

The Development of a National HIV/AIDS Prevention Intervention Taxonomy for Program Evaluation

March 2002

Contract No.: 200-96-0598, Task 29

Submitted to:

Program Evaluation Research Branch
Division of HIV/AIDS Prevention–Intervention, Research, and Support
National Center for HIV, STD, and TB Prevention
Centers for Disease Control and Prevention

Prepared by:

ORC MACROSM

3 Corporate Square NE, Suite 370
Atlanta, Georgia 30329
Phone: (404) 321-3211
Web: www.macoint.com

For more information, please contact:

Timothy Akers, MS, Ph.D.

Senior Behavioral Scientist
Program Evaluation Research Branch
Centers for Disease Control and Prevention
1600 Clifton Road, NE, MS-E59
Atlanta, GA 30333
Phone: (404) 639-0926
Fax: (404) 639-0929
E-mail: tca1@cdc.gov

David Cotton, Ph.D., MPH

Vice-President
ORC Macro
3 Corporate Square, Suite 370
Atlanta, Georgia 30329
Phone: (404) 321-3211
Fax: (404) 321-3688
E-mail: cotton@macroint.com

Kira Sue Sloop, MPH

Project Manager
ORC Macro
3 Corporate Square, Suite 370
Atlanta, Georgia 30329
Phone: (404) 321-3211
Fax: (404) 321-3688
E-mail: ksloop@macroint.com

Suggested format for referencing this document:

ORC Macro. (March 2002). *The Development of a National HIV/AIDS Prevention Intervention Taxonomy for Program Evaluation*. Funded by the Centers for Disease Control and Prevention.

Table of Contents

I.	Acknowledgments.....	Tab 1
II.	Executive Summary	Tab 2
	A. Purpose	1
	B. Methods	2
	C. Findings	5
	D. Recommendations	8
III.	Literature Review.....	Tab 3
IV.	Review of Health Department Classification Schemes.....	Tab 4
	A. Introduction	1
	B. Methodology – Phase I	1
	C. HIV Prevention Intervention Names.....	3
	D. Levels of Specificity of Intervention Definitions.....	14
	E. Classification Structures.....	16
	F. Methodology – Phase II	20
	G. Analysis.....	22
	H. Summary	27
	I. Appendix.....	28
	a. Individual Level Interventions	33
	i. Table of Interventions with Criteria for Intervention Elements	
	ii. Evidence for Each Intervention Element	
	iii. Listing of Intervention Definitions with Elements	
	b. Group Level Interventions	74
	i. Table of Interventions with Criteria for Intervention Elements	
	ii. Evidence for Each Intervention Element	
	iii. Listing of Intervention Definitions with Elements	
	c. Outreach	138
	i. Table of Interventions with Criteria for Intervention Elements	
	ii. Evidence for Each Intervention Element	
	iii. Listing of Intervention Definitions with Elements	
	d. Prevention Case Management.....	212
	i. Table of Interventions with Criteria for Intervention Elements	
	ii. Evidence for Each Intervention Element	
	iii. Listing of Intervention Definitions with Elements	
	e. Partner Counseling and Referral Services.....	244
	i. Table of Interventions with Criteria for Intervention Elements	

ii.	Evidence for Each Intervention Element	
iii.	Listing of Intervention Definitions with Elements	
f.	Health Communication/Public Information	259
i.	Table of Interventions with Criteria for Intervention Elements	
ii.	Evidence for Each Intervention Element	
iii.	Listing of Intervention Definitions with Elements	
g.	Biomedical Interventions	334
i.	Table of Interventions with Criteria for Intervention Elements	
ii.	Evidence for Each Intervention Element	
iii.	Listing of Intervention Definitions with Elements	
h.	Community Level Interventions.....	348
i.	Table of Interventions with Criteria for Intervention Elements	
ii.	Evidence for Each Intervention Element	
iii.	Listing of Intervention Definitions with Elements	
i.	Counseling and Testing.....	380
i.	Table of Interventions with Criteria for Intervention Elements	
ii.	Evidence for Each Intervention Element	
iii.	Listing of Intervention Definitions with Elements	
j.	Needle/Syringe Exchange	423
i.	Table of Interventions with Criteria for Intervention Elements	
ii.	Evidence for Each Intervention Element	
iii.	Listing of Intervention Definitions with Elements	
k.	'Other' Interventions.....	440
i.	Table of Interventions with Criteria for Intervention Elements	
ii.	Evidence for Each Intervention Element	
iii.	Listing of Intervention Definitions with Elements	
V.	Expert Panel Summary Report.....	Tab 5
VI.	Expert Panel Meeting Agenda.....	Tab 6
VII.	Expert Panel Participant List.....	Tab 7

The Development of a National HIV/AIDS Prevention Intervention Taxonomy for Program Evaluation

Acknowledgments

The HIV project team at ORC Macro would like to thank Dr. Tim Akers of the Program Evaluation Research Branch of the Division of HIV/AIDS Prevention for his exuberant leadership and clear vision regarding the development of a common vocabulary in HIV prevention. We are also grateful to the expert panelists for their dynamic participation and compelling insights into the ideal and practical benefits, challenges, and ultimate uses of a standard taxonomy. The team would also like to thank Romel Lacson and Brandi Collins, also of the Program Evaluation Research Branch, for their thoughtful contributions.

“But what is classification but the perceiving that these objects are not chaotic, and are not foreign, but have a law which is also the law of the human mind?”

Ralph Waldo Emerson

U.S. essayist, poet, philosopher

“The American Scholar,” repr. In Emerson: Essays and Lectures, ed.

Joel Porte (1983)

“The terms ‘splitters’ and ‘lumpers’ come from taxonomy, where the classifiers were separated into those who liked to create new taxa because of small differences and those who preferred to coalesce categories because of similarities. The concept has found wider applicability as knowledge in all fields expands. Specialists are confined to ever-narrowing domains while generalists survey the immensity of information in an effort, one hopes, to find higher orders of structure.”

Harold Marowitz

U.S. biologist, educator

“Splitters and Lumpers,”

The Wine of Life and Other Essays on Societies, Energy, and Living

Things (1979)

The Development of a National HIV/AIDS Prevention Intervention Taxonomy for Program Evaluation

Executive Summary

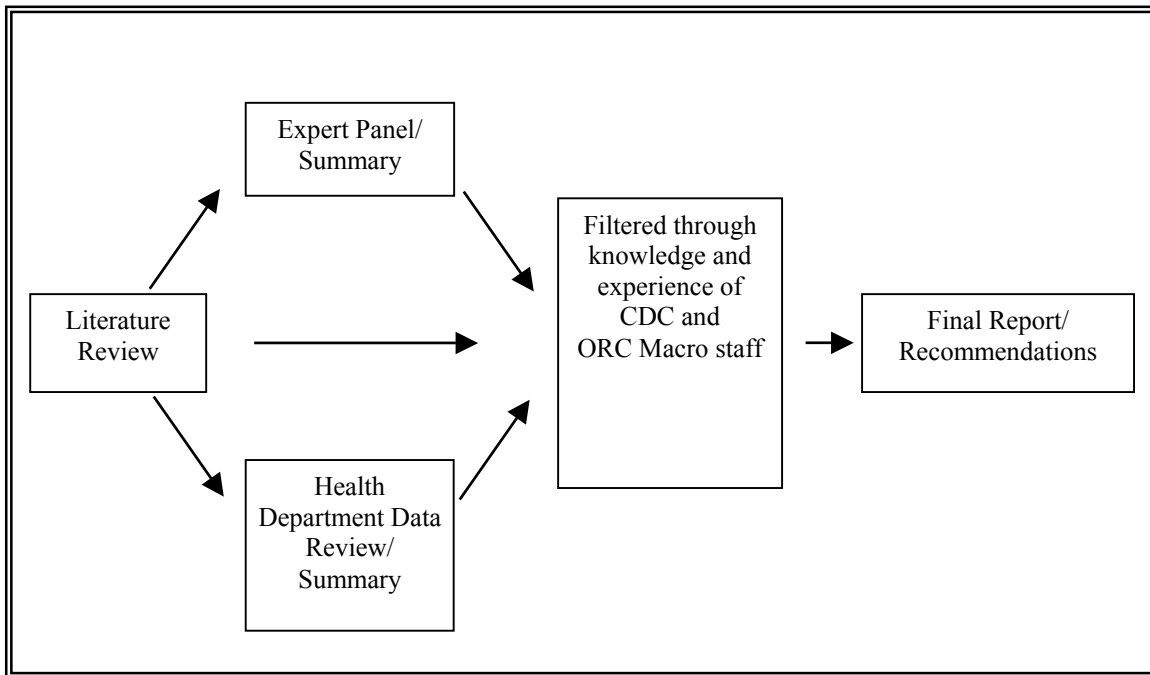
Purpose

The Centers for Disease Control and Prevention (CDC) Division of HIV/AIDS Prevention (DHAP) supports HIV/AIDS prevention interventions that can be classified into eight major categories: individual-level interventions, group-level interventions, outreach, prevention case management, partner counseling and referral services, health communications/public information, HIV antibody counseling and testing, and other interventions.¹ However, debates continue within and between intervention developers, providers, and evaluators regarding the distinctions, definitions, and characteristics of various types of HIV prevention interventions. Moreover, although these categories along with others are used at CDC, though not necessarily consistently nor systematically, to describe HIV prevention at a national level and also by many health departments to organize and aggregate their intervention data for submission to CDC, these categories do not meet any known taxonomy standards for HIV/AIDS prevention interventions.

The lack of a standard taxonomy significantly complicates the continuing refinement of effective interventions, technical assistance, the provision to support development and improvement of interventions, and the evaluation of HIV prevention efforts. Without a standard taxonomy of HIV prevention interventions, CDC and its prevention partners struggle to effectively and scientifically determine 1) how CDC funding is affecting designated priority target groups (such as disproportionately affected minorities) and 2) whether CDC-funded programs are having the desired or intended impact on the HIV/AIDS epidemic. The more consistent CDC and its partners are in classifying a particular type of HIV/AIDS intervention program or strategy (just as CDC does for disease classifications) the more successful CDC will be in providing higher quality data to its stakeholders (i.e., US Congress, other federal agencies, state and local health departments, community-based organizations, and HIV/AIDS community planning groups) for decision-making regarding funding allocation and targeted program development, improvement, and evaluation. This is especially critical in making the link between the array of prevention services provided and impacts on the epidemic assessed through surveillance systems and other data sources.

¹ The “other” category used for current reporting purposes in the *Evaluation Guidance* typically includes community-level interventions, policy and structural interventions, biomedical approaches, and needle/syringe exchange programs (the last of which cannot be supported with CDC or other federal dollars).

To address these issues, the CDC, working with ORC Macro, designed a project to 1) identify known taxonomies of interventions; 2) collect and organize categories of interventions used in CDC-funded health departments; 3) convene a group of experts from a variety of applicable fields and backgrounds to discuss the feasibility, applicability, and utility of a systematic taxonomy of HIV/AIDS interventions that can be integrated into and used by local, state and national groups and organizations for program development, improvement, and evaluation, and 4) to suggest a chronology of necessary activities CDC and its partners could undertake to develop a common vocabulary of HIV prevention interventions. The flow of this process is depicted below.



This final report summarizes the methods and results for each of these activities and concludes with recommendations synthesized from these findings. The products of these activities—a literature review, a review of health department classification schemes, and an expert panel summary—are referenced within this report and are appended in their entirety.

Methods

Literature Review

The **literature review** (*Tab 3*) describes the history of taxonomy, basic concepts of taxonomies and strategies used in their development, selected examples of taxonomies from related fields, and an overview of HIV prevention taxonomies and intervention definitions.

Various search engines, including databases available through ORC Macro’s library, the National Library of Medicine databases, and the National Prevention Information Network were utilized to identify resources for the literature review. Websites recommended by the technical

monitor were also reviewed for pertinent information. These included societies, such as the Classification Society of North America; government offices, such as the Centers for Medicaid and Medicare Services, Center for Substance Abuse Prevention, Health Resources and Services Administration, and Substance Abuse and Mental Health Services Administration; and non-government organizations, like the Council on Foundations, Independent Sector, The Urban Institute's National Taxonomy of Exempt Entities, The Foundation Center, and the Center on Philanthropy at Indiana University. Finally, general Internet search sites such as Yahoo! were also queried to ascertain widely available but non-published literature.

Key words used in the search included, but were not limited to HIV prevention intervention(s), intervention standards, taxonomy, taxonomic development, classification, classification systems, definitions, and glossary. Due to the limited amount of published literature on taxonomies, especially as they relate to HIV prevention interventions and other health care services, no restrictions were placed on the year of publication. However, information on specific HIV prevention interventions was limited to a publication date after 1990. In addition to published books and articles, guidelines on specific interventions by the Centers for Disease Control and Prevention were also included.

Review of Health Department Classification Schemes

For the **review of health department classification schemes** (*Tab 4*), The FY 2001 Applications for HIV Prevention Cooperative Agreements and HIV Prevention Comprehensive Plans from the 65 jurisdictions funded by CDC were reviewed for definitions, descriptions and/or standards for HIV prevention interventions. Information included on jurisdictions' health department or community planning group web pages was also abstracted. Although additional documents—such as protocols and requests for proposals—may exist within health departments and may describe intervention guidelines or standards in more detail, those were not included in this review because that type of documentation is not required for submission to the CDC and was, therefore, not consistently found in the available documents.

The data abstraction and analysis occurred in two phases. During phase one, unique names for interventions as described by each jurisdiction were captured, as well as the level of specificity by which the intervention was presented. Three levels of specificity were created: standards or guidelines, descriptions, and goals and objectives. Those interventions with minimum criteria or standards are the highest level of specificity, while interventions that were presented without an overall definition and contained only minimally descriptive activity goals and objectives were the lowest category of specificity. Finally, the type of intervention was recorded per the CDC Evaluation Guidance categories (individual-level, group-level, outreach, prevention case management, partner counseling and referral services, and health communication/public information, and other interventions) and additional types of interventions to allow preliminary aggregation of the information. The additional intervention types included biomedical, community-level, counseling and testing, and needle/syringe exchange. All of these elements were abstracted, entered, and stored in a MS Access 2000[®] database.

For initial review at the expert panel meeting, lists were provided that showed the wide variation in naming conventions used by the health department grantees for (what appear to be) similar functional intervention activities. The intervention descriptions currently used and documented in the health department materials reviewed were then clustered according their level of specificity. These summaries were presented to the expert panel as background information to facilitate discussion.

In the second phase of data analysis, interventions from the two most specific categories—criteria/standards or detailed descriptions—were reviewed for evidence of particular intervention elements and standards suggested by the expert panel members (*see next section and Tab 5*). The six characteristics recommended during the meeting as the most critical features of an intervention that could describe an intervention and distinguish it from others included duration/dosage, target population, venue, provider, outcome, and level. For each intervention type, there is a table that identifies guidelines or standards for particular intervention elements. Following the table is a listing of the intervention definition with a breakdown of the individual components. Finally, all information about the particular standards used by various jurisdictions as their criteria for each intervention type are clustered. For example, with reference to “venue” for the intervention type “Outreach,” particular venues are listed for every jurisdiction that provided that information for an outreach intervention. This helps the reader understand the variability currently in place with respect to the implementation of that element across the U.S.²

Expert Panel (July 23-24, 2001)

An interdisciplinary group of researchers, practitioners, policy-makers, and informaticians with diverse expertise in HIV prevention, taxonomy and standards development, and informatics, were gathered for an expert panel to provide their unique perspectives on the development and use of a national, standardized HIV/AIDS prevention intervention taxonomy. The technical monitor and other key CDC staff at the Division of HIV/AIDS Prevention (DHAP) selected the group of experts. The meeting was co-facilitated and organized by Dr. Timothy Akers, CDC, and Dr. David Cotton, ORC Macro. After hearing presentations from the invited experts—both developers and end-users—on the need for a consensus taxonomy in the field of HIV prevention, Drs. Akers and Cotton discussed the anticipated challenges and opportunities of developing a taxonomic system. Open discussion on identifying the needs of potential users of such a system and determining what course of action in the development of the taxonomy would best meet those requirements followed the presentations. The meeting concluded with an outline of proposed next steps in this and future CDC activities towards the development of a consensus taxonomy. The meeting was summarized and an **expert panel summary report** (*Tab5*) was distributed to the participants.

² *Please note* that the categories used in classifying intervention definition types and for de-constructing intervention characteristics were created solely for the purpose of this review. As a result, developers and implementers of the interventions may not always agree with the naming convention and labels used for describing the interventions and intervention components for this project.

Findings

This project integrated four sources of information relevant to the development of a standardized vocabulary for HIV prevention interventions: 1) a review of the taxonomy development and HIV prevention literature, 2) a review of vocabularies of HIV prevention interventions used by health departments, 3) a panel of experts who provided critical insight into CDC's needs for a naming system and considerations for its development, and 4) the experience of CDC and ORC Macro staff in this area. The **review of health department vocabularies** (*Tab 4*) of HIV prevention interventions used by CDC-funded grantees in their FY 2001 applications and comprehensive plans revealed some interesting findings with respect to the level of specificity included in those documents and the widespread use of a naming system consistent with CDC's HIV prevention evaluation guidance and the taxonomy proffered by Holtgrave et al. and others (1994).³

The **literature review** (*Tab 3*) demonstrates the need for a national HIV/AIDS prevention intervention taxonomy. It identified many helpful systematic distinctions among interventions—both those that are specific to HIV prevention and to other aspects of public health and human services. Kalichman (1998) suggested a classification system for HIV prevention interventions based on levels of intervention—individual, small group, and community. Cohen and Scribner (2000) offered a distinction between interventions targeting intra-individual factors (e.g., small groups or other behavioral interventions) and structural interventions targeting factors outside the control of a single individual. Both of these suggest taxonomic structures to consider in the development of a more inclusive system.

The suggested taxonomy of Holtgrave and his colleagues (1994), which was further developed in the *Evaluation Guidance for CDC-Funded Health Department HIV Prevention Programs* (CDC, 2001b), was designed to intentionally organize the vast majority of intervention types currently in use in the U.S. As noted by Kalichman (1998), these classifications are based on the intervention technology used (e.g., partner notification or counseling) and the channels through which information is delivered (e.g., one-on-one sessions or street contacts). Subsequent to the introduction of the *Evaluation Guidance* reporting requirements in January 2000, this classification scheme was widely adopted by health departments, especially those that had historically used Holtgrave's suggested taxonomy that was put forth in CDC's Program Announcement 99004 and the Supplemental Guidance for HIV Prevention Community Planning. The literature review highlights other efforts that have made significant advances in identifying critical dimensions and characteristics of interventions. These include the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* (CDC, 1999), *HIV Prevention Among Drug Users: A Resource Book for Community Planners and Program Managers* (AED, 1997; see also Coyle, 1993), and CDC's *Guide to Community Preventive Services* (Zaza et al., 2000), among others. Building on and synthesizing these dimensions will be a major activity in the further development of a single classification system for HIV prevention interventions.

Finally, the guidelines developed by various groups in the Division of HIV/AIDS Prevention for prevention case management, partner counseling and referral services, and health education and

³ All citations included in this final report are found in the bibliography of the Literature Review (*Tab 3*).

risk reduction will provide very helpful information in unifying the language used to describe the universe of interventions in HIV prevention.

The **expert panel** (*Tab 5*) convened for this project strongly endorsed the development of a classification system for HIV prevention interventions. Panelists offered a variety of suggestions and caveats for CDC's consideration as this project moves forward. They stressed that definitions of interventions need to be meaningful to researchers, evaluators and the end-users, while, at the same time, being mindful of those jurisdictions that have already begun to "define" or "taxonomize" their interventions. The panel also emphasized the need to communicate the purpose and mission of the taxonomy so that it is not used inappropriately. The purpose of the taxonomy should be clear and support planning at the local level.

The panel also stressed that the taxonomy should *not* be an "encyclopedia of acceptable interventions." It should be used as an indexing system that can be used to describe any intervention with a common set of concepts and terminology. One *potential* use of the taxonomy would be to catalogue existing (or past) interventions. The act of assigning value to the various characteristics for a particular intervention (e.g., "Group counseling should have at least 4 sessions" or "outreach must be done in outdoor locations in the community") would be a unique project that could use the taxonomy as an organizing principle; this would not be the sole purpose for creating a taxonomy.

The expert panel members identified two significant initiatives in the development of a national HIV prevention intervention taxonomy:

- the development of definitions for the major interventions funded by the CDC (by building on the Evaluation Guidance) that are mutually exclusive, and
- the identification of characteristics and elements that reflect the minimum criteria of activities that go into a particular type of intervention.

The group suggested multiple axes that reflect the primary dimensions of prevention interventions. The taxonomy can then be accessed in various ways, such as by level (e.g., individual or group) or by target population. The panel expressed that in order for a multi-axial model to work, it is imperative to have unambiguous definitions.

The panel identified a long list of characteristics or elements of interventions that could be used as axes; however, they recommended that there be approximately five or six critical elements by which interventions can be catalogued or classified as it takes a considerable amount of money to construct and maintain such a complicated taxonomy.

Some of the most common axes mentioned included:

- Duration/dosage (e.g., 30 minute sessions, 3 sessions, etc.)
- Target (e.g., IDU, MSM, etc.)
- Venue (e.g., mobile van, clinic, etc.)
- Deliverer/provider (e.g., peers, counselors, etc.)
- Desired outcome (e.g., behavior change, referral, etc.)
- Level (e.g., individual, group, etc.)

Each of the elements identified has a series of attributes that enable an intervention to maintain its mutual exclusivity (e.g., deliverer/provider includes peers, professionals, and paraprofessional). It was further noted that there were some characteristics that were functions of other characteristics (e.g., culturally appropriate interventions are a function of characteristics such as target population, level and provider). These types of characteristics were deemed standards and should be differentiated from characteristics; that is, standards involve value judgments that differentiate dimensions of the axis.

The panel also thought that it was important at the outset of an undertaking like this to have a **Mission Statement** to guide further activities and resource allocation. Following extensive discussion, the group proposed the following as a starting place for such statement:

To develop a common [controlled] vocabulary, through a dynamic, integrated process with periodic review, to describe and index HIV/AIDS prevention interventions for the purpose of: defining; comparing; supporting and improving; and establishing standards for [regulating], evaluating, replicating, and communicating about and reporting on those interventions.

The group concluded that there is a definite need for a common language and taxonomy. The purpose of the taxonomy needs to be more clearly defined and priorities must be set in terms of primary and secondary stakeholders. Once these have been decided upon, a working group will need to be established. This group, with input from the various stakeholders, will identify key elements of interventions to be used as axes and define the terms and the interventions in the taxonomy. The taxonomy will need to be updated on a regular basis.

The group emphasized that before proceeding on to the next phase, it will be essential for CDC to communicate their commitment to the development, sustainability, and institutionalization of a national, standardized HIV/AIDS prevention intervention taxonomy if such an undertaking is to be successful. For the panel, this also entailed the selection of a workgroup leader who is committed to the system and who is familiar with the range of users and their needs from federal funders to the end users of interventions. This individual must be able to provide leadership and push toward the completion, and possible institutionalization of the taxonomy.

Recommendations

The activities undertaken as part of this project have converged to suggest some consistent recommendations. There was broad endorsement for the idea that DHAP needs a common language for interventions

- to facilitate research on interventions,
- to be consistent in program announcements,
- to facilitate evaluation and program improvement activities,
- for integration with surveillance activities, and
- to provide a more consistent platform for training and technical assistance.

To do this, the Division must 1) have a vocabulary that will define and distinguish the major types of interventions that are prominent in the field and that will also accommodate new and innovative intervention approaches and 2) clarify what the major intervention types are that will serve as the basis for the distinctions. This classification system needs to be consistent with current and anticipated DHAP data systems and consistent with CDC's National Electronic Disease Surveillance System.

Therefore, several major activities are necessary if a national, standardized HIV/AIDS prevention intervention taxonomy is to be developed and utilized:

1. Establish a standard vocabulary for discussing labels and definitions, as well as the features/dimensions/axes of HIV prevention interventions (e.g., setting, duration) using a consensus development process.
2. Submit a federal register announcement that defines the major categories and selected labels for interventions.
3. Using that vocabulary, promote scientific and programmatic discussion about the common types of interventions prevalent in the U.S. including expectations for the dimensions that comprise each.⁴

⁴ (e.g., "What are the dimensions of outreach that can be agreed upon by a group of service delivery experts?" Dimensions may include where it takes place, nature of the interaction, who provides it, etc.) Currently, there are a variety of labels used to describe interventions that are functionally similar. For example, The same set of activities might be labeled behavior change counseling, prevention counseling, group counseling, or group education, depending on the jurisdiction in which it occurs. Many potentially fruitful discussions about HIV prevention are derailed by a debate over the semantics of labeling rather than the functional similarities of the activities being discussed.

4. Assuming that general agreement can be reached about intervention characteristics, the community of concerned people can begin the discussion about a common set of minimal expectations—often referred to as “practice standards”—for each type of intervention.⁵
5. Assuming that the above initiatives have been undertaken successfully, the resulting terminology should be incorporated into CDC’s communication, including program announcements, guidelines and other assistance documents, about HIV prevention interventions to promote a common language.
6. Finally, if the Division continues to support these initiatives, numeric or alphanumeric designations could be developed and linked to every specific intervention/category of intervention that is described in the field, funded by CDC, or reported to CDC. A coding scheme would allow more sophisticated analysis of program evaluation data and may facilitate linkages with surveillance and other types of disease data.

The literature and input from experts with real-life experience, behavioral and social science backgrounds, and program planning experience can help make these initiatives reasonable and flexible, yet standardized and bar-setting. Lessons learned from other fields would offer a roadmap to guide the development of HIV prevention intervention standards. Specific areas to consider include the composition and conduct of a national advisory board, devising a mechanism for reviewing evidence and reaching consensus, empirical confirmation of intervention standards, dissemination of intervention standards, ensuring accountability of standards once in place, and methods of evaluating standard, among others.

⁵ For example, a group may decide that counseling interventions are effective only if they have 3 or more sessions covering a minimum set of defined content (e.g., risk assessment, barriers to engaging in protective behavior, skills development for overcoming those barriers). If those expectations are met, counseling interventions can include additional content, can be delivered by peers, paraprofessionals, or professional staff; and can be done in a variety of settings. This is just an example of what a knowledgeable group *might* decide; there are many permutations of the attributes of these dimensions.

Recommended Action Steps and Timeline

Broadly speaking, two types of activities are required for this work to move forward: 1) formative research including internal collaboration at DHAP to understand the broad range of needs in the Division, to build stakeholder involvement, and to ensure that commitment to the project and commensurate resources for it are available, and 2) development and implementation of a process for creating an HIV prevention intervention vocabulary, taxonomy, and classification system. We have summarized the major action steps in a logical sequence, from our perspective, based upon other projects ongoing in the Division and our experience with projects that require extensive stakeholder involvement and review.

Formative Research (3-6 months)
<ul style="list-style-type: none">• Establish an internal steering group.• Inform Division of HIV Prevention Project Officers (and AIDS Directors) of the project.• Determine the resources available to develop a national taxonomy.• Determine the resources available to maintain/manage the taxonomy products.• Communicate the expert panel meeting report and recommendations to the stakeholders.• Develop a written plan for the next phase (who is involved, what will be involved, intended outcomes).• Document the benefits for end-users.

Design of the Process for the Development of an HIV Prevention Intervention Taxonomy (18-36 months)
<ul style="list-style-type: none">• Identify inter-branch needs for a national taxonomy within the Division of HIV Prevention.• Establish an external national advisory board.⁶• Survey health departments and a sample of directly and indirectly funded CBOs to determine current classification systems, the advantages and disadvantages they perceive, and the needs and uses they would have for a standardized intervention language.• Identify relevant HIV intervention categories.• Define HIV intervention categories.• Identify relevant primary and secondary axes for differentiating interventions.• Identify the categories that comprise each axis (e.g., <i>duration</i> might include hours, days, number of sessions, etc.)• Pilot test HIV prevention intervention taxonomy.• Create an implementation manual (including plans for regular updating).• Create a web-based system for classifying HIV intervention taxonomies.• Review guidelines for developing intervention or practice standards outside of the field of HIV.• Develop a strategic plan for moving forward with HIV prevention intervention standards.

⁶ It is hard to determine how long this step might take, given the complexity of the project and the large number of stakeholders involved.

