo* attitudes promote sex as a way to prove masculinity, especially when traditional forms of masculine identities, such as being an economic provider, are denied entire groups of men. *Familismo* may be a risk factor for Hispanic gay men if the family perceives homosexuality as wrong. This can create a conflict for individuals to reconcile a duty to family and a duty to self; this can lead to secrecy. However, *familismo* may be protective because Hispanic men feel a strong sense of responsibility towards their families, including taking health precautions to enhance wellness.

Why are they a priority population?

MSM continue to bear the largest burden of the HIV/AIDS epidemic in Texas. Regardless of race/ethnicity and geography, MSM throughout Texas are vulnerable to HIV infection. Additionally, gay men and other MSM face a syndemic of health issues, of which HIV is only one. Other relevant health issues that exacerbate the risk of contracting HIV are high rates of STDs and high rates of depression and substance abuse among MSM[15, 16, 24] Victimization has also been found to predict future HIV seroconversion[25, 26].

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4. HIGH-RISK HETEROSEXUAL BLACK FEMALES

Who are Black heterosexual females in Texas?

Black women are a tremendous, often unrecognized resource to their community and to Texas[1]. They come from a variety of backgrounds, including African-American, Afro-Caribbean, and African. They have a variety of religious backgrounds, including, but not limited to, Christian and Muslim. They live in cities, suburban neighborhoods, small towns, and rural areas, and come from blue- and white-collar families.

What places Black heterosexual females at risk?

Although Blacks represent only 12% of the total population in Texas, the Black population comprises 38% of persons living with HIV/AIDS (PLWHA). The particular risk for Black females is unprotected vaginal or anal intercourse with an HIV-positive male partner. In comparison with other racial and ethnic groups of females, Black females have rates 8 to 14 times higher than rates in Hispanic and White females[2].

A number of biological and social factors increase Black heterosexual women's vulnerability to HIV. During penile-vaginal sex, women are biologically more susceptible to HIV infection due to a greater exposure of tissue that may be penetrated by HIV, unlike the skin of the penis. Higher rates of STDs in Black communities in comparison to other racial/ethnic communities also increase the risk of HIV transmission[3].

How is their risk different?

Due to poverty, racism, and gender inequalities, Black women often find themselves with limited access to a variety of social institutions that facilitate upward social mobility, exacerbating their vulnerability to HIV. Higher rates of poverty in Black communities create social conditions that compete with other priorities. In impoverished conditions, securing housing, food, clothing, and other basic needs are prioritized above HIV prevention[4].

Black women must navigate the complex system of social, cultural, economic, and geographic factors that affect their sexual health decision-making. When considering safer sex, women are often more concerned about pregnancy prevention than HIV/STD prevention. They are less likely to use two methods of protection, such as the Pill and condoms. Black teenage girls are more likely to use implant and injectable contraception than White teenage girls, making them less likely to use condoms, which protect against HIV. Black women living in low-income areas are more likely to use sterilization as contraception[5].

A heterosexual woman's susceptibility to contracting HIV is influenced by her sexual network and opportunities for sexual relationships. Within the Black community,

opportunities appear limited and diminished. The lack of available Black male partners arises out of the social conditions of poverty, including Black men's high mortality rates from disease and violence[6] and high rates of incarceration of Black men[7]. The limited pool of available partners creates competition for those men who are available, and makes women more likely to do what is necessary to keep a partner[8, 9]. Within this network, *concurrency* may be a risk factor for Black heterosexual women. *Concurrency* refers to the overlapping of sexual partners in a serial monogamous pattern, usually characterizing the sexual patterns while transitioning relationships[9].

Why are they a priority population?

Black communities are disproportionately affected by high rates of HIV and other STDs. The likelihood of being exposed to an infected person is much higher for Black women and men than it is for people living in other communities[10]. High rates of transmission of HIV within Black communities will likely continue due to the density of sexual networks and presence of other STDs. Effective intervention is necessary.

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5. INJECTION DRUG USERS (IDU)

Who are IDU in Texas?

An injection drug user (IDU) is anyone who injects an illegal substance into his or her body, some of whom share needles or other injection equipment. This group includes individuals of all sexual identities, races, ethnicities, and ages. Risk for HIV arises when needles, syringes and other injection utensils are shared between serodiscordant injection drug users. In Texas, between 2005 and 2007, three quarters of IDU reported sharing needles or injection equipment[1]. IDU in Texas are substantially more likely to report use of drugs with sex (98%) than men who have sex with men (MSM) and high-risk heterosexuals (HRH)[1]. The prevalence of HIV among IDUs varies according to geographic location; some areas, such as Fort Worth, have a particularly notable epidemic in this population[1].

The proportion of HIV cases involving IDU or IDU/MSM has decreased over time[1]. In 2008, persons infected with HIV or AIDS were increasingly more likely to be people of color. The proportion of adult IDUs entering Texas Department of State Health Services-funded treatment programs decreased from 32% in 1988 to 16% in 2008. In 2008, 60% of heroin injectors were people of color, while injectors of cocaine and stimulants were far more likely to be White[2].

What places IDU at risk?

Sharing injection equipment to either inject or split drugs is a risk factor for IDUs. Shared equipment includes syringes, cookers, water, and cotton. In most cases, sharing occurs because these items are not available or affordable[3].

Unprotected sexual activity with an HIV-positive partner is also a risk factor for IDUs, especially IDU/MSM, women IDUs who trade sex for money, and women with an IDU partner. Risk varies depending on drug use. For example, methamphetamines increase sexual desire and have been associated with unsafe sex[4, 5]. In general, substance abuse can reduce sexual inhibition and facilitate unsafe behavior[6]. HIV/AIDS outreach programs have recently found an increase in individuals trading sex for money or drugs, which is contributing to increases in STD rates[2]. Some research suggests that trading sex for drugs (vs. for money) pertains more to physical drug addiction than to financial need or sexual desire[7].

An analysis of admission data from substance abuse programs shows increased use of methamphetamine and crack cocaine along the US-Mexico border[2]. Use of these drugs is a risk factor for HIV/AIDS either from sharing injection equipment or drug-influenced risky sexual behavior.

How is their risk different?

IDUs are a marginalized group. They often live on the streets, in shelters, or in rundown housing. They spend time evading law enforcement, and are often refused health and social services due to their drug use. For some IDUs, meeting basic needs is difficult enough that preventing disease or seeking help for treatment for their addiction or HIV seems beyond reach[8].

The injection of infected blood through the sharing of injection equipment is responsible for rapid spread of HIV among IDUs. The importance of social relationships and the reality of where injecting drugs takes place is often obscured. The context of drug use includes the natural setting, characteristics of local IDU networks, languages, norms, values, rituals, and rules. This subculture and its interaction with larger societal structures, including law enforcement practices and official drug policy, may have the greatest significance for determining and ultimately changing the concrete behaviors responsible for the spread of HIV within the population of IDU[9].

The single most significant measure of HIV prevention for an IDU is to have personal injection equipment to carry all the time. However, possession of such equipment can be reason for harassment and even arrest. Paraphernalia laws criminalize the possession of needles, syringes, and other injecting utensils, creating an atmosphere of fear of prosecution and social stigma[9].

Why are they a priority population?

For habitual IDUs, sharing drugs and equipment is a significant and frequent activity*. Of all risk behaviors, this activity carries the highest probability of transmission of HIV.*

For IDUs, the risk of arrest and drug withdrawal are greater concerns than the chance of HIV infection[8]. In the face of limited treatment availability and without a change in needle exchange policy, this population's vulnerability to HIV infection will continue.

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6. HIGH-RISK BLACK HETEROSEXUAL MALES

Who are Black heterosexual males in Texas?

Black men in Texas are a diverse group. They come from a variety of backgrounds, including African-American, Afro-Caribbean, and African. They have a variety of religious backgrounds, including, but not limited to, Christian and Muslim. Although Blacks represent only 12% of the total population in Texas, the Black population comprises 38% of persons living with HIV/AIDS (PLWHA) in Texas[1]. In 2007, the rate of cases for the Black population was five to seven times higher than the rate for Whites and Hispanics, 76 per 100,000 vs. 16 and 11, respectively[2]. A disproportionate burden of HIV/AIDS cases exists among heterosexual Black males in comparison to their heterosexual White and Hispanic peers.

What places Black heterosexual males at risk?

The primary risk for heterosexual Black males is unprotected vaginal or anal intercourse with an HIV-positive partner. In comparison to heterosexual men of other racial and ethnic groups in Texas, Black heterosexual men have a much higher prevalence of HIV/AIDS. Black heterosexual males comprise 21% of new diagnoses among Black men in 2007, while only 4.6% of White males and 15.2% of Hispanic males were attributable to heterosexual transmission[1].

How is their risk different?

Black men face a number of health concerns, of which HIV/AIDS is only one. Other factors, such as high rates of depression, substance use, and other STDs in Black communities, increase the ease with which HIV is transmitted in this community[1].

Black men tend to encounter significant barriers to health care, including insurance, employment, and education. Once these barriers are surmounted, Black men are likely to experience discrimination in these settings[1]. Black men in Texas are less likely to complete high school than White men, putting them at a disadvantage in seeking steady employment[3]. Lack of employment often leads to precarious personal circumstances, complicating caring for one's health.

Incarceration particularly disadvantages Black men[1]. A history of incarceration greatly reduces one's ability to achieve full-time employment and complicates maintaining a full-time job once employed. The stigma attached to incarceration creates barriers to resources that inmates need, post-incarceration, to prevent them from re-offending. These resources include, but are not limited to, regular and stable employment, education, treatment, and family-related services. These post-incarceration services are important because, without

them, former inmates may find themselves in secondary labor markets trying to earn livable wages to support themselves and their families[1].

Incarceration also makes it harder to maintain intimate relationships with partners, at times resulting in concurrent partnerships (multiple partners at the same time). Concurrent partnership patterns expose more individuals to HIV/STD than serial monogamous coupling patterns[3].

For Black men, there are many sexual implications to meeting cultural expectations for masculinity. Higher HIV/STD rates can be linked back to these perceived norms, such as a having a high number of female partners, having sex without a condom, and fathering numerous children[4].

The stigma of HIV in Black communities leads to fear of rejection from sexual partners, families, and religious communities, all of which can silence Black men regarding their HIV status and complicate effective HIV prevention[5].

Why are they a priority population?

Black heterosexual males are a priority population due to their disproportionate burden of HIV/AIDS cases. Many Black men are out of care[2], and bringing these men into care may greatly decrease HIV transmission. Black men face a variety of health disparities, and effective work on one health issue may lead to improvements in overall health outcomes.

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7. HIGH-RISK HISPANIC HETEROSEXUALS

Who are high-risk Hispanic heterosexuals in Texas?

Hispanic populations constitute 37% of the population of Texas, and almost 20% of this population is 9 years old or younger[1]. Hispanic populations in Texas are primarily of Mexican and Mexican-American origin and most reside in South Texas along the US-Mexico border and in major urban areas. Compared to other racial groups in Texas, fewer Hispanic individuals (59%) earn high school degrees in comparison to White (92%) and Black (85%). Hispanics in Texas are also more likely to be at or below the official US poverty line than Whites or Blacks. About 39% of all Hispanic Texans had no form of health insurance compared with Whites (14%) and Blacks (23%)[1].

What places Hispanic heterosexuals at risk?

Of all persons living with HIV/AIDS in Texas in 2007, 24.8% were classified as Hispanic. Like the Black population in Texas, Hispanics tend to have less access to health care, insurance, employment, and education, and are likely to experience discrimination in these settings[1, 2]. The current political climate surrounding immigration and the rights of Hispanic communities may impede the undocumented portion of the Hispanic population from seeking health care services[3].

Like the Black population, the Hispanic population tends to seroconvert at earlier ages than their White counterparts[1]. Hispanics represent a young, growing population in Texas whose sexual health is a concern. Hispanic youth have increasingly high pregnancy rates, an indicator for risky sexual practices[4].

How is their risk different?

Of particular concern with the Hispanic population is the identified trend of testing late in the progression of HIV[5]. One third of new diagnoses among Hispanics received an AIDS diagnosis within three months to one year of an HIV-positive test result, in comparison to 24% among Whites and 23% among Blacks[1].

Traditionally, in Hispanic families, the topic of sexuality is not discussed[6]. This lack of discussion between parents and children impedes access to needed information about HIV/STD and pregnancy prevention. Silence about sexuality impacts Hispanic women's ability to initiate a conversation about sex with a male partner, as doing so implies promiscuity.

Machismo in Hispanic culture has sexual implications for both men and women[7]. Hispanic men may prove masculinity through quantity of sexual conquests, unprotected sex, and having the power to make decisions in sexual relationships.

The relationship of acculturation and health risk behavior differs among Latinos depending on country of origin, and socio-economic status before immigration. It is hypothesized that, despite social, economic, cultural and linguistic disadvantages faced by new Latino immigrants, they tend to have better health outcomes than their US-born counterparts. As Latino immigrants acculturate to the US host culture, they have worse health and mental health outcomes. This is known as the Hispanic Health paradox, which is found to be especially true of Mexican-origin immigrants. This paradox is not found in Puerto Ricans, Cubans, and Central Americans. There are two attributable factors to the Hispanic Health Paradox. First immigration to a new country is a considerable, difficult undertaking in which healthier persons are more likely to be successful. Second, Latino culture tends to be a close-knit familial structure with traditional family standards, which may act as protection and insulate the individuals. Deterioration of that culture by time and influence of US culture results in worse health outcomes[8].

Why are they a priority population?

Hispanic heterosexuals need culturally competent HIV prevention services, including increased access to HIV testing opportunities, especially because Hispanics are likely to test later in the disease progression. Testing late can result in high community viral load, which increases prevalence and increases the likelihood for transmission. These services must be available in both English and Spanish, and interpreters should be available when necessary. We must work with Hispanic families to encourage discussion about sexual health and gender role expectations with adolescents. Considering that Latinos are the largest and fastest ethnic group in Texas and the United States, it is imperative to address the disparities and barriers that exist within the Latino community.

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Texas HIV/STD Prevention Community Planning Group (TxCPG)

Priority Populations

8. ALL YOUTH, AGES 13 – 24

Who are youth in Texas?

Every year, 3 million teens, or almost one fourth of all sexually experienced teens, will contract a sexually transmitted disease[1]. HIV/AIDS is increasingly impacting youth, especially youth of color. In 2007, of the 4,784 new diagnoses (all aged groups) of HIV/AIDS in Texas, 759 were among 13- to 24-year-olds (17%). According to surveillance data of new diagnoses of HIV in Texas, youth from communities of color tend to contract HIV disproportionately compared to their White peers[2]. Twenty percent of newly HIV-diagnosed individuals in this age group end up with an AIDS diagnosis within one year[2], suggesting that youth are not testing until late in the disease progression. An AIDS diagnosis at a young age also suggests that a young person has acquired HIV at a much younger age (because progression from HIV to AIDS requires a certain length of time).

Fifty-three percent of high school students in Texas report having had sex[3]. Of these sexually active students, a little over half (56%) report having used a condom at last intercourse[3]. STD data and pregnancy rates show trends of unprotected sexual behavior among youth in Texas. The most recent data (2005) estimate the teen pregnancy rate in Texas to be 88 per 1000 sexually active teenage girls, which is significantly higher than the national average (68 per 1000). Youth of color are at a disproportionately higher risk for teenage pregnancy; Latino girls (ages 15-19) in Texas are pregnant at a rate of 131 per 1000, Black girls of the same age are pregnant at a rate of 98 per 1000, and White non-Latino girls at a rate of 52 per 1000[4].

Youth of color and young MSM are disproportionately at risk for negative sexual health outcomes, such as an STD/HIV diagnosis or unwanted pregnancy. In Texas, youth make up 15% of the population, of which over half are Black or Latino[3].

What places youth at risk?

Characteristics of the social environment contribute to the risk for youth contracting HIV, including, but not limited to, their schools, their relationships with family, their peer networks, and their communities.

The type of sexuality education makes a difference. Comprehensive sexuality education has been shown to lower the risk of pregnancy compared to no sexuality education or "abstinence only" education[5]. Family connections are also important. Adolescents who feel connected to their families and perceive their parents as caring are more likely to postpone their sexual debut, use contraception, have fewer pregnancies, and fewer children[6, 7].

Runaway and homeless youth have complex health issues and survival behaviors that place them at risk for HIV infection[8]. Moreover, young gay and transgender youth are overrepresented in the homeless and runaway youth populations and often must engage in risk behaviors, such as trading sex for food and lodging[9, 10].

While some youth may not engage in more frequent risk behaviors than their peers, they may be at higher risk due to characteristics of their sexual networks*. Higher rates of STDs within a network increase the likelihood that non-infected members will contract disease[11]. Young Black MSM may be particularly at risk due to their sexual networks, a greater preference for same-race partners, and a greater likelihood of an age difference of more than 10 years between partners[12].

The use of alcohol and other substances increases the likelihood of HIV/STD risk behaviors, such as unprotected intercourse. Young people in Texas use substances at rates similar to their peers across the nation[13, 14]. For example, in 2007, 23% of youth who had sexual intercourse in the last three months across the United States and 22% of the youth across Texas drank alcohol or used drugs before last intercourse[13, 15].

How is their risk different?

High-risk behaviors, such as physical violence, substance use, and risky sexual behaviors, may impact the social and emotional development of young people. These behaviors impede their ability to experience or achieve adolescent milestones, such as graduating high school[16].

Biological factors influence youth decision-making. Youth do not achieve full neurological development until they reach their early 20s, which means they have yet to complete decision-making and future-oriented thinking stages. For this reason, youth are prone to making decisions that favor immediate benefits, such as pleasure, while failing to consider long-term consequences, such as pregnancy and disease[16].

Sexuality education across Texas is not standardized. The amount and type of sexual health education adolescents receive in school varies among school districts. In Texas, each school district can determine the type of sexual health education provided to its students[17]. Communities play a role in education through School Health Advisory Councils (SHACs), which are comprised of parents, teachers, students, community leaders, and nonprofit

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* *Sexual networks are groups of persons who are sexually connected to one another. The number of persons in a network, how central high-risk persons are within it, the percentage in monogamous relationships, and the number of links each has to others all determine how quickly HIV/STDs can spread through a network. Sexual networks are distinct from, but often overlap with, social networks.*
Wohlfeiler D, Potterat J. How do sexual networks affect HIV/STD prevention? *Fact Sheet*. San Francisco: Center for AIDS Prevention Studies at the University of California San Francisco 2003: http://caps.ucsf.edu/factsheets/sexual-networks/. Accessed May 26, 2011.

health organizations. SHACs serve as consultants to the school district and help determine the course of health instruction offered in a particular school district[18].

The Texas Education Code allows sexual health education to include “abstinence only” and “abstinence plus,” approaches that discourage sexual relationships outside of marriage and provide little to no information about prevention methods other than abstinence. Beginning in 1996, the federal government tied federal funding to programs emphasizing abstinence. These funds continued to increase[19]. Consequently, Texas schools that accepted the money have been restricted to teaching marriage as the only appropriate context for sex, and that sex outside of marriage will have harmful physical and psychological effects. Unfortunately, “abstinence only” programs have not effectively decreased sexual risk behaviors, whereas comprehensive sexuality education has[5]. In 2008, only 47.5% Texas high schools taught students on topics related to condom use in a required course, compared to 58.8% across the United States[20].

Almost four out of five (79%) of Texas youth have heard homophobic remarks in school, and 29% report their peers are frequently bullied because of sexual orientation or gender expression[21]. Young people who are bullied, in particular gay and gender non-conforming youth, are more likely to engage in high-risk behavior; the internalized bigotry of others and self-loathing make risky behaviors, such as substance use and unprotected sex, attractive options[22].

Many youth access the internet throughout their day[23]. They connect with friends on social networking sites, seek information, and create web content. For marginalized groups, such as young MSM, the internet provides a venue to anonymously find health-related materials. The internet is also a venue to explore sexuality and seek sexual connections. Exploration, inexperience and anonymity may result in high-risk partners and high-risk behaviors[24].

Urban minority youth report that HIV worries them; however, HIV is not at the top of the list of worries. These youth report greater concern about having enough money for daily living; general health; academic performance; getting pregnant; and getting hurt in a street fight[25].

Resiliency can be understood as responding in healthy ways to adverse social conditions. Generally, resiliency represents those protective factors or processes that stop a problem behavior in the face of risk, such as those experienced by urban minority youth and young MSM[26]. Schools, families, and communities can increase resiliency among youth.

Schools can strengthen protective factors by providing opportunities for students to experience success and develop problem-solving and social skills. For young MSM, gay/straight alliance clubs in schools offer protective factors, such as social connectedness and information relevant to their lives. However, only 17% of Texas schools have some form of gay/straight alliance club for LGBT students and their allies. This is below the national average of 21%[20]. Community-based organizations in some areas of Texas

create spaces for young MSM to mature in an affirming environment, an essential component to building resiliency.

Families can also offer protective factors. For example, in the case of Latino youth, mothers considerably influence their children's sexual risk-taking behavior. Mothers who openly discuss sexual health with their children improve the child's sexual health outcomes. Effective parental-child communication can meet children's needs and reduce the negative impact of a lack of comprehensive sexual education for their child[27, 28].

Why are they a priority population?

Youth are at a stage in life that will shape the balance of their lives. When adolescents are impulsive and experimenting with new experiences, they increase their risk of STD infection. Emotional challenges, including depression and stress, can likewise increase the chances that adolescents will engage in high-risk behaviors. Fortunately, a stable, close, and communicative family (in which sex can be discussed) may serve as a preventive factor for adolescents who might otherwise engage in high-risk sexual behaviors[29].

Texas youth show higher levels of risk behaviors than youth in other states. Texas has a high teen birth rate, high rates of STDs and HIV in youth, and limited access to comprehensive sexual health education that teaches protective practices in schools. Among youth, MSM of color stand out as especially vulnerable to HIV/STD infection, as they contract HIV at rates much higher than their peers[3].

Many youth conduct their daily activities in venues where HIV/STD prevention education can be easily implemented. Universities, schools, and religious organizations have regular contact with the young people in their communities. The youth at risk for HIV today are the adults at risk for HIV tomorrow. Early intervention with this population may benefit society through reduced disease burden and human suffering for many years to come.

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9. SPECIAL POPULATIONS

Who are the special populations in Texas?

Special populations* do not fit into the epidemiological categories routinely used in the collection of HIV/AIDS/STD surveillance data; yet other data sources and community experiences in Texas indicate the importance of including them in HIV/STD prevention planning. TxCPG identified the following populations in need of HIV/STD prevention services:

TRANSGENDER INDIVIDUALS

Transgender is an umbrella term for individuals who do not conform to their sex assignment at birth, and may self-identify through a variety of labels[1].

Transgender individuals are vulnerable to HIV[1]. Male-to-female (MtF) transgender individuals have a higher prevalence rate than female-to-male (FtM) transgender individuals. The MtF population may have infection rates between 10% and 30%, and Black MtF transgender individuals have infection rates as high as 56%, though there are no national data on prevalence of HIV among transgender populations[2]. Transmission routes in transgender communities are unprotected anal intercourse and needle sharing. Fear, lack of community, and the damaging effect of stigma and discrimination complicate HIV prevention efforts[3].

PARTNERS OF HIV-POSITIVE INDIVIDUALS

Sex and needle-sharing partners of persons with HIV/STDs are at high risk for infection, as indicated by the high prevalence of infection among sex and needle-sharing partners. Many partners are not aware of their risk and have never been tested for HIV. Partners of individuals newly diagnosed with HIV are particularly vulnerable due to high blood serum load, which is associated with increased risk for HIV transmission[4].

* One individual may fit into multiple population categories listed below.

HOMELESS INDIVIDUALS

People living with HIV/AIDS are at higher risk of becoming homeless. Some studies have found that 50% of people living with HIV/AIDS felt they were at risk of becoming homeless, while others found persons living with HIV/AIDS were unable to afford their housing, a risk factor for homelessness[5]. HIV-infected homeless persons have higher rates of tuberculosis and other illnesses. The homeless population has a median rate of HIV prevalence at least three times higher (3.4% versus 1%) than the general population. Even higher rates (8.5 to 62%) have been found in various subpopulations[6].

INCARCERATED/RECENTLY RELEASED INDIVIDUALS

Incarcerated individuals generally have poorer health outcomes than the general population, including higher prevalence of HIV and other STDs.

More people are incarcerated in Texas than in any other state in the United States; the rate of incarceration in Texas (648 per 100,000) is only behind that of Louisiana[7]. Blacks in Texas are incarcerated at a rate seven times that of Whites. Seven out of every 10 prisoners in Texas are Black or Latino (while about 4 out of 10 Texas residents are Black or Latino)[8].

According to the Texas Department of Criminal Justice (TDCJ) 2,458 incarcerated persons had HIV/AIDS in Texas at the end of 2007, which means Texas ranks third in the nation behind New York (3,500) and Florida (3,626). The individuals living with HIV/AIDS in TDCJ facilities are predominantly male and Black. In 80% of the TDCJ cases, injection drug use was a factor. Over half of the 2,458 persons entered with evidence of a previous HIV antibody test or self-reported a previous positive test. According to TDCJ, the primary reason provided by the inmate for testing in TDCJ is previous history of HIV-positive results (50.1%) and the second highest reason for testing is high-risk behavior. During intake evaluation, all offenders receive HIV pre-test counseling, including information about prevention and bloodborne pathogen infection, and they are offered HIV testing. TDCJ conducts pre-release HIV testing in accordance with Texas law[9, 10].

SEX WORKERS

Sex workers are not a single homogeneous group. Although they work in the sex industry, they come from different backgrounds and cultures that can differ greatly depending where they conduct their business. Some considerations are whether they work in a brothel, on the streets, or as an escort. Despite the diversity among sex workers, they share common factors that place them at risk for HIV.

Risks for HIV includes high rates of infection among sex workers[11], multiple partners, inconsistent condom use, injecting drug use, migration, and the stigmatization, marginalization, and criminalization of sex work[12].

HIV risk varies depending on workplace conditions. Street-based sex workers are at the highest risk within this category, as many have precarious living conditions, are at risk for violence from police and clients, and have histories of abuse[13].

INDIVIDUALS DIAGNOSED WITH AN STD/ HEPATITIS C

Prevalence of Hepatitis C may be as high as 30% among persons living with HIV/AIDS (PLWHA), and up to 90% for those who contracted HIV through sharing needles[14]. Those diagnosed with an STD are more vulnerable to HIV infection through a higher concentration of cells at the infection site or due to ulcers at the site of infection[15].

INDIVIDUALS WITH MENTAL HEALTH ISSUES

It is important to understand that individuals at risk for HIV are also often at risk for mental health issues, including emotional distress, depression, anxiety, and cognitive disorders. Marginalized and minority communities often encounter prejudice and social stress due to the some type of stigmatization. Members of high-risk communities often experience these adverse social conditions[16]. Adapting to chronic, life-threatening illness and corresponding physical and mental changes are an ongoing challenge for the person living with HIV, their family, and partners.

An understanding of mental health issues is essential for understanding how to help people protect themselves from HIV/STD infection, and how to avoid transmission of the virus to others[17].

INDIVIDUALS WITH SUBSTANCE ABUSE ISSUES

A strong association exists between substance use and the risk behaviors that contribute to HIV transmission[18, 19]. Substance users, including injectors of substances and non-injectors of substances, such as methamphetamine, crack, and nitrate inhalants, are more likely to contract HIV and be HIV-positive than non-substance users. Those who use crack cocaine and methamphetamines are highly likely to facilitate HIV exposure and seroconversion[20, 21]. Other substances, such as alcohol, can also create a context conducive to risk behaviors[22]. Drug and alcohol treatment may lead to a reduction in risk behaviors, thereby decreasing the spread of HIV. There are tangible benefits to the integration of care for substance abuse, mental health, and HIV. Integration reduces the duplication of services, increases cost-effectiveness, and yields a greater public health benefit[23]. A solid working knowledge of mental health and substance abuse issues is essential for understanding how to help people protect themselves from HIV infection, help those who are already infected from transmitting the virus to others, and reduce adverse health consequences among those living with HIV[24].

ABOUT SPECIAL POPULATIONS AT RISK

What places special populations at risk?

Patterns of risk factors and conditions often operate synergistically, meaning that, together, they increase the risk of HIV far beyond the effects of one risk condition alone[25]. For example, persons with an STD diagnosis have a greater biological vulnerability for contracting HIV through sores and high concentrations of white blood cells at infection sites[15]. Homeless persons have limited access to medical care and health insurance coverage and may live for a long time unaware of an HIV or STD infection, or without treatment. Research shows transgender individuals, particularly youth, who experience rejection by their families are more likely to become homeless, experience sexual abuse, and engage in unprotected commercial sex, all exacerbating their vulnerability to HIV infection[3]. Incarcerated individuals may not have access to barrier methods for sexual intercourse or access to needed health care, such as treatment and testing. Additionally, incarcerated individuals experience difficulty in gaining employment after release. Sex workers who work on the streets may risk incarceration by carrying condoms on their person, often considered proof of their occupation from law enforcement authorities. These patterns of instability in employment, housing, and family life impact an individual's ability to safeguard their health, leading to a number of negative health outcomes that increase their risk for HIV[11].

How is their risk different?

The special populations experience many barriers to optimal health, differentiating their risk from other populations that may not have the same quantity of confounding factors. Stable employment, access to housing, access to culturally competent and affordable medical care, and fair treatment from the judicial system are often elusive for these populations.

Why are they a priority population?

Each special population has a context that makes them particularly vulnerable to HIV infection. These categories are not mutually exclusive. Belonging to more than one of the special populations increases an individual's vulnerability.

Considering the array of social services that target these populations, many opportunities for HIV prevention intervention exist. Structural interventions, such as assistance in accessing housing, stable employment, and affordable health care, may decrease risk for contracting HIV.

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ACT NOW:

HIV Prevention with Gay Men and Other Men who have Sex with Men in Texas

HIV Prevention and Care Branch – Texas Department of State Health Services
August 2010

Table of Contents

Executive Summary

Where are we now?

In Texas new diagnoses of HIV among gay men and other MSM outnumber those of injecting drug users and heterosexual male and female cases. Overall new diagnoses of HIV in gay men and other MSM have held steady over the past five years; however increases in new diagnoses have been observed in subgroups such as young black and Latino gay men. This has contributed to an ever-increasing prevalence of HIV among these men. It is apparent that we cannot succeed in our efforts to prevent HIV without addressing gay men and other MSM. This document serves as a guide to a comprehensive and coordinated response to HIV among gay men and other MSM in Texas.

Currently, various evidence-based interventions from the Centers for Disease Control and Prevention compendium are being implemented across the state. Interventions operate alongside targeted HIV testing events and routine HIV testing in healthcare settings. While these interventions are effective, other approaches are needed to reach a broader audience with an HIV prevention message.

Why are we here?

Studies show that the underlying factors to HIV risk for gay men and other MSM are numerous. Structural, biological, social, and psychological factors all influence the likelihood of acquiring HIV across the lifespan (Table 1).

Table 1. Underlying factors to HIV epidemic among gay men and other MSM

Structural	Biological	Social	Psychological
Access to optimal health care	Viral load	Consequences of Isolation	Mental Health
Access to resources	Presence of other STDs	Stigma of HIV	Substance Use
Policies that stigmatize homosexuality	Sexual practices and positioning	Relationships	
Policies that stigmatize HIV		Sexual Networks	
Lack of sexual health education		The Internet	

Where do we need to be?

The Texas Department of State Health Services seeks to be responsive to where the epidemic is, namely, in communities of gay men and other MSM. The strategy combines biomedical, behavioral, and structural interventions, using a socio-ecologic approach to each intervention type. Targets for intervention include gay men and other MSM as well as other agents in the environment that influence risk such as organizations and social policy. For example, medical providers can be trained to address particular health care needs of gay men and other MSM.

Three strategies guide action:

- Raise the importance and urgency of HIV prevention
- Promote behavior change among gay men and other MSM
- Reduce the percentage of undiagnosed infections

How do we get there?

We are thirty years into the HIV epidemic. Changes over time require us to re-tool the HIV prevention message to gay men and other MSM. This can be done by providing sound, evidence-based information regarding HIV/STD prevention to gay men and other MSM. Additionally, evidence-based interventions already in operation in Texas need to be supported by innovative approaches such as building the capacity of communities to address their own epidemics. Innovation can continually be discovered by listening to the communities we are a part of and serve.

The Texas Department of State Health Services has dedicated resources to support strategic efforts and hopes to increase impact through collaboration with communities across Texas. New partnerships will be sought. Individual gay men and other MSM, LGBT communities, community-based organizations, religious communities, private and public health-care organizations, families, and schools can take small steps to promote the health of all Texans.

Section I: Introduction

Across the United States, the Centers for Disease Control and Prevention (CDC) estimates gay men and other men who have sex with men (MSM)[1] are 44 times more likely than other men and 40 times more likely than women to become infected with HIV.[2] This dramatic health disparity illustrates the degree to which the domestic HIV/AIDS epidemic is concentrated within communities of gay men and other MSM. Without action now the nation will face rising infections, increased complications in serving people living with HIV, and higher health care costs. The National HIV/AIDS Strategy[3] calls for renewed energy in combating the epidemic with a stated focus on gay men and other MSM.

Data for Texas reflect national trends. New HIV diagnoses among gay men and other MSM have held steady over the past five years while among young black and Latino gay men statewide HIV diagnoses have increased [1]. Year after year, this steady accumulation of new diagnoses continues to increase the prevalence of HIV within these communities. Recent estimates show that 4.4% of gay men and other MSM in Texas are living with HIV. The estimates allow us to understand the intensity of the HIV epidemic among these men for the first time. Preventing HIV in Texas will not be successful without directly addressing gay men and other MSM through a comprehensive and coordinated response.

Nearly 30 years have passed since HIV appeared in our communities. Since then we have established a vast amount of knowledge regarding the underlying social factors that increase risk. The impact of HIV/AIDS among gay men and other MSM cannot be fully understood without considering these underlying social factors and the significant social changes that have occurred over the course of the epidemic, such as advances in communication technology and medical treatment of HIV. Social context matters in how we engage communities as partners as well as the prevention messages we promote.

Independence and leadership are often seen as hallmarks of the Texas spirit. Indeed, doing things differently in Texas has placed the state among the innovators of how to do HIV prevention and treatment. Other jurisdictions have looked to Texas to understand how to implement prevention interventions such as prenatal HIV screening, HIV testing in STD clinics and routine HIV testing in medical settings.