Table of Contents

I.	Overview of the Problem	1
II.	Need for a National HIV Prevention Intervention Taxonomy.....	2
III.	A Brief History of Taxonomy	2
IV.	Basic Taxonomic Concepts and Principles	3
V.	Examples of Taxonomic Systems and Data Standards Initiatives	4
VI.	HIV Prevention-Specific Taxonomies, Definitions, and Attributes	13
VII.	Overviews of HIV Prevention Intervention Types	23
VIII.	HIV Prevention Intervention Characteristics and Features for Classification.....	31
IX.	Conclusion.....	37
X.	References	38

List of Tables

1) National Taxonomy of Exempt Entities	5
2) Health Care Provider Taxonomy	6
3) Taxonomy of Human Services.....	7
4) Nursing Interventions Classifications (NIC)	8
5) International Classification for Nursing Practice (ICN).....	9
6) Examples of Nursing Action-Types from the ICN.....	10
7) Example of Axes and Terms from the ICN	11
8) Taxonomy for Transitional Programming	12
9) Public Health Conceptual Data Model	13
10) Cohen and Scribner’s Taxonomy of STD and HIV Interventions.....	14
11) A Suggested Taxonomy for HIV Prevention and Treatment Services.....	15
12) NIH Consensus Intervention Categories.....	17
13) Community Guide Interventions.....	18
14) Kalichman’s Levels of Interventions.....	18
15) CDC’s Evaluation Guidance Interventions.....	21
16) HERR Guidance Program Areas	24
17) PCM Guidance Components.....	25
18) Comparison of PCM, CT, and Outreach.....	26
19) PCRS Guidance Components	27
20) CTR Activities Defined	28
21) Examples of Structural Interventions	29
22) Compendium Elements of Successful Programs	32
23) AED’s Key Features of Interventions.....	33
24) NIDA Intervention Model	34
25) Community Guide Intervention Components.....	36

HIV Prevention Intervention Taxonomy

Literature Review for Expert Panel Background Information

I. Overview of the Problem

In 1981, the Centers for Disease Control and Prevention (CDC) published its first report of what is now known as Acquired Immune Deficiency Syndrome (AIDS). Since that time, more than 774,000 cases of AIDS have been reported in the United States. Worldwide, there are an estimated 36.1 million people infected with HIV; over one million of those are in the U.S. (CDC, 2001a). Although great strides have been made in the treatment of HIV and AIDS, prevention still remains the most effective strategy in the fight against this epidemic.

For more than 15 years, community-based organizations, health departments, national and regional organizations, the CDC and other federal agencies have been funding and implementing a variety of prevention services. An enormous amount of research has been conducted on the efficacy of HIV prevention interventions. However, the need to programmatically and scientifically *define* and *classify* such interventions still remains. With the exception of some broad categories, no standard naming conventions or taxonomic classification systems have been developed or used to identify and categorize HIV prevention interventions into mutually exclusive functional units that would facilitate a consistency in communication and data sharing among practitioners, researchers and policy makers. Similarly, there have been limited efforts within HIV funding streams or program announcements to establish broadly accepted minimum criteria for the features or characteristics that define or classify a particular type of intervention.

Classification is the ordering of entities into groups or classes on the basis of their similarity, minimizing within group variance and maximizing between group variance (Bailey, 1994). A classification scheme describes and orders the relationships among concepts in a discipline and forms the basis for organizing knowledge within that discipline. In her discussion of a nursing nomenclature system, Gordon (1998) pointed out that “classification system development parallels knowledge development in a discipline.” In the case of HIV prevention interventions, there is a growing body of knowledge that may be adequate to serve as the foundation for an intervention classification system to be developed. One of the many challenges will be to develop new or build-upon existing, though limited, HIV prevention intervention taxonomy classification systems that can be useful by public and private sector grantors and grantees in surveillance data collection and reporting, program planning, organizational and community capacity building, and evaluation to enhance our ability to integrate systems for providing and understanding the characteristics that comprise effective prevention intervention service.

This review of the literature briefly describes the history of taxonomy, some basic concepts of taxonomies and strategies used in their development, examples of taxonomies from related fields, and an overview of HIV prevention taxonomies and intervention definitions.

II. Need for a National HIV Prevention Intervention Taxonomy

Classification advances knowledge of a field through organization of that knowledge, provides a means for the discovery of the principles governing what is known, identifies gaps in what is known, and facilitates understanding through a common language. Classification systems of intervention services are beneficial to the planning, implementation and evaluation of those services. The advantages of classifying interventions range from applied-practical to scientific-theoretical benefits (Fleishman and Quaintance, 1984; McCloskey and Bulecheck, 1996).

The standardization of nomenclature within HIV prevention can facilitate communication and data sharing. Classification of terms can, in addition, assist in the development and use of databases and other information retrieval systems. The standardized nomenclature and taxonomic structure could also be beneficial for conducting literature reviews (Fleishman and Quaintance, 1984).

As we enter the third decade of the AIDS epidemic, the development of an HIV prevention intervention taxonomy will benefit many, including researchers, administrators, service providers, and policy makers. Comparison studies and compatibility issues across interventions and grantors and grantees will increase in validity while data from valid and reliable research can offer leverage for funding and policy changes (Fleishman and Quaintance, 1984; Kerr, 1991; McCloskey and Bulecheck, 1996). Ultimately it will be the public, especially those at risk for contracting HIV and high-risk positives, who will benefit most from a more structured classification of interventions.

III. A Brief History of Taxonomy

Derived from the Greek word *taxis* meaning “arrangement” and *nomos* meaning “law,” taxonomy is the science of arrangement, or classification. More specifically, it is the principles and methodology of the arrangement of items into hierarchies of superior and subordinate groups (Britannica.com, 2001).

The ancient Chinese classification system of animals is thought to be the first taxonomy developed. Centuries later, Plato classified the things in his world into two systems based upon their origin. He described them as either phenomena of the senses or concepts of the mind. Aristotle categorized items based on a key characteristic or ‘essence.’ During the eighteenth century, Linnaeus used the logic of Aristotle in his development of the modern biologic taxonomy (Britannica.com, 2001; Kerr, 1991; WHO, 1998). The systematic statistical classification of diseases dates back to the work of medical statisticians, William Farr and Jacques Bertillon, during the late nineteenth century. Soon thereafter, at the turn of the century, the French government commenced the first International Conference for the revision of the

Bertillon or International Classification of Causes of Death (WHO, 1998). The development of taxonomic structures has expanded beyond the natural sciences into industry, politics, medicine, public health, and the social and behavioral sciences.

IV. Basic Taxonomic Concepts and Principles

Taxonomy can refer both to the process of classification and the end product of that process. As a taxonomy can help provide a common language for a field like HIV prevention, some common terms provide a basis for further discussion of taxonomies and their development. In *Taxonomies of Human Performance*, Fleishman and Quaintance (1984) provide a hierarchy of taxonomic terms, suggesting a common language when discussing taxonomies and taxonomy development:

Taxonomy	The theoretical study of systematic classification including their bases, principles, procedures, and rules. The science of how to classify and identify
Classificatory System	The end results of the process of classification, generally a set of categories or taxa.
Classification	The ordering or arrangement of entities into groups or sets on the basis of their relationships based on observable or inferred properties.
Identification	The allocation or assignment of additional, unidentified objects, to the correct class, once such classes have been established by prior classification.
Taxon (plural = taxa)	A group or category in a classificatory system resulting from some explicit methodology.
Units	Objects and entities that are identified as belonging to one or more taxa constituting a classificatory system. Identification is based on an explicit methodology usually focusing on the similarities/dissimilarities of the units.

Successful classification requires the ability to ascertain the key or fundamental characteristics on which the classification is based. In general, to be successful, a taxonomy must comply with five principles (derived from Bruni, 2001, Mollerup, 1999):

1. Ideal classification systems must consist of classes that are distinct. There must be sharp distinctions between classes (i.e. taxa). The classification of any single entity must be clear.
2. The characteristics on which the classification system is based must be used consistently. Each step in the classification must be based on one principle of division.
3. Co-ordinate classes of the taxonomy must be mutually exclusive. There must be no overlapping between classes.
4. Co-ordinate classes must be collectively exhaustive. They must cover all possible entities.
5. Accurate assignment (identification) of entities to a taxon will ensure that items are not double-indexed.

In the following sections, we provide examples of taxonomies from related fields with some discussion about their development and structure. Then we describe three classification systems that have been developed to organize HIV prevention interventions. Following these taxonomy examples is further information about categories that have been used to help describe interventions (and which may be useful in considering categories for dividing classes of interventions) and discrete definitions and descriptions of intervention types that have been promulgated by CDC and others. These definitions have been developed and disseminated outside the context of a broader taxonomic categorization (e.g., CDC Division of HIV/AIDS Prevention [DHAP] guidelines for HIV Prevention Case Management).

V. Examples of Taxonomic Systems and Data Standards Initiatives

The literature shows that many organizations and professional disciplines already have developed or are beginning to develop classification systems. Several of these taxonomies are briefly described below, along with some public health data standards initiatives.

National Taxonomy of Exempt Entities (NTEE). In the early 1980s, the National Center for Charitable Statistics (a project of the Center on Non-Profits and Philanthropy at the Urban Institute) created a National Taxonomy of Exempt Entities (NTEE). The NTEE is a hierarchical classification of tax-exempt organizations organized by purpose, type and function to facilitate data collection, analysis and presentation of the data. The Exempt Organization Division of the IRS adopted the NTEE system and began adding codes for new organizations in 1995. In 1999, the NTEE replaced the Standard Industrial Classification (SIC) codes for tax-exempt organizations in the federal government (Urban Institute, 2001).

Organizations are classified using various sources of information. Much of the information was extracted from IRS Form 990, which contains program descriptions of the tax-exempt organization. Part 3 of that Form contains program activity descriptions and program expense information in narrative format. Narrative information in Part 8 explains the relationship between organizations' income-producing activities and their exempt purposes. For those that did not contain program descriptions, additional research was conducted, including information in nonprofit directories and other data contained on Forms 990 and 1023.

The NTEE is divided into 10 Major Categories (e.g., Education, Health, Religion-related) divided into 26 Major Groups (e.g., the Health category contains the groups General and Rehabilitative, Mental Health and Crisis Intervention, Disease, Disorders, Medical Disciplines, and Medical Research). Two additional codes further delineate logical divisions (decile level codes) and subdivisions (centile level codes). An example of these categories with AIDS-related providers is shown below in *Table 1*.

Table 1

National Taxonomy of Exempt Entities			
Example of Classification Levels with AIDS-Related Organizations			
Major Category	IV	Health	E. Health -- General and Rehabilitative F. Mental Health and Crisis Intervention G. Disease, Disorders, Medical Disciplines H. Medical Research
Major Group	G	Diseases, Disorders, and Medical Disciplines	Private, nonprofit voluntary health organizations such as the ACS that are organized on an national, state, or local basis and supported primarily by voluntary contributions from the public at large, and are engaged in a program of service, education, and research that is related to a particular disease, condition, or disability, or group of diseases, conditions, or disabilities.
Decile Code	G80	Specifically Named Diseases	Voluntary health organizations active in the prevention or treatment of specifically named diseases and conditions.
Centile Code	G81	AIDS	Voluntary health organizations active in the prevention or treatment of AIDS, a disease that impairs the functioning of the body's immune system, leaving affected individuals vulnerable to illnesses that would not otherwise occur.

Health Care Provider Taxonomy. In 1996, the Health Care Financing Administration (HCFA, now known as CMS, the Center for Medicaid/Medicare Services) and the National Provider System Workgroup, a voluntary federal and state joint venture to support HCFA's Medicare Transaction System, collaborated on the development of a unified health care provider taxonomy to “provide a coding structure to support work by both organizations” (www.wpc-edi.com, 1997). The proposed hierarchy focused on classifying the providers into aggregate groupings around *services*, *provider types*, and *areas of specialization or focus*. The resulting taxonomy of provider categories incorporates four areas of classifications that, when used in concert with one another, create the capability to sort providers into broad and specific categories. The hierarchy and related information is shown in *Table 2*.

Table 2

Level	Description	Examples of Taxonomy Categories	Definitions from Levels I and II
I. Provider Type	A code that identifies a major grouping of service(s) or occupation(s) of health care providers.	<ul style="list-style-type: none"> • Behavioral Health & Social Service Providers • Chiropractors • Dental Service Providers • Dietary and Nutritional Service Providers • Emergency Medical Service Providers 	Dental Service Provider: Broad category to identify practitioners licensed by the State who render services related to the practice of dentistry. The Practice of Dentistry means the diagnosis, treatment, prescription, or operation for a disease, pain, deformity, deficiency, injury or physical condition of the human tooth, teeth, alveolar process, gums or jaws, or their dependent tissues, or an offer, undertaking, attempt to do, or holding oneself out to do any other these acts.
II. Classification Code	A code that identifies more specific services(s) or occupation(s) within the health care provider type. The coding is based on licensed provider classifications.	<ul style="list-style-type: none"> • Chiropractor • Dentist • Registered Dietitian • Optometrist • Adult Nurse Practitioner 	Dietitian, Registered: A registered dietitian (RD) is a food and nutrition expert who has successfully completed a minimum of a bachelor's degree at a US regionally accredited university or college and course work approved by The American Dietetic Association (ADA); an ADA-accredited or approved, supervised practice program, typically 6 to 12 months in length; a national examination administered by the Commission on Dietetic Registration; and continuing professional educational requirements to maintain registration.
III. Area of Specialization	A code that identifies the provider's specialization, a segment of the population that a health care provider chooses to service, a specific medical service, a specialization in treating a specific disease, or any other descriptive characteristic about the providers practice relating to the services rendered.	<ul style="list-style-type: none"> • Addiction Psychiatry • Adolescent Medicine • Adolescent Medicine: Family Practice • Adolescent Medicine: Internal Medicine • Adolescent Medicine: Pediatrics • Aerospace Medicine 	
IV. Training and Education Requirement Indicator	A code that indicates whether the provider type/classification/area of specialization combination is defined through nationally recognized training and education requirements. The TER will be pre-established on the taxonomy and carried as the end position of the area of specialization code equal to a "y"= yes or an "n"= no.	<ul style="list-style-type: none"> • Adolescent Medicine: Pediatrics Y • Aerospace Medicine Y • Adolescents Only, under 21 N • Diabetes N 	

Taxonomy of Human Services. The Taxonomy of Human Services is a classification system of community resources based on the services they provide and the target groups they serve. The Taxonomy provides a common language and common concepts for human services. It includes agreements regarding definitions for what a service involves. The developers maintain that the Taxonomy supports the ability of users to collect and share statistical information at a useful summary level and provides a common ground for organizations engaging in human services research (Bruni, 2001). INFO LINE of Los Angeles and the Alliance of Information and Referral Systems (AIRS), the national professional association of information and referral providers, jointly publish the Taxonomy. It carries the endorsement of United Way of America. *Table 3* below shows an example of the levels of this taxonomy.

Table 3

Taxonomy of Human Services Outline of Taxonomy Structure	
J	Environmental Quality
JP	Public Health
JP-150	Communicable Disease Control
JP-150.170	Disease-Specific Communicable Disease Control
JP-150.170-05	AIDS Control
JP-150.170-10	AIDS Prevention Supplies
JP-150.170-75	Sexually Transmitted Disease Control
L	Health Care
LF	Health Screening/Diagnostic Services
LF-490	Disease-Specific Screening/Diagnosis
LF-490.240	HIV Testing
LF-490.240-05	Anonymous HIV Testing
LF-490.240-15	Confidential HIV Testing
LF-490.240-30	Home HIV Test Kits
LJ	Human Reproduction
LJ-800	Sex Education
LJ-800.250	General Sex Education
LJ-800.800	Safer Sex Education
LJ-800.825	Sexual Abstinence Education Programs
LJ-800.825	Teen Pregnancy Prevention

Nursing Interventions Classification. The Nursing Interventions Classification (NIC), by the Iowa Intervention Project at the University of Iowa, was first developed in 1992 to serve as a comprehensive standardized language used to describe the treatments nurses perform (McCloskey and Bulechek, 1996). In the second edition, the NIC was linked with the North American Nursing Diagnosis Association (NANDA) list of nursing diagnoses. Over 400 nursing interventions were structured into a three-tiered hierarchy of six domains and 27 classes. A label, definition and set of activities were composed for each intervention. The six domains reflect the realms of patient care that the interventions support (e.g., Physiological, Behavioral, etc.).

A coded taxonomic structure was also developed for integration with computer systems and to facilitate reimbursement to nurses. A unique four-digit code was assigned to each intervention and is preceded by the domain number and class letter. For example, “Teaching: Safe Sex” is a patient education activity and would be coded as 3S-5622 (*See Table 4*). Some of the interventions may fall into more than one activity. For example, “Family Planning: Contraception” is organized under childbearing care 5W-6784 and patient education 3S-6784. The following example shows the relationships among domains, classes, and interventions related to HIV prevention.

Table 4

Nursing Intervention Classification			
Example of Domains, Classes, and Interventions			
Domain 3: Behavioral - Care that supports psychosocial functioning and facilitates lifestyle changes			
O. Behavior Therapy			
P. Cognitive Therapy			
Q. Communications Enhancement			
R. Coping Assistance			
S. Patient Education Interventions to facilitate learning	6784	Family Planning: Contraception	Facilitation of pregnancy prevention by providing information about the physiology of reproduction and methods to control contraception.
	5510	Health Education	Developing and providing instruction and learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities.
	5604	Teaching: Group	Development, implementation, and evaluation of a patient teaching program for a group of individual experiencing the same health condition.
	5606	Teaching: Individual	Planning, implementation, and evaluation of a teaching program designed to address a patient's particular needs.
	5622	Teaching: Safe Sex	Providing instruction concerning sexual protection during sexual activity.
T. Psychological Comfort Promotion			

International Classification of Nursing Practices. The International Council of Nurses (ICN) developed the International Classification of Nursing Practices (ICNP) (International Council of Nurses, 1999). This framework defines and organizes nursing practices so that they may be cross-mapped for comparison of nursing data. According to the (ICNP) system, a nursing intervention is an action taken in response to a nursing diagnosis in order to produce a nursing outcome. For the ICNP, these are composed of concepts contained in the Classification of Action axes (*see Table 5*).

A Nursing Intervention:

- Must include a term from the Action Type axis.
- Terms from the other axes are optional to expand or enhance the intervention.
- Only one term can be used from each of the axes for a single intervention.

Table 5

International Classification for Nursing Practice			
Nursing Actions Classification Axes for Composing Nursing Interventions			
Axis	Name of Axis	Definition (Principle of Division)	Examples
A	Action type	The deed performed by a nursing action.	Teaching, inserting, monitoring
B	Target	The entity that is affected by the nursing action or provides the content of the nursing action.	Pain, infant, home services
C	Means	The entity used in performing a nursing action. Means includes both Instruments defined as tools used when performing a nursing action and Services defined as specific work or plan used when performing a nursing action.	Bandages, bladder-training techniques, discharge procedure.
D	Time	The temporal orientation of a nursing action. Time includes both Time Points (events) defined as definite moments in time and Time Intervals (episodes) defined as the duration between two events.	At discharge, intra-operative, prenatal.
E	Topology	The anatomical region in relation to a median point or the extent of an anatomical area involved in a nursing action.	Left, total
F	Location	The anatomical and spatial orientation of a nursing action. Location includes both Body Sites defined as the anatomical location of a nursing action and Place defined as the spatial location where the nursing action is occurring.	Head, arm, home, workplace.
G	Route	The pathway through which a nursing action is performed.	Oral, subcutaneous
H	Beneficiary	The entity to whose advantage a nursing action is performed.	Individual, family, community

Examples of nursing action-types (Axis A) are shown in *Table 6*.

Table 6

ICNP Nursing Actions Classification		
Sample Action Types from Axis A		
2	Nursing Actions Classification	[Note: 1 = Nursing Phenomena Classification]
2A	Nursing Action	Behavior of nurses in practice
2A.5	Informing	Telling somebody about something
2A.5.1	Teaching	Giving systematic information to somebody about health related subjects
2A.5.1.1	Instructing	Giving systematic information to somebody about how to do something
2A.5.1.1.1	Training	Developing skills of somebody or functions of something
2A.5.1.1.1.1	Autogenic Training	Teaching related to self-suggestions to induce relaxation
2A.5.1.2	Educating	Giving knowledge of something to somebody
2A.5.2	Guiding	Directing somebody towards a decision on health related subjects
2A.5.2.1	Anticipatory Guiding	Directing persons on health related subjects in advance
2A.5.2.2	Advising	Suggesting that the course of action being promoted should be followed
2A.5.2.3	Counseling	Enabling somebody to come to their own decision through dialogue
2A.5.3	Describing	Stating the characteristics, appearance, etc. of somebody or something in spoken or written form
2A.5.3.1	Recording	Stating a piece of evidence or information constituting an account of something that has occurred or been said
2A.5.3.2	Documenting	Accumulating, classifying and disseminating information and collected material
2A.5.4	Interviewing	Examining by asking questions and eliciting spoken responses
2A.5.5	Explaining	Making something plain or clear to somebody

The following example (*Table 7*) demonstrates how elements on each axis are combined to create a particular intervention (International Council of Nurses, 1999).

Table 7

SELECT AXES		SELECT TERMS			
Action Types:	—————▶	Alleviating	Reducing	Teaching	Testing
Target:	—————▶	Pain	Anxiety	Exercise habits	Water supply
Beneficiary:	—————▶	Individual	Individual	Group (Distributively)	Community (Collectively)
Means:	—————▶	Cold Pack	Guided Imagery Technique	Instructional Materials	Protocol
Interventions:	Alleviating an individual's pain by applying a cold pack. Reducing anxiety using a guided imagery technique. Teaching group members about exercising habits using instructional materials. Testing the water supply for a community using an established protocol.				

Transition Programming for Disabled Youth. The development of a taxonomy of transition programming for disabled youth involved a multi-staged approach (Kohler, 1996). In the first stage, small working groups conducted three literature reviews to determine the best practices of transition programming and their elements. The groups then classified these practices into five broad categories. The second stage included a national advisory board of over 200 researchers and practitioners and was comprised of three phases: data collection, data refinement and analysis, and evaluation. In the first phase they were asked to select those practices to be included in the taxonomy, list any additional practices, and add or change the name of any category heading. The board was then sent a second mailing in which they were asked to rate the practice statements for importance and to sort the practices into classes within its category, based on their similarity. A taxonomy was produced from hierarchical cluster analysis of the resulting data. Individuals were asked to rate the phases of the methodology, the resulting clusters and categories and the conceptual model derived from their input. They were also asked to give feedback on the utility of the taxonomy.

The evaluation showed that, in general, respondents agreed with the structure of the taxonomy, the usefulness of the conceptual maps and taxonomy and the process used in the development of the taxonomy. Specific uses for the information generated included program and curriculum development; strategic planning and budget development; identification of priorities; and program expansion, replication and evaluation. While many agreed with the comprehensiveness of the model, many were also frustrated with the amount of time required to sort and rate the practices (Kohler, 1996).

The taxonomy developed through this process includes five major categories each of which contain specific types of transition programming. *Table 8* below summarizes the transition programming taxonomy.

Table 8

The Taxonomy for Transition Programming	
<p>Student-Focused Planning</p> <ul style="list-style-type: none"> • IEP Development • Student Participation • Planning Strategies 	<p>Family Involvement</p> <ul style="list-style-type: none"> • Family Training • Family Involvement • Family Empowerment
<p>Student Development</p> <ul style="list-style-type: none"> • Life Skills Instruction • Career/Vocational • Curricula • Structured Work Experience • Assessment • Support Services 	<p>Program Structure</p> <ul style="list-style-type: none"> • Program Philosophy • Program Policy • Strategic Planning • Program Evaluation • Resource Allocation • Human Resource Development
<p>Interagency Collaboration</p> <ul style="list-style-type: none"> • Collaborative Framework • Collaborative Service Delivery 	

Public Health Conceptual Data Model (PHCDM). The PHCDM is a product of the CDC Health Information Surveillance System Board¹, and was created to support the National Electronic Disease Surveillance System (NEDSS). The PHCDM has allowed CDC and its State and local partners to establish data standards for public health, exchange information among public agencies and health care providers, and integrate computer systems for the management and exchange of data among agencies (CDC, 2000a).

The PHCDM employs a hierarchical system comprised of subject areas, classes of information, and attributes. The PHCDM identifies and defines the attributes of a health-related activity and analyzes the relationship among those attributes. According to the PHCDM, an *intervention* is a subtype of the health-related activity subject area. Attributes include (see *Table 9*).

¹ Note: Former HISSB functions will be supported under the direction of the CDC Information Council.

Table 9

Intervention Form	The physical form in which intervention is delivered.
Intervention Quantity	The amount of intervention associated with a single intervention instance.
Intervention Reason Code	The basis for the intervention.
Intervention Route Code	The route by which intervention is administered to object of intervention.
Rate Quantity	The period of time over which a specified dose is delivered. Applies only to continuously divisible intervention forms such as fluids or gases—rate indicates amount of intervention within a specific period of time. Rate quantity is the duration and it is the denominator of the intervention rate, while the intervention quantity is the numerator.
Strength Quantity	The amount of agent per each unit of administration. If continuously divisible, strength is a concentration. If used, the actual amount administered is the product of intervention quantity and strength quantity.

VI. HIV Prevention-Specific Taxonomies, Definitions, and Attributes

STD/HIV Prevention Intervention Framework. Cohen and Scribner (2000) developed a taxonomy of STD and HIV prevention interventions based on the function of the intervention. The two major categories distinguish the risk factor targeted—those targeting *individual* or intra-individual factors (including small groups) and *structural* interventions targeting factors outside the control of a single individual (see *Table 10* below). According to these authors, the individual level interventions follow a biomedical paradigm in which risk behavior is determined by an individual’s biology, education, or psychology. Structural interventions are more representative of a public health paradigm in which physical, social and cultural conditions affect people’s health. Sub-categories of structural interventions include accessibility/availability, physical structures, social structures and media messages. It is possible for an intervention to be both individual and structural in nature. For example, a policy, law or protocol that is adopted to require a large group of individuals receive care or treatment, such as an immunization, would be the structural component. The individual level intervention would be the actual care or treatment received.

Table 10

Functional and Operational Dimensions of Individual and Structural Interventions				
		<i>Functional Dimension</i>		
		Intervention	Individual level effects	Population level effects
Operational Dimension	Individual-level preventive interventions	Educational	Yes, individuals receive educational benefit	No
		Psychological	Yes, individuals receive benefit	No
		Biological	Yes, individual risk or susceptibility affected	Yes, if significant reduction in prevalence results in a reduction in incidence
		Small-group or community level education	Yes, individuals receive educational benefit	Yes, if group or community norms affected
	Structural-level preventive interventions	Availability	Yes, individual access to risk factor decreased	Yes, if current access affects expectations of future access
		Physical structures	Yes, individuals physically separated from risk factor	Yes, if behavioral norms readjust to new physical environment
		Social structures	Yes, individuals constrained by social policy	Yes, if behavioral norms readjust to new social environment
		Media	Yes, individual education received	Yes, if media message is perceived as normative

HIV Prevention and Treatment Services Taxonomy. Efforts to build an HIV prevention intervention classification system have also occurred at the CDC. Holtgrave and his colleagues published *A Suggested Taxonomy for HIV Prevention and Treatment Services* (Holtgrave et al., 1994). The authors of this document were senior staff in the Division of STD/HIV Prevention in the National Center for Prevention Services (since renamed the Division of HIV/AIDS Prevention and the National Center for HIV, STD, and TB Prevention). As part of a review of economic analyses of HIV prevention and treatment, they created a taxonomy (see *Table 11* below) that includes, but was not limited to, the major types of HIV prevention programs funded by CDC and common clinical treatment services. They considered this taxonomy to be “dynamic,” that is, open to new services as they were developed.

This taxonomy expanded on the common broad categories in use at that time—Health Education and Risk Reduction (HE/RR), Counseling and Testing (CT), and Public Information—with multiple subcategories. However, to encompass the variety of program announcements being issued by CDC for HIV prevention, it also included categories that are less intervention-specific, such as Minority/Youth/Women’s Initiatives (which they acknowledge are complementary categories to the substantive programmatic areas noted elsewhere in the taxonomy). These authors had a deep and broad understanding of the field of HIV prevention; however, the taxonomy was not subjected to external input on or refinement of the categories and subcategories used. This taxonomy also does not include definitions, descriptions, or inclusion/exclusion criteria that would help users apply the classification system.

Table 11

A Suggested Taxonomy for HIV Prevention and Treatment Services

1. Counseling, Testing, Referral and Partner Notification

- A. HIV counseling and testing
 - i. non-voluntary testing
 - a. military
 - b. Job Corps
 - c. prisons (where required by law)
 - d. insurance
 - e. sexual assault (where required by law)
 - f. pre-marital (where required by law)
 - g. blood bank screening
 - h. hospital patients (where required by institutional policy)
 - i. general “screening”
 - j. immigrants
 - k. job applicants (where required by institutional policy)
 - ii. voluntary testing
 - a. determine own serostatus (personal risk assessment)
 - (1) clinic setting
 - (a) persons in STD clinics
 - (b) persons in drug treatment
 - (c) persons in TB clinics
 - (d) persons in family planning clinics
 - (e) other clinic setting (e.g., private physician)
 - (2) community setting (e.g., the street; community organizations)
 - b. perinatal screening
 - c. enhanced/repeated post-test counseling in any setting
 - d. enhanced efforts at increasing rate of return for post-test counseling in any setting
 - iii. alternative methods of testing
 - a. saliva testing
 - b. urine testing
 - c. dried blood spot testing
 - d. rapid testing, other
- B. Referral
 - i. referral verification systems
 - ii. staff assisted referrals

- iii. decentralized vs. centralized case management
- iv. linking outreach programs to clinic-based CT services
- C. Partner notification
 - i. provider referral
 - ii. patient referral
 - iii. mixed strategies
 - iv. couples counseling
 - v. special referral systems for partners
- D. Other
 - i. staff training
 - ii. quality assurance programs
 - iii. STD treatment as a strategy for HIV prevention
 - iv. condom distribution in STD clinics

2. Health Education/Risk Reduction

- A. Individual counseling
 - i. peer counseling
 - a. skills training
 - (1) condom use training
 - (2) negotiation of safer sexual behaviors
 - b. other psychosocial issues
 - ii. non-peer counseling
 - a. skills training
 - (1) condom use training
 - (2) negotiation of safer sexual behaviors
 - (3) other psychosocial issues
- B. Group counseling
 - i. peer mediated
 - a. skills training
 - (1) condom use training
 - (2) negotiation of safer sexual behaviors
 - b. other psychosocial issues
 - ii. non-peer mediated
 - a. skills training
 - (1) condom use training
 - (2) negotiation of safer sexual behaviors
 - b. other psychosocial issues
- C. Street and Community Outreach
 - i. peer-led
 - ii. non-peer led
 - iii. street counseling
 - iv. condom distribution and promotion
 - v. bleach distribution

Table 11

A Suggested Taxonomy for HIV Prevention and Treatment Services

- D. School-based programs
 - i. peer led
 - ii. teacher (or other non-peer) led
 - iii. as part of comprehensive health education program
 - iv. condom distribution
 - E. Worksite health promotion
 - i. peer led
 - ii. non-peer led
 - iii. as part of a comprehensive health education program
 - F. Other
 - i. community-level interventions
- 3. Public Information**
- A. Mass media
 - i. print media
 - ii. electronic mass media
 - B. Other printed media
 - i. small media
 - C. Endorsements
 - D. Hotlines/clearinghouses
- 4. Treatment**
- A. Psychosocial services
 - B. Medical treatment
 - i. prophylaxis for *Pneumocystis carinii* pneumonia
 - ii. antiretroviral therapy
 - a. post-exposure prophylaxis
 - b. therapeutic
 - iii. treatment of opportunistic infections other than PCP
 - iv. treatment of HIV-associated malignancies
 - v. treatment of other conditions
- 5. Minority/youth/women's initiatives** (See substantive programmatic areas above)
- 6. Other**
- A. Community development (including private/public ventures)
 - B. Multi-year funding process
 - C. Formula grants
 - D. Funding national organizations to provide technical assistance
 - E. Occupational transmission (not related to AZT)
 - F. Other

NIH Consensus Statement: Interventions to Prevent HIV Risk Behaviors. The NIH Consensus Development Program was established as a mechanism to resolve controversial topics in medicine and public health in an unbiased, impartial manner (NIH, 2001). In the full consensus statement on interventions to prevention HIV risk behaviors, the panel said the urgency of the AIDS epidemic justifies the need for implementing those behavioral intervention programs proven by rigorous scientific study to be the most successful (NIH, 1997). In the discussion on “Studies Ready for Implementation,” the authors divided HIV prevention interventions into four categories or levels: 1) individual, 2) family or dyad, 3) community, and 4) policy. Examples of specific types mentioned are shown in *Table 12* below.

Table 12

Intervention Categories and Interventions Noted in NIH Consensus as “Ready for Implementation”	
<p>Individual Level</p> <ul style="list-style-type: none"> • Outreach • Needle exchange • Treatment programs (for IDUs) • Face-to-face counseling • Cognitive-behavioral small group (i.e., proper condom use, negotiation, refusal) • Condom distribution • Testing and treatment for sexually transmitted diseases 	<p>Policy</p> <ul style="list-style-type: none"> • Lifting government restrictions on needle exchange programs • Providing increased government funding for drug and alcohol treatment programs, including methadone maintenance • Support for sex education interventions that focus beyond abstinence • Lifting constraints on condom availability (e.g., in correctional facilities)
<p>Family or Dyad</p> <ul style="list-style-type: none"> • Counseling for couples 	<p>Community</p> <ul style="list-style-type: none"> • Community outreach

Guide to Community Preventive Services: Prevention of HIV, STD, and Unintended Pregnancy. The Guide to Community Preventive Services (Community Guide), led by the independent Task Force on Community Preventive Services, offers public health decision makers recommendations regarding population-based interventions. The steps for obtaining and evaluating evidence involves: (1) forming multidisciplinary chapter development teams; (2) developing a conceptual approach to organizing and grouping the interventions in each chapter; (3) selecting interventions to be evaluated; (4) searching for and retrieving evidence; (5) assessing the summarizing body of evidence of effectiveness; (6) translating evidence of effectiveness into recommendations; (7) considering information on evidence other than effectiveness; and (8) identifying and summarizing research gaps (Briss, et al., 2000). In Winter 2002, the Community Guide will publish its evidence-based recommendations about interventions to prevent HIV, STD, and unintended pregnancy. The interventions in the HIV, STD, and unintended pregnancy chapter are summarized in the table below.

Table 13

Interventions discussed in the Community Guide	
<p>Education, Counseling, Service Delivery and Referral</p> <ul style="list-style-type: none"> • STD risk reduction counseling • HIV risk reduction counseling • Pregnancy planning and prevention • Condom distribution • Sexuality education • Partner notification • Promoting personal development and parenting skills of new/expectant adolescent mothers • HIV counseling and testing 	<p>Media Campaigns</p> <ul style="list-style-type: none"> • Public information campaigns • Social marketing <p>Policy Interventions</p> <ul style="list-style-type: none"> • Provider-focused • Client/consumer focused • Structural <p>Youth Development Programs</p> <p>Strengthening Family, Social Networks, and Other Support Systems</p>

Classification of HIV Risk-Reduction Interventions. In his book, *Preventing AIDS: A Sourcebook for Practitioners*, Kalichman (1998) discusses the classification of HIV risk-reduction interventions. He reviews the taxonomy developed by Holtgrave, et al. (1994) and notes that their classification was based on the intervention technology used (e.g., partner notification or counseling) and the channels through which information is delivered (e.g., one-on-one sessions or street contacts). He suggests an alternative conceptualization in which group intervention types are based on their level of intervention: individual, small group, and community. Within each of these levels, there can be variability along the dimensions of intensity, exposure duration, and expected outcomes. *Table 14* below reflects Kalichman’s Levels of Intervention Conceptualization.

Table 14

Kalichman’s Levels of Intervention Conceptualization	
Level of Intervention	Interventions in this Level
Individual	<ul style="list-style-type: none"> • HIV testing and counseling • Partner notification • Individualized prevention counseling • Couples counseling • Telephone hotlines
Small Group	<ul style="list-style-type: none"> • Small Groups • Workshops
Community	<ul style="list-style-type: none"> • Social influence models • School-based programs • Street and community outreach • Social marketing • Media interventions • Social action and community mobilization

Intervention Taxonomy from the CDC Evaluation Guidance for Health Departments. As part of the development for the DHAP's *Evaluating CDC-funded Health Department HIV Prevention Programs* (referred to as the Evaluation Guidance; (CDC, 2001b), the Division's evaluation and reporting guidance to its health department grantees, a refined version of the *Suggested Taxonomy* (Holtgrave, 1994) was developed to guide reporting on interventions receiving CDC funding. For this purpose, CDC staff and their contractors determined a set of intervention types believed to represent the overwhelming preponderance of intervention activities being funded. The intervention types were also believed to be optimally (but not completely) mutually exclusive. The interventions and their definitions are presented in *Table 15*.

In the Evaluation Guidance for CDC-Funded Health Department HIV Prevention Programs (CDC, 2001b), an *intervention* is defined as,

“A specific activity (or set of related activities) intended to bring about HIV risk reduction in a particular target population using a common strategy for delivering the prevention messages. An intervention has distinct process and outcome objectives and a protocol outlining the steps for implementation.”

In contrast, a *program* is defined as, “a distinction often used by an agency to describe an organized effort to design and implement one or more interventions to achieve a set of predetermined goals.” In a program, the interventions are distinct (with the characteristics noted above), but may be hypothesized to work independently of one another or in synergistic or complementary ways. This latter situation is exemplified by multiple component interventions, like the AIDS Community Demonstration Projects (CDC, 1996) or the Women and Infant Demonstration Projects (Lauby et al., 2000) both funded by DHAP. In each of these projects, multiple interventions (using the definition above) are implemented simultaneously with the hypothesis that they complement one another in distinct ways and that an individual's exposure to multiple components enhances the prevention effect.

The Evaluation Guidance was not intended to be an exhaustive classification of all types of HIV prevention services. Instead, it was designed for the purposes of data collection to reflect the preponderance of intervention activities funded by DHAP. It purposely leaves out several types of interventions. For instance, needle/syringe exchange is not included because federal funds cannot be used to fund these activities. Therefore, there are no reporting requirements for needle/syringe exchange activities and it is not part of the Guidance taxonomy. Similarly, biomedical prevention services (e.g., treatment of sexually transmitted diseases) are not funded through the CDC HIV prevention cooperative agreements with health departments and, so, are not included.

Another limitation that has arisen with the Guidance intervention taxonomy is that despite the best efforts to differentiate the intervention types, there are interventions that users have a difficult time assigning to a particularly intervention category. A common problem arises with the distinction between *individual counseling* and *outreach*. They both involve face-to-face interactions and discussion of risk and risk reduction. They may both involve a risk assessment,

a structured protocol for the format and content of the “session,” and referrals to other resources. In the Guidance taxonomy, a primary differentiating feature is that the definition of outreach contains a reference to *place*—“HIV/AIDS educational interventions generally conducted... in the clients’ neighborhoods or other areas where clients’ typically congregate.” The definition for individual-level interventions (counseling) contains no such parameter.

Table 15

Intervention Types Used in CDC Evaluation Guidance

	Definition	Exclusion Criteria
Individual Level Intervention (ILI)	Health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior and include skills building activities. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services.	According to a strict categorization, outreach and prevention case management are individual-level interventions. However, for the purposes of this report, ILI does not include outreach or prevention case management, each of which constitutes its own intervention category
Group Level Intervention (GLI)	Health education and risk-reduction counseling (see above) that shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide range of skills, information, education, and support.	Many providers may consider general education activities to be group-level interventions. However, for the purposes of this reporting, GLI does <i>not</i> include “one-shot” educational presentations or lectures (that lack a skill component). Those types of activities should be included in the Health Communication/Public Information category. <ul style="list-style-type: none"> • Lectures or group educational presentations • Outreach solely for the purpose of Counseling, Testing, and Referral (CTR)
Outreach	HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients’ neighborhoods or other areas where clients’ typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Includes peer opinion leader models.	
Prevention Case Management (PCM)	Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.	
Partner Counseling and Referral Services (PCRS)	A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.	

Table 15 (continued)
Intervention Types Used in CDC Evaluation Guidance

<p>Health Communication/ Public Information (HC/PI)</p>	<p>The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services.</p> <p>Electronic Media: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city-, region-, or statewide) audience.</p> <p>Print Media: These formats also reach a large-scale or nationwide audience; includes any printed material, such as newspapers, magazines, pamphlets, and “environmental media” such as billboards and transportation signage.</p> <p>Hotline: Telephone service (local or toll-free) offering up-to-date information and referral to local services, e.g., counseling/testing and support groups.</p> <p>Clearinghouse: Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide a responsive information service to the general public as well as high-risk populations.</p> <p>Presentations/Lectures: These are information-only activities conducted in group settings; often called “one-shot” education interventions.</p>	<p>Group interventions with a skills component</p>
<p>Other Interventions</p>	<p>Category to be used for those interventions funded with CDC Announcement 99004 funds that cannot be described by the definitions provided for the other six types of interventions (example forms A - F). This category includes community-level interventions (CLI).</p> <p>CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions.</p>	

VII. Overviews of HIV Prevention Intervention Types

CDC Guidance Documents—Health Education and Risk Reduction, Prevention Case Management, Partner Counseling and Referral Services, and Counseling, Testing and Referral

The CDC has issued a number of guidance documents to assist state, city, and territorial health departments that receive HIV prevention cooperative agreement funds in planning, implementing, and evaluating the services and interventions provided. These guidance documents have been developed using reviews of the relevant scientific literature, actual program experience, and expert recommendations from within and outside CDC.

Guidelines for Health Education and Risk Reduction (HERR) Activities. CDC developed HERR guidance to “encourage HIV/STD prevention programs to focus on developing programs and services that are based on health education and health promotion strategies” (CDC, 1995). The HERR Guidance discusses four of the eight essential components of a comprehensive HIV prevention program as described in the original Community Planning Guidance document, also issued by CDC (1994). The four program areas are presented in *Table 16*.

The guidance also outlines essential core elements for effective HERR activities:

- State realistic, specific, measurable, and attainable program goals and objectives.
- Identify methods and activities to achieve specific goals and objectives.
- Define staff roles, duties, and responsibilities.
- Define the populations to be served by geographic locale, risk behavior(s), gender, sexual orientation, and race/ethnicity.
- Assure that educational materials and messages are relevant, culturally competent, and language- and age-appropriate.
- Include professional development for all program staff.
- Include a written policy and personnel procedures that address stress and burnout.
- Include written procedures for the referral and tracking of clients to appropriate services outside of the agency.
- Provide for collaboration with other local service providers to assure access to services for clients.
- Assure confidentiality of persons served.

Table 16

Program Areas Discussed in the HERR Guidance

Program Area	Goals	Interventions Include
Individual Level Interventions	Provide ongoing health communications, health education, and risk reduction counseling to assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices which prevent transmission of HIV, and they help clients make plans to obtain those services.	<ul style="list-style-type: none"> • Street outreach: outreach specialists moving throughout a particular neighborhood or community to deliver risk reduction information and materials. • Risk reduction counseling: interactive counseling that assists clients in building the skills and abilities to implement behavior change. • HIV prevention case management: intensive, individualized support and prevention counseling to assist persons to remain seronegative or to reduce the risk for HIV transmission to others by those who are seropositive.
Health Communications, Health Education, and Risk Reduction Interventions for Groups	Provide peer education and support, as well as promote and reinforce safer behaviors and provide interpersonal skills training in negotiating and sustaining appropriate behavior change.	<ul style="list-style-type: none"> • Community outreach: workshops and presentations. • Risk reduction counseling to couples and groups.
Community Level Intervention for Populations at risk for HIV infection	Seek to reduce risk behaviors by changing attitudes, norms, and practices through health communications, prevention marketing, community mobilization/organization, and community wide events.	<ul style="list-style-type: none"> • Interventions such as persuasive behavior change messages or skills-building effort directed at a populations rather than the individual with the primary goal of promoting healthy behaviors and changing those factors (social norms) that negatively affect the health of a community's residents.
Public Information Programs for the General Public	Seek to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination towards persons with HIV/AIDS, and promote support for strategies and interventions that contribute to HIV prevention in the community.	<ul style="list-style-type: none"> • Communication (public information) program: the delivery of planned messages through one or more channels to target audiences through the use of materials.

HIV Prevention Case Management (PCM)—Guidance. For persons living with HIV and AIDS, case management has emerged as the prominent strategy for coordination the wide range of needed health care, psychiatric, psychosocial, and practical support services (Piette, et al, 1992). HIV prevention case management is a highly individualized and intensive client-centered prevention activity, which assists HIV seropositive and seronegative persons in adopting risk-reduction behaviors. Previous guidelines for CDC-funded health department grantees conducting PCM were published in *Guidelines for Health Education and Risk-Reduction (HERR) Activities* (CDC, 1995). The revised CDC guidance for PCM provides more detail about essential components and protocols for PCM programs and was issued in response to questions about “the range of services appropriate for PCM, the type and extent of counseling, and staffing qualifications” (CDC, 1997). See *Table 17* below for the components of PCM.

Table 17

Prevention Case Management (PCM)	
Definition	Components
<p>PCM is a client-centered HIV prevention activity within the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is intended for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevention HIV acquisition, transmission, or reinfection. As a hybrid of HIV risk-reduction counseling and traditional case management, PCM provides intensive, on-going, individualized prevention counseling, support and service brokerage. This HIV prevention activity addresses the relationship between HIV risk and other issues such as substance abuse, STD treatment, mental health, and social and cultural factors.</p>	<ul style="list-style-type: none"> • Client recruitment and engagement. • Screening and assessment (comprehensive assessment of HIV and std risks, medical and psychosocial service needs—including std evaluation and treatment, and substance abuse treatment). • Development of a client-centered “prevention plan.” • Multiple session HIV risk-reduction counseling. • Active coordination of services with follow-up. • Monitoring and reassessment of clients’ needs, risks, and progress. • Discharge from PCM upon attainment and maintenance of risk-reduction goals.

In addition to defining PCM and its essential components, the PCM guidance also differentiates it from other types of HIV prevention activities. The following table (*Table 18*) contrasts characteristics of PCM with other individual-level interventions, such as street outreach and “traditional” HIV counseling and testing.

Table 18

	Street Outreach	HIV Counseling and Testing	Prevention Case Management
Intensity	Low	Moderate	High
Duration	Short	Short	Long
Numbers of People Reached	Potential to Reach <i>High</i> Number of People	Reaches <i>Moderate</i> Number of People	Reaches <i>Low</i> Number of Clients
Cost per Person	Low	Moderate	High
Deliverer	Peers or Paraprofessional Staff	Paraprofessional Staff or Professional Staff	Primarily by Professional Staff

HIV Partner Counseling and Referral Services (PCRS) Guidance. Outreach activities for finding, diagnosing, and treating partners of infected persons infected with sexually transmitted diseases have been conducted by public health workers for many decades. With the rapid spread of HIV in the 1980's, informing people of their possible exposure to HIV and offering counseling, testing, and other services became a central prevention effort. For many years, the terms “contact tracing” and “partner notification” characterized the process of reaching and serving sex and needle-sharing partners. In its guidance to support health departments in these activities, CDC (1998) recommends that the term “partner counseling and referral services” replace those to better reflect the type and range of public health services for sex and needle-sharing partners. In addition to describing in more detail this shift in terminology, the guidance outlines the goals of PCRS, presents two levels of recommendations for conducting PCRS (required standards and suggested guidance), provides assistance for collecting, analyzing, and utilizing PCRS data, and specifies guidelines for ensuring the quality of PCRS data. See *Table 19* below for definitions of components of PCRS as outlined in this guidance.

Table 19

Partner Counseling and Referral Services (PCRS)	
Definition	Components
<p>PCRS is a prevention activity that aims to:</p> <ol style="list-style-type: none"> 1. Provide services to HIV-infected persons and their sex and needle-sharing partners so they can avoid infection or, if already infected, can prevent transmission to others. 2. Help partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services 	<ul style="list-style-type: none"> • Persons seek HIV prevention counseling and testing. • Client tests positive and chooses to participate in PCRS. • PCRS providers and client together formulate a plan and set priorities. • HIV-infected client voluntarily discloses information about partners. • Client and/or provider informs each partner of possible exposure to HIV. • Client and/or provider assists partner in accessing counseling, testing, and other support services.

DRAFT Revised Guidelines for HIV Counseling, Testing, and Referral (CTR). Since the publication of the CTR Guidelines in 1994, important scientific and programmatic advances in HIV CTR, as well as advances in prevention and treatment of HIV-infected persons, prompted the need for a revision. Some of these advances include: demonstrated efficacy of high-quality HIV prevention counseling models aimed at behavioral risk reduction, effective treatments for HIV infections and opportunistic infections, effective treatment regimens for prevention perinatal transmission, new test technologies, and recognition of the need for systems of referral to medical, prevention, and psychosocial support services (CDC, 2000b). The need for early detection is increasingly compelling with these advances, as early detection can benefit infected persons as well as reduce risk of transmission to others. The following table (*Table 20*) shows the definitions this guidance uses for HIV prevention activities.

Table 20
Counseling, Testing and Referral (CTR)

Prevention Activity	Definition
HIV Prevention Counseling	“HIV prevention counseling” is a process that is aimed at personal HIV risk reduction—this is, a type of counseling with the explicit goal of helping the client identify and commit to a specific behavior change step that will help prevent acquisition or transmission of HIV. HIV prevention counseling engages the client in the session. It is usually, but not always, done in the context of HIV testing.
Referral	The process by which client needs for care and supportive services are assessed and prioritized. Clients are then provided with assistance (e.g., setting up appointments, providing transportation) in accessing services. Referral should also include reasonable follow-up efforts necessary to facilitate initial contact with care and support service providers. It does <i>not</i> include ongoing support or management of the referral (see PCM below).
Prevention Case Management	A client-centered HIV prevention activity that promotes adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is a hybrid of HIV prevention counseling and traditional case management that provides intensive, on-going, and individualized prevention counseling, support, and referral to other needed services.

Overview of Structural Interventions. In their review of structural interventions conducted in a range of public health arenas, Blankenship et al. (2000) provide a framework for understanding and analyzing this type of intervention in HIV prevention. They conclude that the most effective structural interventions in HIV prevention are those that attend to the three sources of HIV risk (factors involving availability, acceptability, and accessibility) through interventions targeted to the individual, organizational, and environmental levels. See *Table 21* below for the authors’ examples of structural interventions organized by the sources of risk and level of intervention.

Table 21

Examples of Structural Interventions for HIV Prevention			
	Individual	Organizational	Environmental
Availability	<ul style="list-style-type: none"> • Criminalization of transmission related to sex or drug use • Prohibitions against possession of drug paraphernalia • Criminalization of drug use • Criminalization of prostitution • Community campaigns to put condom machines in bathrooms • Sharps containers in bathrooms • Needle-disposal sites • Pharmacy sale of syringes • Lifting cap on number of syringes NEPs are allowed to distribute, and pharmacists are allowed to sell 	<ul style="list-style-type: none"> • Development of better and more reliable condoms • Development of single-use syringes • Extended school hours • Decriminalization of syringe possession • More structured, alcohol-free leisure time for school children • Minimum drinking age • 100% condom use policies in brothels • 100% condom use policies in bathhouses • Regulations on blood industry to improve quality of blood supply • Treatment on demand • Implementing drug-treatment programs in prison • Distributing syringes or condoms in prisons • Closing bathhouses 	<ul style="list-style-type: none"> • Restricting federal funds for NEPs • Overturning the van on use of federal funds for NEPs • City-sponsored safe-injection parks/rooms/buildings • Quarantine of HIV-infected individuals • Prohibiting HIV-infected individuals from entered the country • Prostitution-free zones
Acceptability	<ul style="list-style-type: none"> • Anti-prostitution stigmatization campaigns (john of the week) • Distribution of anti-drug t-shirts, etc. To teenagers 	<ul style="list-style-type: none"> • Anti-drug use television programming initiatives • Requirements that networks devote time to PSAs, including anti-drug programming • Media campaigns to eroticize condoms 	<ul style="list-style-type: none"> • Social marketing of condoms
Accessibility	<ul style="list-style-type: none"> • Comprehensive case management • Needle-exchange programs • Massive distribution of free condoms • Women-only needle-exchange programs 	<ul style="list-style-type: none"> • Development and production of female-controlled prevention methods such as female condoms and microbicides • Zoning ordinances for alcohol to reduce the concentration of liquor stores in low-income neighborhoods • Expansion of publicly funded drug-treatment programs 	<ul style="list-style-type: none"> • Junkie groups • Prostitute organizing • Medicaid coverage of drug treatment • Regulations restricting eligibility of drug users for income maintenance • Rebuilding infrastructure in urban communities • Legalization of marriage among gay men and lesbians • Decriminalization of drug use and possession • Decriminalization of sex work/prostitution • Elimination of sodomy laws

CDC Outreach Descriptions. Outreach is an effective public health strategy to access underserved or hard-to-reach populations and provide them with pertinent health promotion and risk reduction information. One of the main reasons outreach is effective is because it takes place in natural settings, such as neighborhoods, stores and bars where members of the target population are likely to be. The major goals of street outreach are to increase knowledge, increase condom use, increase bleach use and reduce needle-sharing behaviors (Valentine, 1994). These goals are applicable to prevention for a variety of health conditions or diseases, including HIV prevention. The AIDS Evaluation of Street Outreach Projects (AESOP) was developed in the early 1990s to assess eight CDC-funded street outreach projects in six metropolitan areas.

Three types of street outreach services were identified for AESOP:

1. Distribution of risk reduction materials.
2. Delivery of HIV prevention services in non-traditional locations or natural settings frequented by the population.
3. Provision of or referral to other services that support risk reduction materials or meet immediate social needs.

AESOP site staff were asked to collect information of their contacts and encounters. A contact was defined as “a face-to-face interaction during which materials and/or information is exchanged between an outreach worker and a client (or small group of clients)” (Valentine, 1994). Contacts are often used to establish credibility among persons or groups not familiar with an organization or its outreach workers and can be any one or combination of street outreach services. Once credibility has been established, there is an opportunity for a contact to become an encounter, defined as “face-to-face interaction that goes beyond the contact to include focused assessment, specific service delivery in response to the client’s identified need(s), and a planned opportunity for follow-up” (Valentine, 1994).

Valentine also collapsed outreach interventions into three basic categories of location:

Active Street Outreach	Outreach activities where workers are moving down a street, screening and engaging prospective clients for the purposes of delivering risk reduction information, material and/or referrals
Fixed-Site Outreach	Outreach activities which are conducted at a specific place within a given location (e.g., setting up a table on a corner or working out of a mobile van or storefront)
Drop-off Site Outreach	Outreach activities which provide risk reduction supplies to volunteer distributors who may then distribute the items to persons involved in risk behaviors (e.g., brochures left at a check out counter or bleach kits distributed at an injection drug user “shooting gallery”)

VIII. HIV Prevention Intervention Characteristics and Features for Classification

The Compendium of HIV Prevention Interventions. In 1999, the Division of HIV/AIDS—Intervention Research and Support (DHAP-IRS) of the National Center for HIV, STD, and TB Prevention (NCHSTP) at the Centers for Disease Control and Prevention (CDC) issued the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*. The Compendium describes behavioral and social interventions for HIV prevention that have shown evidence of their effectiveness in the published scientific literature. The summaries of each intervention includes the goal(s) of the intervention, the type of place or setting in which the intervention is to be conducted, population demographics and sample size, the condition of the comparison or control group, a detailed description of the intervention and study findings. The description of each intervention included the theory/model used, duration of the intervention, methods used for implementation, materials (i.e., handouts) and incentives utilized.

The interventions described in the Compendium were organized according to their respective target population; they were not classified by an intervention category. The three types of interventions described included individual level, small group, and community level health education and risk reduction interventions. A few of those, primarily the classroom (group) and community level interventions had multiple interventions within inclusive programmatic frameworks (CDC, 1999).

The following characteristics in *Table 22* were proposed in the compendium as elements of successful programs. These may be interpreted as dimensions into which interventions could be categorized.

Table 22

Elements of Successful Programs (CDC, 1999)	
1. 1. Intervention Items	<p>The intervention has a clearly defined audience.</p> <p>The intervention has clearly defined goals and objectives.</p> <p>The intervention is based on sound behavioral and social science theory.</p> <p>The intervention is focused on reducing specific risk behaviors.</p> <p>The intervention provides opportunities to practice relevant skills.</p>
2. 2. Implementation Items	<p>There is a realistic schedule for implementation.</p> <p>Staff are adequately trained for sensitivity to the target population.</p> <p>Staff are adequately trained to deliver the core elements of the intervention.</p> <p>Core elements of the intervention are clearly defined and maintained in the delivery.</p> <p>Staff uses a variety of teaching methods, strategies, and modalities to convey information, personalize the training, and repeat essential HIV prevention messages.</p>
3. 3. Organization Items	<p>There is administrative support for the intervention at the highest levels.</p> <p>There are sufficient resources for the current implementation.</p> <p>There are sufficient resources for sustainability.</p> <p>Decision-makers are flexible and open to program changes.</p> <p>HIV/AIDS intervention is embedded in a broader context that is relevant to the target population.</p>
4. 4. Consumer/Participant Items	<p>The intervention meets specified priorities and needs defined by the community.</p> <p>For the target population selected, the intervention is culturally competent.</p> <p>For the target population selected, the intervention is developmentally appropriate.</p> <p>For the target population selected, the intervention is gender specific.</p> <p>The intervention as implemented is acceptable to the participants.</p>

Features of Interventions for Drug-Using Populations. Building on the suggested taxonomy developed by Holtgrave et al. (1994), the Academy for Educational Development (AED, 1997) presents key features of interventions that prevention planners and program managers need to consider when designing HIV prevention interventions for drug users. Four major questions guide the feature set (see *Table 23* below).

Table 23

Who is being targeted?	
Race/ethnicity	Describe the racial/ethnic background of the target group(s).
Other characteristics	Describe other demographic characteristics of the target group(s), such as adolescent vs. adult, in-school vs. out-of-school, homeless, mentally ill, female vs. male, MSM, sex industry workers, inmates, parolees, immigrants.
Geographic	Describe the section or neighborhood of the city where the target group(s) are located.
General risk behaviors and stages of behavioral change	Describe the general risk behaviors of the target group(s), such as sexual behaviors, injecting drug use, crack use, and their general readiness for behavior change.
What is the proposed intervention?	
Level	Describe whether the intervention will be delivered at the individual, couples, group, street, and/or community, or general public level.
Behavioral objectives	Describe what risk behaviors the intervention expects to change and the direction of this change.
Factors expected to affect risk behavior(s)	Describe theoretical factors that will need to be addressed to affect the behavioral objectives of the intervention, such as addressing the target group's intentions, skills, perceived efficacy, and supportive community and peer norms, and the barriers and expected outcomes.
Services, materials, and information	Describe the services, materials, and other information that will be delivered in the interventions, such as HIV counseling and testing, case management, peer outreach, skills training, condoms, bleach kits, and/or educational pamphlets.
Where is the intervention being delivered?	
Institutional	Describe whether the intervention will be delivered in a school, prison, STD clinic, drug treatment program, or other institutional setting.
Street	Describe whether the intervention will be delivered in the streets or corners of a street in a high drug-use area, a crack house, park areas where MSM cruise, or other informal settings where high-risk behaviors are performed.
Community	Describe whether the intervention will be delivered in a community-based organization, store front, mobile van, or another community setting or settings (e.g., such as the multiple community settings of a media intervention).
How is the intervention being delivered?	
Persons delivering the intervention	Describe whether the intervention will be delivered by peers, community volunteers, health professionals, or other types of individuals.
Visibility of the intervention to the target groups	Describe how the target group(s) for the intervention will learn about its services, such as through various types of media in the community or through formal or informal outreach on the street or with related agencies.
Frequency/duration	Describe whether the frequency of the intervention will be one-time only, periodic, or ongoing, and whether the duration of the intervention will be minutes, hours, days, and/or years.
Scale and significance	Describe how many members of the target group(s) will be reached by the intervention and, if possible, whether this size is sufficient to make a measurable contribution to influencing the epidemic.
Contextual factors	Describe any contextual factors that will influence how the intervention is delivered, such as the type or level of drug use, the physiologic or mental state of the target group(s), and the competing needs for food, shelter, health care, employment, and protection from violence.