Years of epidemiological evidence unequivocally indicate that HIV prevention for gay men and other MSM in Texas must be more effective. In response to this need, the

[1] "Men who have sex with men" is a category used in public health to describe sexual behavior among biological males regardless of how someone identifies their gender or sexuality.
[2] http://www.cdc.gov/nchhstp/Newsroom/msmpressrelease.html. Accessed on 03/12/10
[3] http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf. Accessed on 08/31/2010

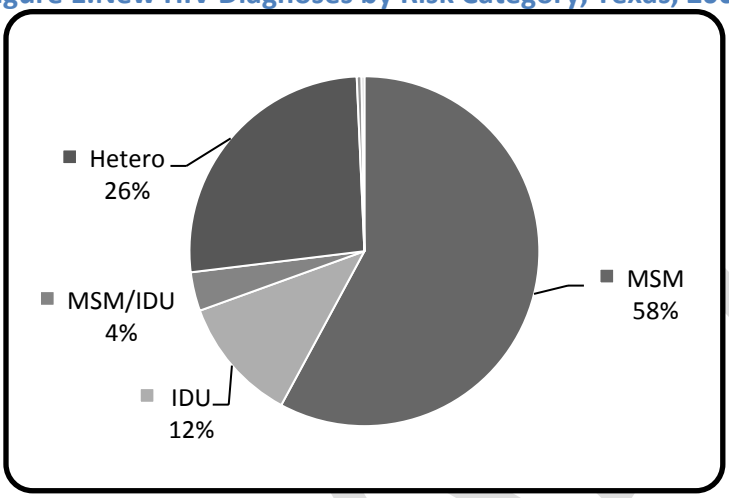
Texas DSHS HIV/STD Prevention and Care Branch has created the *Strategic Plan for HIV Prevention among Gay Men and Other MSM in Texas*.

This document will guide the Texas DSHS HIV/STD Prevention and Care Branch, and its partners in HIV prevention and health promotion for gay men and other MSM. Current data trends across the state are presented as well as the underlying factors facilitating HIV's spread. In conclusion, we provide our strategies to address the epidemic and suggest actions for a variety of stakeholders, including gay men themselves.

Section II: Where are we now? The current state of HIV/AIDS in Texas

Over half of new HIV diagnoses in Texas in 2008 identified MSM as the risk category (Fig 1). If HIV diagnoses that identified both MSM and IDU as risk categories are included, the proportion of HIV cases attributable to MSM approaches two thirds. The next largest risk category is heterosexual men and women, comprising about one quarter of new diagnoses.

Figure 1.New HIV Diagnoses by Risk Category, Texas, 2008

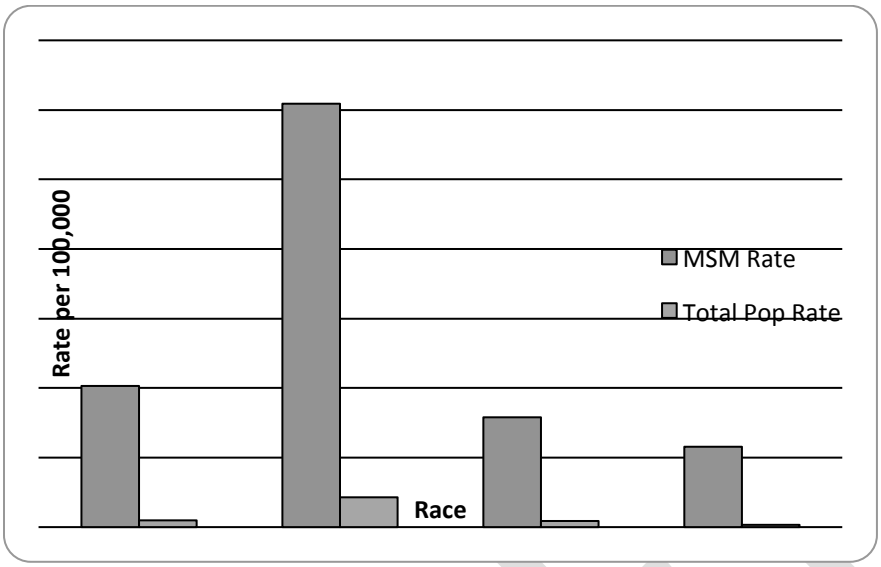


Yet even this difference does not adequately describe the intensity of the epidemic among MSM because MSM make up a relatively small proportion of the overall population. Recent estimates of the MSM population in the southern U.S. enable us for the first time to calculate rate estimates of HIV/AIDS among MSM in Texas.[4]

In 2008, 4.4 percent (or 1 in 23) MSM in Texas were living with HIV. This compares to an overall rate (which still includes MSM) of 0.258 percent (or 1 in 388) Texans living with HIV. Black MSM are especially impacted by HIV/AIDS (Fig 2). About 12% (or 1 in 8) of black MSM in Texas were living with HIV in 2008. White and Latino percentages were close to the overall MSM proportion. While these proportions are startling, it is important to note that the majority of MSM are not infected with HIV. Effective prevention efforts will keep it this way.

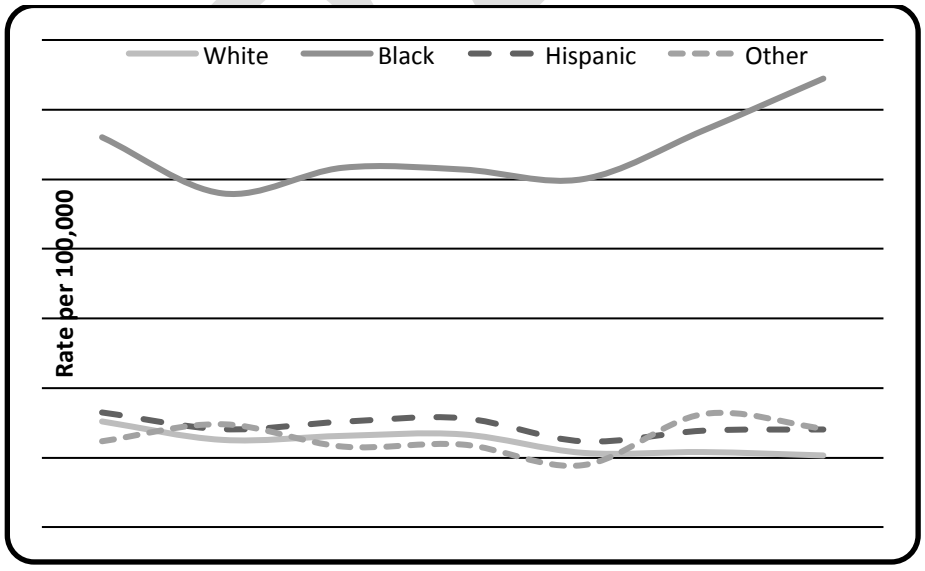
[4] The overall estimate of the number of adult MSM in Texas was 537,887, or 6.3% of the male population. This estimate was further differentiated by race/ethnicity, with 293,215 (55%) white, 47,046 (9%) black, 184,194 (34%) Latino, and 13,431 (2%) other race/ethnicity. We applied these percentages to the census-based population estimates for Texas, using these to calculate rates of adult MSM living with HIV/AIDS and new diagnoses among MSM.

Figure 2. Comparison of MSM and Total Population Rates of PLWHA by Race/Ethnicity, Texas 2008



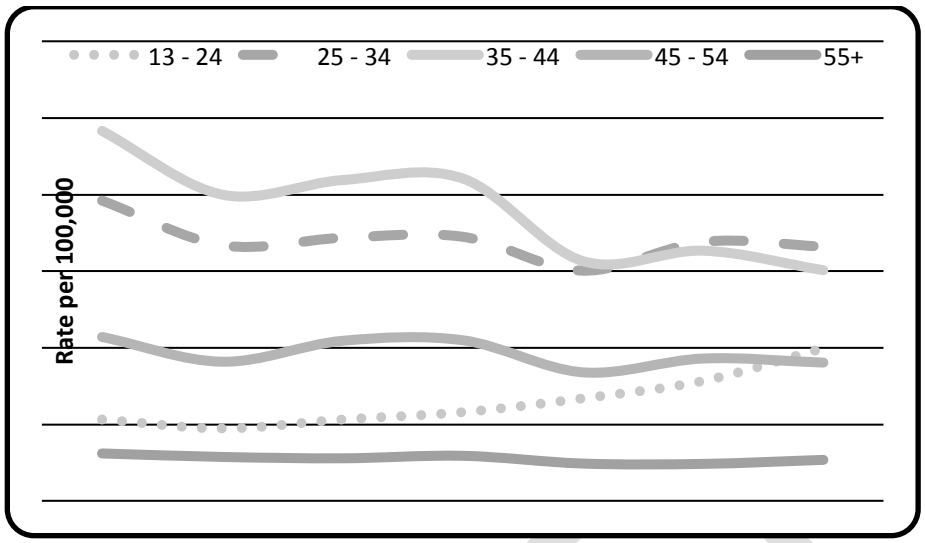
New HIV diagnoses among MSM overall remain stable. However, rates of new diagnoses are increasing for black MSM (Fig 3). About one percent of black MSM were diagnosed with HIV in 2008.

Figure 3. New HIV Diagnoses Rates among MSM by Race/Ethnicity, Texas 2002-2008



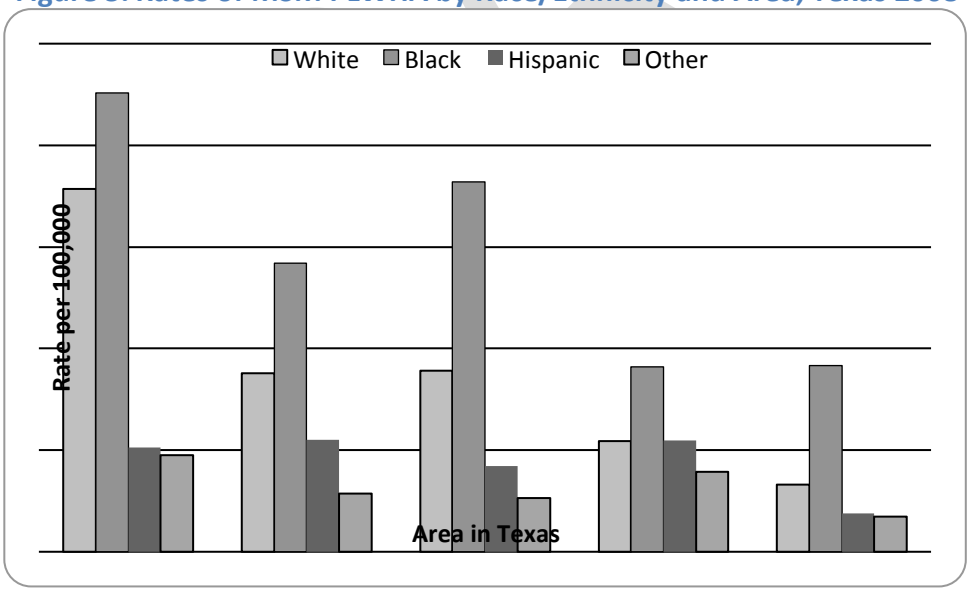
Additionally, new HIV diagnoses among young (13-24 year old) MSM are also increasing, while rates in older MSM are declining slightly (Fig 4). Young black and Latino MSM are being diagnosed at higher and higher rates. This trend may result from increased early testing and diagnosis, increased exposure for young men, or both.

Figure 4. Rates of New HIV Diagnoses among MSM by Age Group, Texas 2002-2008



HIV/AIDS rates in Texas are highest in major urban areas. In particular, Dallas County (Dallas), Harris County (Houston), Travis County (Austin), and Bexar County (San Antonio) have the largest number of cases of HIV/AIDS among MSM. The U.S.-Mexico border region and Tarrant County (Fort Worth) also have substantial epidemics (Fig 5).

Figure 5. Rates of MSM PLWHA by Race/Ethnicity and Area, Texas 2008



Section II: Why is there an HIV epidemic among gay men and other MSM in Texas?

Health-related behavior results from individual action and the environments in which people live[4]. HIV prevention in the United States has heavily emphasized individual behavior change, such as condom usage, without stressing other determinants of health, such as condom availability. Environmental changes facilitate health behavior changes, including HIV-related behaviors. To develop more effective strategies the HIV/STD Prevention and Care Branch seeks to address the following contributing factors to the HIV epidemic among gay men and other MSM:

1. **Consequences of bias:** Attitudes and beliefs that homosexuality and effeminate males are not acceptable foster an environment for HIV and other conditions to thrive [5-6]. Isolation resulting from these attitudes and beliefs allows emotional, verbal and physical victimization of gay and bisexual men to continue largely unnoticed. Victimization related to bias against homosexuality increases the likelihood of experiencing negative physical and mental health effects [6-7]. Rejection from partners, families, and communities contributes to risk.
    a. **HIV stigma within gay communities:** Gay men and other MSM communicate less now among themselves about HIV than they did in earlier stages of the epidemic. HIV stigma within gay communities persists through silence about HIV, fear of, and lack of testing for HIV, as well as reluctance to disclose status or partner with someone living with HIV [8]. HIV stigma within the broader community perpetuates reluctance to honestly address the virus. HIV stigma and the bias against homosexuality are closely linked [9].
2. **Access to optimal health care:** Gay men and other MSM have unique health care needs and have limited outlets to get health information relevant to their lives [6]. Barriers exist for these men to access this care, such as unequal access to job-related health insurance in comparison to opposite-sex spouses and unfavorable health care relationships with providers. MSM patients are often uncomfortable disclosing their identity and behaviors to health care providers, particularly if providers harbor stigmatizing and discriminating attitudes. And in general, men access health care less than women. All of these factors contribute to less than optimal health care for MSM.
3. **Relationships:** Recent studies show that the majority of MSM contracted HIV from primary partners [10]. From an HIV prevention perspective, it is critical to understand that connection (even brief) is as much or more the objective than physical sensation during sexual intercourse. Focusing narrowly on the sexual act ignores the relational, emotional context in which risk behaviors take place. [11-12].
    a. **Unprotected anal intercourse (UAI):** UAI occurs mostly in the context of primary relationships. Risk stems from partners being unaware of their HIV

status, or the breaking of negotiated safety pledges to use condoms with any outside partners [13-14].

b. **Individual and community responsibility:** Beliefs such as "the responsibility to protect oneself from HIV resides within each individual" often results in unprotected anal intercourse between HIV-positive and HIV-negative partners. On the other hand, HIV-positive men who report having a sense of community responsibility to try to protect their partners also report less unprotected sex.

4. **Community viral load:** Long-term survival with HIV means more opportunities to transmit the virus. However, anti-retroviral treatment lowers the concentration of HIV in blood, decreasing the likelihood of transmitting the virus [6, 15]. When most HIV-positive men adhere to treatment regimens, the amount of HIV decreases in entire communities. If HIV-positive men do not adhere to treatment regimens, risk associated with sexual activities increases due to a larger community presence of virus.
    a. **Undiagnosed infection:** Approximately 20 percent of infected persons in the United States are unaware of their HIV status[16]. Approximately one in three MSM in Texas receive an AIDS diagnosis within one year of his HIV diagnosis, indicating that he has been living with undiagnosed infection for many years. Among Latino MSM in Texas, more than two in five (40%+) are diagnosed late in the course of the disease [17]. This pattern of not testing and late diagnosis endangers the health of individuals and communities by contributing to and perpetuating a high community viral load among gay men and other MSM across Texas.
5. **Biological factors:** Some biological factors significantly increase the risk of transmitting HIV.
    a. **Other STDs:** The presence of other sexually transmitted diseases (STDs) greatly facilitates HIV transmission. Rates of STDs among MSM have steadily risen over the past 10 years [6]. Anal infections of gonorrhea or HPV in MSM have been associated with HIV infection; most of these sexually transmitted infections cannot be detected by the individual and many remain unaware of symptoms [18].
    b. **Sexual practices and positions:** Some sexual practices carry more risks than others. For men who have sex with men, unprotected receptive anal sex is far riskier than all other sexual practices, followed by insertive anal sex. In terms of HIV transmission, oral sex is considerably less risky than anal sex; however, receptive oral sex carries more risk than insertive oral sex. Our ability to quantify these risks is limited, as many factors influence the likelihood of any one individual transmitting or acquiring HIV. However, these distinctions are important and relevant to MSM willing to modify their sexual practices in order to reduce their likelihood of acquiring HIV.
6. **The Triple Threat: HIV/STD, mental health, recreational drug and alcohol use:** When MSM suffer from one condition, the likelihood to experience another becomes much greater.

a. **Mental health:** MSM experience stress related to being a sexual minority, a stress that varies by age but persists throughout the life course [19-20].Compared to heterosexuals, gay men and other MSM report more psychosocial health issues, such as anxiety, depression, and suicide, and are more likely to report experiences of discrimination in their everyday lives than heterosexuals[21].
b. **Recreational drug and alcohol use:** MSM report more alcohol and drug use for longer periods of time into adulthood than heterosexual men [6]. Using recreational drugs with sex can increase the risk of contracting and transmitting HIV and other STDs [22]. In addition, MSM use crystal methamphetamine at rates 10 times higher than in the general population. Methamphetamine use is more common among HIV-positive than HIV-negative individuals [23-24] Methamphetamine-users are distinguished from other substance users in that they have been more likely to report behaviors that are most likely to transmit HIV, such as having receptive anal sex while under the influence and performing unintended behaviors such as not using a condom [23, 25].

7. **Sexual network dynamics:** Where partners are met influences risk.
    a. **The Internet**: The Internet provides a means for gay and bisexual men to seek information relevant to their lives – information not readily provided in traditional mainstream social venues [26]. On a population level, the Internet also increases the number of sexual encounters occurring for gay men and other MSM who use it to arrange sexual partners and enables users to find specialized sex networks[27]. Internet sites targeting gay men often include a way to disclose HIV status in a profile; yet HIV stigma may stop men from openly disclosing their status.
    b. **Network segregation:** Racial segregation affects the sexual networks of all MSM. Black MSM are most likely to have a same-race partner, thereby increasing the likelihood of having an HIV-positive partner due to high rates of HIV in black communities. Age mixing in sexual networks potentially exposes younger partners to HIV and other STDs from those with more sexual experience [28]. Age-mixing is a potential factor in disparities faced by younger black MSM due to higher likelihood of having partners 10 years of age or older than themselves [29].
    c. **Concurrency:** Concurrent relationships overlap, as opposed to serial monogamy, where one relationship ends before another begins. Small differences in the concurrency of sexual relationships can greatly affect the spread of HIV and other STDs [30].
8. **Community strategies to prevent new infections:** As a result of the continued presence of HIV, gay communities have developed several harm reduction strategies to reduce risk of HIV infection. Some are more effective than others. A lack of widespread education on these strategies impedes their effectiveness[31].
    a. **Serosorting:** Men who use this strategy only have unprotected anal sex with partners of the same HIV status. HIV-positive men are engaging in a

community protective strategy, eliminating the chance that they could transmit HIV to an HIV-negative person. However, spikes in syphilis among HIV-positive MSM show that serosorting can have negative health outcomes such as contracting other STDs. Serosorting among HIV-negative men is an individual protective strategy and more complicated. Its effectiveness depends on knowledge of and honest disclosure of HIV status, but a substantial reservoir of undiagnosed infection still exists. As currently practiced, serosorting provides little protection from contracting HIV for HIV-negative MSM, and no protection from other STDs for both HIV-negative and HIV-positive MSM.

b. **Strategic positioning**: This refers to the relative risk of insertive versus receptive unprotected anal sex and adopting sexual positions that decrease the risk of HIV transmission. If one partner is HIV-positive, strategic positioning means this partner will take the receptive role during unprotected anal sex.
c. **Negotiated safety:** Negotiated safety is a relationship agreement between primary sex partners regarding condom usage during anal intercourse with non-primary partners [13]. This method requires a level of honest communication that few achieve, and HIV prevention typically does not motivate the agreement [32].
d. **Withdrawal:** During unprotected anal sex, removing the penis before ejaculating lessens the risk of transmission of HIV. However, HIV and other STDs can still be spread through pre-ejaculate dispensed into the anus.
e. **Partner reduction:** Having fewer sex partners has always been a strategy to reduce risk for HIV infection. However, the dominant construct of masculinity encourages men to maximize sexual encounters while devaluing long-term relationships between men.

9. **Complacency about HIV risk:** HIV infection is not inevitable for gay men and other MSM. However, unlike the threat of death from AIDS in the 1980s and early 1990s, HIV has become a part of life in gay communities. This shift has led to multiple reactions from gay men and other MSM. “Treatment optimism” refers to the shift in attitudes towards HIV/AIDS since the development of HAART[5] in the mid-1990s, impacting individuals in two ways. First, many MSM believe HIV-positive partners taking ARV[6] medications will be less likely to transmit the virus. Second, MSM believe advances in medication make the consequences of HIV infection less serious if they do become infected. As many as 25 percent of MSM endorse at least one of these beliefs [6]. These beliefs may be partially related to the failure of HIV prevention programs to update messages according to the needs of gay men and other MSM[33]. Young gay and bisexual men do not know a world without HIV, and as they age their prevention needs will likely differ than their older peers.

[5] Highly Active Anti-Retroviral Treatment
[6] Anti-Retroviral

a. **Prevention fatigue and burnout:** In order to survive the threat HIV/AIDS brought to their communities during the 1980s, gay men and other MSM reduced the behaviors putting them at risk for HIV. One of the first methods identified was the condom. However, messages that center on 100% condom use at all times with all partners have ignored the necessary mental and emotional aspects of relationships and connection often expressed through intimacy. Old HIV prevention messages no longer have the same impact in a changing epidemic.

Section III: Where do we need to be? Priorities for coordinated HIV Prevention among gay men and other MSM in Texas[7]

Raise the importance and urgency of HIV prevention

A. **Increase community awareness of the HIV/AIDS epidemic among gay men and other MSM and increase the urgency to respond**

Gay men and other MSM need facts about HIV that are relevant to their lives. Being informed leads to empowerment and focus [34]. Assessments show that communities across Texas are interested in learning more about the statistics for their own location and situation. In Florida and Houston, providing statistics regarding the HIV epidemic to gay communities was well-received [35].

Promote behavior change among gay men and other MSM

B. Expand access to HIV behavioral interventions for gay men and other MSM in Texas.

The Centers for Disease Control and Prevention (CDC) offers a variety of HIV prevention interventions which have been proven effective to reduce risk behaviors among MSM.[8] However, MSM report fewer encounters with organized HIV prevention efforts than ten years ago [36]. In one study, approximately 80 percent of MSM in 15 U.S. cities did not come in contact with an HIV/STD behavioral intervention [37]. HIV prevention efforts must increase the number of men they reach in Texas. This will require a greater investment in effective interventions and strategies for HIV prevention focused on gay men and other MSM as recommended by the CDC and the World Health Organization (WHO).[9]

C. Confront current social and structural determinants that facilitate HIV transmission among gay men and other MSM in Texas

Multi-level approaches to behavior change

Transmission of HIV and STDs does not occur in a vacuum; rather it exists in cultural and social contexts. A multi-level approach aims to create contexts that make healthy decisions default. This approach requires coordinated intervention on

[7] Strategies approved by Texas HIV/STD Prevention Community Planning Group members in October 2009
[8] http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm.
[9] http://www.who.int/hiv/pub/priority_interventions_web_c1.pdf.

individual, interpersonal, organizational, community, and structural levels. Structural-level interventions such as comprehensive sexuality education have been proven to reduce rates of STD infection[38-40], as have organizational interventions such as providing easily accessible condoms in bathhouses [41]. Community-based strategies for HIV prevention can aim to deter societal stigma towards homosexuality due to its association with disease disparities [42]. Efforts to decrease both internalized and societal stigma could improve overall health outcomes of MSM and engage gay communities as active partners in promoting prevention. [43].

Small-group level interventions designed to empower friend networks have been shown to motivate and maintain safer sex behavior among MSM[44]. At the same time, the potential for intervening with and within the sexual networks of MSM has not been fully explored. Additionally, social marketing approaches to promote HIV prevention and testing among young gay men have been effective [45].

Coordinating a comprehensive HIV prevention approach by intervening on multi-levels has great potential to slow the spread of HIV. CDC echoes a similar strategy by promoting a public health framework based on the health impact pyramid[46]. Applying intervention across all levels of the pyramid and creating synergies between levels potentially leads to the greatest prevention impact. Tobacco prevention in the United States has effectively used this approach [46].

Retooling the Behavior Change Message

Public health has largely promoted strict reliance on condoms as the most viable way to reduce risk for HIV and other STDs. Today's reality is quite different. As a result of HAART[10], gay men and other MSM have developed their own HIV risk reduction strategies beyond using condoms for every episode of anal and oral sex with every partner [6, 36, 47]. Interventions are more effective when they meet people where they are. A sexual harm reduction approach that provides accurate risk information for risk reduction strategies better enables MSM to negotiate their health into their sexual experiences [48].

Treatment as Prevention

In Texas during 2007, 30% of MSM with HIV were not in medical care. One strategy to lower the community viral load is to bring these men back into the health care system through treatment and care that is both culturally competent and sensitive to their individual needs.

Pre-exposure prophylaxis[49], the use of anti-retroviral medications prior to engaging in risk behaviors, is another promising prevention method [50]. Given the

[10] HAART= Highly active anti-retroviral therapy

extremely high levels of infection among MSM, pre-exposure prophylaxis may become a necessary strategy. Health departments, providers, and communities can begin to discuss and plan for the potential use of pre-exposure prophylaxis.

D. Assure culturally competent interventions for the needs of gay men and other MSM

HIV/AIDS prevention and education is most effective when delivered in a nonjudgmental and secure environment. The World Health Organization (WHO) recommends a sexual health approach tailored to the needs of MSM.[11] Texas DSHS and its community partners can listen to communities to acquire cultural knowledge and to learn what their concerns are.

For community interventions, using recognizable and acceptable terms, such as "gay" or "same-gender loving," increases the relevance of the intervention in the community [42]. Community members without public health experience do not recognize or identify as "MSM", and some would argue that no "MSM community" exists since the term reflects a behavior, not an identity[42]. [51],

The HIV prevention needs of MSM vary by race/ethnicity, generation, socioeconomic status, and geographic location. Emphasizing the unique protective factors of each culture or group, such as developing community, supporting healthy relationships, and mentoring youth, can increase the resiliency of all gay men and other MSM.

Reduce the percentage of undiagnosed infections

E. Assure that gay men and other MSM in Texas know their HIV status.

The WHO and the CDC recommend enabling individuals aged 13-64 to know their HIV status so they can protect their own health and the health of others. Targeted testing efforts have been shown to effectively motivate gay men and other MSM to seek an HIV test. Additionally, routine HIV testing in a variety of settings across Texas helps gay men and other MSM access testing opportunities.

F. Promote partner services and encourage acceptance of this service among gay men and other MSM through community collaboration

Historically, MSM have been reluctant to participate in partner services because they mistrust local and regional health departments or believe disease intervention specialists (DIS) to be insensitive [52]. Successful partner notification requires accurate contact information, which is not always available [52]. Increased

[11] http://www.who.int/hiv/pub/priority_interventions_web_c1.pdf.

awareness of partner services among MSM and cultural competence education for DIS about MSM will make partner services more effective.

G. Establish a system of prevention that goes beyond HIV/STD and integrates with other services to address gay men's health

HIV is part of the triple threat, or the gay men's health syndemic, a "chain reaction of interconnected epidemics"[5] each influencing the likelihood of the other conditions[6, 23]. The CDC recommends using a syndemics orientation to focus on the connections among health-related problems as gay men's health extends beyond HIV/STD prevention and treatment.[12] Linked, culturally competent care (comprehensive health care, mental health care, substance abuse treatment) can contribute to more effective HIV prevention. It is important for gay men and other MSM to disclose identity and behavior to health care providers, and it is equally important that providers offer safe places and ways for patients to do that.

Preventing HIV infection among MSM is desirable from individual, social, and economic perspectives. For individuals, living without HIV means not having to manage a serious lifelong illness. For society, prevention of HIV means keeping relationships, families, and communities productive and healthy. For economic reasons, every HIV infection prevented means approximately $355,000 is saved in the cost of providing lifetime treatment[53]. In addition, effective HIV prevention means influencing other co-occurring and costly epidemics among MSM, such as depression, suicide, substance abuse, and other sexually transmitted infections.

HIV prevention requires a focus on the whole health of MSM. Within the MSM population, communities and individuals are concerned about healthy relationships, discrimination, spiritual health, and building supportive communities. These are influential pathways to vulnerability or resilience. A whole health approach addressed through the concerns of MSM can be supported by connections between health care providers, community-based agencies, and communities themselves.

[12] http://www.cdc.gov/syndemics/.

Section IV: How do we get there?

Texas DSHS expresses a commitment to its jurisdictions to help decrease the burden of HIV/AIDS among gay men and other MSM through effective prevention interventions. The HIV/STD Prevention and Care Branch of Texas DSHS has committed to the following goals:

1. Reduce HIV transmission among MSM.
2. Support organizational capacity for interventions with MSM, particularly black MSM.
3. Texas DSHS will develop a package of targeted messages for black and Latino gay men and MSM across a variety of small media.
4. DSHS will engage local/regional health departments and community partners on promoting a better understanding of partner services among MSM.
5. Assure the proportion of DSHS-funded targeted tests among MSM will be 33%.
6. Assure all MSM-focused prevention programs supported by DSHS will have an Internet component.
7. Foster a sound organization with a focus on the health of black gay men and other black MSM to provide HIV prevention in Dallas.

What Texas DSHS will do:

- Support coordination among local public health, prevention providers, other relevant service providers, businesses, and community leaders.
- Support information sharing among prevention providers within the state and with providers across the country.
- Allocate funding for MSM-focused prevention efforts appropriate to the level of HIV burden.
- Expand holistic health approaches in prevention programming.
- Support the development of MSM socialization processes and social structures through MSM interventions targeted to the community level.
- Develop multi-level approaches to prevention with gay men and other MSM.
- Incorporate the ideals of our framework into grant applications and requests for proposals

What you can do:

Gay men and other MSM

- Educate yourself. Gay men are often assumed to know all about HIV and sexual health, but this is not the case. Seek out local and national resources for reliable information on HIV and sexual health.
- Begin a conversation with your friends about health and create support for one another to keep each other healthy.
- Join efforts to raise awareness about HIV in our local communities and with local government.
- Find a health care provider whom you trust and with whom you can openly discuss your health needs.
- If you do not know your HIV status, get tested. Also make sure to get tested for other STDs. Take a good friend who does not know their status and get tested together.

Religious communities

- Talk about HIV openly.
- Offer affirming and supportive religious counseling for gay men and other MSM, their partners, and their families.
- Offer spiritual guidance and support groups for HIV-positive men that respects sexual minorities.
- Train leadership in cultural competency for MSM.

Medical community

- Become comfortable taking sexual and HIV-risk behavior histories and providing risk reduction counseling. Alter intake forms to be inclusive of MSM and assure confidentiality.
- Consider routinely testing all patients for HIV.
- Create a welcoming office culture for sexual minorities.
- Be familiar with appropriate community referrals for gay men. Refer gay men to health resources in their community when appropriate.

Schools

- Support system-wide anti-bullying efforts that include sexual minorities.
- Support student organizations that promote diversity.
- Include sexual minorities in faculty and staff diversity and cultural competence training.

- Address sexual minorities in sexual health curricula.

Colleges and universities

- Educate students on HIV, sexuality, and sexual health.
- Support LGBT student groups.
- Include sexual orientation and gender identity in non-discrimination policies.
- Encourage LBGT students to work in careers associated with public health.

Policymakers

- Assure adequate funding for HIV prevention and treatment programs.
- Support sexuality education that acknowledges gay identity, same-sex behavior, and same-sex relationships.
- Support relationship recognition policies for same-sex couples.
- End employment discrimination based on sexual orientation in Texas.

Local health departments

- Work with community partners to identify appropriate messages and effective program strategies for gay men and other MSM.
- Provide opportunities for conversations between health care providers and MSM-friendly community services.
- Increase cultural competence among staff.
- Provide technical assistance to community based organizations, religious organizations, local colleges, and School Health Advisory Committees.
- Create an Internet presence for HIV/STD prevention and services.
- Provide information to health summits and fairs, task forces, and dialogues.

LGBT community-based organizations

- Create safe spaces for all members of the LGBT community, especially the young.
- Consider incorporating LGBT wellness into programming.
- Collaborate with other LGBT community-based organizations on LGBT wellness.
- Provide directories of LGBT culturally competent service providers to LGBT communities.

Closing

Epidemiologic evidence indicates that in order to adequately address the HIV epidemic, prevention efforts need to speak directly to gay men and other MSM in relevant ways. Effective HIV prevention programming for gay men and other MSM must take into account the social setting of the communities at risk. A focus on HIV alone will not appropriately address the multiple factors that influence HIV risk. To bring prevention into communities, we must be present in their discussions to listen to the needs they express. We must also be prepared to discover that HIV is not necessarily a top priority for the people at risk, as other issues such as employment, housing, family, and relationships may come first.

The aforementioned strategies serve as a guide for future initiatives of HIV prevention among MSM in Texas. The HIV crisis among these men remains, and the moment for action is now. We cannot succeed in preventing HIV in Texas without a sustained focus on gay men and other MSM.

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PARTNER SERVICES

[1]

What are Partner Services?

Partner Services are a broad array of services that should be offered to persons with HIV infection, syphilis, gonorrhea, or chlamydia, and their partners.

Partner services includes partner notification, whereby infected persons are interviewed about their partners, who are then confidentially contacted to discuss their possible exposure.

What is the goal of Partner Services?

The goal of HIV/STD Partner Services is to prevent the transmission and acquisition of STDs, including syphilis, HIV, chlamydia, and gonorrhea, by breaking the chain of infection.

This is accomplished by:

1. Identifying persons infected with STDs
2. Confidentially notifying their sex and/or needle-sharing partners of a possible exposure
3. Providing referrals to a range of medical, prevention, and social services for infected persons and their partners

What are the benefits of Partner Services?

Partner services offer benefits to three main groups:

- Persons infected with HIV/STD: The benefits to persons infected with HIV/STD include assistance with notifying partners of their possible exposure to infection and with accessing medical care and/or treatment, prevention services, and other services (e.g. drug treatment).
- Partner(s): The benefits to partners include being made aware of their exposure to HIV/STD and receiving referrals to testing, treatment, and other services as needed.
- The wider community: The benefits to the community include earlier identification and treatment/linkage to care of previously undiagnosed cases of HIV/STDs. Locating undiagnosed and untreated cases of HIV/STDs sooner may contribute to decreased transmission or burden of disease in the community.

Who conducts Partner Services?

Regional and local health departments prioritize new HIV and early syphilis cases for partner services. Highly trained disease intervention specialists (DIS) that work in local

and regional health departments routinely perform syphilis and HIV partner services that include counseling, partner elicitation, partner notification, and case management activities for individuals infected with these STDs.

In certain locales where resources permit, they also conduct targeted gonorrhea and chlamydia partner services, as well as targeted prevention counseling, to clients at high risk for STDs.

If persons are diagnosed with gonorrhea and/or chlamydia, the healthcare provider may provide medication to the patient to deliver to their partner, commonly referred to as Expedited Partner Therapy (EPT). EPT is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the healthcare provider first examining the partner.

For more information on Expedited Partner Services see:
http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=34561&id=5374&terms=EPT

How does the Partner Service process begin?

Healthcare providers and laboratories in Texas are required to report syphilis, gonorrhea, chlamydia, chancroid, AIDS, and HIV infections[2].