Extent of coordination	Describe the extent of coordination between the intervention and services of other agencies in the area and what the effect of other HIV prevention interventions will be on the implementation of the proposed intervention.
-------------------------------	---

NIDA HIV Counseling and Education Model. Putting the features described above into practice, prevention planners at the National Institute on Drug Abuse (NIDA) created the HIV Counseling and Education Model, an intervention designed to influence the risk behaviors of drug users and their partners (Coyle, 1993). *Table 24* below outlines features of the NIDA intervention model.

Table 24

Features of the NIDA Intervention Model	Description
Taxonomy Category	Counseling, Testing, Referral, and Partner Notification.
Target Population	Out-of-treatment, adult, injection drug users and their sex partners; most were African American and Latino, and located in a specific neighborhood of a city; readiness for behavior change of drug users and partners was not assessed.
Level	Individual.
Behavioral Objectives	Decreased drug-use and sexual risk behaviors.
Factors Affecting Risk Behavior	Knowledge of HIV and AIDS transmission. Perceived vulnerability to acquiring HIV. Perceived self-efficacy with correct condom use. Perceived outcomes of condoms and bleach. Perceived peer and community norms.
Services, Materials, and Information	Education and risk reduction counseling. HIV screening. Free condoms and bleach. Written materials about HIV transmission and HIV-related facilities and services.
Setting	Two mobile vans situated in high-need areas of the targeted neighborhood.
Person(s) Delivering Intervention	Community paraprofessional educator-counselors. Medically trained staff member (for HIV screening).
Visibility of Intervention	Outreach staff of both sexes who reflected the makeup of the neighborhood distributed materials on the program and services to other agencies and through one-on-one contact.
Frequency/Duration	Two 20-30 minute sessions over two to three weeks (moderate intensity).
Scale and Significance	Approximately 1,000 of the estimated 5,000 target group members were reached.
Contextual Factors	Services delivered were partly dependent on the context of the client's HIV status. Seronegative participants received education, counseling, and referrals. Seropositive participants received these services plus medical and treatment counseling.

Features of the NIDA Intervention Model	Description
Extent of Coordination	Formal and informal coordination and referral contracts developed with eight other service agencies in the targeted neighborhood.

Guide to Community Preventive Services: Prevention of HIV, STD, and Unintended Pregnancy. As mentioned previously, the Task Force on Community Preventive Services makes recommendations about interventions based on the strength of the evidence of effectiveness found during systematic reviews (Briss, 2000). The intended audience for these reviews is decision-makers in communities, public health organizations, and health care systems. In the data abstraction form used for intervention reviews, components are defined. These components are presented below in *Table 25*.

Table 25

Intervention Components Defined in the Community Guide Data Abstraction Form		
Provision of Information Only	These interventions try to change knowledge, attitudes, or norms	Intervention methods might involve instruction (e.g., classes, assemblies), small media (e.g. brochures, leaflets, posters, letters, newsletters) or large media (e.g., television, radio, newspapers, billboards). For these interventions, also note the target population.
Behavioral Interventions	These interventions try to change behaviors by providing necessary skills or materials	Intervention methods might involve modeling or demonstration, role playing, participatory skill development, individual benchmarking (i.e., goal setting and achievement), providing feedback, providing incentives or penalties, or providing materials necessary to perform the desired behavior (e.g., condoms, car seats). For these interventions, also note the target population.
Environmental Interventions	These interventions try to change the physical and or social environment to promote health or prevent disease	Interventions in the physical environment might involve adding to (e.g., fluoride in water systems), changing (e.g., resilient playground surfaces), or subtracting from (e.g., lead in gasoline and paint) the environment. Interventions in the social environment might include increasing employment opportunities (e.g., welfare-to-work programs) or development of community coalitions to change social systems (e.g., Detroit’s “Angel Night” anti-arson program).
Legislation/Regulation/Enforcement	These interventions try to change behaviors or alter disease risk factors by legislating particular behaviors, regulating risk factors, and enforcing those laws and regulations	Examples: <ul style="list-style-type: none"> • Mandatory seat belt use laws • School vaccination laws • Increasing tobacco taxes
Clinical	These interventions aim to increase access to and assurance of clinical care (patient-focused)	Public health or medical care system interventions: these interventions aim to change the public health or clinical care systems to increase or improve the delivery of services (system-focused). Examples: <ul style="list-style-type: none"> • Development of registries and surveillance systems. • Incentives to develop hospital policies for standing orders for vaccine administration.

IX. Conclusion

Each piece of this review points to the need for a standard vocabulary of HIV prevention interventions. Researchers in the field of HIV prevention as well as other fields, such as nursing, drug abuse prevention, etc., have struggled to systematically label and define the characteristics of prevention activities to facilitate communication about what is “out there,” to enhance the consistency of intervention delivery and data collection, and to improve the evaluation and dissemination of effective interventions. An attempt to create mutual exclusivity between HIV prevention interventions and dimensions within interventions is critical for the field to move forward.

Clearly, the lack of standard naming conventions, definitions, and characteristics of HIV prevention interventions significantly complicates evaluation of these activities, from a meta-analysis to a scientific perspective. Without a standard taxonomy of HIV prevention interventions, CDC and its prevention partners struggle to effectively and scientifically determine:

1. the effectiveness of federal funding on the HIV/AIDS epidemic,
2. how CDC funding is affecting designated priority target groups (such as disproportionately affected minorities), and
3. whether or not CDC-funded programs are having the desired or intended impact on the HIV/AIDS epidemic.

The more consistent CDC and its inter- and extramural partners are in classifying a particular type of HIV/AIDS intervention program or strategy (just as CDC does for disease classifications), the more successful CDC will be in providing higher quality data to its extramural stakeholders (i.e., congress, other federal agencies, state and local health departments, community-based organizations (CBOs), and HIV/AIDS Community Planning Groups) for their decision-making on funding allocation and targeted program development, improvement, and evaluation.

X. References

1. Academy for Educational Development. (1997). *HIV Prevention Among Drug Users: A Resource Book for Community Planners and Program Managers*. Funded by the Centers for Disease Control and Prevention.
2. Bailey, KD. (1994). *Typologies and Taxonomies: An Introduction to Classification Techniques*. Thousand Oaks, CA: Sage Publication.
3. Blankenship, K., Bray, S., and Merson, M. (2000). Structural interventions in public health. *AIDS*, 14 (suppl 1), S11.
4. Brandeau, M.L., Hau, L.L., Owens, D.K., Sax, C.H., and Wachter, R.M. (1990). Policy Analysis of HIV Screening and Intervention: An Overview of Modeling Approaches. *AIDS & Public Policy Journal*, 5 119.
5. Briss, P.A., Zaza, S., Pappaioanou, M., et al. (2000). Developing an Evidence-Based Guide to Community Preventive Services-Methods. *American Journal of Preventive Medicine*, 18 (1S): 35-43.
6. Britannica (2001). [*Encyclopedia Britannica article*] <http://www.britannica.com>.
7. Bruni, M. G. (2001). Indexing with the AIRS/INFO LINE Taxonomy of Human Services. *Information and Referral: The Journal of the Alliance of Information and Referral Systems*, 22. Available: [on-line] <http://www.infoline-la.org>.
8. Carper, W. B. and Snizek, W. E. (1980). The Nature and Types of Organizational Taxonomies: An Overview. *Academy of Management Review*, 5(1), 65-75.
9. Centers for Disease Control and Prevention (CDC). (2001a). HIV and AIDS—United States, 1981-2000. *MMWR*, 50(21).
10. CDC. (2001b). *Evaluating CDC-Funded Health Department HIV Prevention Programs—Volume 1: Guidance*. Atlanta, GA: author.
11. CDC. (2000a). *Public Health Conceptual Data Model*. Atlanta, GA: author.
12. CDC. (2000b). *Revised Guidelines for HIV Counseling, Testing, and Referral: DRAFT*. Atlanta, GA: author.
13. CDC. (1999). *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*. Atlanta, GA: author.
14. CDC. (1998). *HIV Partner Counseling and Referral Services - Guidance*. <http://www.cdc.gov/hiv/pubs/pcrsg/pcrsg-doc.htm>
15. CDC. (1997). *HIV Prevention Case Management - Guidance*. <http://www.cdc.gov/hiv/pubs/pcmg/pcmg-doc.htm>

16. CDC. (1996). Community level prevention of human immunodeficiency virus infection among high-risk populations: The AIDS Community Demonstration Projects. *MMWR Recommendations and Reports*, 10 (RR-6), 1-24.
17. CDC. (1995). *Guidelines for Health Education and Risk-Reduction Activities*. <http://wonder.cdc.gov/wonder/STD/Title3201.html>
18. CDC. (1994). Supplemental Guidance on HIV Prevention Community Planning for Noncompeting Continuation of Cooperative Agreements for HIV Prevention Projects. Atlanta, GA: author.
19. Coyle, SL (NOVA Research Company, Bethesda, MD). (1993). *The NIDA HIV Counseling and Education Intervention Model: Intervention Manual*. Rockville, MD. National Institutes of Health. Contract No.: 271-90-8407.
20. Fleishman, E. A. and Quaintance, M. K. *Taxonomies of Human Performance: The Description of Human Tasks*. Orlando: Academic Press, Inc., 1984.
21. Gordon, M. (Sept. 30, 1998): Nursing Nomenclature and Classification System Development. *Online Journal of Issues in Nursing*. http://www.nursingworld.org/ojin/tpc7/tpc7_1.htm
22. Hanowski, R. J., Knipling, R. R., Byrne, E. A. and Parasuraman, R. (March 1985). Analysis of Older Driver Safety Interventions: A Human Factors Taxonomic Approach. *Proceeding of the ITS Conference*. Washington, D.C.: ITS America.
23. Holtgrave, D. R., Valdiserri, R. O., and West, G. A. (1994). Quantitative Economic Evaluation of HIV-Related Prevention and Treatment Services: A Review. *Risk: Health, Safety & Environment*, 5(1), 29-47.
24. International Council of Nurses. (1999). *The International Classification for Nursing Practice (ICNP®) Beta Version*. <http://icn.ch/icnpupdate.htm>
25. Kalichman, SC. (1998). *Preventing AIDS: A Sourcebook for Behavioral Interventions*. Mahwah, NJ: Lawrence Erlbaum Assoc.
26. Kerr, M. (1991). Validation of taxonomy. In R. Carroll-Johnson (Ed.) *Classification of Nursing Diagnoses: Proceedings of the Ninth Conference*. Philadelphia: Lippincott. 6-13.
27. Kohler, P. D. (1996). Preparing Youth with Disabilities for Future Challenges: A Taxonomy for Transition Programming. In P. D. Kohler (Ed.), *Taxonomy for Transition Programming: Linking Research and Practice* (pp. 1-62). Champaign, IL: Transition Research Institute. University of Illinois at Urbana-Champaign.
28. Lauby, Jennifer L.; Smith, Philip J.; Stark, Michael; et al. (2000). A Community-Level HIV Prevention Intervention for Inner-City Women: Results of the Women and Infants Demonstration Projects. *American Journal of Public Health*, 90(2) 216.

29. McCloskey, J. C., and Bulechek, G. M. (Eds.) *Nursing Interventions Classification (NIC)*, 2nd Edition. St. Louis, MO: Mosby-Year Book, Inc., 1996.
30. Mollerup, Per. (1999). *Marks of Excellence: The History and Taxonomy of Trademarks*. Phaidon Press Inc.
31. NIH Consensus Development Program. (06/25/2001). *Guidelines for the Planning and Management of NIH Consensus Development Conferences*. Available: [on-line] <http://odp.od.nih.gov/consensus/about/process.htm>
32. NIH. (February 1997). *Interventions to Prevent HIV Risk Behaviors. NIH Consensus Statement*, 15(2), 1-41. Bethesda, MD: author.
33. Piette, J., Fleishman, J. A., Mor, V., and Thompson, B. (1992). The structure and process of AIDS Case management. *Health and Social Work*, 17, 47-56.
34. Sokal, R. R. (1974). Classification: Purposes, Principles, Progress, Prospects. *Science*, 185(4157), 1115-1123.
35. Urban Institute, The (National Center for Charitable Statistics). (2001). *Guide to the National Taxonomy of Exempt Entities*. Available: [on-line] http://nccs.urban.org/ALL_NTEE.pdf
36. Valentine, J. (1994). *Planning and Conducting Outreach Process Evaluation*. Atlanta, GA: Centers for Disease Control and Prevention.
37. Webster, G. (1984). Nomenclature and classification system development. In M. J. Kim, G. McFarland, & A. McClane (Eds.), *Classification of Nursing Diagnoses: Proceedings of the Fifth Conference*. St. Louis: Mosby. 14-25.
38. WHO (1998). *Disease Classification and Nomenclature Documents*. WHO Library: Historical Resources. Available: [on-line] <http://www.who.int/hlt/historical/English/nomenclatures.html>
39. Youth Tobacco Cessation Collaborative (YTCC). (2000). *National Blueprint for Action: Youth and Young Adult Tobacco-Use Cessation*. Washington, D.C: Center for the Advancement of Health.

Table of Contents

I.	Introduction	1
II.	Methodology – Phase I.....	1
III.	HIV Prevention Intervention Names.....	3
IV.	Levels of Specificity of Intervention Definitions.....	14
V.	Classification Structures.....	16
VI.	Methodology – Phase II	20
VII.	Analysis.....	22
	A. Individual Level Interventions (ILI)	22
	B. Group Level Interventions (GLI)	22
	C. Outreach	23
	D. Prevention Case Management (PCM).....	23
	E. Partner Counseling and Referral Services (PCRS)	24
	F. Health Communication/Public Information (HC/PI)	24
	G. Biomedical Interventions	25
	H. Community Level Interventions (CLI)	25
	I. Counseling and Testing.....	26
	J. Needle/Syringe Exchange	26
	K. “Other” Interventions	26
VII.	Summary	27
	Appendix.....	28
	Individual Level Interventions (ILI).....	33
	Group Level Interventions (GLI)	74
	Outreach	138
	Prevention Case Management (PCM).....	212
	Partner Counseling and Referral Services (PCRS)	244
	Health Communication/ Public Information (HC/PI)	259
	Biomedical Interventions	334
	Community Level Interventions (CLI)	348
	Counseling and Testing.....	380
	Needle/Syringe Exchange	423
	“Other” Interventions	440

List of Tables

Table 1. Health Department HIV Prevention Intervention Names by CDC Intervention Category.....	3
Table 2: Health Department HIV Prevention Definition Type by CDC Evaluation	15
Table 3: Number of Intervention Definitions Containing Panel Recommended Characteristics.....	21

Review of Health Department HIV Prevention Intervention Classification Schemes

I. Introduction

The Program Evaluation Research Branch of the Division of HIV/AIDS Prevention – Intervention Research and Support (DHAP-IRS) at the Centers for Disease Control and Prevention (CDC) convened an expert panel to address concerns, gain advice on, and input into the development of a national HIV/AIDS prevention intervention taxonomy.

To aid in meeting the expert panel objectives, a brief overview of findings from preliminary data abstraction was provided to participants. Various definitions of terms and key principles of taxonomy development were presented to the group. Panel members recommended additional information on key elements or features by which to organize interventions. This document describes the processes used in abstracting data and summarizes key findings by intervention type.

II. Methodology – Phase I

The FY 2001 Applications for HIV Prevention Cooperative Agreements and HIV Prevention Comprehensive Plans from the 65 jurisdictions funded by CDC were reviewed for definitions, descriptions and/or standards for HIV prevention interventions. Information included on the jurisdiction’s Health Department or Community Planning Group Web pages was also abstracted. Based on the information provided in these documents, information was coded consistently into the categories used. However, a particular jurisdiction might disagree with the interpretation or categorization of a particular intervention. For the purposes of this review, we believe that that aggregate information is consistent and well represents the state of naming conventions used for HIV prevention services in the U.S.

The categories used in classifying intervention definition types and for deconstructing intervention characteristics, were created for the purpose of this review. Developers of the interventions may disagree with the naming convention and labels used for describing the interventions and intervention components.

The data abstraction occurred in two phases. During the first phase, the intervention name, the definition’s level of specificity, and intervention type were abstracted. The following provides a detailed description of the process used by the abstractors.

- I. The jurisdiction's name for each intervention.

- II. The level of specificity by which the intervention definition was presented. A five tier system was used to differentiate these levels:
 - A. **Standards or Guidelines** – Minimum criteria or standards were included with the intervention definition
 - B. **Description** – The purpose, activities, potential setting, and/or possible methods of implementation were described in terms unique to the jurisdiction
 - C. **CDC definition** – Jurisdictions that referenced CDC Guidelines, *Evaluating CDC-Funded Health Department HIV Prevention Programs, Volume 1: Guidance* (Evaluation Guidance), or the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* (Compendium) for an intervention definition were included here.
 - D. **Goals and Objectives** – Only goals and objectives for intervention activities were given. No overall definition or description was provided for the intervention type.
 - E. **Other** – Insufficient or no information was provided about implementing the intervention.

- III. Intervention type:
 - A. Guidance Interventions – Categorization of intervention per CDC Evaluation Guidance for Health Departments typology and *The Suggested Taxonomy* (Holtgrave et al., 1994). Definitions can be found in the literature review on page 15.
 1. Individual Level Intervention (ILI)
 2. Group Level Intervention (GLI)
 3. Outreach
 4. Prevention Case Management (PCM)
 5. Partner Counseling and Referral (PCR)
 6. Health Communication/Public Information (HC/PI)
 7. Other – these interventions (see below) were included with the HIV prevention interventions in the application and comprehensive plan and included in this category because it:
 - a. did not fit into one of the other categories;
 - b. related to the organizations and individuals providing HIV prevention interventions; or
 - c. was not specifically related to HIV prevention (i.e., HIV intervention was a secondary intervention)
 - B. Other intervention types – The Evaluation Guidance taxonomy is, by design, not exhaustive. Additional categories were created based upon preliminary review of the interventions, information from the literature review and existing CDC and other governmental guidance on particular interventions. These intervention types allowed for more comprehensive coding.
 1. Biomedical Intervention (e.g., STD screening or treatment)
 2. Community Level Intervention (CLI)

3. Counseling and Testing (CT), including Counseling, Testing, Referral and Partner Notification (CTRPN)
4. Needle/Syringe Exchange
5. ‘Other’ – Additional interventions were included in the jurisdictions’ applications and comprehensive plans. An intervention is included in this category because it:
 - a. did not fit into one of the existing categories;
 - b. related to the organizations and individuals providing HIV prevention interventions; or
 - c. was not specifically related to HIV prevention (i.e., HIV intervention was a secondary intervention).

III. HIV Prevention Intervention Names

The preliminary abstraction results were presented at the Expert Panel Meeting in July 2001. One obvious finding was that intervention name varied widely across jurisdictions. *Table 1* presents the different names used and how they were classified per the CDC Evaluation Guidance definitions. Interventions were categorized into the seven general intervention types based upon our own assessment using only the documents referenced previously, and therefore, may not completely reflect how jurisdictions defined or classified the intervention. Furthermore, as the existing categories are not mutually exclusive, interventions could have possibly been reclassified into another category.

Table 1

**Health Department HIV Prevention Intervention Names
by CDC Intervention Category**

CDC Intervention Type	Local names used by health departments
<i>Individual Level Intervention</i>	
	<ul style="list-style-type: none"> • Comprehensive HIV/AIDS Prevention Education and Risk Reduction • Health Education and Risk Reduction (HE/RR) Individual Level Intervention • HIV Education and Risk Reduction Individual-Level Counseling • HIV Prevention Intervention by Physicians • Individual Drug and Alcohol Counseling • Individual Education • Individual Intervention • Individual Level Counseling • Individual Level Counseling, Testing, Referral and Partner Notification

Table 1

**Health Department HIV Prevention Intervention Names
by CDC Intervention Category**

CDC Intervention Type	Local names used by health departments
<i>(Individual Level Intervention continued)</i>	
	<ul style="list-style-type: none"> • Individual Level Education • Individual Level Intervention – Health Education • Individual Level Intervention (One-on-one client services) • Individual Level Prevention Counseling • Individual Peer Education • Individual Prevention Counseling • Individual Risk Reduction Counseling • Institution Based Programs • Motivational Interviewing Interventions • One-to-One Peer Counseling • On-site Risk Reduction Education and Counseling • Paraprofessional Counseling • Programs in Prisons • Referrals • Risk Reduction at antibody HIV Testing Sites • Risk Reduction Counseling • Skills Building (Individual Level)
<i>Group Level Intervention</i>	<ul style="list-style-type: none"> • Community Awareness Sessions • Couples Counseling • Family and Other Support System Centered Education and Counseling • Group • Group Education • Group Education Sessions – One Time • Group Education Sessions – Series • Group Health Education/Risk Reduction • Group Health Education/Risk Reduction (HE/RR) – Multiple Sessions • Group Health Education/Risk Reduction (HE/RR) – Single Session

Table 1

**Health Department HIV Prevention Intervention Names
by CDC Intervention Category**

CDC Intervention Type	Local names used by health departments
<i>(Group Level Intervention continued)</i>	
	<ul style="list-style-type: none"> • Group Intervention • Group Interventions in Non-traditional settings with linkage and coordination to existing programs • Group Level Counseling (Intervention) • Group Level Education • Group Level Health Education/Risk Reduction • Group Level Intervention – Comprehensive Health Programs (CHP) for Youth • Group Level Intervention – Group Risk Reduction Education (GRRE) • Group Level Intervention (GLI) • Group Level Intervention (GLI) – Multiple Session Group Workshop • Group Level Intervention (GLI) – Out-of-School Based Programs • Group Level Intervention (GLI) – School Based Programs • Group Level Prevention Counseling • Group Peer Education • Group Prevention & Support – Events • Group Prevention & Support – Presentations • Group Prevention & Support – Prevention support groups • Group Prevention & Support – Workshops • Group Risk Reduction Sessions with Peer and/or Non-peer Mediators • Health Education and Risk Reduction (HE/RR) Group Level Intervention • Health Education and Risk Reduction (HE/RR) Small Group Counseling • Multiple Session Group • Multiple Session HIV Prevention Workshops • Multi-Session Groups • Non-Peer Led Multiple Small Group Sessions

Table 1

**Health Department HIV Prevention Intervention Names
by CDC Intervention Category**

CDC Intervention Type	Local names used by health departments
<i>(Group Level Intervention continued)</i>	<ul style="list-style-type: none"> • Peer and Non-peer Mediated Counseling and Risk Reduction, Skills Training and Social Support in Groups • Peer Led Multiple Small Group Sessions • Presentations/Lectures • Programs in Prisons • Psycho-Educational Skills Building Groups • Risk Reduction Counseling • School Based Efforts for Youth • School Based Programs • Single Session Group • Single Session HIV Prevention Workshops • Skills Building (Group Level) • Small Group Interventions • Small Group Lecture plus Skills Training • Small Group-Level Interventions • Small/Large Group • Small-Group Education and Skills Development Trainings • Support Groups • Support Groups/Self-Help Groups/Clubs
<i>Outreach</i>	<ul style="list-style-type: none"> • Basic Street/Community Outreach • Bleach Kit Distribution • Community Level Peer and Non-peer Street and Community Outreach • Community Outreach • Community/Street Outreach • Condom Availability • Condom Distribution • Condom Distribution Program • Condoms, Other Barriers, and Bleach Demonstration and Distribution

Table 1

**Health Department HIV Prevention Intervention Names
by CDC Intervention Category**

CDC Intervention Type	Local names used by health departments
<i>(Outreach continued)</i>	<ul style="list-style-type: none">• Health Education and Risk Reduction (HE/RR) Street & Community Outreach• Institutional Outreach with On-site HIV Testing and Counseling• Intensive Street/Community Outreach• Latex and Reality Condom Distribution• Natural Opinion Leaders• Outreach• Outreach – Access to Sterile Injection Equipment• Outreach – Condoms, Latex Barriers, Bleach Distribution• Outreach – Contact• Outreach – Encounter• Outreach – Endorsements/Testimonials by Opinion Leaders• Outreach – Individual Level Intervention• Outreach – Peer Education• Outreach – Street Outreach• Outreach Interventions• Outreach Level Interventions• Outreach with Group and/or Individual• Peer and Non-peer Street and Community Outreach• Peer Driven Street Community Outreach/Social Event• Peer Led Interventions• Peer Opinion Leader in Gay Bars/Street Outreach• Peer or Non-Peer Outreach• Peer Outreach, Social Event• Peer/Natural Opinion Leader Programs• Peer-Driven Interventions• Popular Opinion Leader Intervention• Professional and/or Peer Led Outreach• Public Sex Environment Outreach• Role Models

Table 1

**Health Department HIV Prevention Intervention Names
by CDC Intervention Category**

CDC Intervention Type	Local names used by health departments
<i>(Outreach continued)</i>	<ul style="list-style-type: none">• Street and Community Level Outreach• Street and Community Outreach• Street and Community Outreach Programs• Street Outreach• Targeted Culturally Appropriate Outreach and Education• Venue Based Individual Outreach• Venue-Based Outreach
<i>Prevention Case Management</i>	<ul style="list-style-type: none">• Case Management• HIV Prevention Case Management• Prevention Case Management (PCM)
<i>Partner Counseling and Referral Services</i>	<ul style="list-style-type: none">• Case Follow-up and Partner Notification• Partner Counseling and Referral Services (PCRS)• Partner Notification• Voluntary Partner Notification
<i>Health Communication/Public Information</i>	<ul style="list-style-type: none">• AIDS Hotlines• Broad-Based Media and Education Programs• Clearinghouse• Community Level/Social Marketing• Culturally Appropriate Prevention Marketing• Education, Information and Referral Hotlines• Educational Materials• Electronic Media• Electronic and Print Media• Endorsements/Testimonials• Endorsements/Testimonials By Opinion Leaders• Group Presentations• Health Communication

Table 1

**Health Department HIV Prevention Intervention Names
by CDC Intervention Category**

CDC Intervention Type	Local names used by health departments
<i>(Health Communication/Public Information continued)</i>	
	<ul style="list-style-type: none"> • Health Communication/Public Information • Health Communication/Public Information – Print Media • Health Communication/Public Information (HC/PI) – HIV Awareness Initiatives • Health Communication/Public Information (HC/PI) – HIV Lectures • Health Communication/Public Information (HC/PI) – AIDS/HIV Information Hotline • Health Communication/Public Information (HC/PI) – Media • Health Communications/Public Information Programs • Health Education • Health/Community Fairs • Hotline/Clearinghouse • Hotlines • Hotlines and Telephone Counseling (Including TDD) • Large Group Interventions • Mass Media • Mass Media & Other Media • Media • Media Campaign • Media Events • Media Relations • Other Media • Presentations/Lectures • Public Events • Public Information • Public Information Campaign • Public Information Programs • Public Information/Social Marketing • Small/Large Group • Social Marketing

Table 1

**Health Department HIV Prevention Intervention Names
by CDC Intervention Category**

CDC Intervention Type	Local names used by health departments
<i>(Health Communication/Public Information continued)</i>	<ul style="list-style-type: none"> • Speakers Bureaus • Targetable and Mass Media • Targeted Public Information • Targeted Public Information Efforts • Telephone Hotline • Telephone Hotline and Counseling
Other Interventions	
<i>Biomedical Interventions</i>	<p>Access to STD Diagnosis and Treatment</p> <p>Methadone Maintenance</p> <p>STD Counseling, Testing and Treatment</p> <p>STD CTRPN</p> <p>STD Screening and Treatment</p> <p>STD Testing, Treatment and Prevention Counseling</p>
<i>Community Level Intervention</i>	<ul style="list-style-type: none"> • Targeted STD Outreach, Screening and Referral • Targeted STD Screening & Treatment • Community Building Events • Community Building/Popular Education approaches: • Community Events • Community Intervention • Community Intervention and Mobilizations • Community Level Activities and Events • Community Level Health Education/Risk Reduction • Community Level Interventions (CLI) • Community Level Interventions/Mobilizations • Community Mobilization • Community Planning • Community/Populations • Health/Community Fairs

Table 1

**Health Department HIV Prevention Intervention Names
by CDC Intervention Category**

CDC Intervention Type	Local names used by health departments
-----------------------	--

(Community Level Intervention continued)

- Health Education and Risk Reduction (HE/RR) Community Level Interventions
- Other Community Level Interventions
- Population Level Intervention – Community Level Interventions
- Population Level Interventions – Community Identification Process
- Public Events
- School Curricula
- Social Marketing Campaign

Counseling and Testing

- Client-Centered Counseling
- Counseling and Testing Services (CTS)
- Counseling, Testing and Referral (CTR)
- Counseling, Testing, Partner Referral and Notification
- Counseling, Testing, Referral and Partner Counseling
- Counseling, Testing, Referral and Partner Counseling and Referral Services
- Counseling, Testing, Referral and Partner Notification (CTPRN)
- Counseling, Testing, Reporting and Partner Notification
- Counseling, Testing, Referral and Partner Counseling
- HIV Counseling, Testing and Partner Referral
- HIV Counseling, Testing, Referral and Partner Counseling and Referral Services
- HIV Counseling, Testing, Referral and Partner Notification (CTPRN)
- HIV Antibody Counseling and Testing
- HIV Antibody Testing and Prevention Counseling
- HIV Counseling and Testing
- HIV Counseling, Testing and Referral Services
- HIV Counseling, Testing, and Referral Standards and Guidelines

Table 1

**Health Department HIV Prevention Intervention Names
by CDC Intervention Category**

CDC Intervention Type	Local names used by health departments
<i>(Counseling and Testing continued)</i>	<ul style="list-style-type: none"> • HIV Prevention Counseling, Testing and Referral • Mobile Field Based Counseling and Testing • Risk Assessment • School-based Clinics for HIV Testing and Prevention • Testing and Counseling/Family Centered Education • Voluntary HIV Counseling and Testing • Clinic Based HIV CTRPN (Counseling, Testing, Referral and Partner Notification) • Counseling, Testing and Partner Counseling and Referral Services • Counseling, Testing and Partner Notification • Non-Clinic Based HIV CTRPN
<i>Needle/Syringe Exchange</i>	<ul style="list-style-type: none"> • Needle Availability and Collection • Needle Exchange • Needle Exchange Programs • Needle/Syringe Exchange Programs • Syringe/Needle Exchange Programs
<i>“Other” *</i>	<ul style="list-style-type: none"> • Alcohol And Other Substance Treatment And Methadone Maintenance Programs • Behavioral Skills, Training, Safer Sex Negotiation • Capacity Building • Capacity Building – Training • Capacity Building Activities • Changing High Risk Environments • Cognitive-Behavioral Skills Training • Collaboration, Coordination, and Linkage with Other Related Programs • Distributing Condoms Without Face-to-Face Education • Distributing Educational and Awareness Raising Materials without Face-to-Face Education

Table 1

**Health Department HIV Prevention Intervention Names
by CDC Intervention Category**

CDC Intervention Type	Local names used by health departments
<i>("Other" continued) *</i>	<ul style="list-style-type: none">• Education and Training for providers• Evaluation• Evaluation of HIV Prevention Activities• Health Education/Risk Reduction• HIV Prevention Capacity Building Activities• HIV Prevention Technical Assistance Plan and Capacity Building• Institution Based Programs• Institution-Based Interventions• Limited Drop-in Services• Media Events• Minority Supplemental• Other Activities• Other Collaboration• Other Interventions• Out of School Based Programs• Peer Education• Peer Education Model• Peer Led Educational and Counseling Programs• Perinatal Transmission Prevention Activities• Policy Changes• Program Elements• Program Evaluation• Program Management• Quality Assurance• Quality Assurance and Training• Referral• Religious Support• School- Based Diversity Programs• Skills Building

Table 1

**Health Department HIV Prevention Intervention Names
by CDC Intervention Category**

CDC Intervention Type	Local names used by health departments
<i>("Other" continued) *</i>	<ul style="list-style-type: none">• Structural and Policy Interventions• Substance Abuse Treatment• Surveillance• Systemic Change• Technical Assistance• Training and Quality Assurance• Training in Harm Reduction to Outreach Workers, Substance Abuse Counselors, and Prison Staff

* *"Other"* was included with the HIV prevention interventions in the application and comprehensive plan and included in this category because it:

- 1) did not fit into one of the existing categories;
- 2) related to the organizations and individuals providing HIV prevention interventions; or
- 3) was not specifically related to HIV prevention (i.e., HIV intervention was a secondary intervention).