Partner services begin when a patient is diagnosed with HIV and/or a reportable STD and the healthcare provider and/or laboratory files a report with the local/regional health department. The healthcare provider should encourage patients to work with the DIS to notify their partners and refer them for testing and treatment.

The TB/HIV/STD Epidemiology and Surveillance Branch works with local and regional health departments to ensure persons newly diagnosed with HIV/STD are appropriately referred to a local/regional health department DIS. This provides assurance that persons diagnosed with HIV/STD receive medical care, partner services, and other support services as needed.

The DIS uses the surveillance information to locate the person, refer him/her for examination and treatment, and counsels him/her on methods to reduce the risk of acquiring or transmitting HIV/STD in the future.

The DIS also elicits the names, addresses, and other locating information of the client's sex and/or needle-sharing partners. Using field investigation techniques, the DIS locates and refers partners for examination, treatment, and/or counseling.

Remember: When a contact is notified, they are <u>not</u> told who identified them as a potential contact. All partner service activities are completely confidential.

In 2010, DIS interviewed 2,941 persons with early syphilis, initiated 5,703 partners, and identified 766 new early syphilis cases (approximately 25% of the early syphilis cases in 2010)[3].

In 2010, DIS interviewed 4,447 new HIV-positive persons, initiated 6,676 partners, and identified 243 new HIV positives[3].

When do Partner Services take place?

Partner services should be offered to patients as soon after their diagnosis as possible; partner notification typically occurs within two to three working days of identification.

Partners should be notified of their possible exposure and provided treatment (for curable STDs) or testing and linkage to medical care (for HIV) as soon as possible.

Where do Partner Services take place?

Partner services can take place in a variety of locations, as long it is a private setting. It often depends on the specific situation of the patient and his or her partners. Patients might be interviewed at a doctor's office, STD clinic, HIV counseling and testing site, or their homes. Partners may be notified at their homes, the home of the infected individual, a doctor's office, or a community-based organization.

What about Internet Partner Notification?

The Texas Department of State Health Services (DSHS) has implemented several internet-based tools to enhance partner services in Texas:

- E-mail is used by DIS as one means to locate and notify partners. Specific disease information is not used in e-mail.
- People-finding tools and mapping tools are used by DIS to help locate patients and partners.
- InSpot (www.InSpot.org) creates the opportunity for an infected person to notify partners confidentially or anonymously through use of an e-card.
- Internet Partner Services: Designated personnel at local and regional health departments locate partners online through profile or dating sites and refer them to the DIS for notification, testing, and if necessary, treatment. During 2010, internet partner services received and investigated 146 partners from around the state.

How can Partner Services reduce HIV/STD transmission?

Research suggests that individuals who are infected with HIV/STD and unaware of their infections contribute disproportionately to ongoing disease transmission in the community. In addition, studies have shown that finding and diagnosing these infected individuals may lead to decreased transmission, either by eliminating infection sources (i.e., treatment for those with curable STDs) or by decreasing risk behaviors (i.e., through counseling for those with incurable STDs).

Partner services may lead to decreases in STD and HIV transmission in the community because it is an effective means of finding individuals with undiagnosed infections and linking them to testing, medical care and treatment, and prevention services.

Where does the funding come from for Partner Services?

There are many sources of funding including federal, state, and local funds. Some forms of partner services require limited resources, such as patient referral of their partners.

Federally, the Centers for Disease Control and Prevention (CDC) Comprehensive STD Prevention Systems (CSPS) grant provides funds for local health departments and the DSHS HIV/STD Program to conduct partner services and the following activities:

- *HIV/STD Prevention and Care Services:* Including disease intervention, disease surveillance, testing for HIV/STDs, collaborating with community-based organizations to provide outreach, screening, and treatment services to at-risk populations in non-traditional settings, and training/professional development of staff
- *STD-Related Infertility Prevention:* Including chlamydia and gonorrhea testing, laboratory services, and quality assurance activities in STD clinics, DSHS-supported community and family planning clinics, and state and local adult and juvenile correctional facilities
- *Syphilis Elimination Activities:* Including enhanced disease surveillance, community involvement, clinical and laboratory services, and health promotion in areas of Texas with unusually high incidence of syphilis

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MEMBERSHIP

How open membership requirements were met

Throughout 2005, the Texas Department of State Health Services (DSHS) and the six regional Texas HIV Prevention Planning Groups participated in exercises and dialogue about whether there was still a need to have regional groups. Over the years, as science helped determine effective evidence-based interventions and detailed data on populations were used, the need for six lengthy, time-consuming plans was examined. Results from this process yielded a recommendation, from the regional groups, to develop one statewide HIV prevention community planning process. In 2006, regional planning groups were dissolved and one state group was established. Representatives from each of the old regional groups, along with staff from DSHS, formed a Transition Team that met to establish who needed to be represented in a community group that represented a state as large and diverse as Texas. With the Centers for Disease Control and Prevention (CDC) Planning Guidance as a standard, the committee determined specific skills and representation that would be needed. These positions can be found in the membership matrix at the end of this document.

During the first six months of 2007, the Transition Team and DSHS solicited, through numerous means, applications from interested citizens in multiple venues. Nearly 100 applications were received for membership of the first TxCPG. The Transition Team met and reviewed the applications, which were submitted de-identified, and selected those who would comprise the first state community group. The first face-to-face meeting was held in October 2007 in Dallas. A Community Co-Chair, elected on the last day of the meeting, joined the State-Appointed Co-Chair. At future meetings, TxCPG developed Bylaws, created committees, and developed operating procedures.

Since that first year, active recruitment has been a role of the Membership Committee and emphasized to all members of TxCPG. The members have represented TxCPG at numerous state conferences, meetings, and regional events to promote TxCPG and solicit applications. A brochure, website, and announcements through the "HIV/STD Insider" (a weekly on-line newsletter/e-blast from DSHS) continually recruits members. Membership is an open process by which an application is mailed or submitted online to DSHS and forwarded to the Membership Committee, with personal identifying information removed for review and consideration. Those selected are invited to join the next quarterly meeting (currently held in Austin) and provided relevant materials to begin their orientation process. Members not selected are invited to contribute to the work of TxCPG through workgroups or regional studies. For more complete information on TxCPG membership representation, roles, and responsibilities, please refer to the Bylaws in the appendix.

Development and training of new/existing members

Development and training of new/existing members has been accomplished in a number of ways:

New member orientation is conducted by the Membership Committee at a member's first meeting.

- Presentation of the overall goals and objectives of community planning are presented along with Bylaws.
- "Homework" and materials provided prior to the meeting are discussed.
- Members are assigned a TxCPG Navigator who is a member of the Membership Committee and assists new members at the meetings.

At each quarterly meeting, a portion of the time is dedicated to ongoing training.

- Subject matter experts are invited to present on pertinent topics related to Community Planning.
- Scholarships have been provided for a limited number of members to attend national and state HIV/STD conferences and seminars.
- Beginning in 2009, a members-only website was established for communication and posting of current and archival documents for reference and ongoing education.
- Professional consultants from the University of Texas at Austin work with TxCPG and its committees, providing research information and capturing the meetings with visual facilitation.
- The committees and TxCPG as a whole engage in continuous evaluation for improvement of their processes.

Membership Matrix

Members completed a matrix showing the organizations they represented, their areas of expertise, and their various demographic statuses. As seen in the matrix, most representatives filled a variety of categories.

Consensus

TxCPG decided that decisions would be made by a consensus model. Committees would make decisions for their specific areas of responsibility, with reports given to the full

membership at each meeting. Working documents are also placed in the members-only website for members to complete assignments and make final decisions.

Leadership

TxCPG is supported by DSHS with a staff planner who is dedicated to maintaining the workflow and functioning of TxCPG members. TxCPG also has retained the services of educational institutions in helping with research, data analysis, facilitation of meetings, and general support. Neither the DSHS planner nor the educational institution staff are voting members of TxCPG.

DSHS appoints a Co-Chair and the members elect a member as the Community Co-Chair. For a complete description of the leadership process, roles, and responsibilities, please see the Bylaws in the appendix.

TxCPG Member
Demographic Reflection

	DSHS APPOINTMENTS					TxCPG APPOINTMENTS											ORG / AGENCY APPT					SKILLS / EXPERTISE									
Member	State-Designated Co Chair	Substance Abuse	Family Planning	Perinatal Transmission	Ryan White Part B Staff Planner	Urban HIV Prevention Worker	Rural / Non Urban HIV Prevention Worker	STD Program / Services	Urban Local Health Dept	Rural / Non Urban Local Health Dept	Youth (13-24 year old)	Behavioral / Social Science	HIV Primary Care / Social Services Provider / Client	Immigrant / Migrant Issues	Mental Health / HIV Prevention	US Mexico Border Issues	Texas Rural Health Association	Houston HIV Prevention CPG	Ryan White Part A Staff Planner	Texas Education Agency	Prevention Training Center Part II Grantee	STD Knowledge	Implementing EBIs	Epidemiology	Incarcerated Populations	Minority Populations	Substance Abuse Issues	Sex Workers Issues	Health Care Delivery System	Rural Health	Faith Based Community
A							x			x												x				x		x		x	
B		x				x	x	x							x							x	x		x	x	x				
C	x			x																		x	x								
D												x									x	x	x	x		x		x	x	x	
E							x	x			x		x	x		x						x	x				x	x	x	x	x
F		x																x									x				x
G			x																			x				x					
H						x																x	x	x		x					x
I							x	x			x		x		x							x	x	x	x	x	x	x		x	x
J			x					x				x										x		x							
K											x											x	x		x	x					x
L						x		x			x											x				x					
M					x																	x	x	x	x	x	x	x	x		
N													x		x							x	x	x		x	x		x		
O														x		x								x	x		x				
P																	x									x				x	
Q																						x								x	
R								x	x			x	x	x					x			x	x	x		x					
S																						x	x	x	x	x	x		x		
T							x	x	x	x		x	x			x							x			x					
U					x				x										x											x	
V											x	x	x		x					x				x		x					x
W		x				x	x	x	x	x	x		x	x	x	x						x	x			x	x				
X					x				x										x			x		x							
Y																				x		x	x	x		x					x
Z							x	x		x	x		x									x		x		x				x	x
A1															x							x	x			x	x	x			
B1															x							x							x		
#	1	3	2	2	2	4	7	9	5	4	7	5	8	4	7	4	1	1	3	2	1	22	15	13	6	19	10	6	5	8	8

April 2011

TxCPG Member
Demographic Reflection

	GENDER				AGE		RACE/ETHNICITY								ORIENTATION				GEOGRAPHIC REGION									
Member	Male	Female	Transgender	Prefer not to Answer	<24	>55	Black or African American	White	Latino(a)	Asian / Pacific Islander	Native American / Alaskan / Hawaiian	Mixed	Other	Prefer not to Answer	Bisexual	Heterosexual	Homosexual	Prefer not to answer	Region I Amarillo / Lubock	Region 2 Abilene / Wichita Falls	Region 3 Dallas / Fort Worth	Region 4 Tyler / Lufkin	Region 5 Longview / Texarkana	Region 6 Houston / Beaumont	Region 7 Waco / Austin	Region 8 San Antonio / Uvalde / Victoria	Region 9 Midland / Odessa	Region 10 El Paso	Region 11 Corpus / Harlingen / Laredo
A	x					x	x									x			x										
B	x						x	x				x					x				x								
C	x							x								x									x				
D		x						x								x					x								
E			x					x	x			x		x														x	
F	x					x		x	x							x								x					
G		x				x		x									x								x				
H	x						x										x				x								
I		x					x									x						x	x						
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X	x						x									x					x								
Y		x				x		x								x									x				
Z	x				x			x									x		x										
A1	x						x		x			x					x									x			
B1		x				x		x									x								x				
#	15	12	1	0	1	11	10	14	7	2	0	4	0	1	1	15	11	0	2	1	9	1	1	4	5	1	1	3	1

April 2011

TEXAS HIV / STD PREVENTION COMMUNITY PLANNING BYLAWS

I. Name, Definition and Regulation

a. The name of this planning body shall be the Texas HIV / STD Prevention Community Planning Group, hereinafter known as the TxCPG.
b. The TxCPG is convened by the Texas Department of State Health Services (DSHS) in accordance with mandates from the Centers for Disease Control and Prevention (CDC), to work in coordination with the DSHS to guide and improve HIV / STD prevention activities across Texas.
c. The annual year for the TxCPG begins on January 1 and ends on December 31.
d. These Bylaws are written to supplement the current CDC HIV Prevention Community Planning Guide, and:
    i. Establish the basic structure of the TxCPG;
    ii. Effectively manage TxCPG prevention planning operations;
    iii. Guide decision-making within the TxCPG;
    iv. Foster the openness and participatory nature of the community planning process; and,
    v. Work towards the common goal of HIV / STD prevention community planning.

II. Mission and Purpose

a. The TxCPG is the community entity that shares responsibility with the DSHS in developing a Comprehensive HIV / STD Prevention Plan, for the State of Texas, hereinafter called the Prevention Plan.
b. The purpose of the TxCPG is to actively participate in a collaborative and on-going process that:
    i. Assesses the present and future extent, distribution, and impact of the HIV / AIDS and STD epidemics in at-risk populations.
    ii. Reviews existing community resources for HIV and STD prevention.
    iii. Identifies unmet HIV and STD prevention needs within at-risk populations;
    iv. Uses all existing data and information to determine and identify effective interventions and specific strategies to deliver HIV and STD prevention services.
    v. Defines the potential impact of specific strategies to prevent HIV and STD transmission;
    vi. Prioritizes HIV and STD prevention needs for at-risk populations;
    vii. Evaluates the effectiveness of the planning process; and,

Revised 07-14-10
Revised 04-26-10
Revised 09-01-09

viii. Provides consultation on issues related to HIV / STD prevention programming, as requested by DSHS.

III. Role of the TxCPG, DSHS and Shared Role

a. The role of the TxCPG in the community planning process is to:
   i. Elect a Community Co-Chair;
   ii. Develop operational policies and procedures ensuring all members of the TxCPG have equal opportunity and voice to provide input;
   iii. Assure that HIV and STD prevention strategies are culturally and linguistically appropriate;
   iv. Develop and facilitate mechanisms for community input;
   v. Develop and periodically review membership criteria and selections processes ensuring compliance with Parity, Inclusion, and Representation (PIR) as described in Article IV;
   vi. Provide timely orientation for new members;
   vii. Operate in accordance with DSHS and CDC guidelines;
   viii. Adhere to, and periodically review and update TxCPG Bylaws;
   ix. Assess concurrence between the DSHS application to the CDC and the Prevention Plan; and,
   x. Provide consultation on matters associated with HIV / STD prevention programming as requested by DSHS.

b. The role of the DSHS is to:
   i. Develop an application for federal funds based upon the Prevention Plan;
   ii. Foster integration of HIV / STD prevention planning with other relevant planning efforts;
   iii. Ensure the implementation of the Prevention Plan is in accordance with the priorities identified in that plan;
   iv. Assist the TxCPG in achieving the purposes stated in Article II;
   v. Select a State-Designated Co-Chair for the TxCPG;
   vi. Provide resources and information that support the community planning process;
   vii. Monitor the TxCPG to determine if it is operating according to DSHS and CDC policies and criteria; and,
   viii. Provide regular updates and information on the successes and barriers of implementation of the Prevention Plan.

c. The shared roles of the TxCPG and the DSHS are to:
   i. Assure that the membership of the TxCPG meets PIR requirements;
   ii. Identify and provide technical assistance and capacity building needs of the TxCPG;

iii. Achieve the purposes described in Article II;
iv. Effectively collaborate in all planning processes to ensure a partnership that addresses the HIV and STD prevention needs of Texas; and,
v. Develop a five-year Prevention Plan that includes a statewide list of priority populations, recommended interventions, and goals and objectives for prevention activities.

IV. Membership Definition, Qualifications, Responsibilities, and Removal

a. Members will serve two-year terms with a maximum of three terms for a total of six years.
b. Membership of the TxCPG shall reflect current Parity, Inclusion, and Representation as described below:
    i. Parity: implies that all members of the TxCPG have equal opportunity to provide input and have equal voice in decision-making;
    ii. Inclusion: assures that all communities affected by the HIV / STD/AIDS epidemic are represented and involved in the planning process. In this case, "community" refers to specific characteristics of groups that may be perceived as being at greater risk for becoming HIV / STD infected or are generally affected by the AIDS epidemic; and,
    iii. Representation: assures that those who have been selected to represent a specific community reflect the values, norms and behaviors of that community and participate in TxCPG processes as a voice for that community; and,
c. Determination of current PIR shall be established bi-annually.
d. Member Qualifications:
    i. Membership of the TxCPG should reflect current disease epidemiology and consist of relevant subject matter experts as well as representatives of other planning processes and related fields. Current membership positions are contained in Attachment A.
e. Membership - shall be determined by a process established by the TxCPG Membership Committee.
f. Membership responsibilities include:
    i. Attending the two-day quarterly TxCPG assembly and committee meetings as scheduled;
    ii. Attending TxCPG meetings and casting votes shall be performed solely by the TxCPG member.
    iii. Abiding by confidentiality and conflict of interest requirements;

iv. Serving on a minimum of one (1) committee, but no more than two (2) committees. Co-Chairs are considered members on all committees.

g. Absences (applicable for the entire term of the TxCPG member):
   i. 1st missed meeting within a 12-month period – Co-Chair will contact member for review of attendance requirements;
   ii. 2nd missed meeting within a 12-month period – Co-chair will alert member that he or she will be automatically removed from the TxCPG if another meeting is missed within 12 months of the 1st missed meeting.
   iii. 3rd missed meeting within a 12-month period – member will be automatically removed from the TxCPG.

h. Removal of Members for Absences:
   i. A member who has missed three meetings within a 12-month period will be automatically removed from the TxCPG.
   ii. A member affected by this action will be notified by the Co-Chair within 10 business days.

i. Removal of Members for Causes Unrelated to Absences:
   The Membership Committee will review each potential case for removal on an individual basis and will initiate any removal process necessary.
   i. A member may be removed by a vote of two thirds (2/3rds) of the current TxCPG Membership Committee present.
   A member affected by the action will be notified within 10 business days.
   ii. A member wishing to grieve the process for their removal must submit to the Membership Committee of the TxCPG a written notice of intent within 5 business days of the notification of removal.

The decision of the Membership Committee will be considered final and notification made to the TxCPG General Assembly.

V. Meetings

a. Assembly meetings are defined as convocations of the entire TxCPG. Their frequency, duration and location shall be determined by consensus, though shall occur no less than four times annually.
b. Any TxCPG meeting may be held via conference call, face to face, or electronically, as determined by the chair(s).
c. All scheduled meetings are open to the public.

VI. Decision Making

a. Decision-making shall be conducted through consensus of members present. The Co-Chairs / committee chairs shall declare the point at which consensus appears to have been reached. If consensus cannot be reached, a vote (motion) can be called which would require a "second." A majority of votes by the members present will determine the final decision.

VII. Co-Chairs and Committee Chairs

a. State-Designated and Community-Elected Co-Chairs constitute the leadership of the TxCPG.
b. The Community-Elected Co-Chair shall be elected by the membership of the TxCPG and serve a maximum of two three-year terms.
c. The TxCPG membership may vote to extend the Community-Elected Co-Chair's second term to oversee completion of the Texas Statewide Prevention Plan if the Plan is due to the CDC within twelve (12) months of the end of the Community-Elected co-chair's second term.
d. If the Community-Elected co-chair's second term is extended, the second term shall conclude at the end of the calendar year in which the Texas Statewide Prevention Plan is submitted to the CDC.
    i. Nominations for a new Community-Elected Co-Chair will be accepted eighteen (18) months prior to the end of the term of the current Co-Chair.
    ii. Election of the new Community-Elected Co-Chair shall occur no less than fifteen (15) months prior to the end of the term of the current Co-Chair.
    iii. The new Community-Elected Co-Chair shall serve as Co-Chair Elect until the current Co-Chair's term ends.
    iv. The new Community Elected Co-Chair shall assume the Co-Chair position when the current Co-Chair's term ends.
    v. If the current Community-Elected Co-Chair vacates the position prior to the end of a term, the new Co-Chair shall immediately assume the Co-Chair position.
    vi. If the current Community-Elected Co-Chair vacates the position prior to the end of a term and a new Co-Chair has not yet been elected, nominations and election will be held at the next regularly scheduled TxCPG meeting or upon the vacating of the position by the current Co-Chair.
e. DSHS will select the State-Designated Co-Chair every two years.

f. The Co-Chair's roles include, but are not limited to:
    i. Develop meeting agendas and facilitate meetings;
    ii. Maintain accountability of the TxCPG to DSHS, CDC, and the community;
    iii. Plan strategically for TxCPG activities, coordinate and manage the work of the TxCPG and its committees;
    iv. Collaborate with DSHS to develop and manage the TxCPG budget and expenditures;
    v. Ensure that policies, procedures, updates, and any other federal and/or state requirements are communicated to the TxCPG and that they follow these guidances; and,
    vi. Ensure that processes, policies and procedures for the governance and operation of the TxCPG are developed and adhere to federal and state requirements.
g. Chairs and Vice Chairs of committees are selected annually by the Co-Chairs.
h. DSHS in consultation with the TxCPG members will be responsible for removal of a Co-Chair for cause except in the case where the Co-Chair has forfeited their position.

VIII. Committees and Other Task Groups

a. Committees and other Ad Hoc Groups shall be established by the TxCPG to achieve the mission and purposes of the TxCPG. Current committee descriptions are outlined in Attachment B. This attachment does not require Bylaws revision to be revised.

IX. Conflict Resolution

a. Conflict of interest or dispute issues will be brought before an ad-hoc Conflict Resolution Committee, appointed by the Co-Chairs, in writing. Upon receiving a written statement of a conflict of interest or dispute, the Committee will respond within 5 business days with an acknowledgement of the written request. The Conflict Resolution Committee will follow the conflict resolution procedure in Attachment C.

X. Ratification

a. The TxCPG Bylaws shall be ratified by consensus of the full TxCPG and submitted to the DSHS for final approval.

XI. Amendments

a. Proposed amendments to these Bylaws and attachments shall be submitted by the Bylaws Committee.
b. Ratification of amendments shall be determined by consensus of the full TxCPG.

XII. Dissolution

a. The TxCPG will remain formed for as long as the State of Texas receives funding for the HIV community planning process. The DSHS has the authority, however, to alter the planning process.

Ratified on this: _____day of _____, 2010.

_____
State-Designated Co-Chair

_____
Community-Elected Co-Chair

Revised 07-14-10
Revised 04-26-10
Revised 09-01-09

ATTACHMENT A

Membership

Membership of the TxCPG shall consist of no more than 40 individuals, each filling a defined seat as determined by the rules of parity, inclusion, and representation, as well as the informational and expert needs of the TxCPG.

Defined seats of the TxCPG shall consist of two, non exclusive, groups; (1) population / risk and (2) skills / expertise. Population / risk seats shall reflect the epidemiology of the state and shall be determined annually based on the epidemiological report, created by DSHS, from the previous calendar year. Skills / expertise seats may be reviewed and altered as needed by consensus of the TxCPG.

Individuals will be chosen through a general application review process by the TxCPG Membership Committee and notification provided to the TxCPG General Assembly of newly-selected members. In the case of an individual representing a specific body or organization on the TxCPG, that individual will be appointed by the represented body or organization and will serve at the discretion of said body or organization.

The membership of the TxCPG shall reflect the diversity of the state with regard to sex, race / ethnicity, and geography. At minimum, 15% of the individuals which comprise the TxCPG shall be persons living with HIV / AIDS.

The following skills / expertise seats shall be filled by DSHS staff in consultation with other DSHS programs:
- State-Designated Co-Chair
- Substance Abuse
- Family Planning
- Perinatal Transmission
- Ryan White Part B Staff Planner

The following skills / expertise seats shall be filled by appointment by the respective organization / agency:
- Texas Education Agency
- Houston HIV Prevention CPG
- Ryan White Part A Staff Planner
- Prevention Training Center Part II grantee

The remaining skills / expertise seats shall be filled through the general application review process:

- Urban Local Health Department
- Rural / Non Urban Local Health Department
- STD Program / Services
- HIV Primary Care / Social Services Provider / Client -
- Behavioral / Social Science
- Youth (<24)
- Immigrant / Migrant Issues
- Urban HIV Prevention Worker
- Rural / Non Urban HIV Prevention Worker
- Mental Health / HIV Prevention
- US Mexico Border Issues
- Rural Health Organization
- Faith-based

The entire membership of the TxCPG should also reflect general expertise and experience in substance abuse issues, implementation of evidence-based interventions, the Texas criminal justice system, commercial sex work issues, general health care delivery systems.

ATTACHMENT B

Committees and Other Task Groups
As of July 2010

COMMITTEES

Membership and Bylaws

Concurrence

Assessment and Populations

Interventions

Executive Committee

All Things Considered

Program Materials Review Panel

Revised 07-14-10
Revised 04-26-10
Revised 09-01-09

ATTACHMENT C

Conflict Resolution

Conflict of interest or dispute issues will be brought before an Ad-Hoc Conflict Resolution Committee in writing. Upon receiving a written statement of a conflict of interest or dispute, the committee will respond within 5 business days with an acknowledgement of the written request.

Procedure:

Grievant:
The grievant will file a written statement with a Co-Chair.

Co Chair:

- The Co-Chair, notifies in writing, all parties involved, that a grievance has been filed and the specific allegations or issues involved.
- Co-Chairs appoint an Ad Hoc Conflict Resolution Committee (odd number, maximum of 5).
- Label, date, and sign all documents, keeping all information received confidential.

All Parties:
Meet in closed session by mutually-agreed-upon arrangement with all parties involved to investigate the complaint. This may include interviews and requests for documentation.

Grievance Committee:

- Adheres to the following principles of dispute resolution:
    - Establish a goal that includes the concerns of all involved.
    - Maintain a climate of fairness and mutual respect.
    - Distinguish between the person and the problem.
    - Identify and build upon areas of agreement.
    - Distinguish between interests and positions.
    - Develop options for mutual gain.
    - Use objective criteria.

- Provides and maintains written documentation of proceedings.
- Renders, at minimum, a two-thirds (2/3rds) majority decision by the committee within 30 days of written notification received by the Co-Chairs.
- Presents a written confidential summary statement at the next regularly scheduled TxCPG meeting.

The COMPREHENSIVE PREVENTION RESOURCES INVENTORY

will be available on the HIV/STD section of the DSHS website.

The 2010 TEXAS INTEGRATED EPIDEMIOLOGICAL PROFILE FOR HIV/AIDS PREVENTION AND SERVICES PLANNING: HIV/AIDS IN TEXAS

is available online.

http://www.dshs.state.tx.us/hivstd/reports/default.shtm

HIV/STD PREVENTION
Community Planning Group

Letter of Concurrence

Date: September 9, 2010

CDC Prevention Project Officer for the State of Texas

Dear CDC Project Officer:

We, the members of the Concurrence Committee of the Texas HIV/STD Prevention Community Planning Group (TxCPG) have reviewed the Interim Progress Report (IPR) and 2011 Proposed Plan for CDC's HIV Prevention Projects PS01-1001, Award Number 3U62PS623516, provided by the Texas Department of State Health Services (DSHS).

The Concurrence Committee, comprised of six members, received the IPR and 2011 Proposed Plan on August 19, 2010 for review and comment. DSHS had previously submitted this report to the CDC. The CDC Instructions for Preparing an Interim Progress Report was posted to the TxCPG website August 23, 2010. As the Letter of Concurrence was due September 10, 2010, the Committee had sufficient time to review and comment on the IPR and 2011 Proposed Plan. The Committee communicated their comments and concerns through emails and the TxCPG website. These comments and concerns, as well as any new insights, were then discussed during a conference call held September 8, 2010. The Committee also reviewed the concurrence process. The TxCPG has authorized the Concurrence Committee to conduct concurrence on behalf of the TxCPG. This Committee will report back to the entire TxCPG at the next meeting in October 2010.

As representatives of the TxCPG, we were asked to determine concurrence with the activities proposed for calendar year 2011. As the TxCPG Co-chairs (or other designated representatives), we

____X__ concur (please see comments below)

_____ concur with reservations (please describe)

_____ do not concur (please justify)

The Committee supports the overall document and is pleased with many of the initiatives by DSHS. DSHS and the TxCPG have been collaborating successfully in the development of the new plan, which will be completed in 2011.

In reviewing the funded interventions, the Committee noted that only one intervention addresses African-American Men who have Sex with Men (MSM). As MSM are a priority in the comprehensive HIV Prevention Plan, this is a concern. We believe that a defined process to revise the HIV Prevention Plan, which in turn reprioritizes the interventions that are funded during the multi-year grant cycle, is a challenge that needs addressing.

The Concurrence Committee did not receive the proposed budget and therefore did not review it. We would like DSHS to explain to the TxCPG how their MSM plan fits in with the priorities and interventions determined by the TxCPG. Lastly, we ask DSHS to consult with the TxCPG to ensure that membership information is correct and up-to-date in their progress reports.

Sincerely,

Community-elect Co-chair's printed name: Jamie Schield

Signature Jamie Schield

DSHS Co-chair's printed name: Greg Beets

Signature Greg Beets

Intervention Review

Introduction

This report presents the results of two intervention review processes:

- A review of intervention program materials performed by members of the Texas HIV/STD Prevention Community Planning Group (TxCPG)
- A review of the implementation of interventions currently or previously funded by the Texas Department of State Health Services (DSHS), performed by DSHS staff members who have experience with the interventions

The report is comprised of the following components:

- A matrix that contains a brief description and rating of each of the interventions
- A summary of each of the intervention reviews
- A glossary of terms relevant to HIV prevention
- A summary of implementation reviewers' comments on intervention evaluation
- Background information related to technical assistance (TA) and training
- A list of priority populations identified by TxCPG matched with the interventions that were designed for those populations.

Intervention Review Methods

Interventions were reviewed through two separate processes: a review of the intervention materials and a review of the intervention implementation experiences.

1. Intervention materials review

Members of the TxCPG Interventions Review Committee formed two groups comprised of four to eight members and reviewed materials for twenty interventions (ten by each group) at the July and October 2009 quarterly TxCPG meetings. Their reviews addressed the following points:

- Materials available for review
- Description of the intervention provided in the materials
- Quality of the materials reviewed
- Implementation needs

Production of review summaries involved multiple steps, including:

- Group members reviewed materials from the intervention package and key informant input from group members with experience with the intervention.
- Group members produced individual, written evaluations of each intervention based on their opinions of the materials and on the results of group discussions.
- The written reviews were compiled and summarized by a member of the University of Texas HIV Support Team (UT Support Team). After the summary was completed, the consultant wrote a brief section entitled Review Outcome. Review Outcomes are a simple summary of reviewers' opinions.
- The summaries were next reviewed and edited by other members of the UT Support Team and DSHS staff.
- Subsequently, members of the Intervention Review Committee reviewed and approved the summaries with suggestions for final revision.
- The UT Support Team provided final form and content editing with support of DSHS staff.

2. Implementation review

Seventeen additional interventions (plus three of the 20 reviewed by TxCPG) were reviewed by DSHS staff members who were familiar with the implementation of particular interventions. Depending upon experience, review groups ranged from two to eight members and focused on implementation issues that affected the feasibility and effectiveness of the interventions. The topics addressed by this Intervention Review Panel included:

- Intervention description
- Conditions necessary for successful implementation[1]
- Availability and impact of training
- Resources required to implement the intervention
- Management or staffing issues
- Issues related to recruitment of the target audience
- Issues related to retention of the target audience
- The impact of TA on the implementation process
- The impact of tailoring requests on the implementation process
- The impact of evaluation efforts on implementation
- Statements about successes associated with the intervention
- Statements of desirability of implementation and the conditions under which the intervention would be appropriate

The compilation and summary process used for the materials review was applied to implementation reviews.

[1] Conditions deemed necessary for successful implementation are mentioned on the cover page of an intervention only in the case of ***implementation reviews*** performed by DSHS staff who had direct experience with the actual intervention.

The materials and implementation review summaries have been compiled in a document entitled *Review Summaries*. Each summary is composed of two or three parts: a general description, a materials review (for interventions reviewed by the TxCPG Intervention Review Committee), and an implementation review (for interventions reviewed by the DSHS Intervention Review Panel). Two separate documents addressing evaluation and training/TA have also been produced from the data developed through the review.

The findings reported here were developed between July of 2009 and February of 2010. Some have been modified by more recent editing, but information on materials, training, and TA is subject to continuous change and should be verified by persons planning to implement any of the interventions.

IMPLEMENTATION DECISION KEY

Materials Review Recommendations	
●	Total agreement to recommend implementation
◉	General agreement to recommend implementation under favorable conditions
○	General agreement to not recommend implementation
Implementation Review Recommendations	
■	Total agreement to recommend implementation
▣	General agreement to recommend implementation with minor concerns noted
▣	General agreement to recommend implementation with serious concerns noted
□	General agreement to not recommend implementation

Acknowledgements

The following people contributed to the development of these documents:

Texas Community Planning Group Intervention Review Committee
Floyd Anthony
Tracee Belzle
Anna Danciger
Jeffery Green (Co-Chair)
Gloria Hawkins
Nike Lukan
Nonie Mendias
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Jeff Wagers (Coordinator)
Katy Walter

University of Texas HIV Support Team
Nicole Angotti
Nell Gottlieb
Sandy Graham
Karol Kaye Harris
Todd Harvey
Jessica R. Jarvis
Ken Ripperger-Suhler (Coordinator)

Training and Technical Assistance

Training is provided by a number of entities. The Centers for Disease Control and Prevention (CDC) provides trainings for all interventions in the DEBI program. Technical assistance (TA) for these interventions is generally available from both the CDC and the agency providing funding for implementation. Detailed information on training for DEBIs is available through the training calendar at the following web address: http://www.effectiveinterventions.org/en/TrainingCalendar.aspx

Some interventions are trained through the agency that developed and/or market these prevention programs. These agencies may also provide TA for a specified period of time following purchase of the program.

Training provider web links

Provider	Link
CDC	www.effectiveinterventions.org/en/TrainingCalendar.aspx
ETR	www.etr.org/
Sociometrics	www.socio.com
Select Media	trainings@selectmedica.com

Formal Training Requirements

Formal training requirements vary based on a number of circumstances. The requirements described in Table 1 apply to prevention partners funded by the Texas Department of State Health Services (DSHS) HIV/STD Targeted Prevention and Interventions Team.