IV. Levels of Specificity of Intervention Definitions

Variations were also found in the level of specificity with which jurisdictions defined HIV prevention interventions. In the most detailed instances, jurisdictions provided minimum criteria or standards for implementing funded interventions. These criteria provided more operational procedures for the health departments expectations regarding each type of intervention. Others described the purpose and activities of an intervention globally, but did not delineate what constituted minimum expectations regarding that type of intervention. Some jurisdictions did not have an overall statement for the intervention, but described the intervention activities through goals and objectives for priority populations.

Across the 65 CDC-funded jurisdictions, 609 different interventions were noted (see Table 2). A detailed description was provided for 28% of the intervention. Twenty-seven percent (27%) were described through goals and objectives. Standard definitions/guidelines were seen in 25% of interventions. Approximately 9% of interventions were described utilizing CDC definitions only.

- Table 2 on next page -

Table 2

Health Department HIV Prevention Definition Type by CDC Evaluation

Intervention Type	Standards/ Guidelines	Description	CDC Definition	Goals & Objectives	Other**	Total
Individual Level Intervention	13	21	6	18	5	63
Group Level Intervention	26	22	10	18	8	84
Outreach	25	24	5	23	6	83
Prevention Case Management	11	8	4	9	4	36
Partner Counseling & Referral Services	5	2	6	3	2	18
Health Communication/Public Information	26	45	6	19	6	102
Other Interventions						
Biomedical	5	2	0	1	1	9
Community Level Interventions	13	12	1	8	10	43
Counseling & Testing	17	10	5	21	7	60
Needle/Syringe Exchange	5	6	0	1	1	13
“Other”	12	18	6	46	16	98
Total	158	170	49	167	66	609

* “Other” was included with the HIV prevention interventions in the application and comprehensive plan and included in this category because it:

- 1) did not fit into one of the existing categories;
- 2) related to the organizations and individuals providing HIV prevention interventions; or
- 3) was not specifically related to HIV prevention (i.e., HIV intervention was a secondary intervention).

** Other, as a definition type, indicates insufficient or no information provided about the intervention to classify the definition.

V. Classification Structures

The structure of classifying the interventions varied among jurisdictions. Some jurisdictions specified the interventions under a broader category. Some utilized the *Suggested Taxonomy of HIV Interventions and Treatment Services* by Holtgrave et al. (1994), while others did not have a classification structure for their interventions.

The following are a few examples of the different taxonomies or classification structures reflected in the plans and applications reviewed for this summary. These examples demonstrate the variations in how jurisdictions categorize, define, and label interventions, further justifying the need for a common, standardized, national HIV prevention intervention taxonomy. Variations in classification structures are not limited to these examples.

Example I

- I. Health Education/Risk Reduction (HE/RR)
 - A. Individual Level Intervention (ILI)
 1. Outreach
 2. Individual Level Health Education (ILHE)
 - B. Group Level Intervention (GLI)
 1. Group Risk Reduction Education (GRRE)
 2. Comprehensive Health Programs (CHP) for Youth
 - C. Population Level Intervention (PLI)
 1. Community Level Intervention (CLI)
 2. Community Identification Process
- II. Counseling, Testing and Referral
- III. Partner Counseling and Referral Services
- IV. Prevention Case Management
- V. Public Information

Example II

- I. Individual Level Interventions
 - A. Counseling and testing
 - B. HIV prevention case management (for HIV+ and HIV- persons)
 - C. Partner notification
 - D. Methadone maintenance
 - E. Individual drug/alcohol counseling
 - F. Peer counseling
 - G. Peer and non-peer outreach
 - H. Hotlines and telephone counseling (including TDD)
 - I. HIV couples counseling
 - J. HIV prevention intervention by physicians

- II. Group Level Interventions
 - A. Single session HIV prevention workshop focusing on safer sex or safer drug use
 - B. Multiple session HIV prevention workshop focusing on safer sex or safer drug use
 - C. Support groups/self help groups/clubs
- III. Community Level Interventions
 - A. Media campaigns
 - B. Social marketing, including testimonials by community members
 - C. Natural Opinion Leaders (peer testimonials or community outreach)
 - D. Interventions in (or by) institutions
 - 1. School-based clinics for HIV-testing and prevention
 - 2. Needle exchange programs
 - 3. Religious Support
 - 4. Capacity building in or between institutions or CBOs
 - 5. School curricula
 - 6. Programs in prisons
 - 7. Policy changes

Example III

- I. Counseling, Testing, Referral (CTR)
 - A. Counseling and Testing
 - 1. Enhanced/repeated post-test counseling
 - 2. Enhanced efforts to reduce post-test returning to high risk behaviors
 - B. Referral
 - 1. Sites for referral systems
 - 2. Referral systems linked to outreach programs
 - 3. Referrals to three important HIV prevention services
 - a. Early intervention
 - b. Drug treatment
 - c. Perinatal zidovudine treatment
 - C. STD Diagnosis and Treatment
- II. Partner Counseling and Referral Services
- III. Health Education Risk Reduction
 - A. Individual Level Interventions (ILI)
 - B. Prevention Case Management (PCM)
 - C. Group Level Intervention (GLI)
 - 1. Multiple Session Group Workshops
 - 2. School Based Programs
 - 3. Out-of-School Based Programs
 - D. Outreach
 - 1. Peer Education
 - a. Endorsements/Testimonials by Opinion Leaders
 - b. Street Outreach
 - c. Condoms, Latex Barriers, Bleach Distribution

- 2. Access to Sterile Injection Equipment
- IV. Health Communication/Public Information
 - A. Electronic
 - B. Print Media
 - C. Targetable Media
 - 1. Mass Media
 - 2. Education, Information and Referral Hotlines
 - D. Presentations/Lectures
- V. Community Level Interventions (CLI)
 - A. Speaking Bureaus
 - B. Social Marketing
 - C. Public Events
 - D. Policy Interventions
 - E. Structural Interventions

Example IV

- I. Individual
 - A. STD/HIV Behavioral Counseling
 - B. Skills Building
 - C. Supplying Condoms
 - D. Partner notification
 - E. Clinical Services
 - 1. STD Screening and Treatment
 - 2. HIV Counseling and Testing
- II. Group:
 - A. Group Education
 - B. Facilitated Group Behavioral Counseling
 - C. Peer Programs
 - D. Skills Building Sessions
 - E. Educational Theatre
- III. Community/Population:
 - A. Social Marketing
 - 1. Mass Media Campaigns
 - 2. Small Media
 - B. Mobile units – STD/HIV screening
 - C. Role Model Stories
 - D. Needle Exchange
 - E. Condom Distribution
 - F. Gatekeepers/Social Leaders – Diffusion
 - G. Street Outreach
 - H. Capacity Building/Infrastructure Development
 - I. Community Development
 - J. Policy/Procedure Change
 - K. Legislative change

Example V

- I. Health Education/Risk Reduction
 - A. Individual Level Interventions – both professionally led and peer led including:
 1. Behavior Change, Risk Reduction/Harm Reduction Counseling
 2. Skills Training
 3. HIV Prevention Counseling and Testing, Referral and Partner Notification
 4. Prevention Case Management
 5. Secondary Prevention Efforts
 - B. Group Level Interventions – both professionally led and peer led including:
 1. Behavior Change, Risk Reduction/Harm Reduction Counseling
 2. Skills Training
 3. Secondary Prevention Effort
 - C. Outreach Interventions – including those appropriate for individuals and groups at the following locations:
 1. Street
 2. Community
 3. Public Sex Environments
 4. Institutions
 - D. Community Level Interventions – designed to change norms, attitudes and practices of the community
 1. Community Building Efforts for Social Networks
- II. Health Communications/Public Information Programs
 - A. Mass Media Efforts
 - B. Small Media Efforts
 - C. Social Marketing Efforts
 - D. Hotlines and Clearinghouses
- III. Systematic Change
 - A. Systems Interventions
 1. Policy Changes
 2. Legal Changes
- IV. Program Elements
 - A. Needs Assessment Efforts
 - B. Capacity Building
 1. Training of staff
 2. Technical Assistance
 - C. Program Design and Development
 1. Goals and Measurable Objectives for Behavior Change
 2. Program Evaluation
 3. Maintenance

VI. Methodology – Phase II

At the meeting, expert panel participants identified a list of features or characteristics of an intervention. From the list, six characteristics, *duration/dosage*, *venue*, *provider*, *target population*, *level*, and *outcome*, were recommended to be the most pertinent in describing and distinguishing interventions. ORC Macro staff recommended an additional category of *mode* to capture the means by which an intervention was implemented. Preliminary reviews of the abstracted intervention definitions revealed mode to consist of the method of delivery and the level of structure for delivery. The intervention elements and standards abstracted were:

1. Duration/Dosage
2. Mode
 - a. Method of delivery
 - i. Health education
 - ii. Counseling
 - iii. Health communication/public information
 - iv. Biomedical (e.g., screening/testing, medical care)
 - v. Community mobilization
 - vi. Needle/syringe exchange
 - b. Level of structure for the intervention
 - i. Structured – using an approved curriculum, a presentation
 - ii. Semi-structured – intervention utilizing some predefined curriculum or set of activities, but with flexibility to address issues and concerns of the target audience.
 - iii. Minimally structured – the course of the intervention is determined by the participant(s)
3. Venue (e.g., clinic, community, schools, etc.)
4. Provider – Professional, paraprofessional (non-peer), or peer
5. Target Population
6. Level – Individual, Couple, Group, or Community
7. Outcome – Biomedical, Behavioral, Structural (Policy, Environmental interventions, etc), Health Education
8. Other – a catchall category for those criteria or features not captured by the designated elements, but would differentiate the intervention from another.

In the second phase of data abstraction, interventions deemed to have an operational/standardized or descriptive definition (328 of the 609) were reviewed for criteria of the recommended intervention elements and standards. Expert panel members had suggested six particular characteristics as being the most critical features of an intervention. An ‘other’ category was added to capture other criteria related to the implementation of the intervention, interventions directed at the agency or individuals providing the service and those few interventions that did not fit into any of the predefined categories. The number of interventions that included standards or descriptions for particular elements is shown in Table 3.

Broadly, *Mode* was the feature most frequently included in the intervention definitions. Only 97 definitions had a minimum *Duration/Dosage* described. Additional analysis of the features by intervention type is provided in the analysis section beginning on page 22.

Table 3

Number of Intervention Definitions Containing Panel Recommended Characteristics

Intervention Type	N ¹	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other [‡]
Individual Level Intervention	34	12	13	32	18	31	32	10	20
Group Level Intervention ²	48	33	24	47	33	47	47	21	34
Outreach	49	14	43	47	34	47	39	26	39
Prevention Case Management	19	12	6	17	9	15	18	12	7
Partner Counseling & Referral Services	7	2	3	7	5	7	7	5	4
Health Communication/Public Information ²	71	11	15	65	11	64	52	3	14
Other Interventions									
Biomedical	7	1	5	7	3	6	3	4	4
Community Level Intervention	24	4	22	22	7	20	23	4	45
Counseling & Testing	27	6	13	26	14	25	24	4	3
Needle/Syringe Exchange	11	1	5	11	4	8	6	11	8
“Other” *	31	1	13	24	6	17	13	14	10
Total	328	97	162	305	144	287	264	114	188

* “Other” was included with the HIV prevention interventions in the application and comprehensive plan and included in this category because it:

- 1) did not fit into one of the existing categories;
- 2) related to the organizations and individuals providing HIV prevention interventions; or
- 3) was not specifically related to HIV prevention (i.e., HIV intervention was a secondary intervention).

‡ The characteristic category of “Other” was intended to be at catchall category for those intervention characteristics not captured by the designated elements, but that were deemed to be potentially important for future taxonomy development. Examples include “includes a skills-building component” or “compliance with local or state laws or codes.”

¹ N refers to the number of intervention definitions from the categories “Standards/Guidelines” and “Descriptions” that have referenced at least one of the panel-identified characteristics. Table 2 shows that these two categories contained 334 definitions; therefore, only 14 definitions did not contain at least one of these characteristics.

² One intervention was categorized as both a group level and HC/PI intervention.

VII. Analysis

Three hundred twenty-eight interventions had definitions classified as standards/guidelines or description; these interventions were further dissected to identify the criteria, standards or recommendations for the features specified by the expert panel. Mode, Level and Outcome were the most frequently described feature among all interventions. Target Population was one of the features least mentioned within the definition. However, discussions of target populations were included in other areas of the jurisdictions' applications and comprehensive plans.

The intended type of outcome was the most frequently addressed in the intervention feature. Biomedical outcomes such as screening and treatment of STDs, behavioral risk reduction (i.e., behavioral outcomes), health education, and social, political and environmental changes were the types of outcomes anticipated from particular interventions. A standard for target population(s) was the axis least mentioned in intervention definitions. This may be because populations are focused upon in the prioritization process.

The appendix contains tables and text indicating evidence of descriptions or standards addressing particular intervention elements for each intervention type. Following the table is a listing of the intervention definition with a breakdown of the individual components. A listing of the standards for each element is also included. A more detailed discussion of the features by intervention type is presented below (*note*: the number in parentheses indicates the number of interventions including that element in their intervention definition).

A. Individual Level Interventions (ILI)

Thirty-four individual level interventions had at least one feature addressed in its definition. The number of features included in a definition ranged from two to eight. Mode and Level were the most commonly addressed elements (32 interventions each). Health education and counseling were the primary modes described for individual level interventions. Thirty of the thirty-two ILIs were noted as being individual level only. One intervention was described as being both individual and group level and another as both individual level and for couples. Outcome was the next most commonly mentioned feature for ILI. Thirty definitions described the outcome as behaviorally based; one was identified with a biomedical outcome. The least mentioned feature was Target Population (10). Other criteria, standards or recommendations included skills building and facilitation of linkages and referrals. ILIs were also described as being interactive.

B. Group Level Interventions (GLI)

Definitions for 48 group level interventions were provided criteria, standards or recommendations for at least one of the identified features. At a minimum, an intervention referenced four features; some addressed all eight. Target Population was

least mentioned among GLI definitions. Mode, Outcome, and Level were each discussed by 47 interventions. Health education and counseling, both with varying levels of structure, were the primary modes for this intervention type; workshops were also mentioned. All 47 GLI definitions identified the anticipated outcome as behavioral. As indicated by its name, the majority of interventions were described as group level. Some definitions included that groups could be “of varying sizes”, while others were more specific in stating, “2 or more” or “4 – 12 individuals”. For those interventions specifying the amount of people, groups were always defined as comprised of 20 or fewer individuals. (Any intervention comprising of more than 20 people were considered as either a community level or health communication/public information intervention). Other criteria, standards or recommendations included skills building as a requirement or recommendation; 28 of the 34 definitions included skills building. Also included in this feature category was the ‘use of an approved curriculum’ and having a culturally and linguistically appropriate intervention.

C. Outreach

Forty-nine outreach intervention definitions described criteria, standards or recommendations for at least one feature; the fewest number of features described per intervention was two. Mode and Outcome were each addressed by 47 of the intervention definitions. Many of these described the mode as “outreach”; this often included distribution of supplies or materials with some basic information. Some interventions were more structured by including specific health education or skills building with the distribution of materials. Semi- or minimally structured health education or health education/public information were the main modes for peer or natural opinion leader interventions. Behavioral outcomes were identified for all but two of the outreach interventions. One intervention included both outcomes of behavior change and information; another was information only. Only four intervention definitions for this intervention type referenced Duration/Dosage. The level of implementation for this intervention was primarily at the individual level, but some also described it at the group or community level. Peers were the most commonly described types of Provider; however, professionals and paraprofessionals were also included. Criteria and recommendations for content and activities for knowledge and motivation to promote risk reduction, and peer training and qualifications were also included (as Other) in outreach definitions.

D. Prevention Case Management (PCM)

For the 19 definitions of PCM, the number of features addressed per intervention ranged from one to eight. Eighteen definitions discussed Level, all of which identified PCM as individual level. One jurisdiction also included couples in its definition. Case management, which includes counseling in addition to referrals and brokerage of services, was identified as the Mode for the 17 definitions that addressed this feature. The identified Outcome was behavioral (15). The Duration/Dosage of PCM was often described as an “on-going” relationship between the client and case manager. PCM is to

be implemented by a professional case manager. Venue was the least mentioned feature (6). Other criteria, standards or recommendations included the provision of referrals, skills building, and evaluation and data collection requirements.

Few jurisdictions had their own definition for prevention case management (PCM) because many cited the CDC's HIV Prevention Case Management: Guidance; some included additional guidelines or recommendations in addition to those put forth by the CDC. The guidelines also account for much of the similarity of criteria or recommendations within a feature.

E. Partner Counseling and Referral Services (PCRS)

Seven interventions for partner counseling and referral services had at least one feature addressed in its definition. The number of features included in a definition ranged from three to seven. Mode, Outcome and Level were the most commonly addressed feature (7 interventions each). Counseling, of varying structure and biomedical activities, was the primary mode described for PCRS. All PCRS interventions were described as being individual level only. One intervention was described as for both individuals and couples. Outcome was noted as being biomedical (5) and/or behaviorally based (6). High-risk individuals and sex and needle-sharing partners of HIV positive persons were the specified Target Population. Those definitions addressing venue described PCRS taking place in a variety of settings. The least referenced feature was Duration/Dosage (2), which stated PCRS should be on-going. Other criteria, standards or recommendations included compliance with state or local codes and client consent.

Similar to PCM, few jurisdictions had their own definition for PCRS because many cited the CDC's HIV Partner Counseling and Referral Services: Guidance; some included additional guidelines or recommendations in addition to those put forth by the CDC. The guidelines also account for some of the similarity of criteria or recommendations within a feature.

F. Health Communication/Public Information (HC/PI)

Criteria, standards or recommendations for at least one feature were provided for 71 health communication/public information (HC/PI) interventions. A minimum of one and a maximum of seven features were referenced per intervention definition. Mode (65) and Outcome (64) were most frequently described in HC/PI definitions. The modes mentioned varied from print and electronic media to hotlines and presentations. Others were just the presentation of information (labeled as 'health communication/public information' in the feature breakdown). The Duration/Dosage for those intervention definitions with modes of media or health communication/public information was described as repetitive or on-going. Presentations and hotlines were usually described as one-time events. The primary outcome was identified as behavioral; some were information. The types of Venues and Providers described were varied. Target Population was the least mentioned feature (3). Both definitions described the target

population as the general public or a specific sub-population. Other criteria, standards or recommendations included content areas and skills building. The use of commercial marketing techniques (e.g., engaging the audience, being culturally appropriate, etc.) was recommended for media and health communication/public information interventions. Recommendations and criteria for hotlines also included the interactive nature of the intervention and staff training.

G. Biomedical Interventions

Seven biomedical interventions included at least one feature in its definition. There was a minimum of two features per intervention definition for this intervention type. One intervention had criteria or recommendations for all eight features. Six of the interventions related to screening and treatment of STDs. The other was a methadone maintenance intervention. Mode and Outcome were the most frequently addressed features. The mode for all seven interventions was biomedical (i.e., medical screening and treatment); one definition also included outreach activities. Biomedical outcomes were described for all seven interventions as well. Behavioral outcome was also addressed in one jurisdiction's definition. Only one definition addressed Duration/Dosage, stating it clients should have "regular access to STD screening/clinical care." Other criteria, standards or recommendations for biomedical interventions were related to compliance with state or local codes (2) and the coordination of STD screening and treatment with the other activities, such as outreach or other HIV prevention interventions.

H. Community Level Interventions (CLI)

Twenty-four community level interventions had evidence of addressing at least one of the identified features. The range went from two features per intervention definition up through eight. Level was the most frequently address feature for this intervention type. As indicated by its name, the majority of interventions were described as community level. Two jurisdictions' also included groups in their definition. Mode (22) included community mobilization activities, material distribution with minimal health education, media, and policy changes. Outcomes also varied from behavioral to structural. The types of venue (22) described were community settings or public events, including health fairs. Duration/Dosage and Target Population were mentioned the least (4 each). Other criteria, standards or recommendations included the involvement of community members and design and implementation of interventions based on research. Some definitions also indicated that the purpose of CLIs is to influence the overall community or sub-population's norms and attitudes, not individual behavior.

Note: The premise of most community mobilization interventions is best summarized as an attempt to influence the community's environment, norms and attitudes to be more acceptable and amenable to risk reduction behaviors through media, health education, and health communication/public information. Changes in the political, social and physical community will eventually lead to changes at the individual level.

I. Counseling and Testing

Twenty-seven counseling and testing intervention definitions described criteria, standards or recommendations for at least one feature; the fewest number of features described per intervention was two. Mode and Outcome were most frequently addressed in the intervention definitions (26 and 25, respectively). The modes described were usually a combination of structured or semi-structured counseling and biomedical testing. Some interventions also included material distribution as part of the intervention. Behavioral and biomedical outcomes were identified. The level of implementation for this intervention was primarily at the individual level except for one, which was described at a community level. Duration/Dosage was addressed in six of the intervention definitions. This intervention was described as targeting high-risk individuals and populations (5). All definitions described the provider as a professional. One jurisdiction was very specific in terms of testing from time of exposure through posttest counseling and recommendations for follow-up testing for those who tested negative. Few ‘other’ criteria, standards or recommendations were identified (5). These included compliance with state or local codes, critical components and recommendations for follow-up testing and counseling.

J. Needle/Syringe Exchange

Eleven needle/syringe exchange definitions addressed at least one of the identified intervention features. The number of features per intervention ranged from three to eight. Mode and Target Population were mentioned in all the definitions. The collection of old needles or syringes in exchange for new ones (i.e., needle/syringe exchange) was the mode for all. Some jurisdictions also combined needle/syringe exchange with health education and counseling. The target population was substance abusers, primarily IDUs. Providers of this intervention varied from peer and volunteers to community based organizations to staff of the state health department. Duration/Dosage was only addressed by one jurisdiction’s definition. Other criteria, standards or recommendations included collaboration with other HIV prevention activities, such as health education or outreach, mainly as a requirement for funding. Also included in this category were requirements or recommendations related to the provision of referrals and staff training.

K. “Other” Interventions

Thirty-one additional interventions with descriptive definitions, standards or guidelines were identified as addressing at least one of the intervention features. Intervention definitions provided criteria, standards or recommendations for at least one, and up to six features. Mode, consisting primarily with capacity building, training and technical assistance, and evaluation, was the most commonly referenced feature (24). Duration/Dosage was discussed in only one intervention definition. Other criteria or recommendations included content for activities and materials to help empower organizations provide better services.

VIII. Summary

The review of the FY 2001 Cooperative Agreement Applications and Comprehensive Plans and jurisdictions' web sites revealed wide variation in the ways jurisdictions organize and define interventions. Of the interventions reviewed, approximately one-half provided detailed descriptions or standard, operational definitions. Discrepancies were also found in the criteria or standards for each intervention element. The inconsistency in definitions and classification structure complicate efforts to refine effective interventions, provide technical assistance, support development and improvement of interventions, and evaluate HIV prevention interventions.

Appendix

The following can be found for each intervention category:

- a. A matrix of the intervention characteristics reflected in a definition for each specific intervention.
- b. A listing of the evidence abstracted from the definitions for each intervention component.
- c. The definition of the intervention as presented by the jurisdiction, including a breakdown of the features.

Note:

- Each intervention is included under its respective intervention type.
 - Small/Large Group (MD) is included in both the group level and health communication/public information interventions
- The code associated with each intervention refers to the jurisdiction. State abbreviations are used. The following abbreviations were used for funded territories and municipalities included in this document:
 - CH = Chicago
 - HO = Houston
 - VI = U.S. Virgin Island
- All text, including citations, are direct quotes from the jurisdictions' application, comprehensive plan, or web site. Abstractors' notes are italicized.

Contents:

Individual Level Interventions (ILI)	33
The Number of Intervention Characteristics by Each Individual Level Intervention (ILI)	
34	
Individual Level Interventions (ILI) – Listing of Evidence by Intervention Characteristic	
37	
Duration/Dosage:	37
Venue:	37
Mode:	38
Provider:	40
Outcome:	41
Level:	41
Target Population:	41
Other:	42
Jurisdictions’ Definitions of Individual Level Interventions	44
Group Level Interventions (GLI)	74
The Number of Intervention Characteristics by Each Group Level Intervention	75
Group Level Interventions – Listing of Evidence by Intervention Characteristic	78
Duration/Dosage:	78
Venue:	79
Mode:	81
Provider:	84
Outcome:	85
Level:	85
Target Population:	87
Other:	89
Jurisdictions’ Definitions of Group Level Interventions	92
Outreach	138
The Number of Intervention Characteristics by Each Outreach Intervention	139
Outreach – Listing of Evidence by Intervention Characteristic	142
Duration/Dosage:	142
Venue:	143
Mode:	145
Provider:	148
Outcome:	149
Level:	149
Target Population:	151
Other:	152
Jurisdictions’ Definitions of Outreach	158
Prevention Case Management (PCM)	212
The Number of Intervention Characteristics by Each Prevention Case Management (PCM)	
Intervention	213

Prevention Case Management (PCM) – Listing of Evidence by Intervention Characteristic	215
Duration/Dosage:	215
Venue:	215
Mode:	216
Provider:	216
Outcome:	216
Level:	216
Target Population:	217
Other:	218
Jurisdictions’ Definitions of Prevention Case Management (PCM)	220
Partner Counseling and Referral Services (PCRS)	244
The Number of Intervention Characteristics by Each Partner Counseling and Referral Service (PCRS) Intervention	245
Partner Counseling & Referral Services (PCRS) – Listing of Evidence by Intervention Characteristic	246
Duration/Dosage:	246
Venue:	246
Mode:	246
Provider:	247
Outcome:	247
Level:	247
Target Population:	248
Other:	248
Jurisdictions’ Definitions of Partner Counseling & Referral Services (PCRS)	250
Health Communication/ Public Information (HC/PI)	259
The Number of Intervention Characteristics by Each Health Communication/Public Information Intervention	260
Health Communication/Public Information – Listing of Evidence by Intervention Characteristic	265
Duration/Dosage:	265
Venue:	265
Mode:	266
Provider:	269
Outcome:	269
Level:	270
Target Population:	272
Other:	273
Jurisdictions’ Definitions of Health Communication/ Public Information	275
Biomedical Interventions	334
The Number of Intervention Characteristics by Each Biomedical Intervention	335
Biomedical Interventions	336
Duration/Dosage:	336

Venue:	336
Mode:	336
Provider:	337
Outcome:	337
Level:	337
Target Population:	337
Other:	338
Jurisdictions' Definitions of Biomedical Interventions	339
Community Level Interventions (CLI)	348
The Number of Intervention Characteristics by Each Community Level Intervention	349
Community Level Interventions (CLI) – Listing of Evidence by Intervention Characteristic	351
Duration/Dosage:	351
Venue:	351
Mode:	352
Provider:	353
Outcome:	354
Level:	354
Target Population:	355
Other:	355
Jurisdictions' Definitions of Community Level Interventions (CLI).....	358
Counseling and Testing	380
The Number of Intervention Characteristics by Each Counseling and Testing Intervention	381
Counseling and Testing – Listing of Evidence by Intervention Characteristic.....	384
Duration/Dosage:	384
Venue:	384
Mode:	385
Provider:	387
Outcome:	387
Level:	389
Target Population:	390
Other:	391
Jurisdictions' Definitions of Counseling and Testing	392
Needle/Syringe Exchange	423
The Number of Intervention Characteristics by Each Needle/Syringe Exchange	
Intervention	424
Needle/Syringe Exchange – Listing of Evidence by Intervention Characteristic	425
Duration/Dosage:	425
Venue:	425
Mode:	425
Provider:	426
Outcome:	426

Level:.....	426
Target Population:	426
Other:.....	427
Jurisdictions’ Definitions of Needle/Syringe Exchange Programs	429
“Other”	440
The Number of Intervention Characteristics by “Other” Interventions	441
“Other” – Listing of Evidence by Intervention Characteristic	443
Duration/Dosage:	443
Venue:	443
Mode:	444
Provider:	445
Outcome:	445
Level:.....	446
Target Population:	446
Other:.....	447
Jurisdictions’ Definitions of “Other” Interventions	449

Individual Level Interventions (ILI)

The Number of Intervention Characteristics by Each Individual Level Intervention (ILI)

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Individual Health Education/Risk Reduction (HE/RR)	AK			✓	✓	✓	✓		✓	5
Individual Peer Education	CA			✓	✓	✓	✓			4
On-site Risk Reduction Education and Counseling	CA		✓	✓		✓	✓			4
Individual Level Intervention	CH	✓	✓	✓		✓	✓			5
Individual Level Intervention – Health Education	CO	✓	✓	✓	✓	✓	✓	✓	✓	8
Individual Drug and Alcohol Counseling	CT		✓	✓		✓	✓			4
Programs in Prisons	CT		✓			✓	✓	✓		4
HIV Prevention Intervention by Physicians	CT		✓	✓	✓	✓	✓			5
One-to-One Peer Counseling	CT		✓	✓	✓	✓	✓	✓	✓	7
Motivational Interviewing Interventions	CT	✓		✓	✓	✓	✓		✓	6
Individual Prevention Counseling	DC	✓	✓	✓	✓	✓	✓			6
Individual Level Intervention	DC		✓	✓	✓	✓	✓	✓		6

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
HIV Education and Risk Reduction Individual-Level Counseling	HO			✓		✓	✓		✓	4
Individual Level Intervention (ILI)	IA	✓		✓		✓	✓		✓	5
Individual Level Intervention	ID			✓		✓	✓	✓	✓	5
Risk Reduction Counseling	IL	✓	✓	✓	✓	✓	✓	✓		7
Individual Level Intervention (One-on-one client services)	KS	✓		✓	✓	✓	✓	✓	✓	7
Individual Level Intervention	MD	✓		✓		✓	✓			4
Individual Level Intervention	ME			✓	✓	✓			✓	4
Referral	MI			✓			✓			2
Individual Level Prevention Counseling	MI	✓		✓			✓			3
Institution Based Programs	MN	✓	✓		✓					3
Individual Level Education	MN			✓	✓	✓	✓	✓		5
Individual Level Intervention	MO			✓		✓	✓		✓	4
Risk Reduction/Counseling	NC		✓	✓		✓	✓		✓	5
Individual Counseling	NH	✓		✓	✓	✓	✓		✓	6
Individual Level Intervention	OK			✓		✓	✓		✓	4

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Individual Level Intervention	SC			✓		✓	✓	✓	✓	5
Individual Level Intervention	SD			✓		✓	✓		✓	4
Individual Level Counseling	TN			✓	✓	✓	✓		✓	5
Individual Level Intervention	TX			✓	✓	✓	✓	✓	✓	6
Referrals	TX	✓	✓	✓	✓	✓	✓		✓	7
Individual Level Intervention	VA			✓		✓	✓		✓	4
Individual Level Intervention (ILI)	WI			✓	✓	✓	✓		✓	5
TOTAL (N = 34)		12	13	32	18	31	32	10	20	170

✓ Indicates that evidence of the intervention characteristic was found in reviewing the FY 2001 Cooperative Agreement Applications and Comprehensive Plans and Web sites. Definitions or guidelines addressing these elements may exist in other documentation not reviewed for this study.

Individual Level Interventions (ILI) – Listing of Evidence by Intervention Characteristic

Duration/Dosage:

	Intervention Name:	Evidence of Intervention Characteristic:
CH	Individual Level Intervention	Often sporadic, but part of an ongoing relationship Of sufficient length to informally assess clients needs
CO	Individual Level Intervention – Health Education	Short-term, but more than one session
CT	Motivational Interviewing Interventions	Brief with follow-ups
DC	Individual Prevention Counseling	One-time
IA	Individual Level Intervention (ILI)	One-time
IL	Risk Reduction Counseling	Short-term, possible follow-ups
KS	Individual Level Intervention (One-on-one client services)	On-going
MD	Individual Level Intervention	On-going
MI	Individual Level Prevention Counseling	Single session
MN	Institution Based Programs	Comprehensive or single session
NH	Individual Counseling	Usually weekly, brief period of sessions
TX	Referrals	On-going

Venue:

	Intervention Name:	Evidence of Intervention Characteristic:
CA	On-site Risk Reduction Education and Counseling	Sites where people formally congregate for purposes other than HIV prevention, such as drug treatment centers, work sites or social welfare offices.
CH	Individual Level Intervention	Space [that] is private and conducive to private/personal discussions
CO	Individual Level Intervention – Health Education	Clinic or agency setting in the context of other services, or other setting
CT	Programs in Prisons	Jail/prison

CT	Individual Drug and Alcohol Counseling	Drug treatment facility, a detoxification facility, or an outpatient basis at public health clinics or private clinics.
CT	One-to-One Peer Counseling	Within the context of an HIV prevention intervention setting (e.g., high school class or prison group)
CT	HIV Prevention Intervention by Physicians	Health care facility/clinic
DC	Individual Level Intervention	Where HIV high-risk individuals congregate
DC	Individual Prevention Counseling	Sites where individuals at risk for HIV congregate for purposes other than receiving HIV prevention or education
IL	Risk Reduction Counseling	Any setting that allows for confidential, one-on-one conversation
MN	Institution Based Programs	Schools, worksites, or other institutions such as prisons, group homes, etc.
NC	Risk Reduction/Counseling	Sites where people at risk formally congregate (e.g. clinics, drug treatment ctrs)
TX	Referrals	Health care facility/clinic

Mode:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Individual Health Education/Risk Reduction (HE/RR)	Health education – semi-structured Counseling – semi-structured
CA	Individual Peer Education	Counseling Health education
CA	On-site Risk Reduction Education and Counseling	Health education Counseling
CH	Individual Level Intervention	Health education – semi-structured Counseling – semi-structured or minimally structured
CO	Individual Level Intervention – Health Education	Health education – structured or semi-structured
CT	Motivational Interviewing Interventions	Counseling – structured

CT	HIV Prevention Intervention by Physicians	Health education – minimally structured
CT	One-to-One Peer Counseling	Counseling – semi-structured or minimally structured
CT	Individual Drug and Alcohol Counseling	Counseling – structured
DC	Individual Prevention Counseling	Counseling Health education
DC	Individual Level Intervention	Counseling
HO	HIV Education and Risk Reduction Individual-Level Counseling	Counseling – semi-structured Health education -semi-structured
IA	Individual Level Intervention (ILI)	Counseling – semi-structured
ID	Individual Level Intervention	Counseling – minimally structured
IL	Risk Reduction Counseling	Health education – structured or semi-structured Counseling – semi structured or minimally-structured
KS	Individual Level Intervention (One-on-one client services)	Case management- semi-structured Counseling – semi structured
MD	Individual Level Intervention	Counseling – semi-structured
ME	Individual Level Intervention	Counseling – structured or semi-structured
MI	Referral	Referral – minimally structured
MI	Individual Level Prevention Counseling	Counseling – minimally structured
MN	Individual Level Education	Counseling – semi-structured
MO	Individual Level Intervention	Counseling – semi-structured
NC	Risk Reduction/Counseling	Counseling – semi-structured
NH	Individual Counseling	Counseling – Semi- structured
OK	Individual Level Intervention	Counseling – semi-structr ed or minimally structured Health education – semi-structred or minimally structured
SC	Individual Level Intervention	Counseling – structured or semi-structured

SD	Individual Level Intervention	Counseling – semi-structured or minimally structured Health education – semi-structured or minimally structured
TN	Individual Level Counseling	Counseling – semi-structured Health education – semi-structured
TX	Individual Level Intervention	Counseling – minimally structured Health Education – structured or semi-structured Biomedical
TX	Referrals	Referral – structured
VA	Individual Level Intervention	Health education – structured, semi-structured, or minimally structured
WI	Individual Level Intervention (ILI)	Counseling – structured

Provider:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Individual Health Education/Risk Reduction (HE/RR)	Professional
CA	Individual Peer Education	Peer
CO	Individual Level Intervention – Health Education	Professional, Peer
CT	One-to-One Peer Counseling	Peer
CT	Motivational Interviewing Interventions	Professional
CT	HIV Prevention Intervention by Physicians	Professional
DC	Individual Level Intervention	Peer, Non-peer
DC	Individual Prevention Counseling	Peer, Non-peer
IL	Risk Reduction Counseling	Professional, Peer
KS	Individual Level Intervention (One-on-one client services)	Peer
ME	Individual Level Intervention	Professional, Peer
MN	Individual Level Education	Peer, Non-peer
MN	Institution Based Programs	Peer, Non peer
NH	Individual Counseling	Professional

TN	Individual Level Counseling	Peer, Non-peer
TX	Individual Level Intervention	Peer
TX	Referrals	Professional
WI	Individual Level Intervention (ILI)	Service provider

Outcome:

Thirty of the thirty-one individual level interventions with standards or definitions addressing outcomes indicated the anticipated outcome as behavioral. *Referrals* (TX) was the only intervention that mentioned a biomedical outcome.

Level:

Thirty-two individual level interventions with standards or definitions addressed level. Thirty of those were stated as being individual. Two interventions were identified as being implemented for one (individual), two (couple), or more (group) persons.

	Intervention Name:	Evidence of Intervention Characteristic:
CT	Programs in Prisons	Individual, Group
IL	Risk Reduction Counseling	Individual, Couple

Target Population:

	Intervention Name:	Evidence of Intervention Characteristic:
CO	Individual Level Intervention – Health Education	Individuals who are at high-risk for getting or spreading HIV infection.
CT	Programs in Prisons	High-risk incarcerated individuals
CT	One-to-One Peer Counseling	Drug users, African-Americans (African-American women), Latino/as, young people
DC	Individual Level Intervention	MSM, couples, pregnant women, youth,
ID	Individual Level Intervention	MSM, IDUs or Women at-risk
IL	Risk Reduction Counseling	High-risk individuals
KS	Individual Level Intervention (One-on-one client services)	HIV positive individuals and their partners
MN	Individual Level Education	IDUs
SC	Individual Level Intervention	High-risk of becoming infected with or transmitting HIV

TX Individual Level Intervention High-risk of becoming infected or transmitting the virus

Other:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Individual Health Education/Risk Reduction (HE/RR)	Includes skill building.
CO	Individual Level Intervention – Health Education	Includes skill building.
CT	One-to-One Peer Counseling	May include skills building.
CT	Motivational Interviewing Interventions	Counselor helps to increase the patient's self-efficacy for performing all the behaviors necessary to make the change they have selected.
HO	HIV Education and Risk Reduction Individual-Level Counseling	Personalized, interactive, intensive and private intervention to an individual.
IA	Individual Level Intervention (ILI)	Involves a wide range of skills, information, and support.
ID	Individual Level Intervention	Includes skills component.
KS	Individual Level Intervention (One-on-one client services)	Skills training.
ME	Individual Level Intervention	Skills training.
MO	Individual Level Intervention	Conducted during counseling and testing; skills building component. Includes Prevention Case Management.
NC	Risk Reduction/Counseling	Not linked to Counseling, Testing, Referral, & Partner Notification (CTRPN). Includes negotiation skills and skills to sustain appropriate behavior changes.
NH	Individual Counseling	Work on behavior change goals over a brief period of sessions. Differs from case management in that client does not need additional supports and referrals.
OK	Individual Level Intervention	Skills training.

SC	Individual Level Intervention	Facilitate linkages to services in clinic and community settings in support of behaviors and practices that prevent the transmission of HIV.
SD	Individual Level Intervention	Skills training. Facilitates linkages to services that support behaviors and practices that prevent the transmission of HIV.
TN	Individual Level Counseling	Includes skill building
TX	Individual Level Intervention	Skills development
TX	Referrals	Contractors must document that all HIV seropositive clients are given a formal and trackables referral to early intervention services through local HIV services providers. Required to provide key referral linkages including, but not limited to , STD screening and treatment, TB testing and treatment, substance abuse assessment, counseling and treatment, etc.
VA	Individual Level Intervention	Skills building component. Facilitate linkages to services in both clinic & community settings.
WI	Individual Level Intervention (ILI)	Includes skills building. Service provider must gain enough trust to learn about client's risk and to teach some risk reduction. Not Prevention Case Management or Outreach Considered an interaction.

Jurisdictions' Definitions of Individual Level Interventions

Individual Health Education/Risk Reduction (HE/RR) (AK)

One-on-one, in person, client centered HIV risk assessment and risk reduction counseling that is not an outreach encounter nor Prevention Case Management and is not done in the context of HIV testing. It can be a single session or multiple sessions with the same client

Characteristics of Effective Interventions” and additional information such as applicable target populations, prevention goal, essential components, behavioral/social science, and evidence for effectiveness for Individual HE/RR

- App. target populations: Heterosexual adults, High-risk youth
- Prevention Goal: Reduce unsafe sexual behaviors; increase condom use
- Essential components: Individualized, interactive, client-centered, risk reduction counseling and skill building
- Behavioral/social science theoretical basis: Theory of Reasoned Action and Social Cognitive Theory

Duration/Dosage:

Venue:

Mode: Health education – semi-structured
Counseling – semi-structured

Provider: Professional

Outcome: Behavioral

Level: Individual

Target Population:

Other: Includes skill building

Individual Peer Education (CA)

Program Category 1: Individual-Level Interventions

Individual level interventions provide information, risk assessment, and risk reduction counseling to assist individuals to learn about transmission and risk behaviors, make plans for individual behavior change and ongoing appraisal of their own behaviors, and to facilitate linkages to resources to support behavior changes. The common denominator of these strategies is their focus on one-on-one interactions between provider and individual.

Definition based upon a review of the literature:

1. HIV Antibody Counseling, Testing, and Partner Referral
2. Education, Information, and Referral Hotlines
3. Street and Community Outreach
4. Individual Peer Education – Individual peer education offers education, counseling, risk assessment, and referrals provided by trained peers of target group members.
5. On-site Risk Reduction Education and Counseling
6. Prevention Case Management
7. Needle Exchange Programs
8. Condoms, Other Barriers, and Bleach Demonstration and Distribution

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue:

Mode: Counseling
Health education

Provider: Peer

Outcome: Behavioral

Level: Individual

Target Population:

Other:

On-site Risk Reduction Education and Counseling (CA)

Program Category 1: Individual-Level Interventions

Individual level interventions provide information, risk assessment, and risk reduction counseling to assist individuals to learn about transmission and risk behaviors, make plans for individual behavior change and ongoing appraisal of their own behaviors, and to facilitate linkages to resources to support behavior changes. The common denominator of these strategies is their focus on one-on-one interactions between provider and individual.

Definition based upon a review of the literature:

1. HIV Antibody Counseling, Testing, and Partner Referral
2. Education, Information, and Referral Hotlines
3. Street and Community Outreach
4. Individual Peer Education
5. On-site Risk Reduction Education and Counseling – On-site risk reduction education and counseling involves education at sites where people formally congregate for purposes other than HIV prevention, such as drug treatment centers, work sites or social welfare offices.
6. Prevention Case Management
7. Needle Exchange Programs
8. Condoms, Other Barriers, and Bleach Demonstration and Distribution

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue: Sites where people formally congregate for purposes other than HIV prevention, such as drug treatment centers, work sites or social welfare offices.

Mode: Health education
Counseling

Provider:

Outcome: Behavioral

Level: Individual

Target Population:

Other:

Individual Level Intervention (CH)

Describes:

- I. Minimum Criteria
 - A. Health Education/Risk Reduction (HE/RR) counseling conducted 1:1
 - B. Often sporadic, but part of an ongoing relationship
 - C. Of sufficient length to informally assess client needs
 - D. Assists the individual in making plans for behavior change
 - E. Provides ongoing appraisals of behaviors
 - F. Supports prevention/risk reduction behaviors
 - G. Facilitates linkages to prevention and other services (e.g., substance abuse, group ed., PCM, Counseling and Testing, etc.)
- II. Quality Assurance Measures
 - A. Space is private and conducive to private/personal discussions
 - B. Mechanism in place for tracking and documentation of individual educational sessions
- III. Data Requirements
 - A. In an effort to better document service delivery citywide, all CDPH prevention funded agencies will be required to collect and submit the following data for each intervention used in their program. Data will be submitted to CDPH scan forms (provided by CDPH). This information will be used to improve the quality and effect of HIV prevention projects in Chicago.
 1. Type of agency
 2. Risk population
 3. Client demographics
 4. Setting
 5. Number of interventions
 6. Staffing
 7. Expenditures
 8. Number of clients receiving 1-2-3-4-5 or more sessions

What Works in Prevention?

Key factors of Successful Interventions and Programs

- I. Services are:
 - A. delivered in a culturally appropriate and culturally sensitive manner
 - B. easily accessed
 - C. voluntary
- II. Target Population is:
 - A. clearly defined and with a proven need of HIV prevention services
- III. Goals and Objectives of the Program are:
 - A. clearly defined, time-phased, and measurable
- IV. Interventions are:
 - A. based on sound behavioral research
 - B. well planned, implemented, monitored and evaluated
 - C. created (whenever possible) with input from target population

- D. focused on reducing specific behaviors and address skill levels, attitudes, and behaviors that influence high risk activities (i.e., how to use condoms appropriately, how to clean injection equipment, and reinforcing positive attitudes about condom use)
 - E. vehicles for demonstrating, reinforcing, and promoting positive behaviors
- V. Agencies have:
- A. the ability to maintain multiple contacts with participants
 - B. the ability to document service delivery (i.e., develop and maintain survey questionnaires, client assessment forms, etc.)
 - C. a strong referral and follow-up system exists (formal, established, and written with signed memorandums of agreement)
 - D. the ability and desire to collaborate with other organizations
 - E. policies that conform with prevailing local, state and federal laws regarding client confidentiality
 - F. staff with necessary academic background or experience in a human-services-related field (i.e., social work, psychology, nursing, counseling, or health education); and case management and assessment techniques
 - G. staff that are knowledgeable about HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change.
- VI. How Do We Assure Quality?
- A. Minimum Quality Assurance Standards
- VII. Services are:
- A. offered in a safe environment. The agency should be clean, neat, well ventilated, and clutter free
- VIII. Interventions are:
- A. whenever possible, implemented/delivered by individuals representative of the target population
- IX. Agencies have:
- A. Policies and Procedure Manual. This manual must contain all intervention protocols, policies, and procedures of the services being delivered
 - B. current collaborative linkages within community and, when possible, should participate in one or more Community Planning Groups
 - C. staff that are familiar with available community resources
 - D. staff that are trained in the implementation of program intervention(s). All trainings must be documented in staff folders. The agency should promote and encourage continuing educational trainings.
 - E. grievance procedures in place and a method for informing clients of this process. Proof of client receipt should be documented in client charts
 - F. policies on staff safety (on site and off site)
 - G. a relationship with local authorities (police) such that the program is well known in the community
 - H. regular assessments of clients satisfaction through periodic client satisfaction surveys
 - I. regular management/supervisors meetings with program staff to discuss project and status progress towards stated outcomes.

<i>Duration/Dosage:</i>	Often sporadic, but part of an ongoing relationship. Of sufficient length to informally assess clients needs.
<i>Venue:</i>	Space [that] is private and conducive to private/personal discussions.
<i>Mode:</i>	Health education – semi-structured Counseling – semi-structured or minimally structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	

Individual Level Intervention – Health Education (CO)

Encompassed under Health Education/Risk Reduction – Subcategory of ILI

Individual Level Health Education (ILHE) programs seek to promote and reinforce safer behaviors among at-risk individuals through one-on-one contact. Interactions are meant to be short-term, but often involve more than one session. These programs assist individuals in assessing their own risk for getting or spreading HIV and building the skills and abilities necessary to implement behavior change. ILHE offers training in the interpersonal skills needed to negotiate and sustain appropriate behavior change as well as referrals to appropriate services. This intervention is not intended to duplicated prevention case management.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their program flows from and is consistent with social and behavioral theory and research relevant to HIV risk reduction (See Part 1 “General Characteristics of Successful HIV Prevention Programs”).

Includes goal of the intervention, target population, cultural competence/proficiency, where delivered, when delivered, how much, content and methods employed, qualifications of people to do this work, continuing education/ongoing training requirements, consent/confidentiality considerations, quality assurance, evaluation information, penalties for violating standards and other pertinent information.

- Goal of the Intervention: ILHE programs seek to promote and reinforce safer behaviors among at-risk individuals through one-on-one contact. They aim to help individuals assess their own risk and to build skills to lower risk.
- Target Population: ILHE targets individuals who are at high risk for getting or spreading HIV infection.
- Cultural competence/proficiency: ...

- Where Delivered: ILHE may occur in clinic or agency settings (e.g., drug treatment centers, family planning offices, community health centers, mental health centers, independent living centers, etc.) in the context of other services, or may occur in other settings. Interventions must be accessible to the target audience.
- When Delivered: ...
- How Much: Interactions are meant to be short-term, but often involve more than one session.
- Content and Methods Employed: ...
- Qualifications of People to do this work: ILHE can be delivered by trained professionals or peers. ...
- Continuing Education/Ongoing Training Requirements: Providers of ILHE must receive at least 8 hours of updated HIV prevention training per year, with focus on client-centered counseling.
- Consent/Confidentiality Considerations: ...
- Quality Assurance: ...
- Evaluation: ...
- Penalties for Violating Standards: ...
- Other: ...

<i>Duration/Dosage:</i>	Short-term, but more than one session
<i>Venue:</i>	Clinic or agency setting in the context of other services, or other setting
<i>Mode:</i>	Health education – structured or semi-structured
<i>Provider:</i>	Professional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	Individuals who are at high risk for getting or spreading HIV infection.
<i>Other:</i>	Includes skill building

Individual Drug and Alcohol Counseling (CT)

Encompassed under ILI – Interventions that target one person. In individual level interventions, one person (e.g., an HIV test counselor) is doing an HIV prevention intervention with another single individual (e.g., the person being tested).

Individual Drug and Alcohol Counseling involves one person who is addicted to drugs, alcohol, or both, being counseled by a trained counselor. The counselor helps the patient try to figure out why they use alcohol and drugs, how their alcohol and drug use has hurt them, and what they need to do to quit. This counseling can take place in a drug treatment facility, a detoxification facility, or an outpatient basis at public health clinics or private clinics.

Does the intervention change behavior? ...

With what populations is it successful in changing behavior? ...

Duration/Dosage:

Venue: Drug treatment facility, a detoxification facility, or an outpatient basis at public health clinics or private clinics.

Mode: Counseling – structured

Provider:

Outcome: Behavioral

Level: Individual

Target Population:

Other:

One-to-One Peer Counseling (CT)

Encompassed under III – Interventions that target one person. In individual level interventions, one person (e.g., an HIV test counselor) is doing an HIV prevention intervention with another single individual (e.g., the person being tested).

One-to-one peer counseling is when a member of the individual's peer group shares HIV information, supports positive attitudes and norms regarding HIV prevention, and endorses safer sexual and drug use behavior. They might also teach the person simple behavioral skills necessary for prevention (e.g., showing them how to use a condom by demonstrating in on their fingers). The discussions take place within the context of an HIV prevention intervention setting, like a high school class or in a prison group. Often one-to-one peer counseling is used as one part of a group skills-building intervention.

Does the intervention change behavior? ...

With what populations is it successful in changing behavior?

- One-to-one peer counseling has been successful in many population, but may be especially useful in making interventions for ethnic minorities more culturally relevant. For example, peer counseling has shown success with African American women. Also using peers as interventions may be successful with populations who don't trust interventions that come from public health departments or researchers (e.g., drug users, African-Americans, Latino/as, young people).

Duration/Dosage:

Venue: Within the context of an HIV prevention intervention setting (e.g., high school class or prison group)

Mode: Counseling – semi-structured or minimally structured

Provider: Peer

Outcome: Behavioral

Level: Individual

Target Population: Drug users, African-Americans (African-American women), Latino/as, young people

Other: May include skills building

Motivational Interviewing Interventions (CT)

Encompassed under III – Interventions that target one person. In individual level interventions, one person (e.g., an HIV test counselor) is doing an HIV prevention intervention with another single individual (e.g., the person being tested).

Motivational Interviewing Interventions is a form of brief intervention which was developed to treat alcohol and drug abuse. The technique takes into account that individuals will not change until they have decided: 1) that a change is necessary, and 2) that they could change. In a motivational interview, a counselor gives a patient feedback about their risk behavior without calling it a "problem", and then stresses the patient's personal responsibility for whether or not they feel that they need to change their behavior. The counselor gives the patient clear and direct advice that a change would be healthy, but does not order the patient to change. The counselor gives the patient a list of different ways they could change their behavior, and then the patient and counselor work together to decide on a behavior change goal (e.g., condom use.) The counselor then helps to increase the patient's self-efficacy for performing all the behaviors necessary to make the change they have selected (e.g., how to talk about condom use with a partner). The goal is to help the patient decide for themselves that they can and should make a change. Motivational interviewing often uses follow-up phone calls and reminders to help monitor progress.

Does the intervention change behavior? ...

With what populations is it successful in changing behavior?

- Motivational interviewing could be effective with many populations. Since it is very brief, motivational interviewing could be included into routine clinical care in public health settings as well as private health care.

<i>Duration/Dosage:</i>	Brief with follow-ups
<i>Venue:</i>	
<i>Mode:</i>	Counseling – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	Counselor helps to increase the patient's self-efficacy for performing all the behaviors necessary to make the change they have selected.

HIV Prevention Intervention by Physicians (CT)

Encompassed under ILI – Interventions that target one person. In individual level interventions, one person (e.g., an HIV test counselor) is doing an HIV prevention intervention with another single individual (e.g., the person being tested).

HIV Prevention Intervention by Physicians involve primary care physicians or other providers (e.g., physician's assistants, nurse practitioners) asking their patients about current sexual and drug use behavior which may be putting them at risk for HIV infection, and advocating safer behavior.

Does the intervention change behavior? ...

With what populations is it successful in changing behavior?

- Physician delivered interventions have the potential for wide impact, since the majority of individuals access some type of primary care on a regular basis.

<i>Duration/Dosage:</i>	
<i>Venue:</i>	Health care facility/clinic
<i>Mode:</i>	Health education – minimally structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	

Programs in Prisons (CT)

Encompassed under Community Level Interventions – These are interventions that try to change HIV risk behavior by changing community norms (and sometimes even the laws) of a community to support HIV prevention.)

Programs in prisons are simply individual or group level interventions that take place in prisons. Prisons provide a good opportunity to get access to high risk individuals for interventions.

Does The Intervention Change Behavior?...

With What Population Is It Successful In Changing Behavior?

- One published study showed that an HIV prevention programs was successful with incarcerated women.

Included in Both ILI and GLI

Duration/Dosage:

Venue: Jail/prison

Mode:

Provider:

Outcome: Behavioral

Level: Individual, Group

Target Population: High risk incarcerated individuals

Other:

Individual Level Intervention (DC)

From "Guidance and Standards for HIV Prevention Interventions"

Individual-level interventions (ILI) consist of health education and risk-education counseling provided to one individual at a time. ILI's assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. An example of ILI is individual prevention counseling.