Table 1. Training requirements for prevention programming funded by DSHS[2]

Program	Staff	Training	Timing	Format
PBC	Facilitator	1. Prevention Groundwork Modules 2. PBC (4.5 days)	1. Before delivering services 2. Within 3 months of employment	1. Online 2. In person
PBC	Supervisor	1. Prevention Groundwork Modules 2. PBC (4.5 days) 3. Quality Assurance for PBC Supervisor (4.5 days)	1. Before delivering services 2. Within three months of employment 3. Within 6 months of taking supervisory position	1. Online 2. In person 3. In person
CRCS	Facilitator	1. Prevention Groundwork Modules 2. PBC (4.5 days) 3. Conducting CRCS in Texas (3.5 days)	1. Before delivering services 2. Within 6 months of employment 3. Within 9 months of employment	1. Online 2. In person 3. In person
Group and Community Level Interventions	Facilitators	1. Prevention Groundwork Modules 2. Presentation and Facilitation Skills (3 days) 3. Bridging Theory and Practice (2 days)	1. Within 3 months of employment 2. Within 6 months of employment 3. Within 1 year of employment	1. Online 2. In person 3. In person
All programs	Facilitators	1. STD Facts and Fallacies (2.5 days)	1. Within 1 year of employment	1. In person

[2] For a complete discussion of training requirements and recommendations, visit the DSHS website at http://www.dshs.state.tx.us/hivstd/training/default.shtm

Evaluating Intervention Effectiveness

Analysis of the Implementation Review data yielded several key suggestions and barriers related to the effective evaluation of interventions.

Suggestions for effective evaluation:

- Keep data collections brief to reduce respondent fatigue and avoid interference with delivery of the intervention.
- Evaluation can lead to program improvement, given sufficient resources and time for the evaluation processes to develop.
- Match evaluation tools specifically to the aspects of the program that are the targets of improvement. Logic models should be able to guide evaluation designs. Examples:
  - Use pre-/post- surveys for assessment of short-term knowledge change.
  - Use follow-up focus groups and interviews to assess the ability of clients to overcome barriers and apply new knowledge to real-world situations.
- Collect and analyze multiple types of data (e.g. surveys, facilitator and supervisor observations, focus groups) to produce a more accurate understanding of prevention activity fidelity and effectiveness.
- Develop a clear understanding of the purpose of all evaluation efforts (formative, process, and outcome).

Barriers to effective evaluation include:

- Lack of capacity to perform evaluation processes and understand and apply evaluation results to program improvement. Remedies include:
  - Obtain sufficiently frequent training/technical assistance to ensure that staff has capacity for effective evaluation.
  - Arrange for expert consultation for evaluation tasks that exceed the capacity of staff.
- Lack of staff buy-in because the intervention and/or the use of evaluation was not well understood
- Prevention activities that are difficult to implement may have few clients; the resulting amount of data may be too small to be informative.

Review the CDC guidance if you would like more ideas on the development of an evaluation plan at http://www.cdc.gov/hiv/topics/evaluation/health_depts/guidance/developing.htm

Intervention Review Summaries

Table of Contents

Becoming a Responsible Teen

Becoming a Responsible Teen (BART) is a group-level, education and behavior skills training intervention designed to reduce risky sexual behaviors and improve safer sex skills among African-American adolescents.

Over the course of eight weeks, groups of 5 to 15 youth participate in eight 1-hour sessions. Participants are provided information on HIV and related risk behaviors and the importance of abstinence and risk reduction.

Activities include discussions, games, videos, presentations, demonstrations, role plays, and practice, which assist participants in learning problem solving, decision-making, communication, condom negotiation, behavioral self-management, and condom use skills. The participants also have a discussion with local, HIV-positive youth to promote risk recognition and improve their perception of vulnerability. In addition, the intervention encourages participants to share the information they learn with their friends and family and to provide support for their peers to reduce risky behaviors.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/BART.htm

Created:
1998

Target Populations:
African Americans, ages 14-18

Risk Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from ETR Associates at http://www.etr.org/

Technical Assistance:
Yes, from ETR Associates at http://www.etr.org/

Conditions necessary for successful implementation:

- Provide this intervention in an out-of-school setting.
- HIV and skills-building activities are appropriate for all teens; culture-based sessions can be adapted for other populations.
- Sessions can be combined to help retention.

Materials Review: Becoming a Responsible Teen

Clearly stated in the material:

- Goal behaviors

Not clearly stated in the material:

- Elements of the intervention
- Behavioral determinants
- Immediate outcomes of the intervention

Materials: How adequate? How up-to-date?

The facilitator guide and participant materials were available to most reviewers. No other materials were available for review.

- The facilitator guide and other print-based materials are *inadequate* (most reviewers); the content and format of the materials are *outdated* (one reviewer).
- The audio-visual materials are *inadequate* (most reviewers); the content and format are *somewhat up-to-date* (one reviewer).
- The print-based participant materials are *somewhat adequate* (most reviewers); the content and format are *somewhat up-to-date* (one reviewer).
- The print-based resources are *somewhat adequate* (most reviewers)*;* the content and format are *somewhat up-to-date* (one reviewer).
- At the time of review, the kit cost $54.95.

Implementation Needs

- Reviewers disagreed about the clarity of statements describing the fees charged for certain materials.
- Staff time, number of staff needed, and resources are *clearly stated* (all reviewers).
- Education level of staff, staff skill level, roles for staff, and time needed to prepare and implement the program are *not clearly stated* (all reviewers).
- A sample budget, implementation plan, and program logic model were not available.

Key factors for successful implementation (two or more reviewers):

- Access to the population
- Use of culturally competent facilitators
- Funding
- Tangible reinforcements

Potential Barriers/Pitfalls (one or more reviewers):

- Cost of program materials kit
- Lack of guidance on program implementation
- Lack of technical assistance
- Lack of implementation plan
- Lack of funding
- Difficulty retaining participants

Resources

- The availability of training or technical assistance is not evident.

Review Outcome 

Implementation under favorable circumstances is recommended by the four reviewers who provided a rating.

Reviewers	**Review Date**
(n=5)	7/14/09

Implementation Review: Becoming a Responsible Teen

Training

- Both formal training and self-training with materials are required for this intervention. The training can be purchased from ETR Associates.
- Formal training was rated *readily accessible* by one reviewer and *somewhat accessible* by another.
- The training is *adequate* for initial implementation and ongoing support of the intervention (one reviewer).
- No BART consultant was available at ETR Associates at the time of review, but the original researcher provided one-on-one technical assistance to contractors.

Resources

- Curriculum materials are available at a cost of $54.95 from ETR Associates.
- The implementing agencies used the materials effectively, and the curriculum was well written and complete (one reviewer).
- The materials were updated in 2006 (one reviewer).

Management Issues/Staff

- An experienced facilitator may be necessary to keep youth interested in the intervention activities (one reviewer).

Target Audience: Recruiting

- The intervention targeted Latino rather than African-American teens in San Antonio.

Target Audience: Retention

- The intervention requires an effective facilitator who works well with youth and/or a situation in which attendance is mandatory, such as at school, in a juvenile corrections facility, or in other institutional settings (most reviewers).

Technical Assistance (TA)

- Technical assistance is available from ETR Associates.

Tailoring Requests

- At one location, retention problems were addressed by altering the schedule. Rather than eight once-weekly sessions, the program was held twice weekly for four weeks.

Implementation Decision[3] 

- Implementation is recommended by both reviewers. The intervention includes traditional HIV/AIDS education elements, such as condom use, and also addresses values, sexual decision-making, personalization of risk, and use of social networks to increase awareness among peers.

[3] This decision was rated as *implement with concerns* because of the statements made by reviewers, in spite of their categorical ratings.

Be Proud! Be Responsible!

Be Proud! Be Responsible! is a group-level, skills-building and motivational intervention designed to reduce the frequency of risky behaviors among adolescent African-American men who have sex with men (MSM).

The intervention teaches about HIV/AIDS and risks associated with intravenous drug use and sex behaviors; clarifies myths about HIV; and helps adolescents realize their vulnerability to AIDS and STDs.

Groups of 5 to 6 adolescent males participate in one 5-hour session in a local community building. Activities include videos, games, exercises, and use of other culturally and developmentally appropriate materials to reinforce learning and build a sense of pride and responsibility in reducing HIV risk. Through role playing, participants practice implementing abstinence and other safer sex practices, including practicing condom use skills.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/Be_Proud.htm

Conditions necessary for successful implementation:

None specified.

Created:
1988-1989

Target Populations:
African-American men who have sex with men (MSM), ages 13-18

Risk Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Evidence-Based Intervention (EBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from Select Media; contact trainings@selectmedica.com

Technical Assistance:
Yes, from Select Media.

Materials Review: Be Proud! Be Responsible!

Clearly stated in the material:
- Behavioral determinants
- Outcomes of the intervention
- Goal behaviors

Not clearly stated in the material:
- Elements of the intervention

Materials: How adequate? How up to date?

The facilitator guide, participant materials, and program website materials were available for review.

- The facilitator guide is available in print. The content is *somewhat up-to-date* (all reviewers), the format *not up-to-date* (most reviewers)*,* and the guide generally *inadequate* (all reviewers). Photocopying of the guide is not permitted. Other print-based materials were rated similarly.
- Activity Set (consisting of cards, role plays, and posters) was not evaluated (see website).
- DVD with video clips "Let's Talk About Sex," "Roberts Townsend's Partners in Crime," "Jessie," and "Negotiation," was not evaluated (see website).

Implementation Needs

None of the implementation requirements are stated *clearly* enough (all reviewers). The resources and extra cost of certain supplies/materials were rated *somewhat clear*. The rest of the implementation requirements were rated *not clear* by most reviewers*.*

- The package price does not include all costs (most reviewers).
- The availability of implementation or evaluation materials on the website is not clear.
- Some reviewers viewed the following as key factors for success:
  - Kits
  - Funds for training
  - Access to the community
  - Flexible timing/delivery of sessions
  - Staffing
  - Tangible reinforcements

Key factors for successful implementation (one or more reviewers):

- Skilled facilitators
- Funds for staff
- Evaluation instruments

Potential Barriers/Pitfalls (one or more reviewers):

- Capacity issues
- Retention challenges
- Lack of training
- Lack of technical assistance (TA)
- Lack of access to target population
- Agency capacity
- Selection of capable staff
- Recruitment failure
- Cost of the package ($358 at the time of review)

Resources

- Technical assistance materials and training are available from Select Media.

Review Outcome

Implementation under favorable circumstances is recommended by all reviewers.

Reviewers	**Review Date**
(n=5)	7/16/09

Implementation Review: Be Proud! Be Responsible

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available.

Brother to Brother

Brother to Brother is a group-level behavioral intervention designed to reduce high-risk sexual behavior among African-American men who have sex with men (MSM) and bisexual men.

Over the course of three weeks, groups of 6 to 12 participate in three 3-hour sessions at STD clinics and community organizations. Activities include role play, group discussion, and behavioral skills exercises, which foster positive self-identity development, educate participants about HIV/AIDS risk, teach assertiveness, and encourage sharing commitments and strategies for risk-reduction among group members.

Adapted from the Sociometrics website
http://www.socio.com/hap11.php

Conditions necessary for successful implementation:

- Not recommended in rural areas or areas where there is not an open African -American MSM community.
- Need at least two staff, who should be from the target population.

Created:
Research performed 1989-1991

Target Populations:
African-American men who have sex with men (MSM)/African-American men on the "down low"

Risk Behaviors:
High-risk sexual activity

Intervention Level:
Group

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier:
Meets evidence requirements for HIV/AIDS Prevention Program Archive (HAPPA) developed by the National Institute of Allergy and Infectious Diseases

Legal Considerations:
None noted. Videos must conform to pornography standards, however.

Training:
Yes, from Sociometrics at www.socio.com

Technical Assistance:
Yes, from Sociometrics.

Materials Review: Brother to Brother

Materials were reviewed in a 2005 intervention review process. Not available in this document.

Implementation Review: Brother to Brother

Training

- Training by Sociometrics is available for a fee. Self-training with the facilitator's manual is an option.
- The quality of the training is unclear. Reviewers noted that self-training may be sufficient, though formal training may be preferred.

Resources

- Curriculum materials are available and have been used effectively by implementing agencies.
- Additional materials, such as flip charts, are available, and supplemental videos are provided in the tool kit. Some of the videos are considered effective by reviewers.
- Sociometrics provides the following material formats:
  - Full hard copy kit ($480)
  - Downloadable kit ($160)
  - Comprehensive user's guide for program review and grant preparation ($12)

Management Issues/Staff

- Partner agencies have been able to hire, train, and retain staff. Staff should be from target population (African-American MSM).

Target Audience: Recruiting

- Recruiting enough of the target population is possible; however, saturation can occur quickly in a small target population and at least one agency has experienced difficulty with recruitment.
- Agencies have used internet recruitment, tangible reinforcements for peer recruiters, and a social network strategy. These strategies were somewhat effective in recruiting enough of the target audience to enable the agency to meet performance measures.

Target Audience: Retention

- One agency retained enough participants in the intervention by switching to a three-sessions-in-three-days format.
- Another agency struggled with retention, in spite of using tangible reinforcements.
- "The failure to develop a buddy system made retention more difficult."

Technical Assistance (TA)

- Two reviewers reported providing TA to help partners overcome recruiting and retention barriers. Their efforts resulted in some improvement in the implementation process.
- Purchasers of the program from Sociometrics receive free TA for one year from the time of purchase.

Tailoring Requests

- A two-session, two-hour format was attempted and did not capture all core elements. The agency returned to original format.
- A three-session, three-day format was attempted and found to improve retention somewhat, in spite of concerns about rendering buddy system less useful.

Implementation Success

- A successful, continuous, six-year implementation of the intervention has occurred in one location through a connection to the African-American church community. The reviewers consider this intervention unique because it specifically addresses the multiple stigmas experienced by those who identify as an African-American MSM.

Implementation Decision 

- Implementation is recommended without concerns, though two reviewers note the following:
  - Small communities and hidden populations hinder recruitment.
  - Two staff members are needed for success.

CLEAR

CLEAR (Choosing Life: Empowerment, Action, Results!) is an individual-level, HIV prevention and health promotion intervention designed to promote behavior change among youth and adults (ages 16 or older) living with HIV/AIDS or at high risk for HIV.

CLEAR can be implemented as a stand-alone intervention or integrated into Comprehensive Risk Counseling and Services programs. Because of the way CLEAR is designed (i.e., five required core skill sessions, 21 menu sessions, and a wrap-up session), counselors can tailor the intervention to fit each client's unique circumstances. The intervention uses cognitive-behavioral techniques within a client-centered model to motivate people to change behavior.

Adapted from the Centers for Disease Control and Prevention (CDC) website http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/guidelines/pro_guidance/clear.htm

Conditions necessary for successful implementation:

None specified.

Created:
Before 1999

Target Populations:
Persons living with HIV/AIDS (PLWHA) or high-risk individuals, ages 16-24

Risk Behaviors:
Unprotected sexual activity
• Needle sharing

Intervention Level:
Individual

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx

Technical Assistance:
Yes, from funder.

Materials Review: CLEAR

Clearly stated in the material:

- Core elements of the intervention

Not as clearly stated in the material:

- Behavioral determinants
- Immediate outcomes of the intervention
- Goal behaviors

Materials: How adequate? How up-to-date?

The facilitator guide, participant materials, DEBI website, and program evaluation materials were available for review. All of these items, except the program website, were reviewed.

- The facilitator guide and print-based materials are *available*, and the information they contain is *up-to-date* and *adequate*. *Photocopying only the facilitator's guide is permitted*.
- The print materials for participants are *available*, *up-to-date*, and *photocopying is permitted*. The participant materials were not evaluated for adequacy.
- The internet-based resources are available and are *somewhat adequate* and *up-to-date* in content and format (most reviewers).

Implementation Needs

- Staff time, staff skill, number of staff needed, and staff roles are *clearly stated* (all reviewers).
- Staff education level, resources, time needed to prepare and implement, and extra costs for certain supplies/materials are *somewhat clearly stated* (all reviewers).
- Several reviewers expressed the need for a more detailed budget with realistic estimates for program costs.
- The program supervisor must have extensive cognitive-behavioral therapy (CBT) experience and the use of a licensed social worker is recommended (all reviewers). Counseling skills are especially important for client assessment because no evaluation tools are provided with the intervention package.

Key factors for successful implementation (one or more reviewers):

- Skilled counselor
- Strong implementation strategy
- Sufficient funds
- Skilled supervisor
- Recruitment and retention efforts
- Curriculum
- Training
- Realistic and positive attitude among staff

Potential Barriers/Pitfalls (one or more reviewers):

- Inadequate supervisory skills
- Lack of client adherence
- Lack of program fidelity
- Lack of clinical supervision
- Inadequate counselor skills
- Problems with retention
- Problems with client retention
- Lack of agency readiness
- Lack of recruitment fidelity
- Failure of clients to complete minimum number of sessions
- Under-qualified or unskilled counselors

Resources

- Training and technical assistance are available (most reviewers).
- This intervention is best suited for agencies that are already involved in Comprehensive Risk Counseling and Services (CRCS) (most reviewers).

Other Notes

- The difficulty in retaining clients throughout the 26-session tracks may lead counselors to use the five-session track even when it is not appropriate for the client.

Review Outcome 

Two reviewers recommended implementation and two reviewers recommended implementation only under favorable conditions.

Reviewers	**Review Date**
(n=6)	7/16/09

Implementation Review: CLEAR

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation data not available.

Community PROMISE

Community PROMISE is a community-level intervention designed to prevent HIV/STD infections within established social networks in high-risk populations.

The intervention is implemented over the course of one or more years. It begins with a community identification process to collect and analyze information about the community, including HIV/STD risk behaviors and influencing factors, to help agencies identify target populations and appropriately tailor the intervention. Members of the target population who have made positive HIV/STD behavior change are interviewed and role models stories are written based upon the interviews. The stories are personal accounts about how and why they took steps to practice HIV/STD prevention behaviors and the resulting positive effects on their lives. Peer advocates from the target populations are recruited and trained to distribute the role model stories and prevention materials within their social networks. New role model stories are written based on continuous formative research that reflects behavior change within the target population.

The intervention is based on behavioral theories, including Stages of Change.

Adapted from the Centers for Disease Control and Prevention (CDC) website http://www.effectiveinterventions.org/files/PROMISE_FactSheet.pdf

Created:
Research performed 1991-1994

Target Populations:
High-risk populations in which established social networks exist

Intervention Level:
Community

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: II

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Conditions necessary for successful implementation:

- Understanding the complexity of the intervention
- Staff "buy-in" and understanding that the intervention is not traditional outreach.
- Limit the number target populations to keep program feasible.
- Sufficient number of trained staff
- Understanding the Stages of Change model
- Strong foundation in community assessment
- Established community presence

Materials Review: Community Promise

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Community Promise

Training

- Formal training for contractors and Texas Department of State Health Services (DSHS) consultants is *required* (all reviewers). Self-training with materials is optional (one reviewer).
- Training is available through the CDC. See the training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx

Resources

- The curriculum materials are available, but reviewers disagreed about whether agencies used the materials effectively. One noted that the staff continued traditional outreach and did not conduct a community assessment required by Community Promise.
- Other program-related materials are available on the UT Southwestern website. One reviewer reported that these resources were used effectively, especially the community mapping materials and other tools used to deliver the intervention. Two other reviewers thought they were *somewhat effective*.
- Program materials were updated in 2004.

Management Issues/Staff

- Agencies who used Community Promise were able to hire, train, and retain staff; some long-term employees were cross-trained.
- The overuse of one employee can become a staffing problem.
- Adapting to a curriculum that required a new approach to outreach was difficult for some staff.
- Problems in staff management were observed by two reviewers; one noted that program managers did not adequately supervise the staff and had failed to correctly implement the intervention.

Target Audience: Recruiting

- Sufficient recruitment of the target population was not possible to meet performance measures (one reviewer). Another reviewer was not sure of the feasibility of recruiting the target population because DSHS allowed the agency to pursue too many target populations. The consequent work demand exceeded the capacity of the staff to implement the intervention with fidelity.
- Initial challenges for one agency included problems with police vice patrol, the intervention setting, and the difficulty of facilitating participant access to the agency. These problems were addressed through the agency's strong reputation and ties in the community and the use of a special sign for Community Promise participants, which helped them to know when and where to go.

- At one agency, the board of directors had problems with the target population entering their building. The staff educated the board of directors about the intervention and the population served. The board responded by implementing a screening process that consisted of a background check.
- Lack of community assessment can hamper recruitment.
- One agency approached too many populations, some with poor literacy skills. The agency responded by reducing the number of target populations served, allowing peers who were not literate to contribute in ways that matched their skills, and by posting a color-coded sign (for illiterate clients) at the door, as well as designating a separate entrance just for peer advocates.

Target Audience: Retention

- Retaining a sufficient number of target population members is possible, although it required considerable effort at one agency (two reviewers).
- Barriers to retention included substance use, transient populations, and a lack of understanding by the board of directors (resolved with targeted education for board members).

Technical Assistance (TA)

- Reviewers provided technical assistance for role model story development.
- The reviewers' technical assistance met the needs of the agencies. One reported frequent communication with staff and program managers through phone, e-mail, and in person. Another reported that she drew on the support of DSHS trainers to provide adequate technical assistance.

Tailoring Requests

- No requests to tailor the intervention were received by DSHS.

Implementation Success

- Some noteworthy successes arose from implementation. One agency adjusted to the challenging intervention by hiring new staff.
- Another agency used a tiered, peer advocate approach and incentivized participation. This agency directly addressed peer advocate literacy and provided participation opportunities that were appropriate to volunteer skills level. This tiered approach increased sense of participation for a larger group of volunteers than would otherwise have been possible.
- Process evaluations led to success when an agency was able to re-evaluate their approach.
- One agency was initially unsuccessful because of lack of staff "buy-in," which was remedied by acquiring new staff.
- One agency was successful because of its visibility and its willingness to meet the target population on its own terms.

Implementation Decision ■

- Implementation is recommended with some concerns by three reviewers, while the fourth has serious concerns.
- Reviewers noted that the intervention was too complex to implement with the level and number of staff that funding permits. Concerns include:
  - Staff members' level of understanding of the intervention, both in terms of the role of peer advocates and the development of role model stories
  - Agency attempts to serve too many target populations
  - Development of realistic performance measures

Comprehensive Risk Counseling and Services (CRCS)

Comprehensive Risk Counseling and Services (CRCS, formerly Prevention Case Management) is an individual-level, intensive, client-centered counseling intervention designed to empower individuals to adopt and maintain HIV risk-reduction behaviors.

CRCS is designed for HIV-positive and HIV-negative individuals who are at high risk for acquiring or transmitting HIV and STDs and struggle with issues such as substance use and abuse, physical and mental health, and social and cultural factors that affect HIV risk.

Individuals participate in three or more sessions in a private counseling setting. Core activities include session activities and assist participants in desired behavior changes.

Adapted from the Centers for Disease Control and Prevention (CDC) website http://www.cdc.gov/hiv/topics/prev_prog/CRCS/resources/CRCS_Manual/introduction.htm

Conditions necessary for successful implementation:

- Staff must have strong counseling skills and understand risk reduction.
- Staff must be paid a professional counseling wage.
- Supervisor needs to understand CRCS because of its complexity and the long duration of the intervention cycle.
- In-house recruitment is helpful

Created:
1997

Target Populations:
High-risk HIV-positive and high-risk HIV-negative individuals

Risk Behaviors:
Unprotected sex • Other substance use • Unsafe needle use • Failure to disclose HIV status to appropriate persons • Perinatal transmission • Other high-risk behaviors

Intervention Level:
Individual

Intervention Type:
Evidence-Based Strategy

Evidence Tier:
Limited evaluations do not meet CDC criteria for rigor

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx

Technical Assistance:
Yes, from funder and DSHS.

Materials Review: CRCS

No kit is provided for implementing CRCS. Online guidance is available from Texas Department of State Health Services (DSHS) and from the CDC, as noted above.

Implementation Review: CRCS

Training

- Timely training has been offered for the provision of technical assistance (TA) by DSHS consultants (most reviewers), though one reviewer noted that training is no longer offered in a timely fashion.
- Training is adequate for implementation, but follow-up training, ongoing support, and training for new staff is necessary (all reviewers). Reviewers suggest the following:
  - Develop low-cost, web-based support, including both training and materials
  - Provide new staff with individual-level TA, followed by formal training
  - Train CRCS supervisors
  - Ensure that sufficient TA is provided on-site
- The adequacy of training for ongoing support is unclear. Concerns include:
  - Follow-up by quality assurance (QA) supervisor is often not done; training is necessary.
  - Follow-up after training is not adequate.
  - It is difficult to balance the need for training one or two people with the need to schedule more than once per year.
- Web-based training may be useful (all reviewers):
  - Webinar to provide support for ongoing TA at low cost
  - Web-based modules on CRCS key components such as logic models, risk reduction plans, documentation, etc.
  - Web-based training, possibly in two parts. Offer individual TA with new CRCS staff, followed by formal training six months later.
- On-site TA is helpful after CRCS staff have been trained and have started implementation (one reviewer).

Resources

- While multiple training curricula are available for this program, guidance is also available in the CDC implementation guide, which is online and includes manuals and forms that can be used to structure the program.
- DSHS standards and Program Operating Procedures and Standards (POPS) are available online, though these describe only the minimum standards for the program.
- Training materials and guidance were used effectively by partner agencies (most reviewers). Reviewers noted the following:
  - CRCS training manuals and the CDC CRCS guidance are thorough and can be used effectively.
  - Blank logic models should be made available to contractors to assist with prevention plan preparation.

  - Some agencies struggle to effectively complete logic models. They may need more resources.
  - Other agencies use logic models routinely.
- Additional supportive materials include the CDC implementation guide; the DSHS POPS; sample prevention plans, logic models, behavioral assessments, screening tools, progress notes, and referral logs from DSHS.
- The most recent update was produced by the CDC in 2006 and technical assistance bulletins were available on the DSHS HIV/STD Prevention website (http://www.dshs.state.tx.us/hivstd/).
- One reviewer recommended that DSHS streamline CRCS and clarify the POPS.

Management Issues/Staff

- Hiring, training and retaining staff is possible (most reviewers). However, low funding levels for the counseling position can make it more difficult to hire and retain highly trained counselors, especially where the supply of licensed counselors is low (typically in rural areas).
- Counselors must be able to maintain focus on risk reduction while exploring issues that underlie behavior change for many clients.
- Management of staff is not problematic as long as supervisors understand CRCS. Where this is not the case, counselors need to be more experienced and/or highly trained and capable of managing the work themselves.

Target Audience: Recruiting

- Recruiting enough of the target population to meet performance measures may be challenging. Where internal referrals or regular interagency referrals occur, recruitment is usually successful. Referrals from internal counseling and testing programs, services for HIV-positive persons, or EBIs (especially those focused on HIV-positive clients) seem to work best. Where this does not happen, counselors may need to actively seek clients in the community.
- Finding clients in rural areas can be difficult because of low morbidity.
- Community assessments must be performed by staff with adequate evaluation skills.
- Pursue new recruitment strategies rather than relying on low-risk clients to meet performance standards. Low-risk clients may not be impacted even by well-delivered CRCS programming because of lack of motivation. This will be reflected in outcome monitoring results.
- Ryan White case managers (RWCM) are an effective source of clients for programs located in the vicinity of a services program. RWCM may require training on CRCS, as they do not necessarily understand that CRCS is risk-reduction counseling and not case management. Such lack of understanding can lead to lack of cooperation.
- It may be difficult to market a CRCS program because the program does not sound exciting.

Target Audience: Retention

- Because of the variability among agencies, reviewers disagreed about the ability of agencies to retain clients.
- Barriers to retention include:
  - Target population: High-risk clients (such as active drug users) can be hard to retain because the program is long-term.

- If a staff member is not sufficiently trained or lacks understanding of the intervention process and/or target population, attrition may result. For example, the staff member may not include harm reduction strategies in the client's risk-reduction plan.
- Some agencies think that true behavior change can occur in four sessions with a client; the purpose of CRCS is to work with the client over the long term to change behavior.

- Solutions attempted by sites using CRCS include:
  - TA/training for counseling, marketing, and recruitment skills
  - Visits to clients' homes and other community settings
  - Responsiveness to client need, including flexibility with time, length, and location of meetings
  - Tangible reinforcements such as gift cards, food, T-shirts, pens, paid utility bills, and certificates of accomplishment
- Tangible reinforcements have produced mixed results.
- Counselors with strong, client-centered counseling skills are generally more successful in retaining clients. Key skills relate to the development of a comprehensive risk-reduction plan, logic model, and achievable risk-reduction steps.

Technical Assistance (TA)

- Barriers to effective implementation were identified and addressed through technical assistance from reviewers. They include:
  - Lack of training/counseling skills
  - Lack of understanding of CRCS as a risk-reduction rather than case management program
  - Barriers to recruitment and retention
- Most reviewers reported that they were able to provide the frequency, type, and quality of TA that was needed for the contractor to effectively implement the intervention. Failure of TA to support effective implementation was associated with one or more of the following:
  - Failure of the local supervisor to understand the program
  - TA sometimes not available when needed
  - Lack of resources

Tailoring Requests

- Tailoring requests were seen as irrelevant to this intervention because CRCS is individualized and client-centered. CRCS does not have a curriculum to follow in each session.

Implementation Success

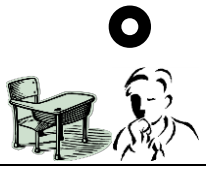
- Successes included:
  - Development of thorough, logical client charts
  - Development of client-centered counseling skills and understanding of the program
  - Recruitment and retention rates (in some programs)
  - Observable client behavior change
- Many factors contributed to the successes of these programs, including:
  - Program structure – multi-session, individual-level, and with a focus on risk reduction
  - Staff with strong, client-centered counseling skills

  - Effective management
  - CRCS was integrated with other programs
  - Stable, motivated staff
  - Meeting clients in the community as needed
  - Use of tangible reinforcements (in some cases)
- Implementation of this intervention is unique (most reviewers) in the following ways:
  - Focus on the individual
  - Complexity
  - Lack of a prescribed curriculum
  - Dependence on the counselor's technical ability and enthusiasm
  - Staff's ability to be truly client-centered
  - Staff's understanding of the Stages of Change model

Implementation Decision 

- Implementation is generally recommended with some concerns, including:
  - DSHS needs to be clear in its messages regarding the expected duration of CRCS.
  - Agencies should not base their programs on the recruitment and retention of low-risk clients.
  - Staff must demonstrate specific and varied skills, including marketing; recruitment and retention; logic model and prevention plan development; paperwork; and counseling.
  - Training and TA need to be combined more effectively, including effective QA/TA by agency supervisors.
- Outcome monitoring tools and processes are currently being developed by DSHS.

Connect



Connect, a couple-level counseling intervention, emphasizes the importance of relationship communication, safer sex negotiation and problem solving skills among intact heterosexual romantic couples. The intervention also highlights how relationship dynamics are affected by gender roles and how social supports can help maintain safer sex behavior. It is delivered to either the couple or only the woman.

Participants attend an orientation session and five relationship-based sessions, 1 ½-2 hours each, delivered in a private office. An initial orientation session is delivered one-on-one to each woman and her partner. The orientation session increases participants' motivation for attendance, heightens risk awareness, and prepares participants for the intervention. The five relationship-based sessions are delivered to intact intimate couples.

The intervention delivered to each woman alone is identical in content and session format as the couples' intervention.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.effectiveinterventions.org/en/Interventions/Connect.aspx

Conditions necessary for successful implementation:

None specified.

Created:
Research performed 1997-2001

Target Populations:
Heterosexual women and their partners or women only

Risk Behaviors:
Unprotected sex • Multiple sex partners

Intervention Level:
Couple

Intervention Type:
Group & Individual

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Connect

Clearly stated in the material:

- Core elements
- Immediate outcomes
- Behavioral goals

Reviewers *disagreed* on the clarity of the following:

- The description of behavioral determinants

Materials: How adequate? How up-to-date?

The facilitator guide and materials, participant materials, program website, diffusion of effective behavioral interventions (DEBI) website, and program evaluation materials were reviewed.

- The facilitator guide and audio-visual materials are *adequate* and *up-to-date* in content (one reviewer).
- The participant guide, materials, and updates are *up-to-date* in content and format (one reviewer).
- One reviewer examined the internet-based resources and found the information to be *somewhat up-to-date*.
- Program guidance is more informative than the DEBI website.

Implementation Needs

- The education level of the staff; staff skill; and resources required are *clearly stated* (all reviewers).
- The number of staff and staff role definitions were *clearly* stated (most reviewers).
- Reviewers disagree about the clarity of statements describing the amount of staff time required to implement the intervention.
- The following elements are *not clearly stated* (most reviewers):
  - Time needed for implementation
  - Need for extra money for supplies and materials
- Also noted:
  - Staff are required to have at least a bachelor's degree in a mental health/counseling subject area or be a practicing Licensed Chemical Dependency Counselor or Licensed Professional Counselor.
  - Childcare is required for implementation.

Key factors for successful implementation (one or more reviewers):

- Male and female staff members who are culturally competent, qualified, experienced in working with groups, and knowledgeable in relationship issues.
- Agency community involvement and community assessment
- Childcare
- Considerable financial resources

Potential Barriers/Pitfalls (one or more reviewers):

- Lack of childcare
- Poor recruitment and retention (especially given the length of the intervention)
- Lack of tangible reinforcements
- Lack of culturally competent staff or culturally appropriate materials
- Age-inappropriate recruitment
- Lack of agency capacity
- Lack of couple "buy-in"
- Lack of qualified facilitators
- Poor recruitment and retention
- Potentially high program cost

Resources

- Training and technical assistance are available.
- Two reviewers recommend that this intervention be implemented by agencies that are experienced with counseling.
- Providing a tangible reinforcement for the couples is recommended (one reviewer).

Review Outcome 

Implementation is recommended for agencies that counsel couples (three reviewers) and under favorable conditions (four reviewers).

Reviewers	**Review Date**
(n=7)	10/15/09

Implementation Review: Connect

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available.

Doing Something Different

Doing Something Different is a group-level skill-building intervention designed to encourage change in norms, expectations, and social skills for promoting safer sex and condom use among African-American high-risk heterosexuals (HRH).

This single-session, one-hour intervention is held at health clinics. Groups of 10 to 25 begin by watching a video, "Let's Do Something Different," which depicts condom use as socially acceptable. After the video, an African-American female health educator facilitates a group discussion on methods of preventing STDs and promoting condom use. This discussion includes the reasons why people like and dislike condoms. Role-playing gives the clinic patients an opportunity to practice condom negotiation, first with the health educator and then with another patient. Questions relating to medical aspects of STDs are referred to clinic nursing and medical personnel. All participants are offered 10 free condoms by clinic nurses.

Adapted from the Center for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/different.htm

Conditions necessary for successful implementation:

- "Buy-in" from the facility where it is implemented, as appointment scheduling processes may need to change.
- Settings other than clinics should be considered, such as apartment complexes or community-based organizations.
- This intervention should be limited to high-risk heterosexual populations.
- Up-to-date video

Created:
Research performed 1988-1989

Target Populations:
HRH, predominantly African-American (male and female)

Risk Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Evidence-Based Intervention (EBI)

Evidence Tier:
II - Promising

Legal Considerations:
None noted.

Training:
No

Technical Assistance:
Yes, from funder.

Materials Review: Doing Something Different

Materials were reviewed in a 2005 intervention review process. Not available in this document.