The purpose of this individual prevention counseling is to provide one-time counseling and health education interventions to persons who are at high risk for HIV infection, to promote and reinforce safe behavior. This type of counseling – which is not linked with HIV antibody testing – provides education and counseling at sites where individuals at risk for HIV congregate for purposes other than receiving HIV prevention or education, such as drug treatment centers,

social service offices, or medical clinics, Individual prevention counseling may be delivered by peers or non-peers.

Also includes:

- *Guidance and Standards for Individual Prevention Counseling – (Under development)*
- *CDC Guidelines for Risk Reduction Counseling – provided*

Duration/Dosage:

Venue: Where HIV high-risk individuals congregate

Mode: Counseling

Provider: Peer, Non-peer

Outcome: Behavioral

Level: Individual

Target Population: MSM, couples, pregnant women, Youth,

Other:

Individual Prevention Counseling (DC)

From "Guidance and Standards for HIV Prevention Interventions"

Individual-level interventions (ILI) consist of health education and risk-education counseling provided to one individual at a time. ILI's assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. An example of ILI is individual prevention counseling.

The purpose of individual prevention counseling is to provide one-time counseling and health education interventions to persons who are at high risk for HIV infection, to promote and reinforce safe behavior. This type of counseling – which is not linked with HIV antibody testing – provides education and counseling at sites where individuals at risk for HIV congregate for purposes other than receiving HIV prevention or education, such as drug treatment centers, social service offices, or medical clinics, Individual prevention counseling may be delivered by peers or non-peers.

Also includes:

- *Guidance and Standards for Individual Prevention Counseling – (Under development)*
- *CDC Guidelines for Risk Reduction Counseling – provided*

<i>Duration/Dosage:</i>	One-time
<i>Venue:</i>	Sites where individuals at risk for HIV congregate for purposes other than receiving HIV prevention or education.
<i>Mode:</i>	Counseling Health education
<i>Provider:</i>	Peer, Non-peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	.

HIV Education and Risk Reduction Individual-Level Counseling (HO)

Its purpose is to provide personalized, interactive, intensive and private intervention to an individual. It is based on a person's needs, resources, readiness to change and circumstances. Individual counseling blends traditional psychotherapy with public health education. It emphasizes delivery of information and teaching strategies for behavior change. It is an integral part of HIV CTRPN, case management, substance abuse and AIDS hotline counseling. (Kalichman, 1998).

<i>Duration/Dosage:</i>	
<i>Venue:</i>	
<i>Mode:</i>	Counseling – semi-structured Health education -semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	Personalized, interactive, intensive and private intervention to an individual.

Individual Level Intervention (ILI) (IA)

Includes description from the Taxonomy of HIV/AIDS Prevention Interventions from the Academy of Educational Development and the CDC's 2000 Evaluation Guidance (CDC, 1999) for the purpose of "making meaningful distinctions and choices among possible interventions."

Encompassed under Health Education/Risk Reduction

Using the taxonomy originally proposed by Holtgrave, et al., 1994, the following interventions will be included under the broad category of Health Education and Reduction (HE/RR): individual-level intervention, prevention case management, group level intervention, and outreach. HE/RR describes organized efforts to reach persons at increased risk of becoming HIV infected or, if already infected, of transmitting the virus to others. The goals of health education and risk reduction activities are to go beyond the provision of information to provide education and counseling that assists individuals in developing the skills, abilities, and self-esteem to carry out behavior change (CDC, 1995). Health education and risk reduction interventions can be delivered at individual, group, community, or outreach levels. HE/RR activities can include counseling, workshops, educational programs and materials, presentations, and outreach activities.

An individual-level intervention is defined as health education and risk-reduction counseling provided to one individuals at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services.

ILI is a one-on-one intervention involving a wide range of skills, information, and support. ILI is an intensive, individualized support intervention designed to assist persons at high risk for or infected with HIV to either remain seronegative or to reduce their risk of transmission to others.

Individuals who need more intensive individualized support may be candidates for prevention case management. Prevention case management is individual level intervention directed at persons who need highly individualized support, including substantial psychosocial, interpersonal skills training, and other support, to remain seronegative or to reduce the risk of substitutes for medical case management or extended social services.

<i>Duration/Dosage:</i>	One-time
<i>Venue:</i>	
<i>Mode:</i>	Counseling -semi structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	Involves a wide range of skills, information, and support.

Individual Level Intervention (ID)

Health Education/Risk Reduction counseling with a skills component, provided to one person at a time.

Duration/Dosage:

Venue:

Mode: Counseling – minimally structured

Provider:

Outcome: Behavioral

Level: Individual

Target Population: MSM, IDUs or Women at-risk

Other: Includes skills component.

Risk Reduction Counseling (IL)

Risk reduction counseling is a short term, one-on-one intervention designed to increase the ability or motivation of high risk clients to independently initiate HIV/STD behavior changes, maintain safer behaviors, or access services. Risk reduction counseling provides clients with an opportunity to receive:

- confidential, client-centered HIV/STD risk assessment, including an assessment of the variables that influence client risk taking;
- individualized client education and skill-building, such as role plays or problem solving practice with the counselor;
- the development of a personal risk reduction plan; and
- referrals to other services, including CTRPN services.

Trained peers or service professionals provide risk reduction counseling to individuals or couples. Clients may be offered follow-up sessions to assess client progress, completion of referrals, or additional needs.

Risk reduction counseling may be offered in any setting that allows for confidential, one-on-one conversation. Examples of appropriate settings include shelters, storefronts, mental health centers, syringe exchange programs, WIC offices, or coffee shop. Telephone hotlines and online "office hours" can also make risk reduction counseling more accessible to some clients, such as youth or rural men who have sex with men.

Distinguishing Features of Risk Reduction Counseling:

Risk reduction counseling extends individualized prevention services to persons who are unlikely or unable to access test decision counseling services or prevention case management (PCM). Risk reduction counseling is distinguished from PCM by:

- shorter time commitment
- fewer sessions or contact
- easier staff training requirements
- basic risk reduction plans
- less comprehensive referrals
- independent client follow-up

Unlike PCM, risk reduction counseling clients do not receive in-depth assessments or referrals to address their psychosocial and medical needs. Counseling clients do not need to commit to multiple counseling sessions to work on a comprehensive client plan. As a result, the intervention may be conducted by peers or others without a background in social work or ongoing-counseling. Risk reduction counseling may be provided to clients who do not provide their names or contact information.

Relationship to Other Services:

Risk reduction counseling should not duplicate test decision counseling services available through confidential or anonymous CTRPN sites. Programs should neither replace nor duplicate the individual risk assessment and risk reduction counseling services currently provided by DHS substance abuse treatment centers, Ryan White CARE Act case managers, health care providers or mental health providers. Such professionals should be offered counseling skills training if needed

Also includes: Quality Assurance Tool for Risk Reduction Counseling

<i>Duration/Dosage:</i>	Short-term, possible follow-ups
<i>Venue:</i>	Any setting that allows for confidential, one-on-one conversation
<i>Mode:</i>	Health education – structured or semi-structured Counseling – semi-structured or minimally-structured
<i>Provider:</i>	Professional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual, Couple
<i>Target Population:</i>	High-risk individuals
<i>Other:</i>	

Individual Level Intervention (One-on-one client services) (KS)

Encompassed under Health Education and Risk Reduction (HE/RR)

Implement HE/RR programs that are tailored to reach persons infected or at high risk of becoming HIV infected by using interventions that are:

1. based in scientific theory or program experience;
2. developed to reduce the risk of primary and secondary infection;
3. culturally, linguistically age and gender appropriate; and
4. sensitive to sexual identity.

Individual Level Interventions (One-on-one client services)

- Provide individual prevention case management services to HIV+ persons and their partners for the purpose of delivering on-going
 1. health education,
 2. skills training, and
 3. support long term behavior change that prevents the transmission of HIV and facilitates the development of peer-to-peer education, advocacy, and networking structures.
- Link HIV prevention case management services with clinics that conduct HIV counseling, testing referral and partner counseling and referral services, early medical intervention programs, STD services, TB testing, substance abuse treatment programs, other health agencies to recruit or refer persons at high risk for primary and secondary HIV infection.
- Provide case management services to HIV infected individuals and their sex partners and provide support and education regarding secondary infection.
- Provide intensive individualized support to persons when needed, including substantial psycho social, interpersonal skills training, and other support, to remain HIV-, or to rescue the risk of HIV transmission to others.
- Provide clean needle exchange and risk reduction programs, which include psycho social, medical and substance abuse referrals to injection drugs users and their sex partners.
- Provide condoms, safer sex seminars, to at-risk populations using workers who reflect the at-risk population served and are knowledgeable and have engaged in the highest-risk behaviors.

<i>Duration/Dosage:</i>	On-going
<i>Venue:</i>	
<i>Mode:</i>	Case management- semi-structured Counseling – semi structured
<i>Provider:</i>	Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	HIV positive individuals and their partners
<i>Other:</i>	Skills training

Individual Level Intervention (MD)

Individual level intervention which provide ongoing health communications, health education, and risk reduction counseling to assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to service in both clinic and community settings (in support of behaviors and practices that prevent transmission of HIV, and the help clients make plans to obtain these services.

<i>Duration/Dosage:</i>	Ongoing
<i>Venue:</i>	
<i>Mode:</i>	Counseling – semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	

Individual Level Intervention (ME)

Encompassed under CPG taxonomy primary category HIV Risk Reduction and Education.

Individual Level Intervention – a range of one-to-one client services that offer counseling, assist clients in assessing their own behavior and planning individual behavior change, support and sustain behavior change, and facilitate linkages to services in clinic and community settings.

Professionally led and peer led:

- a. Behavior Change, Risk Reduction/Harm Reduction Counseling
- b. Skills Training
- c. HIV Prevention Counseling and Testing, Referral and Partner Notification
- d. Prevention Case Management
- e. Secondary Prevention Efforts

Duration/Dosage:

Venue:

Mode: Counseling – structured or semi-structured

Provider: Professional, Peer

Outcome: Behavioral

Level:

Target Population:

Other: Skills training.

Referral (MI)

In the context of HIV prevention, referral is the process through which an individual's needs for medical and supportive services are assessed, prioritized and 'connected' to needed services.

Duration/Dosage:

Venue:

Mode: Referral – minimally structured

Provider:

Outcome:

Level: Individual

Target Population:

Other:

Individual Level Prevention Counseling (MI)

Health education and risk-reduction counseling provided to one individual at a time, typically single-session. The focus of this intervention is to assess risk reduction needs of clients and assist them in making plans for individual behavior change. Can also assist clients in obtaining access to other prevention services in clinical and community settings (e.g., referrals).

<i>Duration/Dosage:</i>	Single session
<i>Venue:</i>	
<i>Mode:</i>	Counseling – minimally structured
<i>Provider:</i>	
<i>Outcome:</i>	
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	

Individual Level Education (MN)

Based on the work of Holtgrave et al.

Individual level education including condom use training, negotiation of safer sexual behaviors, risk reduction strategies for IDUs, other psychosocial issues, implemented by a:

- peer
- non-peer, or
- through prevention case management.

<i>Duration/Dosage:</i>	
<i>Venue:</i>	
<i>Mode:</i>	Counseling – semi- structured
<i>Provider:</i>	Peer, Non-peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	IDUs
<i>Other:</i>	

Institution Based Programs (MN)

Comprehensive or single session programs can be provided by peers or non-peers at schools, worksites, or other institutions such as chemical dependency treatment centers, group homes, or prisons.

<i>Duration/Dosage:</i>	Comprehensive or single session
<i>Venue:</i>	Schools, worksites, or other institutions such as prisons, group homes, etc.
<i>Mode:</i>	
<i>Provider:</i>	Peer or non peer
<i>Outcome:</i>	
<i>Level:</i>	
<i>Target Population:</i>	
<i>Other:</i>	

Individual Level Intervention (MO)

This encompasses one on one risk reduction counseling with a skill building component and is most commonly conducted throughout the regions during counseling and testing interventions. Individuals who need additional intensive services are referred to HIV prevention case management programs across the state. Prevention case management includes client-centered HIV prevention activities offered in conjunction with traditional care case management which links HIV positive individuals to care and other community services. The fundamental goal is the promotion, adoption, and maintenance of reduced HIV risk behaviors along with linkages to care. This represents a holistic approach by ensuring access to care which should increase the quality of health outcomes, while reducing the potential for secondary infections which is a primary public health prevention outcome.

<i>Duration/Dosage:</i>	
<i>Venue:</i>	
<i>Mode:</i>	Counseling – semi structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	Conducted during counseling and testing; skills building component Includes Prevention Case Management

Risk Reduction/Counseling (NC)

Not Linked to CTRPN. One-to-one education/counseling at sites where people at risk formally congregate for purposes other than receiving HIV prevention or education services, such as at clinics and drug treatment centers.

...strategy provides counseling/education to persons at high risk that promote and reinforce safer sexual behaviors. This intervention includes skills which might assist persons in negotiating and sustaining appropriate behavior changes (i.e., avoiding unsafe self, negotiating safer sex, needle cleaning).

Duration/Dosage:

Venue: Sites where people at risk formally congregate (e.g., clinics, drug treatment centers)

Mode: Counseling – semi-structured

Provider:

Outcome: Behavioral

Level: Individual

Target Population:

Other: Not linked to CTRPN.

Includes negotiation skills and skills to sustain appropriate behavior changes.

Individual Counseling (NH)

- Usually weekly sessions between an individual client and a licensed professional (e.g., mental health counselor, LADAC)
- Counselor and client work on behavior change goals over a brief period of sessions
- Differs from case management in that client does not need additional supports and referrals.

Overall Premises to be Considered in All Interventions:

1. All interventions need to explicitly define a population to be served and the steps to reach that population.
2. All interventions must have explicitly defined HIV prevention goals (e.g., reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required

data collection will be more limited than for individual and group level interventions due to the nature of the work.)

6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.
7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

<i>Duration/Dosage:</i>	Usually weekly, brief period of sessions
<i>Venue:</i>	
<i>Mode:</i>	Counseling – semi- structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	Work on behavior change goals over a brief period of sessions. Differs from case management in that client does not need additional supports and referrals.

Individual Level Intervention (OK)

Encompassed under Health Education/Risk Reduction.

Individual level interventions include a range of one-on-one client services. This can consist of education and support to promote and reinforce safer behaviors and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change. Individual prevention counseling assists clients in assessing their own behavior and planning individual behavior change; support and sustains behavior change; and facilitates linkages to services that support behaviors and practices that prevent the transmission of HIV.

Includes – Evidence of Effectiveness.

Duration/Dosage:

Venue:

Mode: Counseling – semi-structured or minimally structured
Health education – semi-structured or minimally structured

Provider:

Outcome: Behavioral

Level: Individual

Target Population:

Other: Skills training

Individual Level Intervention (SC)

Encompassed under HE/RR.

Individual level interventions provide a range of one-on-one client services that offer counseling, assist clients in assessing their own behavior and planning individual behavior change, support and sustain behavior change, and facilitate linkages to services in clinic and community settings (e.g., substance abuse treatment programs) in support of behaviors and practices that prevent the transmission of HIV. Some clients may be at very high risk of becoming HIV-infected or, if already infected, of transmitting the virus to others. Either through referral, or onsite, HIV prevention service providers are encouraged to provide additional prevention counseling, as appropriate to the needs of these clients.

Duration/Dosage:

Venue:

Mode: Counseling – structured or semi-structured

Provider:

Outcome: Behavioral

Level: Individual

Target Population: High risk of becoming infected with or transmitting HIV.

Other: Facilitate linkages to services in clinic and community settings in support of behaviors and practices that prevent the transmission of HIV.

Individual Level Intervention (SD)

Encompassed under HE/RR

Individual level interventions include a range of one-on-one client services. This can consist of education and support to promote and reinforce safer behaviors and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change. Individual prevention counseling assists clients in assessing their own behavior and planning individual behavior change; supports and sustains behavior change; and facilitates linkages to services that support behaviors and practices that prevent the transmission of HIV.

Includes:

- *Evidence of Effectiveness*
- *Prevention Case Management*

Duration/Dosage:

Venue:

Mode: Counseling – semi-structured or minimally structured
Health education – semi-structured or minimally structured

Provider:

Outcome: Behavioral

Level: Individual

Target Population:

Other: Skills training
Facilitates linkages to services that support behaviors and practices that prevent the transmission of HIV.

Individual Level Counseling (TN)

Taken from section: Description of interventions – Encompassed under Category II HE/RR.

Individual-level counseling is one-on-one peer or non-peer intervention involving a wide range of skills, information, and support.

Negotiation of safer sex behaviors include refusal skill building. Interventions or negotiation of safer sex behaviors and refusal skills include peer-led education, and support groups which utilize role playing and interactive video presentation. The emphasis should be given to accessing devices necessary for safer sex and safer drug use practices (i.e., dental dams, female condoms and sterile/clean needles). In addition, interventions in this category should address family, sexuality, self-esteem, the impact of other STDs, and empowering individuals with skills necessary to negotiate safer sex. Interventions should also address abstinence as a prevention option.

Duration/Dosage:

Venue:

Mode: Counseling – semi-structured
Health education – semi-structured

Provider: Peer, Non-peer

Outcome: Behavioral

Level: Individual

Target Population:

Other: Includes skill building.

Individual Level Intervention (TX)

Individual level interventions provide one-on-one client services such as skills development, information exchange and support which assist clients in 1) appraising their own behavior, 2) planning individualized behavior change(s), 3) facilitating linkages to services in clinical and community settings (e.g., substance abuse treatment programs) in support of behaviors that prevent the transmission of HIV, and 4) helping clients make plans to obtain these services. Individual level interventions are designed for clients who may be at very high risk of becoming HIV-infected or, if already infected, of transmitting the virus to others.

Individual level interventions include 1) prevention counseling and partner elicitation, 2) health education and risk reduction activities, 3) prevention case management, and 4) STD detection and referral for diagnosis and treatment. Individual level interventions must be client-centered with a focus on developing HIV prevention goals and strategies with the client rather than simply providing information. Individual level interventions must be provided by peer members of the target population. Peers are defined as members of the target populations or trained persons who are sensitive to the issues affecting that population. These activities must be targeted to populations as indicated in the RAPs.

Listed below are some additional guidance and activity requirements for the following individual interventions: prevention counseling and partner elicitation, health education and risk reduction activities, prevention case management, and STD screening and referral for diagnosis and treatment. ...

*Holtgrave, Valdessari and West Taxonomy (1994) in Comprehensive Plan – Appendix 3 ...
HE/RR by peer or non-peer counselor (not as inclusive as program requirements)*

Duration/Dosage:

Venue:

Mode: Counseling – minimally structured
Health Education – structured or semi-structured
Biomedical

Provider: Peer

Outcome: Behavioral

Level: Individual

Target Population: High risk of becoming infected or transmitting the virus.

Other: Skills development

Referrals (TX)

All HIV prevention programs are required to provide key referral linkages including, but not limited to, STD screening and treatment, TB testing and treatment, substance abuse assessment, counseling and treatment, family planning services, prenatal services including treatment to reduce maternal transmission of HIV, ongoing HIV prevention counseling, prevention case management, and early medical intervention for HIV infection. Grantees are required to document referrals for certain individuals as prescribed below:

Contractors must document that all HIV seropositive clients are given a formal and trackable referral to early intervention services through local HIV services providers. The referral must be noted on the PERForm for prevention counseling sites and/or other case management records. Clients may decline a referral; contractors must document this declination.

1. Seronegative clients with ongoing risk due to mental health and/or psychosocial issues or compulsive behaviors must be offered referrals to local prevention services such as mental health counseling, or to Prevention Case Management (PCM), where available.
2. Persons whose HIV risk is related to alcohol or other drug abuse must be offered referrals to alcohol and drug assessment and treatment programs. Prevention staff should be trained and prepared to offer other harm reduction options to clients who decline alcohol or drug treatment.
3. HIV prevention projects are required to develop and implement written referral procedures for pregnant women that are accessible to all prevention staff. Projects should refer all women who may be pregnant for prenatal care. Referrals for prenatal services must be documented in the appropriate client records. Counselors and/or other prevention staff must inform pregnant women that, unless refused, the HIV test will be performed by their health care provider at the first prenatal visit and also at delivery.

4. HIV prevention projects are required to develop and implement written referral precedes for HIV seropositive pregnant women that are accessible to all prevention staff.
5. All HIV prevention programs must ensure that TB testing is delivered on site or referral made and documented for high-risk persons and/or HIV seropositive persons.
6. All HIV prevention programs must ensure that STD services including screening, diagnosis and treatment are delivered on site or referral made and documented for high-risk persons and/or HIV seropositive persons.
7. PCM providers must additionally document and track all referrals.

<i>Duration/Dosage:</i>	On-going
<i>Venue:</i>	Health care facility/clinic
<i>Mode:</i>	Referral – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Biomedical
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	Contractors must document that all HIV seropositive clients are given a formal and trackables referral to early intervention services through local HIV services providers. Required to provide key referral linkages including, but not limited to , STD screening and treatment, TB testing and treatment, substance abuse assessment, counseling and treatment, etc.

Individual Level Intervention (VA)

Encompassed under Category II – Health Education/Risk Reduction.

Individual Level Intervention (ILI)

Providing one-to-one, personalized education which includes formal/informal assessments and a skills building component. May include HIV/STD awareness, primary and secondary prevention education, and referral. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help make plans to obtain these services.

Duration/Dosage:

Venue:

Mode: Health Education – structured, semi-structured, or minimally structured

Provider:

Outcome: Behavioral

Level: Individual

Target Population:

Other: Skills building component

Facilitate linkages to services in both clinic and community settings

Individual Level Intervention (ILI) (WI)

Individual level interventions usually occur face-to-face and always in a one-on-one format. The service provider exchanges information with individual member of the target population, regarding the individual's risk and possible skills to reduce the risk. In other words, the service provider gains enough of the individual's trust to learn about some of his/her risk and to teach some risk reduction skills. This is not one-way communication in which the provider merely gives the individual literature, risk reduction materials, or a referral.

ILI emphasize an increase in knowledge for the individual through education and support to promote and reinforce safer behaviors and to provide skills training. According to the definition of skills-building, the individual must be able to demonstrate the learned skill. Individual prevention counseling sessions assist clients in assessing their own behavior, planning individual behavior change, and sustaining behavior change. Finally, service providers facilitate linkages to additional support services.

Effective risk reduction counseling sessions:

- emphasize confidentiality.
- Begin with an assessment of the specific HIV/STI prevention needs of the client.
- Identify, with group or individual, the appropriate goals/objectives (e.g., condom use negotiation skills for female sex partners of IDUs).
- Use skills-building exercises designed to meet the specific needs of the client.
- Include negotiations with the client on suggestions and recommendations for changing and sustaining behavior change as appropriate to their situation.
- Enable/motivate participants to initiate and maintain behavior change independently.
- Enhance abilities of the participant to access appropriate services (e.g., referrals to drug treatment).

Includes:

- *Scientific Basis*
- *Resources*

Duration/Dosage:

Venue:

Mode: Counseling – Structured

Provider: Service provider

Outcome: Behavioral

Level: Individual

Target Population:

Other: Includes skills building.
Service provider must gain enough trust to learn about client's risk and to teach some risk reduction.
Not PCM or Outreach
Considered an interaction.

Group Level Interventions (GLI)

The Number of Intervention Characteristics by Each Group Level Intervention (GLI)

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Group Health Education/Risk Reduction (HE/RR) – Single Session	AK	✓		✓	✓	✓	✓	✓	✓	7
Group Health Education/Risk Reduction (HE/RR) – Multiple Sessions	AK	✓		✓	✓	✓	✓	✓		6
Multi-Session Groups	CA	✓		✓		✓	✓			4
Group Peer Education	CA			✓	✓	✓	✓			4
Support Groups	CH	✓		✓		✓	✓			4
Group Education	CH	✓		✓	✓	✓	✓			5
Group Level Intervention – Group Risk Reduction Education (GRRE)	CO	✓	✓	✓	✓	✓	✓	✓	✓	8
Group Level Intervention – Comprehensive Health Programs (CHP) for Youth	CO	✓	✓	✓	✓	✓	✓	✓	✓	8
Single Session Workshops	CT	✓	✓	✓	✓	✓	✓	✓	✓	8
Multiple Session Workshops	CT	✓	✓	✓	✓	✓	✓	✓	✓	8
Support Groups/Self-Help Groups/Clubs	CT			✓	✓	✓	✓			4
Programs In Prison	CT		✓			✓	✓	✓		4
Couples Counseling	CT			✓		✓	✓	✓		4
Group Level Intervention	DC			✓	✓	✓	✓	✓	✓	6
Psycho-Educational Skills Building Groups	DC	✓	✓	✓	✓	✓	✓	✓	✓	8
HERR Small Group Counseling	HO	✓	✓	✓	✓	✓	✓			6

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Group Level Intervention (GLI) – Multiple Session Group Workshop	IA	✓	✓	✓	✓	✓	✓	✓	✓	8
Group Level Intervention (GLI) – School Based Programs	IA	✓	✓	✓	✓	✓	✓	✓	✓	8
Group Level Intervention (GLI) – Out-of-School Based Programs	IA	✓	✓	✓		✓	✓	✓	✓	7
Group Level Intervention	ID	✓		✓		✓	✓		✓	5
Group Prevention & Support – Events	IL	✓	✓	✓	✓	✓	✓			6
Group Prevention & Support – Workshops	IL	✓	✓	✓	✓	✓	✓		✓	7
Group Prevention & Support – Presentations	IL	✓	✓	✓	✓	✓	✓		✓	7
Group Prevention & Support – Prevention support groups	IL	✓	✓	✓	✓	✓	✓		✓	7
Group Level Intervention	KS	✓		✓	✓	✓	✓	✓	✓	7
School Based Efforts for Youth	KS		✓	✓		✓		✓	✓	5
Community Awareness Sessions	LA	✓	✓	✓	✓	✓	✓	✓	✓	8
Peer Led Multiple Small Group Sessions	LA	✓	✓	✓	✓	✓	✓	✓	✓	8
Non-Peer Led Multiple Small Group Sessions	LA	✓	✓	✓	✓	✓	✓	✓	✓	8
Small-Group Education and Skills Development Trainings	MA			✓	✓	✓	✓		✓	5

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Small/Large Group	MD			✓	✓	✓	✓		✓	5
Group Level Intervention	ME			✓	✓	✓	✓	✓	✓	6
Group Level Prevention Counseling	MI	✓		✓		✓	✓			4
Group Health Education/Risk Reduction	MI			✓		✓	✓		✓	4
Group Level Education	MN			✓	✓	✓	✓		✓	5
Group Level Intervention	MO	✓		✓		✓	✓		✓	5
Group Education Sessions- One Time	NC	✓	✓	✓		✓	✓			5
Group Education Sessions- Series	NC	✓	✓	✓		✓	✓		✓	6
Group Education Sessions – One Time	NH	✓	✓	✓		✓	✓		✓	6
Group Education Sessions – Series	NH	✓		✓	✓	✓	✓			5
Support Groups	NH	✓		✓	✓	✓	✓		✓	6
Small Group Interventions	NV			✓	✓	✓	✓			4
Group Level Intervention	SC	✓		✓	✓	✓	✓	✓	✓	7
Group Level Intervention	TX		✓	✓	✓	✓	✓			5
Group Level Intervention	VA	✓		✓		✓	✓		✓	4
Group Level Intervention (GLI)	WI	✓	✓	✓	✓	✓	✓		✓	7
Risk Reduction Counseling	VI			✓		✓	✓	✓	✓	5
TOTAL (N = 48)		33	24	47	33	47	47	21	34	286

✓ - Indicates that evidence of the intervention characteristic was found in reviewing the FY 2001 Cooperative Agreement Applications and Comprehensive Plans and Web sites. Definitions or guidelines addressing these elements may exist in other documentation not reviewed for this study.