Implementation Review: Doing Something Different

Training

- Self-training is required. Formal training is not available.
- Training is adequate for implementation (most reviewers).
- Training is adequate for consultants providing ongoing support to the agency (one reviewer).
- Conducting the intervention in a waiting room created inherent difficulties that could not be resolved through training (one reviewer).

Resources

- Curriculum materials are available from Sociometrics and have been used effectively by partner agencies, in part because implementation is straightforward.
- A video is available, but has become outdated, according to the reviewers. No updated videos have been provided.

Management Issues/Staff

- Hiring, training, and retention of staff were problematic, and led to periodic lapses in programming. No other staff management issues were reported.

Target Audience: Recruiting

- Recruiting the target audience is easy because clinic waiting rooms have many STD patients for whom the intervention could be offered, but these participants were not always engaged in the intervention.

Target Audience: Retention

- Because patients have clinic appointments, they are not always able to attend the entire presentation.

Technical Assistance (TA)

- All reviewers have offered TA on outcome monitoring and on recruitment, engagement, and retention of clients. One reported that while the intervention was somewhat successful, it might have been more effective in a less transient setting.

Tailoring Requests

- One agency provided the program in a beauty shop without changing the curriculum. This change in venue appeared to have a positive effect on engagement of clients.
- Another agency made formal requests to expand into beauty shops and family planning clinic waiting rooms. They also requested to modify the approach to include a one-on-one role play format rather than a format in which most participants observed the role play. The new role play format improved engagement levels, but retaining participants for the entire presentation was no easier than in the original clinic.

Implementation Success

- It was possible to deliver the intervention as designed in the venues for which it was designed (i.e. clinic waiting rooms) (two reviewers). At least some of the success has been due to the program simplicity, which has facilitated implementation with reasonably high fidelity.

Implementation Decision ☒

- One reviewer recommended the intervention not be implemented.
- Implementation is recommended by the other two reviewers, with concerns about the following:
  - A need to "think outside the box" with regard to the choice of venues.
  - The intervention should be targeted to an HRH audience and attempts should not be made to adapt it to men who have sex with men (MSM).
  - The video, made in the '90s, could become outdated.

d-up: Defend Yourself!

d-up: Defend Yourself! (*d-up!*) is a community-level behavioral intervention designed to mobilize an existing social network of African-American men who have sex with men (MSM) to support condom use and improve their sense of self-worth.

d-up! uses specific social network members, called opinion leaders, who are respected and trusted by their peers, to promote the benefits of consistent condom use and increase self-worth among their friends and acquaintances. *d-up!* is an evaluated cultural adaptation of the Popular Opinion Leader intervention model for social networks of African-American MSM; it incorporates culturally relevant messages, materials, and activities throughout the intervention. Opinion leaders endorse condom use and deliver messages to affirm a sense of authority, pride, and confidence in themselves as African-American MSM by having casual one-on-one conversations with their friends and acquaintances. Opinion leaders are identified through the social settings of the targeted social network, where the size of social network can be estimated, friendship groups observed, and opinion leaders identified.

Adapted from the Centers for Disease Control and Prevention (CDC) website http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/guidelines/pro_guidance/d-up.htm

Conditions necessary for successful implementation:

None specified.

Created:
Research performed 2004-2005

Target Populations:
African-American MSM

Intervention Level:
Community

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: d-up: Defend Yourself!

Clearly stated in the material:

- Elements of the intervention
- Behavioral determinants
- Immediate outcomes of the intervention
- Goal behaviors

Not clearly stated in the material:

- Core elements and determinants (one reviewer)

Materials: How adequate? How up-to-date?

The facilitator guide, participant materials, diffusion of effective behavioral interventions (DEBI) website, and program evaluation materials were available for review (most reviewers).

- All print materials are *available*, *up-to-date*, *adequate*, and *photocopying is permitted*.
- The web-based materials are *available*, *up-to-date*, and *adequate*, and *photocopying is permitted* (two reviewers).

Implementation Needs

Most implementation requirements are *clearly stated* (most reviewers). Education level of staff is *somewhat clearly stated* (most reviewers).

- Expertise in working with the community is important. The use of a staff member who has strong assessment skills and the capacity to perform an effective community assessment is recommended by reviewers.

Key factors for successful implementation (one or more reviewers):

- Culturally competent facilitators
- Tangible reinforcements
- Champions in the community who motivate their peers
- Strong connection between agency and MSM community
- Participation of opinion leaders
- Ability to identify strong sexual networks

Potential Barriers/Pitfalls (one or more reviewers):

- Lack of familiarity with the community
- Failure to recruit effective motivators for outreach

Other factors mentioned:

- Community ”buy-in”
- Motivated educators
- Recruiter
- Logo/branding for the program
- Participation of a skilled problem solver

Resources

- Training and technical assistance (TA) are available (most reviewers).
- Potential pitfalls:
  - Weak relationship between the agency and the MSM community
  - Ineffective motivator/influencer
  - Absence of pre-implementation preparation
  - Lack of a needs assessment

Review Outcome ●

Implementation is recommended by all reviewers, including one who highly recommends implementation.

Reviewers
(n=7)

Review Date
7/16/09

Implementation Review: d-up: Defend Yourself!

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available.

Enhancing Motivation

Enhancing Motivation is a group-level, behavioral intervention designed to reduce HIV-related risk behaviors by enhancing motivation for behavior change among low-income African-American women in urban areas.

Over the course of two weeks, clients engage in four 90-minute small group counseling sessions. *Session 1* focuses on the development of motivational statements and risk sensitization. *Session 2* focuses on women's perceptions of community problems, their HIV knowledge and personal risk situations, and preparation of risk-reduction action plans. Video is used in each of the first two sessions. *Session 3* introduces the pros and cons of behavior change, the development of risk-reduction plans, and skills training related to condom usage and eroticizing safer sex. *Session 4* enhances communication and interpersonal skills.

Adapted from the UT Southwestern Medical College website
http://www8.utsouthwestern.edu/vgn/images/portal/cit_56417/21/46/267382Enhancing_Motivation_fs_pdf.pdf

Conditions necessary for successful implementation:

- Skilled facilitators
- Skilled management and quality assurance (QA), because training and technical assistance (TA) are not available
- Program implementers must update statistics and videos because no formal updates are forthcoming.

Created:
Research reported in 1997

Target Populations:
Low-income, urban African-American women

Risk Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Evidence-Based Intervention (EBI)

Evidence Tier: III

Legal Considerations:
None noted.

Training:
No

Technical Assistance:
Yes, from funder.

Materials Review: Enhancing Motivation

Clearly stated in the material:

- Core elements of the intervention

Reviewers *disagreed* on the clarity of the following:

- Behavioral determinants
- Immediate outcomes of the intervention
- Goal behaviors

Materials: How adequate? How up-to-date?

- The material guide is *available*, *somewhat adequate*, *and up-to-date in content*, and *photocopying is permitted* (most reviewers).
- The participant guide is *somewhat adequate,* and the content and format are *somewhat up-to-date* (one reviewer).
- Print-based facilitator materials are *generally inadequate*, *outdated in format* (one reviewer), *somewhat up-to-date*(one reviewer), and *somewhat adequate* (one reviewer).
- Video materials are *somewhat inadequate* (two reviewers). No consensus was reached on whether the content and format are *up-to-date*.
- Photocopying of audio-visual materials is permitted.
- Also noted:
  - The Texas Department of State Health Services (DSHS) plans to review this intervention soon.
  - The videos and fact sheets needed to be updated.
- Implementation and outcome monitoring have been created for this program.

Implementation Needs

Implementation needs were *generally unclear* in the program description. The following needs were most *clearly* stated:

- Resources
- Clearly defined staff roles
- Extra money for supplies/materials

Key factors for successful implementation (one or more reviewers):

- Skilled facilitators
- Effective videos
- Facilitators' knowledge of HIV/AIDS
- Use of a flip chart
- Availability of adequate supplies
- Availability of a curriculum
- Agency experience with implementing the intervention
- Three to six months recommended for pre-implementation

Potential Barriers/Pitfalls (one or more reviewers):

- Lack of training
- Lack of TA
- Outdated videos and statistics
- Three reviewers noted a lack of recruitment activities as a barrier

Resources

- Training and TA are not available (most reviewers).
- Unskilled facilitators and lack of client retention were potential pitfalls (most reviewers).
- Failure to recruit new clients was also noted as a potential barrier (most reviewers).
- Each of the following was recommend by one of the reviewers:
  - See the UT Southwestern toolbox website for more information.
  - Use tangible reinforcements.
  - Offer condoms to participants.
  - Update materials.
- Intervention information and materials were not available in a central location.

Review Outcome 

Implementation under favorable circumstances is recommended by all reviewers.

Reviewers
(n=5)

Review Date
7/15/09

Implementation Review: Enhancing Motivation

Training

- Self-training with manuals is required for an agency planning to implement the intervention. The manual is available online. No formal training is available.

Resources

- The manual is available and has been used effectively in the implementation of the intervention.

- The original videos are outdated and not available from any agency or from the original researcher.

Management Issues/Staff

- The same facilitator has worked for the implementing agency for a number of years. Staff problems related to the intervention are not evident.

Target Audience: Recruiting

- Two out of the three agencies that have implemented this intervention have had no problems with recruitment. Management and staff turnover, neither of which was specific to the intervention, occurred in a third agency and led to recruiting problems.

Target Audience: Retention

- The length and number of sessions has been associated with retention problems.
- The following strategies have been used successfully to increase client retention:
  - Changing the order of sessions
  - Changing to six 1-hour sessions instead of four 90-minute sessions
  - Holding four sessions in four days
  - Giving tangible reinforcements

Technical Assistance (TA)

- Technical assistance is more likely to improve program fidelity if intervention staff members have a basic understanding of the intervention. Staff understanding is more likely to grow if they can be retained through multiple cycles of the intervention.

Tailoring Requests

- A number of tailoring requests improved client retention and program quality:
  - The introduction of new videos
  - A change in the order of the sessions
  - A change to four- and six-session formats

Success

- Two agencies had considerable success with this intervention. Recruitment, retention, and participant engagement were considered effective. Outcome monitoring indicated that subjects gained the intended knowledge and skills as a result of the intervention.
- Intervention success is at least partly due to consistent staff and consistent use of quality management processes.

Implementation Decision ■

- Implementation is recommended with some concerns, including:
  - Lack of available TA and training
  - Outdated materials
  - Low level of evidence supporting this intervention (Tier III)

Focus on Youth

Focus on Youth (FOY) is a group-level, educational and skill-building, behavioral intervention designed to enhance decision-making skills among African Americans, ages 12-15. The intervention is delivered to small, naturally formed peer friendship groups (3 to 10 youths) via discussions, games, and multimedia formats.

Groups of 3 to 10 clients participate in eight weekly sessions (seven 90-minute sessions and one day-long session) at a recreation center meeting room. The seven 90-minute sessions focus on decision-making, which includes discussions concerning extrinsic (social approval) rewards with exercises related to communication and negotiating skills and information regarding the high prevalence of peer condom use. Other discussions focus on intrinsic (personal pleasure) rewards and emphasize values clarification and goal setting. Facts regarding AIDS, STDs, contraception, and human development are presented and condoms are provided. In the seventh session, youths develop community projects with specific target audiences and intervention messages. The primary intervention series concludes with the eighth session, which is an all-day field trip in which projects are presented and a "graduation" ceremony is conducted.

The intervention is followed by monthly and annual booster sessions in which youth are given specific challenges to work through to reinforce the skills (e.g., decision making, communication, and condom use) they acquire in the primary sessions.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/FOY.htm

Conditions necessary for successful implementation:

None specified.

Created:
Before 1999

Target Populations:
African Americans, ages 12-15; parental participation for Focus on Youth (FOY) plus ImPACT

Risk Behaviors:
Sexual risk behaviors • Truancy

Intervention Level:
Group

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Focus on Youth

Clearly stated in the material:

- Elements of the intervention
- Behavioral determinants
- Immediate outcomes of the intervention
- Goal behaviors

Materials: How adequate? How up-to-date?

- The following materials were available for review:
  - Facilitator guide
  - Participant materials
  - DEBI website
  - Phone data from the Texas HIV/STD Prevention Community Planning Group (TxCPG)
  - Program website
  - Evaluation materials
  - Print materials
- Print materials are considered *up-to-date* and *adequate*, and *photocopying is permitted*.

Implementation Needs

- Implementation requirements were *clearly stated*, with the exception of education level of staff (most reviewers).

Key factors for successful implementation (one or more reviewers):

- Tangible reinforcements
- Nonjudgmental facilitators
- Strong community investment
- Agency readiness
- Pair novice facilitators with experienced, skilled facilitators.
- Ongoing supervision
- Community referral
- Needs assessment to determine the connection to the community
- Fidelity
- Effective materials
- Culturally competent facilitators
- Peer encouragement

Potential Barriers/Pitfalls (one or more reviewers):

- Judgmental facilitators
- Novice facilitators
- Lack of agency readiness
- Untrained facilitators
- Lack of fidelity
- Problems scheduling and maintaining "buy-in" with parents
- Lack of community investment in the program components

Resources

- Training and technical assistance (TA) were available.
- Potential pitfalls:
  - Unskilled facilitators
  - Lack of agency "buy-in"
  - Lack of fidelity
  - Judgmental facilitators
  - Lack of community investment
  - Lack of participant retention

Review Outcome 

Implementation is recommended by all reviewers (highly recommended by one).

Reviewers	**Review Date**
(n=7)	7/16/09

Implementation Review: Focus on Youth

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available

Healthy Living Project (HLP)

Healthy Living is an individual-level, behavioral intervention designed to improve the quality of life of persons living with HIV/AIDS (PLWHA).

Individuals participate in three modules, each consisting of five sessions that last 90 minutes each. Sessions are conducted in private settings at community-based organizations and clinics.

Each of the three modules is designed to improve quality of life in a different broad area of health: physical, mental, and sexual. The modules focus on developing positive strategies for managing symptoms of depression, anxiety, complex medication regimens, injection drug use, and sexual risk behavior in order to avoid unwanted consequences for themselves, their friends, families, and partners.

Module 1 (stress, coping, and adjustment) focuses on quality of life, psychological coping, and achieving positive affect and supportive social relationships. *Module 2* (safer behaviors) centers on self-regulatory issues, such as avoiding risky sexual and drug use behavior. *Module 3* (health behaviors) addresses accessing health services, adherence, and active participation in medical care decision making. Sessions have a standard structure and set of activities that are tailored to the individual participant. Psycho-education, skills-building exercises, and cognitive-behavioral techniques (trigger identification, problem solving, and goal setting) are included in each session so the participant can use these skills independently to effectively meet challenges in their daily lives.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/healthy-living.htm

Conditions necessary for successful implementation:

None specified.

Created:
Research performed 2000-2004

Target Populations:
PLWHA

Risk Behaviors:
Sexual behavior • Needle sharing

Intervention Level:
Individual

Intervention Type:
Evidence-Based Intervention (EBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Information limited; Information accessed at the Substance Abuse and Mental Health Services Administration (SAMHSA) registry of evidence-based programs at www.nrepp.samhsa.gov/ViewIntervention.aspx?id=169

Technical Assistance:
Yes, from funder.

Materials Review: Healthy Living Project

Clearly stated in the material:
- Goal behaviors

Not clearly stated in the material:
- Elements of the intervention

- Most reviewers neither agreed nor disagreed that the statements on behavioral determinants and immediate outcomes were clear.
- The intervention can be tailored to meet individual clients' needs (one reviewer).

Materials: How adequate? How up-to-date?

Web-based materials were available for review, including: facilitator guide, participant materials, evaluation materials, and program website.

- The information in the facilitator's guide is *up-to-date* (most reviewers) and rated *adequate* and *up-to-date* in format by half of the reviewers. *Photocopying is permitted*.
- The content of the print-based facilitator materials was rated *somewhat up-to-date* or *up-to-date*. The format was rated *up-to-date* or *somewhat up-to-date*. The guide was rated *adequate* or *somewhat adequate*. *Photocopying is permitted*.
- The print-based participant materials are *up-to-date* and *adequate* or *somewhat adequate* (most reviewers). *Photocopying is permitted*.
- The content and format of the web-based resources are considered *up-to-date* by one reviewer and the content *somewhat up-to-date* by another. *Photocopying is permitted*.

Implementation Needs

Implementation requirements are *not clearly stated* (most reviewers).

- The following requirements are *least clearly* stated:
  - Time needed to prepare for implementation
  - Extra money required for supplies
  - Clearly defined roles for staff
  - Staff time
  - Number of staff needed
  - Resources
- Opinions varied about the clarity of the following requirements:
  - Education level of staff
  - Staff skill
- Training, budget, implementation guide, and best practices were not provided.

Key factors for successful implementation (one or more reviewers):

- Facilitators
- Modules
- Structured activity
- Organization
- Curriculum guide
- Participant handouts
- Engagement and retention of clients
- Licensed, trained professional staff
- Organized materials

Potential Barriers/Pitfalls (one or more reviewers):

- Poor retention
- Scheduled three-month break between modules
- Staff turnover
- No training or technical assistance
- No budget
- Facilitator required to have specific licensure/training
- Length of program
- Need for clinical supervision of the facilitator

Resources

- The availability of training and TA was unclear.
- Potential challenges include staff turnover and the length of sessions.

Review Outcome 

Opinions about implementing the intervention vary. Implementation is recommended by four reviewers, three of whom recommend implementation under favorable circumstances. One reviewer does not recommend implementation.

Reviewers	**Review Date**
(n=8)	7/16/09

Implementation Review: Healthy Living Project

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available.

Healthy Relationships

Healthy Relationships is a group-level, behavioral intervention designed to reduce risky behavior among HIV-positive men and women.

Over the course of five weeks, small groups participate in five 2-hour sessions in a counseling appropriate setting. The intervention is based on Social Cognitive Theory and focuses on developing skills and building self- efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills. Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure and behavior. The sessions create a context where people can interact, examine their risks, develop skills to reduce their risks, and receive feedback from others.

Adapted from Effective Interventions website
http://www.effectiveinterventions.org/files/Healthy_Relationships.pdf

Conditions necessary for successful implementation:

- Video clips need to be updated and regularly accessible for agencies that use the intervention. (See the list of appropriate clips at www.effectiveinterventions.org/includes/MM_hrclip_search.cfm.)
- Consider the mental health professionals' needs as implement the program.
- Volunteers and/or target population peers must be used.
- HIV-positive staff and HIV-positive volunteers working in counseling settings should receive psychological support.
- The agency needs strategies to address challenging situations that arise during intervention.
- The agency needs strategies for outreach and retention specific to heterosexual males.

Created:
2004

Target Populations:
HIV-positive heterosexual men; HIV-positive heterosexual women; HIV-positive men who have sex with men (MSM)

Risk Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from the CDC, visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Healthy Relationships

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Healthy Relationships

Training

- Formal training and self-training materials are available.
- Training is available when needed, leaving sufficient time to prepare for implementation by prevention partners and technical assistance (TA) support by consultants (most reviewers).
- Training is adequate for implementation and for ongoing support of the intervention.
- Formal training is available at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx

Resources

- Curriculum materials are available.
- Partner agencies have used the materials effectively (most reviewers).
- Some of the materials are outdated or contradictory (one reviewer).
- Additional materials are available, including an online list of film clips and a posted clips used by other agencies.
- While the additional clips are helpful, they quickly become outdated. The reviewers do not know if the clips have been updated. Special African-American clips have been made and clips made by agencies have been sent to UT Southwestern for suggestions. One reviewer recommended that the TA provider update and improve the clips.

Management Issues/Staff

- Agencies have been able to hire, train and retain staff, although it is difficult to hire professional staff at low salaries (all reviewers).
- Finding and retaining volunteers who share the characteristics of the groups is difficult.
- HIV-positive facilitators need supervisor support to help them meet their own needs (one reviewer).

Target Audience: Recruiting

- Recruiting enough participants to meet performance measures is possible (most reviewers). Challenges include: recruiting heterosexual males and recruiting without the use of outreach workers reflective of the target population. One reviewer noted the effectiveness of using a social gathering before the first programmatic session.
- One agency tailored the intervention by mixing male and female participants, but results of this experiment are unavailable.

Target Audience: Retention

- Retaining heterosexual men across the multi-session intervention is challenging.
- Retention has been improved by increasing the frequency of sessions except for cases in which a social get-together at the beginning reduced the number of clients completing the program.

Technical Assistance (TA)

- Reviewers provided technical assistance to participating agencies (all reviewers).
- Reviewers provided the frequency, type and quality of support, including TA, to support successful implementation (most reviewers).

Tailoring Requests

- Tailoring requests were granted, including requests to increase the frequency of the sessions and to add sessions for group cohesiveness and graduation.
- Tailoring had a positive impact on group cohesiveness, but a negative effect on long-term retention because of the increase in the number of sessions required.

Implementation Success

- One reviewer reported noteworthy successes, citing as evidence the high levels of attendance and meeting performance measures. The agency is excited about the intervention and has been doing well on performance measures.
- One particular agency was successful because staff members are creative problem-solvers and took advantage of available TA.

Implementation Decision 

- Recommendations vary. One reviewer recommends implementation *with no concerns*; one has *some concerns*; and one has *serious concerns.*
- Reviewers noted several concerns:
  - Agencies need funding sufficient to hire competent facilitators, preferably mental health professionals (one reviewer).
  - Agencies need more support from contract monitors and peer organizations in finding and evaluating film clips (one reviewer).
  - Client retention is challenging because the intervention takes place over several sessions (one reviewer).

Hot, Healthy, & Keeping it Up

Hot, Healthy, & Keeping It Up is a culturally specific, group-level, behavioral intervention designed to decrease HIV risk behaviors among Pacific Islander and/or Asian gay men.

In this intervention, groups of 8 to 12 participate in one 3-hour session at a community setting.

The intervention is designed to increase positive ethnic and sexual identity in order to help participants acknowledge HIV risk behaviors by discussing negative experiences of being both Asian or Pacific Islander and homosexual (e.g., lack of social support, racism, homophobia, etc.).

Guided by the Health Belief Model, the theory of reasoned action, and social cognitive theory, facilitators use interactive and group process techniques to address the following four intervention components: 1) development of positive self-identity and social support; 2) safer sex education; 3) eroticizing safer sex; and 4) negotiating safer sex.

Adapted from the HIV/AIDS Prevention Program Archive? (HAPPA) website
http://www.socio.com/srch/summary/happa/hap07.htm

Conditions necessary for successful implementation:

- Staff committed to high fidelity in presentation
- Cultural component must fit actual target population

Created:
1996

Target Populations:
Pacific Islander men who have sex with men (MSM); adapted to African-American MSM

Risk Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Evidence-Based Intervention (EBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
No

Technical Assistance:
Yes, from funder.

Materials Review: Hot, Healthy, & Keeping it Up

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Hot, Healthy, & Keeping it Up

Training

- Self-training materials are available. Formal training is not available.
- Self-training is adequate for implementation (all reviewers).
- Adequate ongoing support by consultants is available (all reviewers).

Resources

- Curricula are available and are generally used effectively (all reviewers).
- Supplemental materials or updated basic materials are not available (all reviewers).

Management Issues/Staff

- Agencies are generally able to recruit, hire, and retain staff.
- Fidelity is compromised when staff members lack "buy-in."
- Agencies have been able to supervise staff implementation.

Target Audience: Recruiting

- Initially, agencies have been able to recruit enough members from the target population to meet performance measures. Saturation may become an issue within the geographic limits of the recruiting program.
- New and varied venues have been used, and this sometimes has led to the inclusion of clients from outside of the target population. This diversification may have compromised the effectiveness of the intervention.

Target Audience: Retention

- Retention has not been a problem in this one-session intervention.

Technical Assistance (TA)

- TA has been able to resolve the fidelity issues that have developed to date.

Tailoring Requests

- One agency made a tailoring request to target the African-American MSM population. This amended intervention was successful.

Implementation Success

- The intervention was successfully adapted to African-American MSM. This was primarily due to the selection of a high-priority and abundant target population, as well as an appropriate match between agency resources and program demands.
- As implemented, *Hot, Healthy and Keeping it Up* provides a particularly innovative approach to working with this population.

Implementation Decision ☒

- All reviewers recommend implementation of the intervention "as is" or adapted to another MSM population, but *with serious concerns*, including:
  - The content of the intervention is somewhat outdated, but could easily be updated.
  - The intervention is overly simplistic; it addresses condom use but not the depth of behavioral issues that are significant today.
  - If this intervention is adapted to another population, the cultural component must be completely developed for that group.

Intensive AIDS Education

(Formerly Riker's Health Advocacy Program (RHAP))

Intensive AIDS Education is a group-level education program for incarcerated male adolescents based on problem solving therapy.

Over the course of two weeks, groups of eight participate in four 1-hour sessions in jail. The Problem-Solving Therapy approach is used to guide group discussions and includes the following steps: problem orientation, defining and formulating the problem, generating alternative solutions, decision-making, and implementing a solution.

As part of the first step in the discussion – problem orientation – participants share and discuss facts and beliefs about HIV. Then, participants define and formulate the problem by identifying specific attitudes or behaviors that need to be modified in order to prevent HIV. For generating alternative solutions, participants suggest and compile possible courses of action. During the decision-making step, participants critique and evaluate the alternative solutions. Finally, participants engage in role-play and rehearsal exercises to practice implementing the solution. Topics covered during the group discussions are general HIV education information, factors related to drug initiation or drug use, the meaning and consequences of sexual activity, and the relationship between drug use and sexual activity and HIV risk, and how to seek health care services, social services, and drug treatment.

Adapted from the Centers for Disease Control and Prevention (CDC) website http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/intensive-AIDS-ed.htm

Created:
1994

Target Populations:
Incarcerated adolescent male drug users

Risk Behaviors:
Unprotected sex • Substance use

Intervention Level:
Group

Intervention Type:
Evidence-Based Intervention (EBI)

Evidence Tier: II

Legal Considerations:
None noted.

Training:
No

Technical Assistance:
Yes, from funder.

Conditions necessary for successful implementation:

- Intervention is best limited to the identified target population (adaptations for females and older males may be less successful).
- Updated HIV information

Materials Review: Intensive AIDS Education

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Intensive AIDS Education

Training

- Self-training is required for this intervention as formal training is not available.

Resources

- Curriculum and evaluation materials are available in a kit by Sociometrics. The curriculum material is thorough but outdated. Material was updated in 1999 and 2001.

Management Issues/Staff

- No staff/management issues have been reported.

Target Audience: Recruiting

- Recruitment has been successful because the intervention was implemented in Texas Youth Commission facilities and at a substance abuse facility, both locations where the target population was contained.

Target Audience: Retention

- Retention was excellent because participation was compulsory in partner agencies.

Technical Assistance (TA)

- Reviewers provided little assistance to the agencies during implementation.

Tailoring Requests

- Due to participant requests for additional information, the agency added four sessions on relationships, homelessness, and STDs. The original researcher noted that the agency could have adapted the intervention to female participants, but chose not to.

Implementation Success

- Recruitment and retention were successful, as were efforts to educate clients. The effectiveness of the intervention can be attributed to process monitoring, adaptation, and outcome monitoring.

Implementation Decision ■

- Implementation is recommended by both reviewers, who cite some concerns:
  - The HIV information must be updated.
  - Expanding efforts outside of the target population may be problematic.
  - Supplementary sessions should be added to enhance the information presented to participants.

Many Men, Many Voices

Many Men, Many Voices (3MV) is a group-level, peer-led intervention designed to prevent HIV and sexually transmitted diseases among African-American men who have sex with men (MSM) who may or may not identify themselves as gay.

Groups of 6 to 12 participate in seven 2- to 3-hour sessions at/in a community setting. Adaptation for a weekend retreat or with briefer sessions can also be performed.

The intervention addresses factors that influence the behavior of African-American MSM: cultural, social, and religious norms; interactions between HIV and other sexually transmitted diseases; sexual relationship dynamics; and the social influences that racism and homophobia have on HIV risk behaviors. The sessions aim to foster positive self-image; educate participants about their STD/HIV risks; and teach risk reduction and partner communication skills. The sessions are highly experiential, incorporating group exercises, behavioral skills practice, group discussions, and role play.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.effectiveinterventions.org/files/3MV_Fact_Sheet_rev09_0814.pdf

Conditions necessary for successful implementation:

- Seven sessions of group-level intervention
- Facilitator should be a member of the target population
- Facilitator must be comfortable talking candidly about sexual issues and dual identity concerns.

Created:
2002

Target Populations:
African-American and Hispanic MSM; non-identifying MSM; adapted to Hispanic males

Rick Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Many Men, Many Voices

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Many Men, Many Voices

Training

- Formal training is:
  - Recommended
  - Only available outside of Texas, unless specifically arranged with California HIV/STD Prevention Training Center[4]
  - Not provided prior to implementation (due to challenges with scheduling in-state training)
  - Adequate to support implementation and for ongoing support
- Trainings that address general intervention implementation skills are available from the Texas Department of State Health Services (DSHS).

Resources

- Curriculum materials are available and have been used effectively by partner agencies (all reviewers).
- Updated materials (as recent at 2009) and supplemental materials are available.

Management Issues/Staff

- Non-identifying MSM facilitators may have difficulty meeting the needs of MSM clients.
- Problems with staff management appear to have been related to management turnover rather than the intervention.

Target Audience: Recruiting

- The use of a non-identifying MSM facilitator may hurt recruitment.
- In one agency, participant groups were typically small (3-4 individuals), a problem that was not addressed through formal tailoring requests or other adjustments.

Target Audience: Retention

- The length of the intervention (seven sessions) may present a problem for retention, although this may be more of an issue for programs run by inexperienced staff.

[4] http://www.stdhivtraining.org/course_catalog.html

Technical Assistance (TA)

- DSHS staff members have been able to provide the frequency, type, and quality of support needed for implementation of the intervention.

Tailoring Requests

- None submitted

Implementation Success

- The implementing agency was able to hire staff from the target population.

Implementation Decision 

- Implementation is recommended by both reviewers, who were surprised that no agency was funded to use this intervention (at the time of the review).
- This intervention was considered an effective update of an older intervention. (It expanded to target Latino men and more deeply explored topics than the original intervention.)

Modelo de Intervención Psicomédica

Modelo de Intervención Psicomédica (MIP) is an intensive individual-level counseling and case management intervention designed to decrease risky behaviors among intravenous drug users (IDUs).

Over the course of 3-6 months clients engage in six counseling sessions in a private setting. The sessions are conducted by a registered nurse and use motivational interviewing strategies to engage injection drug users for behavior change. The first three counseling sessions focus on participants' motivation to change behavior, the development of a work plan to facilitate behavior change, encouragement to enter into drug treatment, and strategies for relapse prevention. *Session 4* focuses on strategies participants can use to explain to their peers why they rejected the practice of needle sharing. *Session 5* provides skill building for safer sex negotiation and correct male and female condom use. The final session reinforces self-efficacy to reduce risk behaviors and drug injection and to increase the use of health care and drug treatment services.

The case management component involves active assistance from a case manager to help participants get through the intervention and to provide access to drug treatment, primary health care services, and other legal or social welfare services. Participants also receive standard HIV counseling and testing.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/MIP.htm

Created:
Before 1998

Target Populations:
Male and female IDUs seeking treatment

Intervention Level:
Individual

Intervention Type:
Evidence-Based Intervention (EBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Conditions necessary for successful implementation:

Unknown.

Materials Review: Modelo de Intervención Psicomédica

Clearly stated in the materials:
- Elements of the intervention
- Behavioral determinants
- Immediate outcomes of the intervention
- Goal behaviors

Materials: How adequate/ How up-to-date?

The facilitator guide, participant materials, diffusion of effective behavioral interventions (DEBI) website, and program evaluation materials were available for review (most reviewers).

- All web-based materials are *available*, *up-to-date in content and format*, and *adequate* (one reviewer). *Photocopying is permitted* (one reviewer).
- The intervention can be adapted to non-IDUs with assistance from the CDC.
- A community assessment is required before implementation (one reviewer).

Implementation Needs

Implementation needs were generally *clearly stated* (most reviewers).

- Staff education level requirement is *clearly stated* (most reviewers).
- Staff education requirements are "significant" with knowledge of and skills in motivational interviewing required (one reviewer).

Key factors for successful implementation (one or more reviewers):
- Counselors/case managers must have strong connections to the community.
- Community assessment
- Sufficient funding
- Access to drug treatment facilities
- Staff trained in Motivational interviewing and use of Stages of Change/Tran Theoretical Model
- Pre-implementation planning
- Well trained and committed staff
- Accessible services

Potential Barriers/Pitfalls (one or more reviewers):
- Challenging staff training requirements (three trainings consuming 36 person/days and agency capacity.
- The need for an auditor on staff

Resources

- Training and technical assistance (TA) are available.
- Concerns (one or more reviewers):
  - Clients must be ready to access services.
  - Clients must have a strong relationship with and access to the case manager.
  - Adequate staff and supplies must be available.
  - Recruitment can be challenging.
  - Agency must have sufficient capacity.

Comments

- The intervention can be adapted to non-IDUs (some reviewers)
- It was the only intervention on the DEBI website targeting only Latinos.

Review Outcome 

Implementation is recommended by all reviewers.

Reviewers	**Review Date**
(n=4)	7/15/09

Implementation Review: Modelo de Intervención Psicomédica

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available.

Mpowerment

The Mpowerment Project is a community-level community-building intervention designed to reduce the frequency of unprotected anal intercourse among young gay and bisexual men.

The Mpowerment Project is run by a "core group" of 10 to 15 young gay men from the community and paid staff. The young gay men from the core group, along with other volunteers, design and carry out all project activities. Ideally, the project has its own physical space where most social events and meetings are held and which serves as a drop-in center where young men can meet and socialize during specified hours.

The program relies on a set of four integrated activities: *Formal Outreach:* Teams of young gay men go to locations frequented by young gay men to discuss and promote safer sex, deliver appealing informational literature on HIV risk reduction, and distribute condoms. Additionally, the team creates their own social events to attract young gay men (e.g., dances, video parties, picnics, discussion groups) and at which safer sex can be promoted. *M-groups:* These peer-led, 2–3 hour meetings of 8 to 10 young gay men discuss factors contributing to unsafe sex among the men (e.g., misconceptions about safer sex, beliefs that safer sex is not enjoyable, poor sexual communication skills). Through skills-building exercises, the men practice safer sex negotiation and correct condom use. Participants receive free condoms and lubricant and are trained to conduct informal outreach. *Informal outreach:* Informal outreach consists of young men discussing safer sex with their friends. *Ongoing publicity campaign:* The campaign attracts men to the project by word of mouth and through articles and advertisements in gay newspapers.

Adapted from the Centers for Disease Control and Prevention (CDC) website http://www.cdc.gov/hiv/topics/prev_prog/rep/packages/pdf/MPOWER.pdf

Created:
1997

Target Populations:
Gay and bisexual men, ages 18-29

Risk Behaviors:
Unprotected sex

Intervention Level:
Community

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: II

Legal Considerations:
None noted.

Training:
Yes, from the CDC, visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Conditions necessary for successful implementation:

- Consideration of differences between rural and urban communities
- Where recruitment is difficult, alternative methods are necessary (including the internet)
- Sufficient funding
- Facilitation skills and trainings
- Training on professional boundaries
- Highly organized staff
- Access to space for activities involving project participants

Materials Review: Mpowerment

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Mpowerment

Training

- Both formal training and self-training are available and useful, though formal training is offered infrequently and the trainers are from out of state (all reviewers).
- Training is adequate for implementation and for ongoing support (all reviewers).
- Additional training is helpful for implementation (one reviewer).

Resources

- Curriculum materials are available and agencies have used them effectively.
- Additional materials are available, including a website for Mpowerment and a YouTube video. Most reviewers noted that these supplemental materials are useful.
- Program materials were updated in 2009.

Management Issues/Staff

- Agencies have been able to hire, train, and retain staff (two reviewers).
- The internet may be a useful tool, but could require special guidance for the program manager to effectively supervise staff working online (one reviewer).

Target Audience: Recruiting

- Because of the unique challenges in rural settings, sufficient recruitment of the target population is very difficult. The internet might be a useful tool in this regard.
- Additional barriers to recruitment:
  - Men who have sex with men (MSM) often use the internet, rather than bars, to meet other men.
  - The status of being "out" could be problematic for some participants.
  - Mpowerment is not viewed as "cool."
  - Potential participants might not feel comfortable associating with HIV prevention programming.
- Online recruitment has expanded access to the target population.
- Through the use of a marketing group and social events, new procedures have been developed for internet recruitment and training.
- The inclusion of women in core groups has led to more of a gay-lesbian-bisexual (GLB) community, but agencies still struggle to recruit enough participants to meet performance measures.
- One agency had to recruit 1,755 individuals in one year just to train 59 participants as peer volunteers.

Target Audience: Retention

- Participant retention has been successful in urban areas because of the larger population base, but a rural area has presented unique retention challenges.

Technical Assistance (TA)

- Rural areas have had specific problems with implementation.
- Two reviewers reported providing TA.
- Two reviewers reported they were able to provide the frequency, type, and quality of support needed for successful implementation. One collaborated with the agency's training department. The other reported that the program was already being implemented successfully when she became involved.

Tailoring Requests

- A tailoring request was granted to one agency, which included women in the M-groups to assist with recruitment of MSM peers. This did not completely solve the difficulty in recruiting the target population.

Implementation Success

- Two urban programs observed noteworthy success, while a rural program did not.
- Because of the many barriers faced by a rural program, full implementation of the intervention was difficult, if not impossible.
- One agency has been successful because it developed an internet presence and used skilled, innovative, and responsive staff whose personalities were appropriate for the intervention. Staff understood the intervention and how to effectively reach the target population. The agency also benefited from a budget that was sufficient to support activities and rental of a space where program participants can engage in project activities.
- Another agency was successful because it fostered strong community support.

Implementation Decision ■

- Implementation is recommended by all reviewers, though they cite the following concerns:
  - Staff and managers must understand the complexity of the intervention.
  - Funding must be sufficient to support all activities and rental of space.
  - The implementing agency must pay attention to detail and use well-organized staff.
  - Staff must be familiar with the internet and how it is integral to the intervention.
  - Online recruitment must be used.
  - Agencies should explore the possibility of facilitating a virtual M-group.
  - The funding agent should accept the use of new social networking processes.
  - Rural settings must be reconsidered and the internet should be part of that evaluation.

Nia

*Nia i*s a group-level, video-based, motivational skills-building intervention designed to reduce unprotected sex among heterosexual and bisexual African-American men.

Groups of 6 to 10 participate in 2-4 sessions varying from 1 ½-3 hours in length. Sessions are held in a community setting.

The intervention includes videos, movie clips, and discussion to educate men about HIV/AIDS, elevate their mood, and entertain them while reinforcing information and motivating behavior change.

Facilitators discuss with participants ways to prevent HIV/AIDS, including condom use, condom attitudes and the pros and cons of condom use, and teach problem-solving, safer sex, and decision-making skills. Facilitators also teach male condom use skills through demonstration, modeling and practice with feedback using penile anatomical models, as well as showing and discussing female condoms. The intervention also teaches personal risk reduction and sexual communication skills such as negotiating safer sex, sexual assertiveness, and risk refusal through movie clips and discussion.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/nia.htm

Conditions necessary for successful implementation:

None specified.

Created:
Before 1999

Target Populations:
African-American men (heterosexual and bisexual) who have sex with women

Risk Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: II

Legal Considerations:
None noted.

Training:
Yes, from the CDC, visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Nia

Clearly stated in the materials:

- Core elements of the intervention
- Immediate outcomes of the intervention
- Goal behaviors of the intervention
- Behavioral determinants addressed by the intervention:
  - Reduction in negative attitudes toward condoms
  - Increase in positive attitude toward condoms
  - Decrease in drug and alcohol use before or with sex

Materials: How adequate? How up-to-date?

The facilitator guide, facilitator materials, participant materials, CDC program website, DEBI website, and program evaluation materials were available for review.

- The facilitator guide and materials are available in print format and are *adequate* and *up-to-date in content and format*. *Photocopying is permitted*.
- The audio-visual materials, available on CD, are *somewhat adequate* and *up-to-date. Photocopying is permitted*.
- The participant guide was not available to the reviewers.
- Participant materials, available in print and CD format, are *adequate* and *up-to-date*. *Photocopying is permitted*.
- Both print and internet-based resources are *up-to-date* and *adequate*. *Photocopying is permitted*.
- Updates, available in print form, are *somewhat adequate* and *somewhat up-to-date* (one reviewer).
- The participant updates in print form are rated *somewhat up-to-date* or *up-to-date* and *somewhat adequate* or *adequate* (two reviewers).

Implementation Needs

The following implementation requirements were *clearly stated* (most reviewers):

- Staff skill
- Resources
- Definition of staff roles
- Time needed for implementation
- Requirements for extra money for supplies and materials
- The number of staff required was rated *somewhat clear* or *clear*.

Time commitments required of staff are *somewhat clear* and the educational level required of staff is *not clear*.

- Concerns noted by some reviewers:
  - Large number of staff required for implementation
  - Lack of clarity regarding staff educational requirements
  - Cost of extra items not included in the core budget

Key factors for successful implementation (one or more reviewers):

- Culturally competent facilitators
- Well-trained facilitators who could make the intervention fun
- Access to African-American men

Potential Barriers/Pitfalls (one or more reviewers):

- The need to develop video clips
- Challenges with recruitment of male participants
- Facilitators with inadequate skills
- Time and commitment required of facilitators
- Problems with client retention

Resources

- Training is available through CDC as of January 2011, and technical assistance (TA) is available through UT Southwestern.
- Potential pitfalls:
  - Lack of access to the target population.
  - Failure to recruit clients.
  - Availability of skilled facilitators.
  - Training is not immediately available but pending.

Review Outcome 

Implementation is recommended by all reviewers, one of whom recommends implementation under favorable conditions.

Reviewers	**Review Date**
(n=6)	10/15/09

Implementation Review: Nia

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available.

Partners in Prevention - MSM

Partners In Prevention - Men's Edition is a group-level, behavioral intervention designed to decrease risky behavior among men who have sex with men (MSM).

Groups of up to 12 participate in six 1 1/2-hour sessions in a community setting. The program addresses relationships, condom skills, trigger management, self-statements and negotiation. The intervention addresses risk factors and behavior change, as well as threat personalization, self-efficacy for and commitment to risky behavior change, risk-reduction skills, planning for risky situational contingencies, self-reinforcement, and social support for behavior change.

Adapted from the PIP-MSM manual on the Medical College of Wisconsin website
http://www.mcw.edu/display/docid6269/PartnersinPrevention/MensIntervention.htm

Conditions necessary for successful implementation:

- Because training is unavailable, agency management must understand the basics of interventions and group facilitation.
- Because technical assistance (TA) is unavailable, the implementing agency should be proactive in asking the Department of State Health Services (DSHS) for assistance.
- Statistics and videos need to be updated.
- The agency must hire a facilitator who is strongly connected to the target population.

Created:
1995

Target Populations:
Men who have sex with men (MSM)

Risk Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Evidence-Based Intervention (EBI)

Evidence Tier: III

Legal Considerations:
None noted.

Training:
No

Technical Assistance:
Yes, from the original researcher.

Materials Review: Partners in Prevention - MSM

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Partners in Prevention - MSM

Training

- Self-training is required because no formal training is available.

Resources

- Curriculum materials are available through a download of the entire manual.
- The agency that has implemented this program used the materials effectively; the curriculum layout and content are user-friendly.
- The videos are no longer available, though the original researcher may have a script.
- The reviewers were not aware of any updates to materials.

Management Issues/Staff

- Hiring, training, and retaining staff are feasible, as only two MSM facilitators are required (all reviewers).
- Agencies have not had problems with management or supervision of staff.

Target Audience: Recruiting

- Recruitment of clients was achievable as long as the intervention focused on any MSM rather than those from specific racial/ethnic groups (all reviewers).

Target Audience: Retention

- The six-week intervention period is unusually lengthy and may contribute to retention problems. When the number of sessions was reduced, retention improved.
- Tangible reinforcements and updated videos may also improve retention.

Technical Assistance (TA)

- A consultant and an EBI specialist have worked with the agency to resolve implementation problems.

Tailoring Requests

- Tailoring requests addressed reducing the number of sessions. These modifications were successful.

Implementation Success

- This intervention has been effective when the implementing agency has had stable management, commitment to fidelity, and has effectively tailored the intervention. One reviewer noted that the intervention has been easy to implement.
- This intervention goes beyond communication and condom skills, and results in a number of positive aspects of the intervention (all reviewers):
  - A self-statement component
  - Discussion of trigger management with a cognitive-behavioral approach
  - A focus on relationships

Implementation Decision ■

- Implementation is recommended by both reviewers, who expressed some concerns:
  - Because of the lack of training, the agency must be proactive in pursuing TA.
  - Materials need to be updated.

Partners in Prevention – Women's Edition

Partners in Prevention - Women's Edition is a six-session intervention targeting high-risk heterosexual (HRH) women.

Topics covered include relationships and social-sexual norms, male and female condom demonstrations, skills building and practice, information on HIV risk knowledge, reasons to stay healthy, risk reduction, and personal vulnerability.

This intervention also targets trigger management, including problem solving of these triggers, risk reduction, problem-solving, positive self-talk, needle-cleaning techniques, assertiveness and negotiation skills, and education on the importance of HIV testing to know status. This closes with maintenance of new behavior and relapse prevention into unsafe sexual practices.

Description from the Medical College of Wisconsin website
http://www.mcw.edu/FileLibrary/Groups/CAIR/PiP/PiP_women_entire.pdf

Conditions necessary for successful implementation:

- Focus on original target population. (Do not adapt for high-risk heterosexual men or intravenous drug users (IDUs).)
- Facilitator must have comprehensive HIV knowledge and strong facilitation skills. (No kit is available—only a downloadable implementation manual from the internet.)
- Facilitator should be a member of the target population and must be connected to the community.

Created:
1994

Target Populations:
High-risk heterosexual women

Risk Behaviors:
Unprotected sex • Unsafe needle use

Intervention Level:
Group

Intervention Type:
Evidence-Based Intervention (EBI)

Evidence Tier: III

Legal Considerations:
None noted.

Training:
No

Technical Assistance:
Yes, from the original researcher.

Materials Review: Partners in Prevention – Women's Edition

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Partners in Prevention – Women's Edition

Training

- Because formal training is unavailable, self-training with materials is required.
- The intervention is relatively simple; self-training should be adequate for implementation. Nonetheless, all reviewers recommended that agency management be involved in quality assurance (QA).

Resources

- The curriculum is available in an online manual through the Medical College of Wisconsin.[5]
- The agency must identify and obtain supplemental videos.

Management Issues/Staff

- One agency experienced retention problems, but the issues did not appear to be related to the intervention.
- Reviewers shared the impression that staff at the implementing agency enjoyed implementing this intervention (two reviewers).

Target Audience: Recruiting

- Recruitment has been successful when agency staff visited venues such as Planned Parenthood, homeless and women's shelters, jail programs, and church-based agencies.
- Initial problems identifying appropriate participants have been resolved by using a more stringent screening process and a presentation that accurately represents the program.
- Recruitment and implementation are easier and more effective in venues where populations are "captive."

Target Audience: Retention

- Barriers to retention:
  - Incomplete recruitment information
  - Use of venues that were not conducive to completion of this lengthy program
  - Long sessions
  - Lengthy outcome monitoring document

[5] Medical College of Wisconsin website at http://www.mcw.edu/FileLibrary/Groups/CAIR/PiP/PiP_women_entire.pdf

- Retention has been improved by the use of new venues and by reducing time between sessions. Some problems persist.

Technical Assistance (TA)

- Through the identification of new venues and the reduction of time between sessions, TA has helped reduce the negative impact of early barriers.
- The effort to adapt this program to other populations has been time-intensive and has required extensive technical assistance.

Tailoring Requests

- Two tailoring efforts have been effective: reducing the number of sessions from 6 to 4 and reducing the time between sessions. One agency added information on Hepatitis C and offered the intervention in two sessions per week for two weeks.
- One agency attempted to adapt the intervention to other populations (HRH men and IDUs) by only by changing pronouns in the program materials. The agency has now developed a more thoroughly adapted version of the intervention.

Implementation Success

- One agency experienced considerable success. Due to their skilled staff and their persistent collaboration with the Texas Department of State Health Services (DSHS), they effectively improved retention and adapted the curriculum to other populations.
- For a skilled facilitator with basic HIV knowledge, this intervention is simple to deliver.

Implementation Decision 

- Implementation is recommended by two reviewers, one of whom cited some concerns:
  - The duration of class time should be adjusted to address retention problems.
  - While the intervention raises awareness, it is not clear that it changes behavior.

Popular Opinion Leader

Popular Opinion Leader (POL) is a community-level intervention designed to reduce unprotected sex among men who have sex with men (MSM).

POL is designed to identify, enlist and train key opinion leaders to encourage safer sexual norms and behaviors within their social networks of friends and acquaintances through risk-reduction conversations. Cadres of trusted, well-liked men who frequent gay bars are trained to endorse safer sexual behaviors in casual, one-on-one conversations with peers at bars and other settings. During these conversations, the POL corrects misperceptions, discusses the importance of HIV prevention, describes strategies he uses to reduce his own risk (e.g., keeping condoms nearby, avoiding sex when intoxicated, resisting coercion for unsafe sex), and recommends that the peer adopt safer sex behaviors. Popular opinion leaders wear buttons displaying the project logo, which also is on posters around the bars, as a conversation-starting technique.

POLs attend four weekly 90-minute training sessions that involve didactic and group discussions, modeling of effective health promotion messages, and extensive role play. Each POL has at least 14 conversations with peers and recruits another POL.

Adapted from the Centers for Disease Control and Prevention (CDC)/HIV website http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/POL.htm

Created:
1991 (Updated 2004)

Target Populations:
MSM

Risk Behaviors:
Unprotected sex

Intervention Level:
Community

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: II

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Conditions necessary for successful implementation:

- Recruitment of effective opinion leaders
- Understand that, due to stigma, implementation is difficult in small communities.
- Hire staff who intends to stay with the agency; prevent staff turnover.
- Consider increasing internet capacity in rural areas.

Materials Review: Popular Opinion Leader

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Popular Opinion Leader

Training

- Formal training is available and required for this intervention. The training is typically out of state, which makes it more expensive. Self-training with manuals is also an option.
- Training is adequate for implementation, but one reviewer noted that it is not adequate for ongoing support of the intervention by consultants providing technical assistance.

Resources

- Curriculum materials are available and have been used effectively.
- Community-level statistics were available.
- More technical assistance (TA) is usually required for a community-level evidence-based intervention (EBI) such as POL (one reviewer).
- d-up! is an available update to this intervention.

Management Issues/Staff

- One agency was able to hire, train, and retain staff (one reviewer).
- Another agency struggled with staff retention because of challenges unique to the rural area, possibly including inadequate salaries.

Target Audience: Recruiting

- Recruitment becomes increasingly difficult with time as the population becomes saturated with intervention contacts. This problem appears to be worse in rural areas with small population bases (most reviewers).
- Another barrier to effective recruitment is the difficulty in ascertaining a participant's level of commitment to participation.

Target Audience: Retention

- Sufficient retention of the target population was not possible.
- Retention can become challenging if community leaders do not connect with the material presented.
- Participants tended to have trouble with the time commitment and often finished training and quit or attempted to engage in only a few conversations.
- Efforts to improve retention include:
  - Hiring a private contractor to serve as a popular opinion leader

- Providing tangible reinforcements
- Reducing time between sessions

- Of these efforts, reducing time between sessions had some positive impact, but retention was still problematic because of the small population of MSM in the rural setting.
- Staff turnover is common with this intervention, so continual recruitment is typical.

Technical Assistance (TA)

- All reviewers reported that they provided TA to overcome barriers to implementation.
- One noted that community-level interventions are somewhat difficult for agencies to understand, and another added that she would like to have provided more TA.

Tailoring Requests

- Tailoring requests were approved for:
  - Combining the first three sessions into one
  - Extending Sessions 3 and 4 to allow for more role plays and to use two different intervals between the 3rd and 4th sessions
  - Adding an interactive game
  - Changing the formal language to better fit the language of the population
  - Updating statistics from program model
  - Adding a condom demonstration to Session 1

Implementation Success

- The initiation of internet recruitment has been a success (three reviewers). One reviewer suggested that internet conversations could be saved for evaluation purposes.
- This intervention succeeded in areas with larger population bases (one reviewer).
- This intervention was viewed as unique because it used the target population to spread a message and mobilized the community to help solve a common problem.

Implementation Decision ■

- Implementation is recommended by four reviewers, two of whom cite some concerns and suggestions:
  - The intervention could be more internet-oriented with some adjustment.
  - In the absence of a physical gathering space, urban communities may be able to use the internet.
  - The popular opinion leader does not have to be a member of the target population as long as he has conversations with the target population, especially in rural areas.
  - Rural communities should incorporate internet outreach.
  - Saturation is a problem.
  - More ongoing TA is needed.
  - Include women from the local gay community.
  - Use arts and political groups for recruitment (e.g. Stonewall Democrats, gay film festival, etc.).

Project AIM (Adult Identity Mentoring)

Project AIM (Adult Identity Mentoring) is a group-level behavioral intervention designed to reduce risky behavior among African-American adolescents.

Groups of 10 to 20 participate in 12 (originally 10) 50-minute sessions at a community setting. Sessions are scheduled to allow time for participants to process material covered each time.

The intervention is divided into four parts. Using group discussions and interactive activities, *Part One* encourages youth to explore their personal interests, social surrounding, and what they want to become as an adult. Youth also identify people in their lives who may be barriers or supporters to their successful adulthood. Young adults from the community who are on their road to success are invited to speak with youth in Part One. In *Part Two* of the intervention, youth envision themselves in a future career and connect current behavior with success as an adult through activities such as completing a career interest inventory, developing business cards and resumes, and participating in interviews. *Part Three* of the intervention engages youth in role-plays around communication and small group activities involving planning and decision-making. *Part Four* provides the opportunity for youth to think about their future in terms of milestones to accomplish goals and overcome potential obstacles they may encounter in life.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/prev_prog/rep/packages/aim.htm

Conditions necessary for successful implementation:

None specified.

Created:
Before 2005

Target Populations:
African-American youth, ages 11-14

Risk Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Evidence-Based Intervention (EBI)

Evidence Tier:
Not available at present

Legal Considerations:
None noted.

Training:
Yes, from the CDC, visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Project AIM (Adult Identity Mentoring)

Materials: How adequate? How up-to-date?

- The program website was reviewed.
- The web-based facilitator guide is considered *up-to-date* and *adequate* by one reviewer, and *somewhat up-to-date* and *adequate* by another. *Photocopying is permitted*.
- The print-based facilitator materials are *adequate* and *up-to-date* (one reviewer).
- The audio-visual materials for the facilitator are considered *up-to-date* and *adequate* by two reviewers and *somewhat up-to-date* and *adequate* by a third.
- The updated materials are *somewhat up-to-date* and *adequate* (one reviewer).
- The participant materials are *somewhat up-to-date* and *adequate* (one reviewer). *Photocopying is permitted.*
- Print-based and web resources are *up-to-date* and *adequate* (most reviewers). *Photocopying is permitted*.
- The core elements of the intervention are *clearly stated* (most reviewers).
- Behavioral determinants are *not clearly stated* (most reviewers).
- Reviewers disagree about the clarity of statements describing the immediate outcomes of the intervention.
- The goal behaviors of the intervention are *clearly stated* (most reviewers).
- Information on the outcomes is not readily available (one reviewer).

Implementation Needs

- The number of staff needed is *clearly stated* (most reviewers).
- Several implementation needs are *not clearly stated*:
  - Education level of staff
  - Resources required for implementation
  - Staff roles
  - Time needed to prepare for implementation
  - The possible need for extra money for supplies
- Reviewers disagree about the clarity of statements describing the required amount of staff time and skills.
- At the time of review, the intervention was in its first year of replication and the materials needed to be refined and released. No guidance was available and the intervention website offered only a general description of the intervention.

Key factors for successful implementation (one or more reviewers):

- Access to adolescents (permission from school administration and from parents)
- Resources
- Facilitator "buy-in"
- Facilitation of a pre-implementation session with parents
- Facilitators comfortable with the topic and skillful in presenting it
- Adequate training for facilitators

Potential Barriers/Pitfalls (one or more reviewers):

- Lack of school administrator "buy-in"
- Problems with retention
- Inadequate time for implementation
- Lack of parental consent
- Absence of program materials for presentation
- Length and number of sessions held outside of school

Resources

- Training is available through the CDC (see the training calendar).
- Information on technical assistance (TA) is not currently available.

Review Outcome ○

Implementation under favorable circumstances is recommended by one reviewer, while two reviewers do not recommend implementation.

Reviewers
(n=6)

Review Date
10/15/09

Implementation Review: Project AIM (Adult Identity Mentoring)

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available.

Project START

Project START is an individual-level intervention designed to reduce risky behaviors among men soon to be released from prison. It incorporates features of prevention case management, motivational interviewing, and incremental risk reduction.

This intervention consists of two individual 60-90 minute sessions conducted within 60 days before release and four 30-60 minute individual sessions at 1, 3, 6, and 12 weeks after release. In the first in-prison session, the interventionist assesses the participant's knowledge of HIV/AIDS, STD, and hepatitis, conducts a brief HIV risk assessment, and helps the participant develop a personal risk-reduction plan. The interventionist also provides information, skills training, and referrals and helps to identify incremental steps towards risk reduction. The second in-prison session focuses on community reentry needs and referrals for housing, employment, finances, substance abuse, mental treatment, legal issues, and avoiding re-incarceration. The post-release sessions involve a review of the previous sessions and discussion of the facilitators and barriers to implementing the risk-reduction plan. Additional sessions are available for participants in the enhanced session as needed during the intervention period.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/Project_START.htm

Conditions necessary for successful implementation:

None specified.

Created:
Research performed 2001-2003

Target Populations:
Individuals, ages 18-29, transitioning from incarceration into the community

Risk Behaviors:
Unprotected sex

Intervention Level:
Individual

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Project START

Materials: How adequate? How up-to-date?

The facilitator guide, participant materials, DEBI website, and program evaluation materials were available for review. The intervention website was not available.

- The following materials are *adequate* and *up-to-date in format and content*. (*Photocopying is not permitted.):*
  - Facilitator guide
  - Audio-visual materials
  - Print-based materials
- The participant materials are *up-to-date* (most reviewers)*. Photocopying is permitted.*

Implementation Needs

Implementation needs were *clearly stated* (most reviewers)*.*

Key factors for successful implementation (one or more reviewers):

- "Starting where the client is"
- Staying client-centered
- Adherence to the curriculum – focus on presenting HIV knowledge and engaging clients in goal setting
- Staff experience working with HIV/STD/Hepatitis C
- Warden and staff "buy-in"

Potential Barriers/Pitfalls (one or more reviewers):

- Lack of staff access to prison systems
- Inadequate agency capacity
- Lack of cultural competency in the prison
- Not being networked in jails
- Staff lack of familiarity with the prison system
- Staff lack of experience with target population

Resources

- Training and technical assistance (TA) are available.
- Potential pitfalls (one or more reviewers):
  - Inmates not interested in issues addressed
  - Lack of agency capacity
  - Lack of staff experience
  - Post-release relapse
  - Lack of culturally competent staff
  - State and local policies that make it difficult for clients to find work after release
  - Lack of access to post-release sessions because of limited transportation options and/or constraints imposed by residential setting.

Review Outcome 

Implementation is recommended by all reviewers, three of whom specify implementation under favorable circumstances.

Reviewers	**Review Date**
(n=6)	7/16/09

Implementation Review: Project START

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available

Protocol-Based Counseling

Protocol-Based Counseling (PBC) is an individual-level counseling intervention designed to reduce risky behaviors among HIV-negative individuals.

PBC uses a two-session, client-focused, interactive HIV risk-reduction counseling model, drawing on a protocol book for guidance. The protocol book has specific goals listed in order, with subsequent tasks and sample questions to accomplish each goal. A Risk Reduction Specialist (RRS) is a person who provides counseling to clients on issues related to reducing a client's risk of acquiring or transmitting HIV, often in conjunction with an HIV test. The RRS uses the protocol book as a guide to work one-on-one with a client to educate on his/her specific risks for HIV and increase the client's perception of risk for HIV/STD/HCV and intent to change risk behavior by developing an incremental risk-reduction step. The counseling goals are designed to increase the client's motivation to change behavior.

The protocol book, quality assurance standards, and tools can be found on the Texas Department of State Health Services (DSHS) website http://www.dshs.state.tx.us/hivstd/training/qastandards.shtm#pbc.

Conditions necessary for successful implementation:

- Clients in this intervention need to be at moderate to high risk of contracting HIV through sexual behavior and/or drug use.
- This intervention must be used in a confidential setting where the client can talk freely about his/her HIV risks.
- Use the protocol book as a guide, not a script.
- Persons implementing this intervention should be non-judgmental and display excellent counseling and communication skills.
- Adequate training and supervision
- Competent RRS
- Strong program supervision,
- Appropriate venues for program delivery

Created:
Piloted in 2004; modified in 2005; published in 2006

Target Populations:
HIV-negative persons who engage in high-risk behaviors

Risk Behaviors:
Unprotected sex • Substance use • Unsafe needle use • Number of sexual partners • Perinatal transmission • Any behavior that increases a person's risk for HIV infection

Intervention Level:
Individual

Intervention Type:
Modification of a Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: III

Legal Considerations:
None noted.

Training:
Yes, from DSHS.

Technical Assistance:
Yes, from funder.

Materials Review: Protocol-Based Counseling

No materials review was performed.

Implementation Review: Protocol-Based Counseling

Training

- A 4 ½ day formal PBC training has been developed by DSHS along with a one-day *Quality Assurance for PBC* module, and a one-day *Rapid Testing* module. The training is provided in person and incorporates counseling skills, writing risk-reduction steps, role plays and the use of the protocol book
- An online prerequisite course, *Risk Reduction Groundwork: Basics of Disease Transmission, Prevention, and Testing*, is self-paced and required before taking the PBC training. All Risk Reduction Specialists (RRS) must attend the PBC course within the first three months they see clients. It is preferable that they complete the course before seeing any clients. All managers and supervisors must take the PBC and *Quality Assurance for PBC* courses. The *Rapid Testing* module is optional.
- Formal training is readily accessible and *adequate* for implementation (most reviewers). Currently, no follow-up training is available, and a follow-up "refresher" would be helpful (all reviewers).
- Some common comments from the reviewers:
  - RRS struggle with writing incremental risk-reduction steps even after training.
  - Training needs to focus more on counseling skills, less on protocol.
  - Training is adequate for certain aspects of the intervention, especially for using the protocol book, but not adequate for counseling skills.
  - Training is adequate but requires strong quality assurance (QA) from supervisors, which is not always available.
    RRS need a lot of practice.
- Suggestions (at least one reviewer):
  - Offer an additional training to discuss in-depth issues, including working with gay men and risk-reduction.
  - More training on motivational interviewing
  - More counseling skills training
  - The prerequisite *Risk Reduction Groundwork* is not adequate; counselors need more training on the basics of HIV.
  - Offer a one-day follow-up booster class.
  - Offer a refresher course on writing risk-reduction steps, especially creative risk-reduction, and creative follow-up steps.
  - Ideally, supervisors would develop staff within the implementing agency, reducing the necessity for follow-up training.
  - A degreed person is not necessarily the best person for the job; the individual should have a passion for the field and be respectful and nonjudgmental toward the target population (one reviewer).

Resources

- Curriculum materials and tools are readily available. The main tool is a laminated protocol book, with the goals and tasks listed in order and sample questions that can be used to accomplish each task. Each person who attends the training receives a protocol book. A Spanish-language version is also available, along with duplicate risk-reduction step forms on which RRS write an incremental risk-reduction step with each client. These materials are available by order from DSHS.
- In the training, participants receive a participant manual with an appendix to write down information learned in the PBC course. Training materials are available for persons who want to train others.
- Updates were made to the protocol book in 2007, and training and QA standards and forms were updated to reflect the changes.
- In addition, QA standards and the following QA forms are listed online:
  - Chart review forms
  - Session observation forms
  - Session documentation forms
  - Forms for RRS use:
    - Personal assessment forms
    - Self-assessment forms
- Reviewers disagreed about whether the curriculum materials were used effectively. About half of the reviewers thought that the protocol book was most effective when used as a framework and not a "script."
- Other comments:
  - Some staff never learn to develop risk-reduction steps and accomplish all goals.
  - QA should focus on the communication style of the RRS and less on the specific questions.
  - The protocol book is not appropriate for all agencies and all clients.

Management Issues/Staff

- Implementing agencies are able to hire staff (all reviewers), but the staff may not be appropriate to perform this kind of work (some reviewers). The main comment was that the hiring varied greatly. Retention of staff is difficult, given insufficient pay for staff (most reviewers).
- Reviewer responses varied on whether management and staff shared a common understanding of program goals and the implementation process.
- Some common themes:
  - How supervisors oversee this program helps to ensure its success or failure.
  - Supervisory understanding of protocol is often lacking.
  - Staff often do not understand that, in the Stages of Change model of behavior change, developing ambivalence about risky behavior can be a realistic goal for the client.
  - In general, staff do not understand risk-reduction steps and risk-reduction.
  - Many supervisors do not provide sufficient QA.
  - Supervisors were not always able to think of creative ways to use the protocol as a framework.

- All reviewers noted staff problems in addition to management and staff not sharing understanding and common goals for this intervention.
- The most common problems:
  - RRS did not always understand how to use the protocol.
  - RRS struggled to identify the most appropriate venues and target populations.
  - Many seasoned staff trained in Prevention Counseling and Partner Elicitation (PCPE) were resistant to straying from the original method of HIV counseling and testing.
  - The intervention "takes too long" and "feels redundant." If not implemented effectively, PBC can be cumbersome and repetitive, especially with low-risk clients.
- Instead of using the protocol book as a framework, RRS were trained to use it as a script.

Target Audience: Recruiting

- Recruitment is an issue but this is agency-specific and not related to the use of the protocol (all reviewers).
- The main barrier cited is the length of the protocol sessions.
- Other barriers include:
  - The intervention itself is a barrier in the "I want it [the test] now" culture.
  - For many high-risk populations, implementation in the field is difficult.
  - PBC as an intervention is effective, but not for every venue.
  - RSS should do a better job defining when and where to use PBC, and other options for risk-reduction should be offered as appropriate.
  - Sessions are too long, with 20-minute sessions recommended.
  - The requirement that some counseling should happen with each test.
- Solutions have been attempted with moderate success, such as implementing HIV testing without counseling; shortening the protocol session length; changing the training to focus on not addressing every task in every goal; and not using the protocol with low-risk clients.

Target Audience: Retention

- Retention of the target audience is less of a problem than recruitment because this is a one- or two-session intervention, but some implementing agencies are unable to get clients to return for the HIV test results sessions.
- Some solutions included:
  - Moving the *Groundwork* course online
  - Not using the protocol for every client
  - Providing a pre-screening tool to direct low-risk clients to testing without counseling
  - Increasing the proportion of rapid HIV tests
  - Offering tangible reinforcements to access test results
- All of these helped with retention to varying degrees.
- One reviewer suggested not using the protocol book for the HIV test results session and suggested giving HIV-negative results over the phone.

Technical Assistance (TA)

- DSHS provides a lot of in-person, email, and phone TA for all of the issues listed above, with varying degrees of success (all reviewers). Additional TA is provided in the form of quarterly conference calls with contractors, a quarterly newsletter called *The Poke*, and TA bulletins sent to agencies and listed on the DSHS web site.
- The reviewers disagreed about whether DSHS is able to provide the frequency, type, and quality of support that is needed for implementing agencies and staff to successfully implement the intervention.
- Those reviewers who did not believe they were able to provide adequate support noted the following barriers:
  - Poor supervision at agencies
  - Some RRS are never able to grasp the concept of balancing the use of the protocol book with counseling skills.
  - PBC is too long and prescriptive.
- One reviewer suggested splitting the training into two 3-day courses.

Tailoring Requests

- No formal tailoring requests have been made, but individualized tailoring by request is allowed for some implementing agencies. One agency to shortened the protocol and another agency did an abbreviated version in a strip club. These were both successful.
- Testing without counseling could be considered tailoring. This has helped with retention of the target audience.
- One reviewer was concerned with testing without counseling, commenting that all RRS will want to do it this way because it is shorter and quicker, and the standard would become no risk-reduction counseling when providing an HIV test.

Implementation Success

- Each reviewer agreed with a version of this statement: "When an RRS hits the goals of the protocol in order, understands that they can make the language 'their own,' and can do it in 20-30 minutes, [PBC] is most effective."
- Other descriptions of effective use include:
  - PBC works with high-risk clients in certain confidential venues, such as an office setting; the client will actually benefit from being able to speak openly about his/her risk for HIV and being given a set of options to reduce his/her HIV risk.
  - PBC can be effective when:
    - The RRS has other testing options and the right setting for implementation.
    - Ongoing quality assurance is performed by supervisors.
    - RRS is nonjudgmental and has basic counseling skills and a conversational style.
    - RRS uses the protocol as a framework, not a script, and addresses all of the goals but not all of the tasks (too long).

- RRS develops an understanding of the discrepancy between the motives underlying the client's current risk behavior and their desire to change. The RRS then addresses the resulting ambivalence about risk-reduction in terms of this discrepancy.
- Client's awareness of risk increases
- Client learns HIV status/RRS gives clear results
- RRS develops creative risk-reduction steps.
- Increased opportunity for referrals; links into care are available

- Some reasons for success include:
  - RRS take the goals of PBC, puts it in their own words, and knows how to negotiate a risk-reduction step within 30 minutes.
  - Supervisors are skilled in providing ongoing training for RRS and in QA procedures.
  - Skilled counselors are able to adapt the protocol to meet the client's needs.
  - The client is exposed to risk-reduction when they become aware of their status.
- Other suggestions for successful implementation include:
  - Do a "PBC Light" or "PBC Brief" session.
  - Do not use the protocol book when giving an HIV-positive test result.
  - Do not employ a risk-reduction step with every client.
  - Do not employ a risk-reduction step in any HIV test result session.
  - Develop a screening tool to "weed out" low-risk clients.
  - Create a screening tool that uses the Stages of Change Model.
- What makes this intervention different from other interventions:
  - It is a written protocol for a client-centered intervention.
  - The protocol book is helpful but it encourages an overly rigid approach to implementation, whereas trainers would prefer to see a more flexible use of the protocol.
  - The RRS provides information to the client as requested/needed by the client; it is not imposed by the counselor.
- Some reviewers had suggestions for using this intervention. Three mentioned that this is appropriate as part of a package of options of providing counseling with HIV testing; one reviewer said the state standard should be PCPE—the former Texas standard, which is brief HIV prevention counseling.

Implementation Decision 

- Two reviewers recommend implementation. Five reviewers recommend implementation *with some concerns.* Three recommend implementation *with serious concerns.* One reviewer does not recommend implementation.
- The reviewers who liked the intervention said that, if implemented properly, it helps individuals reduce their risk for contracting and transmitting HIV. One cited that PBC, coupled with increased HIV screening, is an important part of the continuum of public health interventions in Texas.
- Other key comments:
  - PBC works effectively with some populations in some structured settings (office).
  - Some RRS never could grasp the concept of balancing the protocol with counseling skills.

- Clients should be high-risk individuals (not repeat testers) in a format that allows time for developing more of a one-on-one intervention than simply giving test results.
- This intervention is extremely scripted, too long and repetitive. It could be effective with some clients who come in to a clinic setting for testing. It may not be effective in the field, e.g. bars, streets, community events.
- RSS are not encouraged to assess the appropriateness of this intervention for each client.
- Staff should avoid imposing counseling/risk-reduction steps on clients who have not requested this service.
- PBC should not be the state standard, but could be offered as a model for HIV counseling and testing (most reviewers).
- PBC needs to be less scripted and more flexible to allow for an actual client-focused session.
- The protocol book does not help with the DSHS goal of "finding new HIV-positive persons."

Real AIDS Prevention Project (RAPP)

Real AIDS Prevention Project (RAPP) is a community-level intervention that mobilizes the networks of community volunteers, organizations, and business.

The intervention consists of five main components: conducting community outreach using peer networkers; having one-on-one safer sex discussions based on the participants' stage of readiness to change; distributing printed stories about community members and safer sex decisions (role model stories); obtaining program support from community organizations and businesses (community networking); and sponsoring small group activities in communities, such as safer-sex discussion parties and workshops conducted by outreach specialists. The role model stories describe how women in the local community overcome barriers or have learned from experience about the need to use condoms, and how they have progressed to more consistent condom use. The role model stories are distributed through flyers, brochures, posters, and newsletters. The community contacts, activities, and materials provide tailored prevention messages and encourage behavior change to increase condom use among women.

Description from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/rapp.htm

Conditions necessary for successful implementation:

- Highly skilled staff
- Minimum of two staff
- Staff familiarity with development and delivery of role model stories
- Strong relations between agency and community
- Staff able to conduct community assessment
- Agency/staff familiarity with the concept of Community-Level Intervention

Created:
2000

Target Populations:
Women

Risk Behavior:
Unprotected sex

Intervention Level:
Community

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: II

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Real AIDS Prevention Project (RAPP)

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Real AIDS Prevention Project (RAPP)

Training

- Formal training is available for consultants and contractors, but is not readily accessible.
- Training is currently available with registration through the DEBI website.
- The reviewers were unsure if training was adequate for implementation.
- Training was not adequate for those providing technical assistance (TA) to an implementing agency (one reviewer).

Resources

- Curriculum materials are available and have been used effectively by agencies (all reviewers).
- The materials referred to a video that was not available for review.
- One reviewer commented that the intervention would probably be easy to adapt. The Texas Department of State Health Services (DSHS) does not currently fund an agency to implement this intervention.

Management Issues/Staff

- The intervention has multiple components, requires a high level of skill with street intercept surveys, and may be challenging for staff because of its complexity. At one agency, staff members were initially motivated and excited by the intervention, but became discouraged because of the required level of skill.

Target Audience: Recruiting

- While it was easy to recruit enough of the target population to run classes at one agency, staff attrition prevented dissemination of the role model stories. Continued training and TA were provided, but staff turnover was a persistent problem.

Target Audience: Retention

- Agencies tended to get frustrated by the brief tenure of volunteers.

Technical Assistance (TA)

- The requirement of staff expertise was the most significant barrier to successful implementation. One agency received enough TA to succeed, while the other had needs that exceeded the supportive capacity of DSHS.

- Training and TA were provided for writing role model stories, but outreach staff often struggled to produce them.

Tailoring Requests

- No tailoring requests were filed.

Implementation Success

- One agency connected with the community and successfully recruited target population members. The agency succeeded because it used long-term, committed volunteers and performed a thorough community assessment.

Implementation Decision ■

- Implementation is recommended by both reviewers, one of whom cites some concerns, noting the following necessary elements:
  - Availability of long-term, committed, enthusiastic volunteers
  - Use of volunteers and staff who are strongly connected to the community
  - Use of highly skilled staff

Safe in the City

Safe in the City is an individual-level video-based intervention designed to encourage safe sex behaviors among STD clinic patients.

This single-session intervention involves the presentation of a 23-minute STD/HIV prevention video to patients in an STD clinic waiting room. The video contains key prevention messages aimed at increasing knowledge and perception of STD/HIV risk, promoting positive attitudes toward condom use, and building self-efficacy and skills to facilitate partner treatment, safer sex, and the acquisition, negotiation, and use of condoms. The video contains three interwoven vignettes that model negotiating safer sexual behaviors among young couples of diverse racial/ethnic backgrounds and sexual orientations. Animated segments demonstrate proper condom use and the variety of condoms available. Movie-style posters in the waiting room and exam rooms direct patients' attention to the video and reinforce key messages. Condoms and educational pamphlets on STD prevention are made available to patients in the clinics.

Adapted from the Centers for Disease Control and Prevention (CDC) website http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/Safe-in-the-City.htm

Conditions necessary for successful implementation:

None specified.

Created:
Before 2008

Target Populations:
STD clinic patients

Risk Behaviors:
Unprotected sex

Intervention Level:
Individual

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from the CDC, visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Safe in the City

Clearly stated in the materials:
- Core elements
- Behavioral determinants
- Immediate outcomes
- Goal behaviors

Materials: How adequate? How up-to-date?

- The facilitator guide, participant materials, website, and DEBI website are available.
- The facilitator guide, audio-visual materials, and print-based materials are generally considered *adequate* and *up-to-date in format and content*.
- Photocopying guidelines are unclear.
- The participant materials are available. The guide is *adequate* and *up-to-date* and other materials are *somewhat adequate* and *somewhat up-to-date* (one reviewer).
- Print resources are considered *adequate* and *up-to-date in format and content* by one reviewer and *somewhat adequate* and *somewhat up-to-date in format* by another.
- *Photocopying is permitted*.

Implementation Needs

Implementation needs are *clearly stated* (most reviewers).

- Intervention materials assume availability of equipment to play a DVD and/or download the videos (most reviewers). The materials are free (two reviewers).

Key factors for successful implementation (one or more reviewers):
- Staff "buy-in"
- DVD player
- Materials in Spanish

Potential Barriers/Pitfalls (one or more reviewers):
- Lack of Spanish-language materials
- Lack of DVD player
- Lack of staff "buy-in"
- Lack of appropriate place to screen DVDs
- Staff not trained to follow up with participants

Resources
- Training and technical assistance (TA) are not available for this intervention, but could be useful for training staff to follow up with participants and to assess the impact of the intervention.
- Concerns:
  - Lack of Spanish-language materials

  - Inaccurate description of condom disposal
- Comments and recommendations:
  - UT Southwestern could provide a Spanish version of the video.
  - Ensure that distributed condoms are safe for sex.
  - The Spanish-language poster was not available on the internet.

Review Outcome 

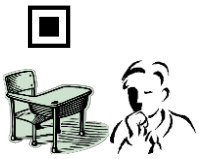
Implementation is recommended (four reviewers).

Reviewers	**Review Date**
(n=5)	7/14/09

Implementation Review: Safe in the City

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available

Safety Counts



Safety Counts is a group-level intervention for out-of-treatment active injection and non-injection drug users aimed at reducing both high-risk drug use and sexual behaviors.

Groups of 4 to 8 clients participate in an individual enrollment session, two group educational sessions, an individual follow-up session, two social events, and one group follow-up session.

This behaviorally focused intervention includes both structured and unstructured psycho-educational activities in group and individual settings. This intervention works well with the Center for Disease Control and Prevention (CDC) Advancing HIV Prevention initiative, as it strongly encourages HIV testing as a precursor to program enrollment; clients can be recruited from testing programs; and sessions include a discussion of the importance of testing. The intervention addresses the needs of both HIV-negative and HIV-positive clients.

Adapted from the Texas Department of State Health Services (DSHS) website
http://www.effectiveinterventions.org/files/SF_FactSheet.pdf

Conditions necessary for successful implementation:

- Adequate staffing of three people, one partly designated for quality assurance (QA).
- At least $120,000 in funding (including tangible reinforcements)
- Use of a skilled, seasoned facilitator with an extensive substance use background
- Inclusion of methadone clients and others in drug treatment

Created:
2000

Target Populations:
Active drug users

Risk Behaviors:
Unprotected sex • Unsafe needle use

Intervention Level:
Group and individual

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: II

Legal Considerations:
Yes, needle exchange and active drug use are illegal in Texas. Educational and social support components can be implemented in Texas.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Safety Counts

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Safety Counts

Training

- Self-training is recommended because formal training is not available in Texas. Formal training was most recently performed in California.
- Training was considered *adequate* for implementation and ongoing support of the intervention by most reviewers, though one found it *inadequate* for those providing support to agencies.

Resources

- The materials have been used effectively by partner agencies.
- Writing effective success stories can be challenging.
- Additional videos are available, though they are intended for staff use.
- Some of the information about the use of nonoxynol-9 for HIV-prevention is outdated and should be updated based on CDC guidance.

Management Issues/Staff

- This program was initially funded for one staff person, but it was difficult to find a single person to perform all necessary functions. With additional funding, another person was hired and the intervention operated as designed.

Target Audience: Recruiting

- Active drug users have been difficult to recruit. The inclusion of individuals in treatment and other substance users has made finding enough clients to run classes easier.

Target Audience: Retention

- The intervention is designed to last 4-6 months; this is considered to be an unrealistically long period of time to expect an active drug user to participate. For at least one agency, when the period was shortened and tangible reinforcements offered, retention improved.

Technical Assistance (TA)

- TA helped one agency overcome a number of barriers, including the difficulty of writing role model stories and problems with retention due to the length of the intervention. Because the agency staff members were proactive, they sought assistance to overcome problems.

Tailoring Requests

- Approved tailoring requests included:
  - Modifying the order of the sessions
  - Reducing time between sessions
  - Using existing video role model stories rather than writing new ones
  - Including clients currently on methadone

Implementation Success

- The implementing program reached its objectives, retained clients, and succeeded with a challenging population. Success was largely due to the efforts of the proactive and communicative agency, which cultivated a supportive relationship with the Texas Department of State Health Services (DSHS).

Implementation Decision ☒

- One reviewer does not recommend implementation, while two reviewers recommend implementation with some concerns:
  - Active drug user populations are difficult to recruit and retain.
  - Adequate staffing is essential for success.
  - This intervention may be more feasible in a big city.
  - Ongoing TA and tailoring may be necessary.

Self-Help in Eliminating Life-Threatening Diseases (SHIELD)

Self-Help in Eliminating Life-Threatening Diseases is a group-level interactive intervention that relies on peer networks to reduce drug and sex risk behaviors among low-income African-American adult intravenous drug users (IDUs).

Groups of 4 to 12 participate in six sessions at a community based setting such as a clinic.

Participants are asked to make public commitments to increase their own health behaviors and to promote HIV prevention among their networks and community contacts. The intervention includes multiple training and skill-building sessions that involve setting goals, role plays, demonstrations, and group discussions. In addition, one session occurs in the community and provides a "street outreach" practice session. These sessions teach participants techniques for personal risk-reduction and the development of correct condom use and safer sex negotiation skills.

The intervention also addresses injection drug use risk and the avoidance of risky situations. To present HIV risk within a broader community context, the intervention emphasizes the interrelatedness of HIV risk among individuals, their risk partners, and their community. Participants are also provided tools and strategies for effective community outreach, and are encouraged to conduct HIV education and become advocates of risk reduction among their sex and drug partners, family and friends, and other community members.

Description from the Centers for Disease Control and Prevention (CDC) website
http://effectiveinterventions.org/en/Interventions/SHIELD.aspx

Created:
Before 2003

Target Populations:
Low-income African-American adult IDUs

Risk Behaviors:
Unprotected sex • Unsafe needle use

Intervention Level:
Group

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Considerations:
Unknown

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Conditions necessary for successful implementation:

None specified.

Materials Review: Self-Help in Eliminating Life-Threatening Diseases (SHIELD)

Materials: How adequate? How up-to-date?

The DEBI website and program evaluation materials were reviewed. No other materials were available.

- The core elements, behavioral determinants, immediate outcomes, and goal behaviors of the intervention are *clearly stated* (all reviewers).
- No logic model was reviewed.

Implementation Needs

- Staff education level and extra money needed for materials are *somewhat clearly stated*.
- One reviewer noted that two full-time employees are needed, but the cost is not included in the sample budget.
- The following implementation needs are *clearly stated*:
  - Staff time
  - Staff skill
  - Number of staff
  - Resources
  - Clearly defined staff roles
  - Time needed to implement

Key factors for successful implementation (one or more reviewers):

- Facilitator is knowledgeable of the drug use culture
- Ability to find former drug users
- Ability to recruit, retain, and train peer counselors, especially those who would serve as nonjudgmental, full-time recruiters.

Potential Barriers/Pitfalls (one or more reviewers):

- The difficulty of persuading participants to talk to their peers about safe drug use
- The difficulty of training current drug users to be peer educators
- The challenge of finding someone to serve as recruiter, facilitator, and marketer
- Reviewers also noted the problems presented by relapsing recruiters and judgmental counselors.

Resources

- Training and technical assistance (TA) are available.
- Potential pitfalls (one or more reviewers):
  - Relapse by recruiters
  - Insufficient agency commitment
  - Lack of tangible reinforcements for participation
- One reviewer was concerned about the availability of training and implementation guides. He noted that the intervention should be reviewed again when more materials are available.
- There was some discussion about whether this intervention operated as a community-level intervention (because of peer training) despite its classification by CDC as a group-level intervention.

Review Outcome 

Implementation is recommended by six reviewers, one of whom recommends implementation under favorable circumstances.

Reviewers	**Review Date**
(N=7)	10/15/09

Implementation Review: Self-Help in Eliminating Life-Threatening Diseases (SHIELD)

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available

Sistering, Informing, Healing, Living, Empowering (SiHLE)

Sistering, Informing, Healing, Living, Empowering (SiHLE) is a group-level skills training intervention designed to reduce risky sex behavior among African-American adolescent females.

Over the course of four consecutive Saturdays, groups of 10 to 12 participate in four 4-hour sessions in a community-based setting.

Through interactive discussions, the intervention emphasizes ethnic and gender pride and enhances awareness of HIV risk-reduction strategies, such as abstaining from sex, using condoms consistently, and having fewer sex partners. Through the use of role plays and cognitive rehearsal, the intervention enhances confidence in initiating safer-sex conversations, negotiating for safer sex, and refusing unsafe sex encounters. In addition, proper condom use skills are modeled and the importance of healthy relationships is discussed.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/SiHLE.htm

Conditions necessary for successful implementation:

None specified.

Created:
Research performed 1995-2002

Target Populations:
African-American females, ages 14-18, who have had vaginal sex in the last six months.

Risk Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Consideration:
No, but a parental consent plan should be developed by the local health department.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Sistering, Healing, Living, and Empowering (SiHLE)

Clearly stated in the materials:
- Elements of the intervention
- Behavioral determinants
- Goal behaviors

Materials: How adequate? How up-to-date?

The facilitator guide, participant materials, program evaluation materials, and program website were available for review.

- The facilitator's guide is available in print and web formats. The guide is *somewhat adequate* (all reviewers). The content is *somewhat up-to-date* and the format is rated *somewhat up-to-date.*
- The participants' guide and materials are available in print and web formats and are *up-to-date* and *adequate*. *Photocopying is permitted*.
- Program materials are now available through the DEBI website.

Implementation Needs

- The following implementation requirements are *somewhat clearly* or *clearly stated* (most reviewers):
  - Staff time
  - Roles for staff
  - Staff skill
  - Number of staff needed
- Reviewers disagree about the clarity of statements describing the following requirements:
  - Staff education level
  - Resources
  - Time needed for implementation
  - Extra money for certain supplies/materials
- Intervention requirements are sometimes unclear because it is in the pilot phase and still in development (one reviewer).
- Trained peer educators and tangible reinforcements have been key factors for successful implementation (most reviewers).
- Reviewers disagreed on the importance of a stipend for peer education, peer educator retention, and peer recruitment.

Key factors for successful implementation (one or more reviewers):

- Adequate funding
- Participant retention
- Peer educator commitment

Potential Barriers/Pitfalls (one or more reviewers):

- Insufficient access to teens
- Length of sessions
- Problems with transportation
- Difficulty obtaining consent
- Insufficient retention of participants and peer educators
- The large number of sessions made it difficult to obtain peer commitment

Resources

- Training and technical assistance (TA) are available.
- Potential pitfalls (one or more reviewers):
  - Problems with staff and participant "buy-in"
  - Lack of cultural competency
  - Transportation
  - Length of sessions
- Reviewers disagreed on whether agency capacity, agency commitment level, and funding were potential pitfalls.

Review Outcome ●

Implementation is recommended by all reviewers.

Reviewers
(n=6)

Review Date
7/16/09

Implementation Review: Sistering, Healing, Living, and Empowering (SiHLE)

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available.

Sisters Informing Sisters about Topics on AIDS (SISTA)

Sisters Informing Sisters about Topics on AIDS (SISTA) is a group-level, peer-led, skill-building intervention designed to reduce risky behaviors among heterosexual, sexually active African-American women at highest risk for HIV.

Over the course of five weeks, groups of 8 to 12 participate in five 2-hour sessions delivered by peer facilitators in a community setting. SISTA gives women the social and behavioral skills they need to adopt HIV risk-reduction strategies. Each session is gender and culturally relevant and includes behavioral skills practice, group discussions, lectures, role-playing, a prevention video, and take-home exercises. The intervention applies the social cognitive theory and the theory of gender and power.

Adapted from the Centers for Disease Control and Prevention (CDC) website http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/guidelines/pro_guidance/sista.htm#link1

Conditions necessary for successful implementation:

- Skilled facilitator
- Access to training early in implementation process
- Adequate budget to retain appropriate staff
- Sufficient time for adaptation of intervention
- Effective process evaluation and community assessment skills
- Address barriers such as transportation and childcare
- Use of props/decor to build cultural pride and awareness

Created:
1995

Target Populations:
Heterosexual African-American females, ages 18-29

Risk Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: III

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Sisters Informing Sisters about Topics on AIDS (SISTA)

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Sisters Informing Sisters about Topics on AIDS (SISTA)

Training

- Both formal training and self-training are effective, but formal training is not easily accessible and may require out-of-state travel and a long wait to schedule. Individuals can become SISTA trainers by attending the facilitators' training and a training of trainers (TOT).
- Formal training has not been scheduled before implementation but, once available, has helped consultants provide program support to partner agencies.
- Training is adequate for implementation and ongoing support (all reviewers).
- Training has been updated and that new materials are available on the CDC website as of January 2011.

Resources

- The curriculum is available but somewhat outdated.
- "While materials were generally used effectively, in one case the facilitator did not address issues that were elicited by the materials."
- Other materials, available through the Texas Department of State Health Services (DSHS) and the CDC website, are considered effective, especially those that address ethnic pride and statistical updates.
- Materials were updated in September 2008, as follows:
  - Substitution of "HIV" for "AIDS Virus"
  - Additional forms to assist staff with implementation
  - Improved facilitation guidance
  - Sample budget and logic model
  - Removal of a reference to spermicide
  - Information about adaptation to other populations

Management Issues/Staff

- Agencies have been able to hire, train, and retain staff, although training was delayed and expensive when held out of state. Retention of facilitators was sometimes problematic (one reviewer).
- When agency salaries were too low to attract and retain qualified staff, chronic staff turnover occurred (one reviewer).
- One reviewer observed a problem with differences in opinion among staff about how the program should be implemented.
- Formal training has been able to help with staff "buy-in" (one reviewer).

- Managing or supervising staff for this intervention is not difficult (all reviewers).

Target Audience: Recruitment

- Agencies have been able to recruit enough target population members to meet performance measures (most reviewers). Recruitment is more difficult when agencies limit their recruitment venues (two reviewers).
- Recruiting only African-American women while excluding other women has been difficult. One agency learned that selective recruitment can be accomplished by targeting areas with large numbers of the target population and by selecting venues on a trial and error basis.

Target Audience: Retention

- Retaining enough members of the target population to meet performance measures was possible (all reviewers). Challenges have been met in a variety of ways.
- Problems with childcare, transportation, and scheduling were barriers to retention at one agency (one reviewer). In response, the program was offered at local housing complexes and apartment facilities. This helped with transportation and scheduling, but childcare remained an occasional issue.
- The schedule of sessions (five sessions over the course of five weeks) was a problem (one reviewer). Tailoring allowed the sessions to be held closer together.
- Other efforts have been helpful for retention, including offering transportation, serving snacks, and giving participants credits through a local charter school.
- A "weekend retreat" format was being piloted at the time of review.

Technical Assistance (TA)

- All reviewers provided TA to overcome barriers to implementation. One noted that she had provided the frequency, type, and quality of support that was needed for successful implementation. She also observed that agencies had sought support from consultants, evidence-based intervention (EBI) specialist/trainees, and the CDC.
- Another reviewer noted that, because she had competing responsibilities that required her attention, she was unable to provide adequate TA.
- The third reviewer noted that it was not possible to provide the necessary frequency and type of TA because the rollout of the intervention coincided with staff changes among Texas Department of State Health Services (DSHS) consultants and contractor facilitators.

Tailoring Requests

- Tailoring requests were granted for the following changes:
  - A "booster session" was added to allow women's partners to attend a graduation ceremony. It was unclear if this had an impact.
  - Sessions were scheduled closer together, which improved retention.
  - Hispanic females were targeted.

Implementation Decision ■

- Implementation is recommended by all reviewers, one of whom cites some concerns:
  - Lack of childcare
  - Problems with transportation
  - Insufficient funding for staff salaries
- A need for strong, skilled facilitators.

Sister to Sister

Sister to Sister is an individual-level, skill-based, risk-reduction behavioral intervention for sexually active African-American women 18-45 years old who have male partners.

The 20-minute intervention is designed to provide women with the knowledge, beliefs, motivation, confidence, and skills necessary to help them make behavioral changes that will reduce their risk for STDs, especially HIV. The intervention is highly structured and implemented in a primary health care setting by nurses, health educators, or other professional clinic staff using an implementation manual. It is educational, engaging, and gender-appropriate and uses videos, brainstorming, experiential exercises, and skills-building activities. It is designed to be easily integrated it into the health care provider's standard clinical practice. As such, the Sister to Sister intervention is an effective tool for addressing the needs of both patients and providers in primary care clinics.

Adapted from the Centers for Disease Control and Prevention (CDC) website http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/guidelines/pro_guidance/sister-to-sister.htm

Conditions necessary for successful implementation:

None specified.

Created:
Before 2007

Target Populations:
Sexually active, heterosexual, African-American women, ages 18-45

Risk Behaviors:
Unprotected sex

Intervention Level:
Individual

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Sister to Sister

Materials: How adequate? How up-to-date?

The CDC program website (intervention fact sheet) and the DEBI website were available for review. Sufficient information was not available to evaluate the quality of intervention materials.

- The core elements were *clearly* described (all reviewers).
- The behavioral determinants and goal behaviors of the intervention were *clearly* described (most reviewers).
- Reviewers disagreed about the clarity of statements describing the immediate outcomes.

Implementation Needs

Implementation needs were *clearly stated* (all reviewers).

Key factors for successful implementation (one or more reviewers):

- Staff "buy-in," training, and cultural competency
- Confidentiality and data security
- Legal and ethical policies, such as informed consent
- Referral to the program by clinic staff
- Quality assurance (QA)

Potential Barriers/Pitfalls (one or more reviewers):

- Lack of staff "buy-in"
- Failure to document appropriate legal and ethical procedures
- Problems maintaining confidentiality
- Lack of participant consent
- Insufficient paid staff or volunteers to implement the program in a busy clinic setting
- Insufficient time for implementation
- Difficulty conducting behavioral interviews in a clinical setting
- Lack of QA

Resources

- Training and technical assistance (TA) are available
- Lack of clinic "buy-in," documentation issues, and lack of structure for QA are seen as potential pitfalls.
- At the time of review, the curriculum cost $145 plus $89 for the DVD.

Review Outcome 

Implementation is recommended by all reviewers.

Reviewers	Review Date
(n=6)	10/15/09

Implementation Review: Sister to Sister

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available

Sniffer

Sniffer is a group-level, social learning based, AIDS/drug injection prevention intervention for intranasal drug users.

Over the course of two weeks, groups of 8 to 12 participate in four 60- to 90-minute sessions at a community storefront setting.

The intervention is designed to create a support-group type of atmosphere so participants feel comfortable discussing personal problems and seeking help from the facilitators and their peers. The sessions include information on AIDS, drug use, drug injection, sexual behavior and AIDS, and seeking entry into drug treatment programs. Coping skills, such as self-assertion, dealing with depression, and seeking treatment, are addressed. Through role play, participants learn how to refuse an offer to inject drugs and learn to seek entry into a drug treatment program. Participants are taught 'safer' injection procedures, such as cleaning drug injection equipment with bleach to decontaminate. As part of the intake procedures, all participants are provided HIV pre-test counseling and are offered HIV testing. Post-test counseling is provided to those electing to take the HIV test, and Hepatitis B testing is required for all participants.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/sniffer.htm#ref1

Created:
1986-1988

Target Populations:
Active drug users, specifically intranasal users and intravenous drug users (IDUs)

Risk Behaviors:
Unsafe needle use • Other substance use

Intervention Level:
Group

Intervention Type:
Evidence-Based Intervention (EBI)

Evidence Tier: II

Legal Considerations:
None noted.

Training:
No

Technical Assistance:
Yes, from Sociometrics at www.socio.com.

Conditions necessary for successful implementation:

- A facilitator with expertise in substance use and the philosophy of harm reduction.
- Participation of IDUs and intranasal drug users.
- Implementation in a large city.

Materials Review: Sniffer

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Sniffer

Training

- Self-training with materials is required, as formal training is not available (all reviewers).
- Self-training was sufficient for an agency with a harm reduction philosophy and a facilitator with a substance abuse background (one reviewer).

Resources

- Sociometrics released a kit in 1999 that was somewhat outdated by the time of review. Reviewers were unsure if the material had been updated and were concerned that needle cleaning and safe intranasal use instructions be based on current CDC recommendations. Otherwise, the materials appeared thorough (all reviewers).
- A video is available but outdated.

Management Issues/Staff

- One implementing agency was able to hire, train, and retain staff, though oversight by management was lacking.
- Management will have difficulty with fidelity to the intervention design if it has a poor understanding of EBI concepts.

Target Audience: Recruiting

- One agency was able to recruit enough of the target population to run classes, while another struggled with the challenge of finding enough active drug users to participate in a group intervention.
- A third agency initially targeted only IDUs and was unable to overcome the shortage of target population members. The reviewer noted that, in spite of a tailoring request to involve other drug users, the agency moved toward recruiting only IDUs and struggled to find enough clients to hold classes.
- The effects of using tangible reinforcements were unclear.

Target Audience: Retention

- Retention was more challenging than recruitment.
- The effects of using tangible reinforcements were unclear.

Technical Assistance (TA)

- One reviewer noted that, in spite of his efforts (observing sessions; engaging in discussions with the executive officer of the agency; and providing a half-day outcome monitoring session), he was not able to support successful implementation of the intervention. He attributed this failure to the difficulty of locating a sufficient number of target population members.

Tailoring Requests

- Tailoring requests were granted for inclusion of IDUs who use drugs other than heroin, which improved recruitment to a point, but participant numbers remained low.

Implementation Success

- An agency whose clients are IDUs and interested in harm reduction rather than terminating injection drug use might be able to implement this program successfully (one reviewer).

Implementation Decision ☒

- Both reviewers cited serious concerns about implementation, including:
  - The target populations are too restrictive.
  - The materials for the intervention are outdated.

Street Smart

Street Smart is a group-level, intensive, skills-based intervention designed to reduce risk behavior among runaway youth.

Over the course of 6-8 weeks, groups of 10 to 12 participate in ten 1 ½- to 2-hour sessions at a homeless or runaway shelter. The intervention focuses on providing access to health resources, making condoms available, training youth on personal skills, and training staff to help support the youth in changing their behavior.

In small groups, the youth discuss the following topics: basics about HIV/STD risk, assessing personal risk and avoiding sexual risk, the correct use of male and female condoms, how substance use affects sexual control and judgment, identifying and managing triggers for unsafe sex, and problem solving. Each session, youth use a "Feeling Thermometer" to help them recognize and discuss their feelings. Youth are taught to cope with their feelings by practicing coping skills and relaxation skills to control feelings of anxiety, depression, anger, and desire.

The intervention focuses on positive self-talk to build self-esteem, help with difficult situations, and increase self-efficacy for safer sex. Tokens of appreciation and compliments are exchanged among the youth to provide positive support for appropriate behavior and meeting HIV-related goals. Activities to promote positive attitudes, increase self-efficacy, and build effective communication, personal, and technical skills include games, exercises, practicing, and role-playing. In addition, youth attend video and art workshops to develop media messages through soap opera dramas, public service announcements commercials, or raps to reinforce safer sex. An individual counseling session is provided to discuss attitudes, identify triggers and barriers, and develop a plan for coping and overcoming barriers to practice safer sex. Finally, youth visit a local community-based agency providing health and mental health care to learn about other available resources in the community.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/StreetSmart.htm

Created:
Before 1991

Target Populations:
Runaway and homeless youth, ages 11-18

Risk Behaviors:
Unprotected sex • Substance use associated with sex

Intervention Level:
Group

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from the CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Conditions necessary for successful implementation:

None specified.

Materials Review: Street Smart

Clearly stated in the materials:
- Intervention
- Behavioral determinants
- Immediate outcomes of the intervention
- Goal behaviors

Not clearly stated in the materials:
- Behavior change logic model for the intervention

Materials: How adequate? How up-to-date?

The DEBI website is available for review for some aspects of the program. Other materials are made available at training and were not reviewed at this time.

Implementation Needs

Implementation requirements were *clearly* stated (all reviewers).

Key factors for successful implementation (one or more reviewers):
- Ability of participants to trust facilitators and access counseling, testing, and referral
- Access to the target population
- Participation of respected target community members
- Recognized runaway shelters at which to locate youth
- Committed facilitators
- Available phone numbers for participants to access additional information

Potential Barriers/Pitfalls (one or more reviewers):
- Lack of agency capacity
- Lack of agency readiness
- Inaccessible location
- Problems with retention
- Difficulty of finding qualified staff
- Problems linking to other services
- Problems accessing intended population members
- Inadequate staff training
- Access to a sufficient number of youth for program implementation

Resources
- Training and technical assistance (TA) are available.
- Potential pitfalls (one or more reviewers):
  - Problems accessing to the target population
  - Lack of staff “buy-in”
  - Problems with retention
  - Participants with intentions contradictory to the demands of the program
  - Length of the program

Comments and Recommendations

- Effective monitoring tools, including a fidelity report, are available for the sessions (one reviewer).
- The intervention could be adapted for other high-risk youth in other settings (one reviewer).
- It was unclear if there was a charge for the kit (one reviewer).
- Parental consent might be a concern (two reviewers).

Review Outcome 

Implementation under favorable circumstances is recommended by all reviewers.

Reviewers	**Review Date**
(n=5)	7/15/09

Implementation Review: Street Smart

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available

Turning Point

Turning Point is comprised of two group-level interventions designed to reduce the frequency and probability of injection-risk behavior among intravenous drug users (IDUs) not participating in drug abuse treatment programs.

The basic intervention consists of two sessions. In the first session, participants undergo HIV antibody tests and receive pre-test counseling. In the second session, a counselor-educator provides detailed information about HIV and HIV transmission and guides the participant group through activities intended to teach behavioral strategies for avoiding exposure to HIV. Participants in the enhanced intervention complete the basic intervention and attend three additional sessions, in which they address HIV/AIDS pathology, drug addiction, and safer sex practices. Both interventions employ videotape presentations, role-play, hands-on demonstrations, and print materials. The enhanced intervention also employs slide presentations, self-assessment tests, and lecture/discussion.

Adapted from the Sociometrics website
http://www.socio.com/hap06.php

Created:
Research reported in 1995

Target Populations:
HIV-negative IDUs

Intervention Level:
Group

Intervention Type:
Not available

Evidence Tier:
Not available

Legal Considerations:
None noted.

Training:
No

Technical Assistance:
Yes, from funder.

Conditions necessary for successful implementation:

The intervention is not recommended.
If you implement this intervention, consider the following:

- Videos and facts must be updated since the curriculum is so old (over 20 years).
- Not appropriate for HIV+ persons because it is a fear-based curriculum, and discusses the ravages of AIDS.
- Agency needs to have the ability to provide HIV testing, as this is a core element.
- Sixth session needs to be split between men and women, since they approach relationships differently.

Materials Review: Turning Point

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: Turning Point

Training

- Self-training is required because formal training is not available.

Resources

- Kits are available, but do not include videos.
- The curriculum materials have been used effectively by partner agencies, according to two reviewers. Another reviewer disagreed, citing the numerous tailoring requests needed to support implementation.
- While a manual is available in addition to curriculum materials, appropriate videos have been difficult to find. All supplemental information was considered outdated and reviewers are unaware of any updated materials.

Management Issues/Staff

- Agencies have been able to hire, train, and retain staff.
- Some agency staff did not support the fear-based approach (one reviewer).

Target Audience: Recruiting

- Sufficient recruitment of the target population to meet performance measures was challenging (most reviewers). This difficulty was attributed to the selection of inappropriate recruiting venues and the challenge of locating IDUs.
- One agency was able to overcome barriers to recruitment through tailoring to allow venue changes (one reviewer).

Target Audience: Retention

- Retention was very difficult because recruitment numbers were low to begin with.
- Multiple tailoring efforts resulted in some improvement in retention and an intervention that was essentially “home grown” because of the extent to which it had been changed.

Technical Assistance (TA)

- TA was provided to agencies, but was generally not sufficient to support effective implementation. In some cases, agencies lacked the capacity to implement the intervention and in others, the information was too outdated to be effective.

Tailoring Requests

- Tailoring requests addressed the order of sessions, the combination of sessions, venues, updating statistics, and changing videos. These changes were seen as essential to implementation.

Implementation Success

- Tailoring led to some improvements, including improved rates of HIV testing and improved retention.
- The original intervention was ineffective and only through a series of changes was it functional. Its fear-based approach is not consistent with Texas Department of State Health Services (DSHS) policy.

Implementation Decision ☐

- Implementation is not recommended. Reviewers cite the following concerns:
  - It is difficult to find active IDUs who will commit to six sessions and adding HIV+ participants would have a detrimental effect.
  - The curriculum is outdated.
  - The curriculum is fear-based.
  - TA and training are not available.

Positive Choice: Interactive Video Doctor

Positive Choice is an individual-level, interactive computer-based intervention designed to improve screening and counseling about ongoing sex risk and substance use among HIV-positive patients.

While waiting for the scheduled visit with a care provider, HIV patients first complete the Positive Choice risk assessment on a laptop computer. Based on the risk assessment, a video clip appears on the computer in which an actor-portrayed "Video Doctor" delivers interactive risk-reduction messages to the patient. The clip is matched and tailored to the patient's gender, risk profile, and readiness to change. This risk-reduction Video Doctor counseling session is based on Motivational Interviewing principles, which emphasize a patient-centered approach, non-judgmental tone, empathy, and support. The Video Doctor counseling session lasts an average of 24 minutes. After this brief session, the computer prints out two documents: (1) an educational worksheet for participants with questions for self-reflection, harm reduction tips, and local resources; and (2) a cuing sheet for health care providers, which offers a summary of the patient's risk profile and readiness to change, and suggested risk-reduction counseling statements to serve as a prompt for discussing risky behaviors with patients. A booster Video Doctor counseling session is provided three months later and includes feedback reflecting changes made since the initial visit, along with an updated output for the patient and provider to review and discuss during the clinic visit.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/positive-choice.htm

Created:
Before 2008

Target Populations:
HIV-positive clinic patients

Risk Behaviors:
Unprotected sex

Intervention Level:
Individual

Intervention Type:
Evidence-Based Intervention (EBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
None identified at this time.

Technical Assistance:
Yes, from funder.

Conditions necessary for successful implementation:

None specified.

Materials Review: Positive Choices: Interactive Video Doctor

Clearly stated in the materials:
- Goal behaviors

Not clearly stated in the materials:
- Core elements
- Behavioral determinants
- Immediate outcomes

Materials: How adequate? How up-to-date?

Participant materials from the Compendium website were reviewed. Reviewers did not assess whether these materials were *up-to-date*.

Implementation Needs

Detailed implementation plans were not available to reviewers. They offered only general comments regarding implementation needs:

Key factors for successful implementation (one or more reviewers):
- Availability of laptops
- Availability of software
- Clinic "buy-in"

Resources
- Training and technical assistance (TA) are not available for this intervention.
- Potential pitfalls:
  - Inadequate software
  - Absence of plans for replication and dissemination
  - Lack of necessary components (described above)
- While the intervention sounds promising, two other video interventions were in replication phase at the time of review, and no entity has accepted responsibility for evaluating/replicating this intervention's effectiveness study.

Review Outcome ○

Although reviewers were enthusiastic about the intervention, they all agreed that the intervention could not be implemented at this time because the software was not currently available.

Reviewers
(n=6)

Review Date
10/15/09

Implementation Review: Positive Choices: Interactive Video Doctor

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available

VOICES/VOCES

VOICES/VOCES is a group-level, single-session, video-based program designed to encourage condom use and improve condom negotiation skills among high-risk heterosexual (HRH) African Americans and HRH Hispanics.

During the 45- to 60-minute session, a group of 4 to 8 clinic patients watch a video, receive instruction in condom use, and discuss safe sex negotiation. The program is based on the theory of reasoned action, which explains how behaviors are guided by attitudes, beliefs, experiences, and expectations of other persons' reactions. VOICES/VOCES is grounded in extensive formative research exploring the culture- and gender-based factors that can facilitate behavior change. An evaluation of the intervention showed that VOICES/VOCES is effective when delivered at a "teachable moment," for instance when a visit to an STD clinic may motivate a person to change behavior.

Adapted from the Centers for Disease Control and Prevention (CDC) website http://www.effectiveinterventions.org/Libraries/VOICES_Docs/VOICES_Fact_Sheet_revised_1_26_2011_1.sflb.ashx

Conditions necessary for successful implementation:

- Videos and materials have been updated and will need to be updated continuously.
- Must be implemented in a venue that allows condom distribution.
- Availability of a Spanish language video to be used for Spanish-speaking clients.

Created:
1999

Target Populations:
HRH African Americans and HRH Hispanics

Risk Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from CDC; visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: VOICES/VOCES

Materials reviewed in 2005 intervention review process. Not available in this document.

Implementation Review: VOICES/VOCES

Training

- Formal training is required for this intervention and is offered through the Academy for Educational Development (AED)[6] and the City of Houston Department of Health Services. The Arizona-Mexico Border Health Foundation[7] has also provided training in the past.
- Self-training with the materials is also an option, though the training guide does not include sufficient detail on facilitation (one reviewer).
- Formal training is generally adequate for both implementation and ongoing support of the intervention.
- Formal training is adequate for a staff member who already has some facilitation skills (one reviewer).

Resources

- Curriculum materials are available and have been used effectively by partner agencies (all reviewers).
- Other materials, such as videos and a condom display board, are also available and effective (all reviewers).
- Updates were provided in 2008 and 2009, including newer videos, activity sheets, key messages, and a facilitation guide.

Management Issues/Staff

- Agencies have been able to hire, train, and retain staff (most reviewers). One agency struggled in this area, but a reviewer considered the problem related to agency rather than intervention issues.

Target Audience: Recruiting

- Recruiting enough target population members to meet performance measures is possible, though one reviewer suggested that agencies will need to do outreach.
- Keeping groups small and homogeneous by gender and ethnicity is difficult (most reviewers).
- Agencies should not tailor the intervention by venue (one reviewer).

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[6] http://www.aed.org/

[5] http://www.cdc.gov/hiv/topics/cba/providers.htm

- Some partner agencies were new to targeting heterosexuals (one reviewer).
- Some agencies used "Safe in the City" videos for mixed audiences and experienced some success.
- Some agencies were able to recruit enough of the target population by experimenting with larger groups and groups of mixed gender and ethnicity.

Target Audience: Retention

- Retention has generally not been considered an issue because the intervention is a single one-hour session.

Technical Assistance (TA)

- TA has been provided to help agencies overcome barriers, most relating to MSM adaptation and, to a lesser degree, adapting to a venue and outdated videos that are not relevant to clients.
- Reviewers have been able to provide the frequency, type, and quality of support that has been needed, though one reported that the time allowed in site visits is not always sufficient.
- One reviewer noted that, while she has been able to resolve group-related issues like size, she has had limited success helping contractors find alternative videos when clients reported disliking the one in use.
- One reviewer noted that TA is most effective when an evidence-based intervention (EBI) specialist and a Texas Department of State Health Services (DSHS) consultant work together to strategize.

Tailoring Requests

- Tailoring requests were granted for the selection of new videos to better fit target populations.
- One request was not granted because it was a response to a problem with a venue rather than a target population need.
- Video adaptations for both MSM and mixed group audiences have been considered effective and important for success.

Implementation Success

- The intervention has been successfully adapted to MSM and mixed gender groups (two reviewers).
- Program success is attributed to three elements of the intervention:
  - The one-session format
  - A focus on condom use
  - The adaptability of the intervention to different venues

Implementation Decision 

- Implementation is recommended by all reviewers.
- The intervention should not be implemented at a venue where condom distribution is not allowed (one reviewer).
- TA on time management might be necessary for successful implementation (one reviewer).

Wall Talk

Wall Talk is a peer education program in which participants can learn about the history and rationale behind this project, discuss the linkages between prison and public health populations, explore activities and lessons from "Wall Talk," and plan to adopt and adapt this for their own communities and populations.

Description from the Texas Department of State Health Services (DSHS) website
http://www.dshs.state.tx.us/hivstd/conference/2004/trackg.shtm

Conditions necessary for successful implementation:

None specified.

Created:
2003

Target Populations:
Texas Department of Criminal Justice (TDCJ) inmates

Risk Behaviors:
Unprotected sex • Unsafe needle use

Intervention Level:
Community

Intervention Type:
"Homegrown"

Evidence Tier: III

Legal Considerations:
None noted.

Training:
No

Technical Assistance:
No

Materials Review: Wall Talk

Clearly stated in the materials:
- Core elements
- Goal behaviors
- Immediate outcomes of the intervention

- The behavioral determinants are *clearly* stated (most reviewers). One reviewer believed that the behavioral determinants are *unclear* without a logic model for reference.
- Because the behaviors addressed by the intervention are illegal in correctional facilities, Wall Talk focuses on skills, attitudes, and beliefs.

Materials: How adequate? How up-to-date?

The facilitator guide and materials, participant materials, program evaluation materials, and Texas HIV/STD Prevention Community Planning Group (TxCPG) data were available for review. Program developers and representatives from an implementing agency served as key informants.

- The following materials are *up-to-date* and *adequate*, and *photocopying is permitted*:
  - Facilitator materials, including guide, print-based materials, and updates
  - Participant materials, including guide and updated documents
  - Print-based resources
- Audio-visual materials are available only via the internet. The format is *up-to-date* (one reviewer).
- All participant materials, print-based resources, and facilitator audio-visual materials are available on the internet.

Implementation Needs

- The following implementation needs are *clearly stated*:
  - Staff education level
  - Staff skills
  - Staff implementation roles
  - Resources
- Staff time and number of staff needed are *somewhat clearly stated* (all reviewers).
- Reviewers were split as to whether the need for additional monies beyond those listed in the budget were clearly described in the materials reviewed.
- The time required for initial implementation is *not clearly stated* (most reviewers).
- The education level of the staff is not critical for implementation (all reviewers).

Key factors for successful implementation (one or more reviewers):

- Staff knowledge of prison culture
- Strong relationship between the agency and Texas Department of Criminal Justice
- Staff access to correctional facilities
- Flexible, well-trained, culturally competent staff
- Peer trainers must be skilled at motivating their peers
- The agency and its staff must exhibit flexibility

Potential Barriers/Pitfalls (one or more reviewers):

- Lack of knowledge about prison culture and policies
- Lack of access to the prison and warden
- The culture of care in a correctional facility

Resources

- A budget, the logic model, and a description of resources needed for implementation are available by request (some reviewers).
- A budget was not available as of the time of the review.
- Peer educators are not paid staff at the prison; staff are hired by the implementing agency and peers are inmates.
- Training and technical assistance (TA) are available.
- *Potential Barriers/Pitfalls* (one or more reviewers):
  - Prison leadership practices
  - Corrections culture
  - Prison policies
  - Changes in prison leadership
  - Unqualified staff
  - High staff turnover
  - The implementing agency must have experience working with inmates in correctional facilities, must understand correctional policies and culture, have a strong relationship with TDJC, and must respect the boundaries of the relationship.
  - The TDJC unit representative must be supportive of the intervention.

Review Outcome 

Implementation is recommended by seven reviewers, three of whom specify the need for the support of prison leadership.

Reviewers	**Review Date**
(n=8)	10/15/19

Implementation Review: Wall Talk

Not recently funded by the Texas Department of State Health Services (DSHS). Implementation information not available

Women Involved in Life Learning from Other Women (WiLLOW)

WiLLOW is a group-level skill-training intervention designed to reduce risk behavior among women living with HIV.

Over the course of four weeks, groups of 8 to 10 participate in four 4-hour sessions. Through interactive discussions, the intervention emphasizes gender pride and informs women how to identify and maintain supportive people in their social networks.

The intervention enhances awareness of HIV transmission risk behaviors, discredits myths regarding HIV prevention for people living with HIV, teaches communication skills for negotiating safer sex, and reinforces the benefits of consistent condom use. WiLLOW also teaches women how to distinguish between healthy and unhealthy relationships, discusses the impact of abusive partners on safer sex, and provides information about local shelters for women in abusive relationships.

Adapted from the Centers for Disease Control and Prevention (CDC) website
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/WiLLOW.htm

Conditions necessary for successful implementation:

- The facilitator should be familiar with women's issues, particularly regarding women with HIV.
- It is helpful for the facilitator to be a member of the target population (including HIV-positive status).
- It is helpful for the agency to have connections with AIDS service organizations, through which the intervention can be marketed.
- The agency should provide tangible reinforcements and childcare.
- The agency should bring the intervention to the clients rather than request that clients find transportation to a central location.

Created:
2004

Target Populations:
HIV-positive women

Risk Behaviors:
Unprotected sex

Intervention Level:
Group

Intervention Type:
Diffusion of Effective Behavioral Interventions (DEBI)

Evidence Tier: I

Legal Considerations:
None noted.

Training:
Yes, from the CDC, visit the DEBI training calendar at http://www.effectiveinterventions.org/en/TrainingCalendar.aspx.

Technical Assistance:
Yes, from funder.

Materials Review: Women Involved in Life Learning from Other Women (WiLLOW)

Clearly stated in the material:
- Goal behaviors

Not clearly stated in the material:
- Elements of the intervention

Materials: How adequate? How up-to-date?

The facilitator guide, participant materials, program website, DEBI website, and program evaluation materials were available for review.
- The facilitator guide was available in print and web versions. The guide's information is *somewhat up to date* (all reviewers); the format of the materials are *up to date* (all reviewers), and the guide is viewed as *somewhat adequate* (most reviewers).
- Other print-based facilitator materials are *adequate* (most reviewers); the content and format are *up-to-date* (all reviewers).
- Print based facilitator materials could not be copied.
- Audio-visual materials were not available in any form.
- The print form of updates was in the process of being prepared (one reviewer).
- The print- and internet- based participant materials are *adequate* (all reviewers); the content and format are *t up-to-date* (all reviewers).
- Print-based participant materials were able to be photocopied.
- Program impact/outcome evaluation materials were not available at training, but were available for the project officer (some reviewers).

Implementation Needs

- None of the implementation requirements were clearly stated (all reviewers). It was suggested by most reviewers that these statements were being developed at the present time.

Key factors for successful implementation (two or more reviewers):
- Training
- Agency access to 2 peer educators
- Access to the target population

Potential Barriers/Pitfalls (one or more reviewers):
- No linkage to clinic setting
- No linkage to services
- Program cost
- Client recruitment
- Client retention

Resources
- Training was not available at time of materials review and
- Reviewers could not tell if technical assistance was available.
- Potential pitfalls
  - Poor relationships with case managers

- Poor recruitment to HIV treatment
- Facilitator lack of cultural competence

Review Outcome 

Implementation is recommended by all reviewers.

Reviewers	**Review Date**
(n=7)	7/15/09

Implementation Review: Women Involved in Life Learning from Other Women (WiLLOW)

Training

- Self-training with a trial manual is required. The CDC provides training, which may be found on the effective interventions website training calendar.

Resources

- The curriculum materials are available, user-friendly, and have been used effectively.
- Supplementary materials provide activities for the four sessions.

Management Issues/Staff

- Agencies have struggled to find a facilitator with all of the following traits: HIV-positive, African-American, female, skilled in facilitation, and able to pass a background check. Loosening the background check has helped with recruitment.
- The failure of agency supervisors to understand the intervention can lead to competition between agency programs and an absence of appropriate patterns of referral.
- Conflicting staff roles have created some problems with management.

Target Audience: Recruiting

- Barriers to recruitment include following factors:
  - A failure to market the intervention
  - Limited internal and external referrals
  - The length of the intervention sessions
  - Lack of childcare and transportation
  - Inconvenient program location
- Some adjustments to these barriers have been implemented and appear to be working. These include:
  - Better screening

- Internal marketing
- Reduced session length
- Provision of childcare

Target Audience: Retention

- Inadequate recruitment initially made retaining a sufficient number of clients to run classes impossible.
- Some HIV-positive women have been unwilling to leave home to participate in the intervention because of concerns about infectious disease and other health issues. The agency responded by delivering the program at women's homes.

Technical Assistance (TA)

- Texas Department of State Health Services (DSHS) staff and the CDC provide TA, although support from the CDC has declined over time.

Tailoring Requests

- Changes in the number and duration of sessions were approved, as was the use of a non-HIV-positive health educator on a temporary basis.
- The inclusion of HIV-negative (Hepatitis C-positive) clients was not approved.
- Shortening the sessions, providing childcare, and using two skilled facilitators improved retention.

Implementation Success

- At one agency, women who stayed in the group were engaged and enjoyed the sessions. They gained knowledge and skills as a result of their participation in the intervention. They demonstrated their learning during "teach-backs" to their fellow students at the last session.
- The success of the program is attributed to skilled facilitators who balanced fidelity and flexibility in their delivery of the material.
- This intervention is unique because it is one of the few interventions for HIV-positive women of color.

Implementation Decision 

- Implementation is recommended by both reviewers, who cite some concerns:
  - Current lack of formal training
  - Difficulty of providing TA for a new intervention
  - Challenge of recruiting enough HIV-positive women
  - Time commitment required by four 4-hour sessions

Population – Intervention Match List

1. HIV-Positive

Population-Specific Interventions
CLEAR
WILLOW
Healthy Living Project
Healthy Relationships
SHIELD (Drug users)

2. Black MSM

Population-Specific Interventions
Brother to Brother
D-Up
Many Men, Many Voices (3MV)
Popular Opinion Leader

3. All MSM (Except Black)

Population-Specific Interventions
PIP MSM
Popular Opinion Leader
Many Men, Many Voices (of Color)
Mpowerment

4. High-Risk Heterosexual Black Females

Population-Specific Interventions
CONNECT
Doing Something Different
Enhancing Motivation
PIP-WE
Popular Opinion Leader
RAPP
Safe in the City
SHIELD
SiHLE
SISTA
Sister to Sister
VOICES/VOCES

5. Intravenous Drug Users

Population-Specific Interventions
Modelo Intervencion de Psicomedico (MIP)
Safety Counts (Active Drug Users)
SHIELD
Sniffer

6. African-American High-Risk Heterosexual Men

Population-Specific Interventions
CONNECT
Doing Something Different
NIA
SHIELD
Safe in the City
VOICES/VOCES

7. High-Risk Hispanic Heterosexual Women

Population-Specific Interventions
CONNECT
PIP-WE (Female)
RAPP (Female)
Safe in the City
SHIELD
VOICES/VOCES

8. All Youth aged 13-24

Population-Specific Interventions
BART
Be Proud, Be Responsible
Focus on Youth
SiHLE
Project AIM

9. Special Populations

A. Transgendered Individuals

Population-Specific Interventions
None

B. Partner of HIV+ Persons

Population-Specific Interventions
None

C. Homeless

Population-Specific Interventions
Street Smart (Youth)

D. Incarcerated Persons

Population-Specific Interventions
Project Start
RHAP (Male Youth)
Wall Talk

E. Sex Workers

Population-Specific Interventions
Popular Opinion Leader
Community Promise

F. STD/HEP C Diagnosis

Population-Specific Interventions
None

G. Persons Ages 50 and Older

Population-Specific Interventions
None

H. Mental Health

Population-Specific Interventions
None

Additional HIV/STD Strategies/Interventions

CRCS*
CTR (PBC)*
Respect (http://www.effectiveinterventions.org/en/Interventions/RESPECT.aspx)
Linkage to care
Peer-led models
Structural interventions
Community mobilization /Engagement
Social networking strategies
Social marketing
Social media
Outreach – Internet/Community
Routine screening – HIV/STD

Intervention identified for universal implementation among prioritized populations

CLEAR
Community PROMISE*
Popular Opinion Leader*
Safety Counts – Active Drug Users*

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*Reviewed by Texas Department of State Health Services Intervention Review Panel

Key Terms: Evidence-Based Interventions[8]

Adaptation: Making changes to the intervention, such as the target population, setting, or location, but not changing or contradicting the internal logic of the intervention.

Behavioral Change Theories: Social science theories or ideas about the processes through which people begin to consistently engage in new, healthful behaviors.

Core Elements: Components of the intervention that are believed to be essential to achieve the desired behavior change outcomes. They refer to the features in the intent and design of an intervention that are responsible for its effectiveness. Changes to core elements are not permitted.

Culturally Appropriate: Conforming to a culture's acceptable expressions and standards of behavior and thoughts. Interventions and educational materials are more likely to be culturally appropriate when representatives of the intended target audience are involved in planning, developing, and pilot testing the materials.

DEBI (stands for Diffusion of Effective Behavioral Interventions): Effective behavioral interventions that meet the Centers for Disease Control and Prevention's (CDC) standards for evidence of behavior change and have been chosen by the CDC for national diffusion. These interventions have been rigorously evaluated by CDC standards for proven effectiveness.

Evaluation:
The collection and analysis of data for one of several purposes:

- Formative evaluation – data collected before an intervention or new phase in an intervention begins. This information shapes the intervention design.
- Process evaluation – data collected during an intervention to assure fidelity with the intervention design. This information shapes both corrective actions and changes to the intervention design in midstream.
- Outcome evaluation – data collected before the intervention is begun and after the intervention is completed. This data describes changes in the target of the intervention. Examples include:
  - Changes in client knowledge of HIV transmission
  - The adoption of comprehensive sex education by a school district
  - A reduction in a client's risky sexual activity

Outcome evaluation refers to research in which the greatest possible control is exercised over other causes of change. When such control is not possible, the research is referred to as outcome monitoring.

[8] Definitions are based on language used by the Centers for Disease Control and Prevention, as adapted for use in Texas Department of State Health Services trainings.

Evidence-Based Interventions (EBI): A set of activities designed to motivate a specific audience, or target population, to change behavior. These are based in behavioral theory and meet the CDC's Research Synthesis criteria for best or promising evidence.

EBIs can be implemented at the individual, group, or community level.

- Individual Level Interventions (ILI): EBIs in which one staff member works with one person at a time to promote individual behavior change.
- Group Level Intervention (GLI): EBIs in which one or two staff members work with a group of persons (either in one session or multiple sessions) to promote change in HIV risk behavior for the individuals of the group.
- Community Level Interventions: EBIs in which staff train peer members of a community or population to promote positive changes to HIV-related behavioral norms and beliefs within a population.

Facilitator's Guide: Curriculum guide or manual that is used to implement an intervention.

Factors that Influence Behavior – FIBs (also known as Influencing Factors, Risk Factors, or Behavioral Determinants): The factors that are associated with an HIV risk behavior.

Fidelity: Staying true to the internal logic and the core elements of an intervention; not altering activities that are considered essential for the intervention to work.

HIV Risk Behaviors: The behaviors that can directly pass HIV from one person to another. All EBIs have specific HIV Risk Behaviors that they are designed to change. The following are of primary concern:

- Unprotected Sex
- Unsafe Needle Use
- Perinatal Transmission

Immediate Outcomes: Changes in the goal HIV risk behavior of the participants or target population of an intervention.

Implementation: Taking a curriculum or guidance for an intervention and putting it into practice with participants.

Implementing Agency: Refers to an entity funded by the Texas Department of State Health Services (DSHS) to implement an intervention.

Internal logic: The relationships between intervention activities and behavioral determinants that explain why the intervention will impact behavior. Adherence to the internal logic of the intervention is important for the intervention to retain its effectiveness. Changes to an intervention's internal logic are not permitted.

Intervention

- Duration: The length of time of an intervention.
- Session: One meeting of an intervention.
- Setting: Where the intervention is held.

Key Characteristics: Those features of an intervention that are considered less essential and can therefore be modified or changed without diminishing the effectiveness of the intervention.

Logic Model: A model that describes the main elements of an intervention and how the elements work together to achieve the expected behavioral outcomes.

Priority Populations: Subsets of the general population that have been identified as most in need of prevention activities. Populations are typically identified in terms of one or more characteristics associated with elevated risk for HIV infection, such as:

- Injection drug users
- Men who have sex with men
- High-risk heterosexual

Outcomes: The consistent changes in the skills, knowledge, attitudes, beliefs, perceptions, or behaviors of the participants or population in an intervention. Structural interventions can also be associated with changes in organizational behavior and policy changes at the community, state or national level. Each intervention has specific outcomes that are being addressed.

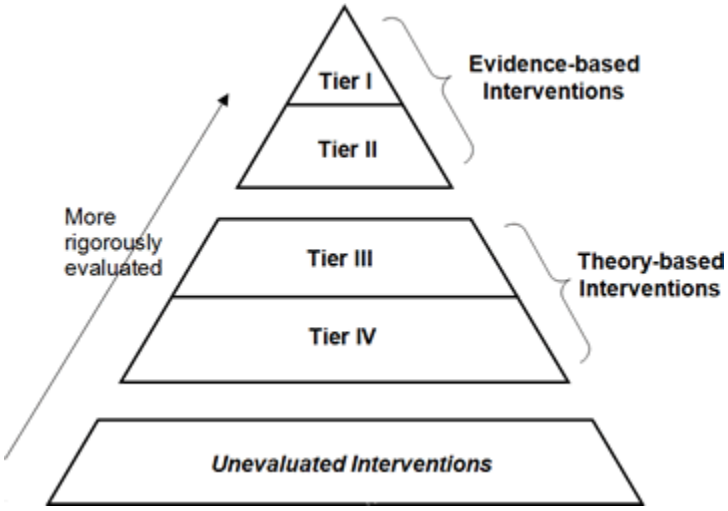
- Immediate Outcomes: Immediate changes that can be measured as the direct result of the intervention, such as change in knowledge, skills, attitudes, perceptions or beliefs of the participants or population.
- Intermediate Outcomes: Changes in the goal HIV risk behavior of the participants or target population of an intervention.

Tailoring: Small changes to an intervention that do not alter the core elements or internal logic of the intervention, thus maintaining fidelity to the intervention. Examples could be changes in the delivery method, key characteristics, or activities.

Target Population (also Target Audience): A group of people who have similar characteristics. It can be defined by geographic status (a community), ethnic or racial group, gender, age, sexual orientation, or an HIV risk behavior (such as intravenous drug use). They can be general (all women) or specific (African-American HIV+ MSM youth, 12-20 years of age).

Technical Assistance: The process by which assistance is given to an agency to better implement an intervention. Challenges or barriers to implementation can often be solved through technical assistance.

Tiers of Evidence Framework: The CDC developed this framework to distinguish the levels of evaluation that have been provided for HIV prevention interventions. The level of rigorous evaluation increases from the bottom to the top. The top level has the most rigorous level of comparison evaluation.



Centers for Disease Control and Prevention. (2007). http://www.cdc.gov/hiv/topics/research/prs/tiers-of-evidence.htm

Training: Formal and generally comprehensive instruction in the delivery of an intervention.

		Target Population Characteristics									
Intervention Name	**Weblink**	**HIV+**	**Gender**	**Age**	**Race/ Ethnicity**	**Other**	**Risk Behaviors Addressed**	**Intervention Level**	**Materials Review Rating**	**Implementation Review Rating**	**Review Date: Materials Review/ Implementation Review**
Be a Responsible Teen (BART)	http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/BART.htm			14-18 Yr.	AA		Unprotected Sex; Needle Use; Perinatal Transmission	Group	⭘	■	July 2009/ November 2009
Be Proud, Be Responsible	http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/Be_Proud.htm		Males	13-18 Yr.	AA	MSM	Unprotected Sex;	Group	⭘		July 2009
Brother to Brother	http://www.utsouthwestern.edu/vgn/images/portal/cit_56417/21/26/267360Brother_to_Brother_fs_pdf.pdf		Males		AA	MSM & Non-Identifying MSM	Unprotected Sex	Group		■	December 2009
Choosing Life: Empowerment, Actions, Results! (CLEAR)	http://www.effectiveinterventions.org/go/interventions/clear	HIV +	Males and Females	16 + yr.			Unprotected Sex; Unsafe Needle Use	Individual	⭘		July 2009
Community Promise	http://www.effectiveinterventions.org/go/interventions/promise						Unprotected Sex; Unsafe Needle Use	Community		◘	November 2009
Comperhensive Risk Counseling and Services (CRCS)								Individual		◘	June 2010
CONNECT	http://www.effectiveinterventions.org/go/interventions/connect		Males and Females	18+ yrs		Heterosexual individuals and their main sexual partners	Unprotected Sex	Individual Group	⭘		October 2009
Doing Something Different	http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/different.htm				AA		Unprotected Sex	Group		▣	November 2009
D-Up: Defend Yourself	http://www.effectiveinterventions.org/go/interventions/d-up-defend-yourself		Males		AA	MSM	Unprotected Sex	Community	●		July 2009
Enhancing Motivation	http://www.utsouthwestern.edu/vgn/images/portal/cit_56417/21/46/267382Enhancing_Motivation_fs_pdf.pdf		Females	Adult	AA		Unprotected Sex; Reduce Substance Use	Group	⭘	◘	July 2009/ January 2010
Focus On Youth (plus ImPACT)	http://www.effectiveinterventions.org/go/interventions/focus-on-youth--impact			12-15 yrs (+ parents)	AA		Unprotected Sex	Group	●		July 2009
Healthy Living Project (HLP)	http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/healthy-living.htm	HIV +	Males and Females	18+yrs			Unprotected Sex; Unsafe Needle Use	Individual	⭘		July 2009

		Target Population Characteristics									
Intervention Name	**Weblink**	**HIV+**	**Gender**	**Age**	**Race/ Ethnicity**	**Other**	**Risk Behaviors Addressed**	**Intervention Level**	**Materials Review Rating**	**Implementation Review Rating**	**Review Date: Materials Review/ Implementation Review**
Healthy Relationships	http://www.effectiveinterventions.org/go/interventions/healthy-relationships	HIV +	Males and Females	Adults			Unprotected Sex	Group		◘	November 2009
Hot, Healthy, and Keeping it Up	http://www.utsouthwestern.edu/vgn/images/portal/cit_56417/33/15/286624HHKIU.pdf		Males	18+yrs	Asian and Pacific Islander	MSM	Unprotected Sex	Group		▣	December 2009
Intensive AIDS Education	http://www.utsouthwestern.edu/vgn/images/portal/cit_56417/21/14/267569RHAP_fs_pdf.pdf		Males	16-19 yrs	Non-white	Active Drug Use	Unprotected Sex; Other Substance Use	Group		◘	November 2009
Many Men, Many Voices	http://www.effectiveinterventions.org/go/interventions/many-men-many-voices		Males		AA	MSM & Non-Identifying MSM	Unprotected Sex	Group		■	November 2009
Modelo de Intervencion Psychomedica (MIP)	http://www.effectiveinterventions.org/go/interventions/mip			18+ yrs		IDU	Unprotected Sex; Unsafe Needle Use	Individual	●		July 2009
Mpowerment	http://www.effectiveinterventions.org/go/interventions/mpowerment		Males	18-29 yrs		MSM	Unprotected Sex	Community		◘	November 2009
NIA	http://www.effectiveinterventions.org/go/interventions/nia		Males	18+yrs	AA	Heterosexual	Unprotected Sex	Group	◘		October 2009
PIP MSM	http://www.mcw.edu/FileLibrary/Groups/CAIR/PiP/PiP_men_entire.pdf		Males			MSM	Unsafe Needle Use	Group		◘	January 2010
PIP-WE	http://www.mcw.edu/FileLibrary/Groups/CAIR/PiP/PiP_women_entire.pdf		Females			HRH	Unprotected Sex; Unsafe Needle Use	Group		◘	November 2009
Popular Opinion Leader	http://www.effectiveinterventions.org/go/interventions/popular-opinion-leader					MSM	Unprotected Sex	Community		◘	December 2009
Project AIM	http://www.cdc.gov/hiv/topics/prev_prog/rep/packages/aim.htm			11-14 yrs	AA		Unprotected Sex	Group	○		October 2009
Project START	http://www.effectiveinterventions.org/go/interventions/project-start			18-29 yrs		Released from a correctional facility	Unprotected Sex	Individual	◘		July 2009
Protocol-Based Counseling								Individual		◘	October 2010
RAPP	http://www.effectiveinterventions.org/go/interventions/rapp		Females	Adult		Heterosexual women & their partners	Unprotected Sex	Community		◘	November 2009
Safe in the City	http://www.effectiveinterventions.org/go/interventions/safe-in-the-city			Adults		STD clinic patients	Unprotected Sex; Unsafe Needle Use	Individual	●		July 2009
Safety Counts	http://www.effectiveinterventions.org/go/interventions/safety-counts					Active Drug Use	Unprotected Sex; Unsafe Needle Use	Group		▣	November 2009
Shield	http://www.effectiveinterventions.org/go/interventions/shield		Male and Females	18+ yrs		Current or former 'hard' drug users	Unprotected Sex; Unsafe Needle Use	Group	◘		October 2009

		Target Population Characteristics									
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SiHLE	http://www.effectiveinterventions.org/go/interventions/sihle		Females	14-18 yrs	AA		Unprotected Sex	Group	●		July 2009
SISTA	http://www.effectiveinterventions.org/go/interventions/sista		Females	18-29 yrs	AA	Heterosexual	Unprotected Sex	Group		◘	November 2009
Sister to Sister	http://www.effectiveinterventions.org/go/interventions/sister-to-sister		Females	18-45 yrs	AA		Unprotected Sex	Individual	●		October 2009
Sniffer	http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/sniffer.htm					IDU & Intransasl DU	Unsafe Needle Use	Group		▣	November 2009
Street Smart	http://www.effectiveinterventions.org/go/interventions/street-smart			11-18 yrs		Runaway Homeless	Unprotected Sex; Reduce Substance Abuse	Group	◘		July 2009
Turning Point	http://www.utsouthwestern.edu/vgn/images/portal/cit_56417/21/7/267615Turning_Point_fs_pdf.pdf					HIV, IDU, & their partners	Unprotected Sex; Unsafe Needle Use	Group		◘	December 2009
Video Doctor	http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/positive-choice.htm	HIV +		18+yrs			Unprotected Sex; Substance Use	Individual	○		October 2009
VOICES/VOCES	http://www.effectiveinterventions.org/go/interventions/voices-/-voces		Males and Females	Adult	AA & Hispanic	HRH	Unprotected Sex	Group		■	November 2009
Wall Talk	http://www.dshs.state.tx.us/hivstd/conference/2004/trackg.shtm					State Jail and TDCJ prisoners	Unprotected Sex; Unsafe Needle Use	Community	●		October 2009
Women Involved in Life, Learning from Other women (WILLOW)	http://www.effectiveinterventions.org/go/interventions/willow	HIV +	Females	18-50 yrs			Unprotected Sex	Group		▣	July 2009/ January 2010

Materials Review Outcome and Validity

●	Total agreement to recommend implementation
◘	General agreement to recommend implementation under favorable conditions
○	General agreement not to recommend implementation

Implementation Review Outcome

■	Total agreement to recommend implementation
◘	General agreement to recommend implementation with minor concerns noted
▣	General agreement to recommend implementation with serious concerns noted
◘	General agreement not to recommend implementation