Group Level Interventions (GLI) – Listing of Evidence by Intervention Characteristic

Duration/Dosage:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Group Health Education/Risk Reduction (HE/RR) – Single Session	Single occasion
AK	Group Health Education/Risk Reduction (HE/RR) – Multiple Sessions	Multiple times with same group of participants
CA	Multi-Session Groups	Multiple sessions held over a period of time
CH	Support Groups	Regularly scheduled
CH	Group Education	A planned specific period of time with scheduled beginning and end point.
CO	Group Level Intervention – Group Risk Reduction Education (GRRE)	Single allowed, multiple preferred
CO	Group Level Intervention – Comprehensive Health Programs (CHP) for Youth	Multiple sessions
CT	Single Session HIV Prevention Workshops	Single session
CT	Multiple Session HIV Prevention Workshops	Multiple sessions
DC	Psycho-Educational Skills Building Groups	4-12 sessions for a total of 12-24 hours
HO	HERR Small Group Counseling	Single or multiple sessions
IA	Group Level Intervention (GLI) – Multiple Session Group Workshop	Multiple
IA	Group Level Intervention (GLI) – School Based Programs	Multiple
IA	Group Level Intervention (GLI) – Out-of-School Based Programs	Multiple
ID	Group Level Intervention	More than one interaction
IL	Group Prevention & Support – Workshops	One-time or part of a series
IL	Group Prevention & Support – Presentations	One-time or part of a series

IL	Group Prevention & Support – Prevention support groups	One-time or part of a series
IL	Group Prevention & Support – Events	One-time or part of a series
KS	Group Level Intervention	On-going
LA	Community Awareness Sessions	One time interaction
LA	Peer Led Multiple Small Group Sessions	Multiple sessions
LA	Non-Peer Led Multiple Small Group Sessions	Multiple sessions
MI	Group Level Prevention Counseling	Multiple sessions
MO	Group Level Intervention	Multiple sessions recommended
NC	Group Education Sessions – One Time	One time
NC	Group Education Sessions – Series	More than one session with same group
NH	Group Education Sessions – One Time	One Time
NH	Group Education Sessions – Series	4-8 sessions
NH	Support Groups	Usually weekly
SC	Group Level Intervention	One-time or on-going
VA	Group Level Intervention	More than one
WI	Group Level Intervention (GLI)	Closed w/fixed number of sessions Open/on-going sessions Usually more than one session 4 hour min. recommended

Venue:

	Intervention Name:	Evidence of Intervention Characteristic:
CO	Group Level Intervention – Group Risk Reduction Education (GRRE)	Convenient and accessible to members of target populations
CO	Group Level Intervention – Comprehensive Health Programs (CHP) for Youth	In schools or other setting convenient and accessible to members of the target audience.
CT	Single Session HIV Prevention Workshops	Clinics, schools, community-based organizations
CT	Multiple Session HIV Prevention Workshops	Clinics, schools, community-based organizations
CT	Programs in Prisons	Jail/prison

DC	Psycho-Educational Skills Building Groups	Locations and times that are convenient and safe for the target population.
HO	HERR Small Group Counseling	Community settings
IA	Group Level Intervention (GLI) – Multiple Session Group Workshop	Vans or before/after bar groups
IA	Group Level Intervention (GLI) – School Based Programs	Schools
IA	Group Level Intervention (GLI) – Out-of-School Based Programs	Treatment or alternative educational setting (e.g., youth detention centers, mental health facilities, alternative high school programs).
IL	Group Prevention & Support – Workshops	Appropriate settings for group programs include mental health centers, substance abuse treatment programs, youth centers, correctional facilities, waiting rooms, private homes or social gatherings
IL	Group Prevention & Support – Presentations	Appropriate settings for group programs include mental health centers, substance abuse treatment programs, youth centers, correctional facilities, waiting rooms, private homes or social gatherings
IL	Group Prevention & Support – Prevention support groups	Appropriate settings for group programs include mental health centers, substance abuse treatment programs, youth centers, correctional facilities, waiting rooms, private homes or social gatherings
IL	Group Prevention & Support – Events	Appropriate settings for group programs include mental health centers, substance abuse treatment programs, youth centers, correctional facilities, waiting rooms, private homes or social gatherings
KS	School Based Efforts for Youth	Schools
LA	Community Awareness Sessions	Churches, beauty shops, shelters, schools, etc. and other locations where target populations may be reached
LA	Peer Led Multiple Small Group Sessions	Schools, after school programs, churches, community centers, job corps, shelter, bars, clinics, jails and other locations
LA	Non-Peer Led Multiple Small Group Sessions	Schools, after school programs, churches, community centers, job corps, shelter, bars, clinics, jails and other locations

NC	Group Education Sessions – One Time	Homes, etc.
NC	Group Education Sessions – Series	Homes, etc.
NH	Group Education Sessions – One Time	May be in a home of group member
TX	Group Level Intervention	Areas where target population congregate
WI	Group Level Intervention (GLI)	Usually take place face-to-face, but may be conducted by conference call or computer to accommodate barriers to distance or illness; comfortable, safe environment

Mode:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Group Health Education/Risk Reduction (HE/RR) – Single Session	Health education – structured
AK	Group Health Education/Risk Reduction (HE/RR) – Multiple Sessions	Health education – structured
CA	Multi-Session Groups	Counseling – structured, semi-structured or minimally structured
CA	Group Peer Education	Counseling – structured, semi-structured or minimally structured
CH	Support Groups	Counseling – semi-structured or minimally structured
CH	Group Education	Education
CO	Group Level Intervention – Group Risk Reduction Education (GRRE)	Health education – structured
CO	Group Level Intervention – Comprehensive Health Programs (CHP) for Youth	Health education – structured or semi-structured
CT	Single Session HIV Prevention Workshops	Workshop – structured
CT	Multiple Session HIV Prevention Workshops	Workshops – structured or semi-structured
CT	Support Groups/Self-Help Groups/Clubs	Counseling -semi-structured or minimally structured
CT	Couples Counseling	Counseling – semi-structured
DC	Group Level Intervention	Health education – structured or semi-structured; Counseling – semi-structured

DC	Psycho-Educational Skills Building Groups	Workshops – structured
HO	HERR Small Group Counseling	Counseling – semi-structured
IA	Group Level Intervention (GLI) – Multiple Session Group Workshop	Health education – structured or semi-structured; Counseling – semi-structured or minimally structured
IA	Group Level Intervention (GLI) – School Based Programs	Health education – structured
IA	Group Level Intervention (GLI) – Out-of-School Based Programs	Health education – structured
ID	Group Level Intervention	Health educations – semi-structured Counseling – semi-structured
IL	Group Prevention & Support – Workshops	Workshops – structured or semi-structured
IL	Group Prevention & Support – Presentations	Presentations – structured
IL	Group Prevention & Support – Prevention support groups	Health education – semi-structured Counseling – semi-structured
IL	Group Prevention & Support – Events	Event – structured or semi-structured
KS	Group Level Intervention	Health education – semi-structured Counseling – semi-structured
KS	School Based Efforts for Youth	Health education – structured
LA	Community Awareness Sessions	Health education- structured or semi-structured Material Distribution
LA	Peer Led Multiple Small Group Sessions	Health education – structured
LA	Non-Peer Led Multiple Small Group Sessions	Health education – structured
MA	Small-Group Education and Skills Development Trainings	Health education – structured
MD	Small/Large Group	Health education – semi-structured
ME	Group Level Intervention	Health education – semi-structured Counseling – semi-structured and minimally structured

MI	Group Level Prevention Counseling	Health education – structured or semi-structured Counseling – structured or semi-structured
MI	Group Health Education/Risk Reduction	Health education – structured
MN	Group Level Education	Health education – structured or semi-structured Counseling – semi-structured or minimally structured
MO	Group Level Intervention	Workshops – structured Counseling – semi-structured
NC	Group Education Sessions – One Time	Health education – structured or semi-structured
NC	Group Education Sessions – Series	Health education – structured or semi-structured
NH	Group Education Sessions – One Time	Health education – semi-structured
NH	Group Education Sessions – Series	Health education – structured
NH	Support Groups	Counseling – minimally structured
NV	Small Group Interventions	Health education – minimally structured Counseling – minimally structured
SC	Group Level Intervention	Health education – structured or semi-structured Counseling – semi-structured or minimally structured
TX	Group Level Intervention	Health education – structured or semi-structured
VA	Group Level Intervention	Counseling – structured or semi-structured Health education – structured or semi-structured
VI	Risk Reduction Counseling	Counseling – semi-structured
WI	Group Level Intervention (GLI)	Counseling – semi-structured Health education – semi-structured

Provider:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Group Health Education/Risk Reduction (HE/RR) – Single Session	Professional
AK	Group Health Education/Risk Reduction (HE/RR) – Multiple Sessions	Professional
CA	Group Peer Education	Peer
CH	Group Education	Professional
CO	Group Level Intervention – Group Risk Reduction Education (GRRE)	Professional, Peer Must be able to demonstrate competence. Must receive at least 8 hours of updated HIV prevention training per year.
CO	Group Level Intervention – Comprehensive Health Programs (CHP) for Youth	Professional and/or peer who are competent in regard to culture and other diversity. Must be able to demonstrate competence. Must receive at least 8 hours of updated HIV prevention training per year.
CT	Support Groups/Self-Help Groups/Clubs	Professional, Paraprofessional
CT	Single Session HIV Prevention Workshops	Peer, Non-peer
CT	Multiple Session HIV Prevention Workshops	Peer, Non-peer
DC	Group Level Intervention	Peer, Non-peer
DC	Psycho-Educational Skills Building Groups	Professional, Paraprofessional
HO	HERR Small Group Counseling	Varies
IA	Group Level Intervention (GLI) – School Based Programs	Professionals (teachers), Peers
IA	Group Level Intervention (GLI) – Multiple Session Group Workshop	Peer, non-peer
IL	Group Prevention & Support – Workshops	Professional, Peer
IL	Group Prevention & Support – Presentations	Professional, Peer May be suitable for volunteers or less experienced staff

IL	Group Prevention & Support – Prevention support groups	Professional, Peer
IL	Group Prevention & Support – Events	Professional, Peer
KS	Group Level Intervention	Peer
LA	Non-Peer Led Multiple Small Group Sessions	Professional
LA	Peer Led Multiple Small Group Sessions	Peer
LA	Community Awareness Sessions	Peer
MA	Small-Group Education and Skills Development Trainings	Professional, Peer
MD	Small/Large Group	Peer
ME	Group Level Intervention	Professional, Peer
MN	Group Level Education	Peer, Non-peer
NH	Group Education Sessions – Series	Professional, Peer
NH	Support Groups	Professional
NV	Small Group Interventions	Professional, Peer
SC	Group Level Intervention	Professional, Peer
TX	Group Level Intervention	Paraprofessional, Peer
WI	Group Level Intervention (GLI)	Professional, Peer (independently or as co-facilitator)

Outcome:

All forty-six (46) individual level interventions with standards or definitions addressing outcomes indicated the anticipated outcome as behavioral.

Level:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Group Health Education/Risk Reduction (HE/RR) – Single Session	Group
AK	Group Health Education/Risk Reduction (HE/RR) – Multiple Sessions	Group
CA	Multi-Session Groups	Group
CA	Group Peer Education	Group
CH	Support Groups	Group

CH	Group Education	Group
CO	Group Level Intervention – Group Risk Reduction Education (GRRE)	Group – approximately five to 20 individuals
CO	Group Level Intervention – Comprehensive Health Programs (CHP) for Youth	Group
CT	Single Session HIV Prevention Workshops	Group
CT	Multiple Session HIV Prevention Workshops	Group
CT	Support Groups/Self-Help Groups/Clubs	Group
CT	Programs in Prisons	Individual, Group
CT	Couples Counseling	Couple
DC	Group Level Intervention	Group – varying sizes
DC	Psycho-Educational Skills Building Groups	Group – varying sizes
HO	HERR Small Group Counseling	Group
IA	Group Level Intervention (GLI) – Multiple Session Group Workshop	Group – varying sizes
IA	Group Level Intervention (GLI) – School Based Programs	Group
IA	Group Level Intervention (GLI) – Out-of-School Based Programs	Group
ID	Group Level Intervention	Group
IL	Group Prevention & Support – Workshops	Group
IL	Group Prevention & Support – Presentations	Group
IL	Group Prevention & Support – Prevention support groups	Group
IL	Group Prevention & Support – Events	Group
KS	Group Level Intervention	Group – varying sizes
LA	Community Awareness Sessions	Group
LA	Peer Led Multiple Small Group Sessions	Group
LA	Non-Peer Led Multiple Small Group Sessions	Group

MA	Small-Group Education and Skills Development Trainings	Group – approx. 4-15 members
MD	Small/Large Group	Group
ME	Group Level Intervention	Group
MI	Group Level Prevention Counseling	Group – varying sizes of two or more individuals
MI	Group Health Education/Risk Reduction	Group
MN	Group Level Education	Group
MO	Group Level Intervention	Group
NC	Group Education Sessions – One Time	Group
NC	Group Education Sessions – Series	Group
NH	Group Education Sessions – One Time	Group
NH	Group Education Sessions – Series	Group
NH	Support Groups	Group
NV	Small Group Interventions	Group – 2 or more, less than 20 members
SC	Group Level Intervention	Group – of varying sizes
TX	Group Level Intervention	Group
VA	Group Level Intervention	Group – two or more individuals of varying sizes
VI	Risk Reduction Counseling	Group
WI	Group Level Intervention (GLI)	Group

Target Population:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Group Health Education/Risk Reduction (HE/RR) – Single Session	Heterosexual adults, MSM, youth-at-risk
AK	Group Health Education/Risk Reduction (HE/RR) – Multiple Sessions	High-risk youth, heterosexual adults, IDU, sexual partners of IDU, MSM
CO	Group Level Intervention – Group Risk Reduction Education (GRRE)	Individuals who are at high risk of acquiring or transmitting HIV infection.
CO	Group Level Intervention – Comprehensive Health Programs (CHP) for Youth	Children (ages 0-12) and high risk youth (ages 13-19)

CT	Single Session HIV Prevention Workshops	Difficult to reach populations such as: homeless, runaways, IDUs not in treatment; and College women, African-American adolescent and adult males
CT	Multiple Session HIV Prevention Workshops	MSM, IDU, heterosexual women, adolescents, seriously mentally ill patients, gay youth, and college students.
CT	Programs in Prisons	High-risk incarcerated individuals
CT	Couples Counseling	Serodiscordant and serocordant couples.
DC	Group Level Intervention	Target those at low risk for HIV/AIDS as well as those at high risk
DC	Psycho-Educational Skills Building Groups	Target those at low risk for HIV/AIDS as well as those at high risk
IA	Group Level Intervention (GLI) – Multiple Session Group Workshop	Individuals at high risk Composition may be characteristic-specific or mixed.
IA	Group Level Intervention (GLI) – School Based Programs	In-school youth
IA	Group Level Intervention (GLI) – Out-of-School Based Programs	Youth in non-traditional school or treatment settings (e.g., incarcerated youth, youth in mental health facilities, and youth in alternative high school programs).
KS	Group Level Intervention	Individuals infected with or at high risk of becoming infected with HIV.
KS	School Based Efforts for Youth	Youth
LA	Community Awareness Sessions	Racial/ethnic minorities, Sexually active females, males who have sex with males, youth, substance users.
LA	Peer Led Multiple Small Group Sessions	Racial/ethnic minorities, Sexually active females, males who have sex with males, youth, substance users.
LA	Non-Peer Led Multiple Small Group Sessions	Racial/ethnic minorities, Sexually active females, males who have sex with males, youth, substance users.
ME	Group Level Intervention	Persons at increased risk of becoming infected or already infected
SC	Group Level Intervention	Women at risk, youth at risk, school age youth, drug users, MSM, and incarcerated individuals.

VI Risk Reduction Counseling High risk individuals

Other:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Group Health Education/Risk Reduction (HE/RR) – Single Session	Culturally appropriate materials Skills building component Interactive discussion or role play
CO	Group Level Intervention – Group Risk Reduction Education (GRRE)	Cultural competence/proficiency, where and when delivered and how much, content and methods employed, consent/confidentiality considerations, etc.
CO	Group Level Intervention – Comprehensive Health Programs (CHP) for Youth	Cultural competence/proficiency, where and when delivered and how much, content and methods employed, consent/confidentiality considerations, etc.
CT	Single Session HIV Prevention Workshops	Teach behavioral skills
CT	Multiple Session HIV Prevention Workshops	When they include information, motivation, and behavioral skills content, multiple session HIV prevention workshops have consistently and successfully increased safer sexual and drug use behavior across almost all populations
CT	Support Groups/Self-Help Groups/Clubs	In general, more specific group interventions that provide information about HIV/AIDS, attempt to increase motivation to be safe, and teach behavioral skills for HIV prevention are more successful than support groups without a curriculum.
DC	Group Level Intervention	Includes a skills component.
DC	Psycho-Educational Skills Building Groups	Includes a skills component Workshop topics usually build on each other from session to session.
IA	Group Level Intervention (GLI) – Multiple Session Group Workshop	Includes a skills component.
IA	Group Level Intervention (GLI) – School Based Programs	Includes a skills component.

IA	Group Level Intervention (GLI) – Out-of-School Based Programs	Includes a skills component.
ID	Group Level Intervention	Includes a skills component.
IL	Group Prevention & Support – Workshops	Trained facilitators attempt to bring knowledge, skills and ideas out of the group.
IL	Group Prevention & Support – Presentations	May be appropriate when time is limited or when learners lack the maturity, knowledge, or skills to be more actively involved.
IL	Group Prevention & Support – Prevention support groups	May be open (people can join any time) or closed (the same group meets for a set period of time) Support groups encourage disclosure and learning of RR behavior.
KS	Group Level Intervention	Includes skills component Culturally, linguistically, age, and gender appropriate
KS	School Based Efforts for Youth	All programs should be skills-based and help to develop self-efficacy.
LA	Community Awareness Sessions	Includes skills building. Use approved curriculum.
LA	Peer Led Multiple Small Group Sessions	Use established/approved curriculum. Focuses on skill building.
LA	Non-Peer Led Multiple Small Group Sessions	Use established/approved curriculum. Focuses on skill building.
MA	Small-Group Education and Skills Development Trainings	Includes skills building component. Follows a standardized curriculum.
MD	Small/Large Group	Includes a skills component.
ME	Group Level Intervention	Includes skills training.
MI	Group Health Education/Risk Reduction	Includes skills building . Must include client demonstration of skills.
MN	Group Level Education	Includes a skills component.
MO	Group Level Intervention	Includes skills building component.
NC	Group Education Sessions – Series	Often a prescheduled activity.
NH	Group Education Sessions – One Time	May include practice of skills.

NH	Support Groups	Comprised of people with shared concerns.
SC	Group Level Intervention	Includes interpersonal and skills training for clients. Can include more tailored individual level interventions with some of the group members.
VA	Group Level Intervention	Includes a skills building component.
VI	Risk Reduction Counseling	Includes skills building.
WI	Group Level Intervention (GLI)	Includes a skills building component. Collection of pre- and post-session assessments of knowledge, attitudes, and behaviors and surveys of client satisfaction to guide future program development.

Jurisdictions' Definitions of Group Level Interventions

Group Health Education/Risk Reduction (HE/RR) – Single Session (AK)

Single Session – A presentation to or facilitated interactive discussion with a group of participants from the target population on a single occasion. Ideally it includes a skills component.

“Characteristics of Effective Interventions” and additional information such as applicable target populations, prevention goal, essential components, behavioral/social science and evidence for effectiveness for Group HE/RR (Single Session included separately from definition).

- App. target populations: Heterosexual adults, MSM, youth-at-risk
- Prevention Goal: Reduce unsafe sexual behaviors; increase condom use
- Essential components: culturally appropriate materials; skills building component; interactive discussion or role play
- Behavioral/social science theoretical basis: cognitive learning theory; empirical studies

<i>Duration/Dosage:</i>	Single occasion
<i>Venue:</i>	
<i>Mode:</i>	Health education – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	Heterosexual adults, MSM, youth-at-risk
<i>Other:</i>	Culturally appropriate materials Skills building component Interactive discussion or role play

Group Health Education/Risk Reduction (HE/RR) – Multiple Sessions (AK)

Multiple Session – A structured series of presentations, discussions, or curricula whereby the same group of participants from the target population meet multiple times over a specific period of time. Involves a skills building component and some opportunity for participant self-assessment of personal risk.

“Characteristics of Effective Interventions” and additional information such as applicable target populations, prevention goal, essential components, behavioral/social science, and evidence for effectiveness for Group HE/RR (Multiple Sessions included separately from definition).

- App. target populations: High-risk youths, heterosexual adults, IDU, sexual partners of IDU, MSM.
- Prevention Goal: Reduce unsafe sexual behaviors; increase condom use; in youth, decrease number of sexual partners and delay initiation of sexual activity.
- Essential components: Structured group education program with specific goals tailored to a specific audience, ideally based on a curriculum with demonstrated effectiveness. Curriculum modified for local use must retain essential components of the original; includes skills building opportunities for condom use and communication (refusal and negotiation); interactive, not didactic.
- Behavioral/social science theoretical basis: transtheoretical model of stages of behavior change and common theoretical factors derived from the health belief model, theory of reasoned action, and social cognitive theory; groups targeting a specific ethnicity include a component of ethnic pride; groups targeting women include gender and power issues.

<i>Duration/Dosage:</i>	Multiple times with same group of participants
<i>Venue:</i>	
<i>Mode:</i>	Health education – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	High-risk youth, heterosexual adults, IDU, sexual partners of IDU, MSM
<i>Other:</i>	

Multi-Session Groups (CA)

Program Category 2: Group-Level Interventions

Group level interventions provide education and risk reduction support groups to promote and reinforce safer behaviors, and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change. The common denominator of these strategies is their focus on group.

1. Speakers Bureaus
2. Group Presentations
3. Multi-Session Group – Multi-session groups are closed structured groups, drop-in groups and support groups held over a period of time to develop risk reduction skills, and receive ongoing education and psychosocial support to maintain safer sex practices.
4. Group Peer Education

Outcome effectiveness and/or cost effectiveness provided for each intervention.

<i>Duration/Dosage:</i>	Multiple sessions held over a period of time
<i>Venue:</i>	
<i>Mode:</i>	Counseling – structured, semi-structured or minimally structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	

Group Peer Education (CA)

Program Category 2: Group-Level Interventions

Group level interventions provide education and risk reduction support groups to promote and reinforce safer behaviors, and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change. The common denominator of these strategies is their focus on group.

1. Speakers Bureaus
2. Group Presentations
3. Multi-Session Group
4. Group Peer Education – Group peer education provides education, counseling, risk assessment, and referrals by trained peers of target group members.

Outcome effectiveness and/or cost effectiveness provided for each intervention.

<i>Duration/Dosage:</i>	
<i>Venue:</i>	
<i>Mode:</i>	Counseling – structured, semi-structured or minimally structured
<i>Provider:</i>	Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	

Support Groups (CH)

Describes:

- I. Minimum Criteria
 - A. Regularly scheduled meetings for purpose of discussing and/or adopting/reinforcing positive behavior change in participants
 - B. Requires a written outline of appropriate (i.e., relevant to the participants)
 - C. Group activities must involve a skills building component (e.g., role playing, safer injection techniques, negotiation skills, etc.)
 - D. A pre/post HIV/AIDS risk assessment (measurement tool provided by Department of Public Health [DPH]) is implemented with all participants
- II. Quality Assurance Measures
 - A. Support Group goes beyond the minimum criteria and incorporates discussion issues specific to target population
- III. Data Requirements
 - A. In an effort to better document service delivery citywide, all DPH prevention funded agencies will be required to collect and submit the following data for each intervention used in their program. Data will be submitted to DPH scan forms (provided by DPH). This information will be used to improve the quality and effect of HIV prevention projects in Chicago.
 1. Type of agency
 2. Risk population
 3. Client demographics
 4. Setting
 5. Number of interventions
 6. Staffing
 7. Expenditures
 8. Pre/Post HIV/AIDS Behavioral Risk Assessment Measurement (DPH tool)
 9. Number of clients participating in 1-2-3-4-5 or more sessions

What Works in Prevention?

Key factors of Successful Interventions and Programs:

- I. Services are:
 - A. delivered in a culturally appropriate and culturally sensitive manner
 - B. easily accessed
 - C. voluntary
- II. Target Population is:
 - A. clearly defined and with a proven need of HIV prevention services.
- III. Goals and Objectives of the Program are:
 - A. clearly defined, time-phased, and measurable.
- IV. Interventions are:
 - A. based on sound behavioral research
 - B. well planned, implemented, monitored and evaluated
 - C. created (whenever possible) with input from target population
 - D. focused on reducing specific behaviors and address skill levels, attitudes, and behaviors that influence high risk activities (i.e., how to use condoms appropriately,

<i>Duration/Dosage:</i>	Regularly scheduled
<i>Venue:</i>	
<i>Mode:</i>	Counseling – semi-structured or minimally structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	

Group Education (CH)

Describes:

- I. Minimum Criteria
 - A. A planned (i.e., 2 x per month, 1 x per week, etc., over a specific period of time with a scheduled beginning and endpoint) series of educational experiences targeted to meet the informational, social, behavioral skills building, support or referral needs of the individuals.
 - B. A written curriculum (which must be approved by a CSRP) covering: HIV/AIDS; STDs; risk/harm reduction; substance use/abuse; and counseling and testing must exist.
 - C. The curriculum must contain a skills building component (e.g., role playing, safer infection techniques, negotiation skills, etc.)
 - D. A minimum participation standard exists
 - E. A pre/post HIV/AIDS knowledge assessment (measurement tool provided by Department of Public Health [DPH]) is implemented with all participants.
- II. Quality Assurance Measures
 - A. Curriculum goes beyond the minimum criteria and incorporates discussion of issues specific to the target population.
 - B. Group facilitator debriefs and documents main discussion points of each session
- III. Data Requirements
 - A. In an effort to better document service delivery citywide, all DPH prevention funded agencies will be required to collect and submit the following data for each intervention used in their program. Data will be submitted to DPH scan forms (provided by DPH). This information will be used to improve the quality and effect of HIV prevention projects in Chicago.
 1. Type of agency
 2. Risk population
 3. Client demographics
 4. Setting
 5. Number of interventions
 6. Staffing
 7. Expenditures

8. Pre/Post HIV/AIDS Knowledge Assessment Measurement (DPH tool)
9. Pre/Post HIV/AIDS Behavioral Risk Assessment Measurement (DPH tool)
10. Number of clients participating in 1-2-3-4-5 or more sessions

What Works in Prevention?

Key factors of Successful Interventions and Programs:

- I. Services are:
 - A. delivered in a culturally appropriate and culturally sensitive manner
 - B. easily accessed
 - C. voluntary
- II. Target Population is:
 - A. clearly defined and with a proven need of HIV prevention services.
- III. Goals and Objectives of the Program are:
 - A. clearly defined, time-phased, and measurable.
- IV. Interventions are:
 - A. based on sound behavioral research
 - B. well planned, implemented, monitored and evaluated
 - C. created (whenever possible) with input from target population
 - D. focused on reducing specific behaviors and address skill levels, attitudes, and behaviors that influence high risk activities (i.e., how to use condoms appropriately, how to clean injection equipment, and reinforcing positive attitudes about condom use)
 - E. vehicles for demonstrating, reinforcing, and promoting positive behaviors
- V. Agencies have:
 - A. the ability to maintain multiple contacts with participants
 - B. the ability to document service delivery (i.e., develop and maintain survey questionnaires, client assessment forms, etc.)
 - C. a strong referral and follow-up system exists (formal, established, and written with signed memorandums of agreement)
 - D. the ability and desire to collaborate with other organizations
 - E. policies that conform with prevailing local, state and federal laws regarding client confidentiality
 - F. staff with necessary academic background or experience in a human-services-related field (i.e., social work, psychology, nursing, counseling, or health education); and case management and assessment techniques
 - G. staff that are knowledgeable about HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change.
- VI. How Do We Assure Quality?
 - A. Minimum Quality Assurance Standards
- VII. Services are:
 - A. offered in a safe environment. The agency should be clean, neat, well ventilated, and clutter free
- VIII. Interventions are:
 - A. whenever possible, implemented/delivered by individuals representative of the target population
- IX. Agencies have:

- A. Policies and Procedure Manual. This manual must contain all intervention protocols, policies, and procedures of the services being delivered
- B. current collaborative linkages within community and, when possible, should participate in one or more Community Planning Groups
- C. staff that are familiar with available community resources
- D. staff that are trained in the implementation of program intervention(s). All trainings must be documented in staff folders. The agency should promote and encourage continuing educational trainings.
- E. grievance procedures in place and a method for informing clients of this process. Proof of client receipt should be documented in client charts
- F. policies on staff safety (on site and off site)
- G. a relationship with local authorities (police) such that the program is well known in the community
- H. regular assessments of clients satisfaction through periodic client satisfaction surveys
- I. regular management/supervisors meetings with program staff to discuss project and status progress towards stated outcomes

Duration/Dosage: A planned specific period of time with scheduled beginning and end point.

Venue:

Mode: Education

Provider: Professional

Outcome: Behavioral

Level: Group

Target Population:

Other:

Group Level Intervention – Group Risk Reduction Education (GRRE) (CO)

Encompassed under Health Education/Risk Reduction

Subcategory of GLI:

Group Risk Reduction Education (GRRE) provides small groups of individuals at high risk of acquiring or transmitting HIV infection with education interventions that promote and reinforce safer behaviors; emphasis on the relationship between substance use and risky behaviors; educational materials; and referrals to appropriate services."

Includes goal of the intervention, target population, cultural competence/proficiency, where delivered, when delivered, how much, content and methods employed, qualifications of people to do this work, continuing education/ongoing training requirements, consent/confidentiality considerations, quality assurance, evaluation information, penalties for violating standards and other pertinent information.

- Goal of the Intervention: GRRE seeks to lower risk behavior among small groups of individuals who are at high risk of acquiring or transmitting HIV infection
- Target Population: GRRE occurs in a small-group setting with approximately five to 20 individuals who are at high risk of acquiring or transmitting HIV infection.
- Cultural competence/proficiency: ...
- Where Delivered: The locations are convenient and accessible to members of the target group (as determined by formative evaluation).
- When Delivered: ...
- How Much: The intervention should allocate time to each of the content areas listed below, whether in single or multiple sessions. Multiple sessions are generally preferred because this allows for opportunities to develop and discuss topics in more depth, “real world” experience between sessions, and time for reinforcement of skills, without overwhelming the client.
- Content and Methods Employed: ...
- Qualifications of People to do this work: Providers of GRRE should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.
- Continuing Education/Ongoing Training Requirements: Providers of GRRE must receive at least 8 hours of updated HIV prevention training per year.
- Consent/Confidentiality Considerations: ...
- Quality Assurance: ...
- Evaluation: ...
- Penalties for Violating Standards: ...
- Other: ...

<i>Duration/Dosage:</i>	Single allowed, multiple preferred
<i>Venue:</i>	Convenient and accessible to members of target populations
<i>Mode:</i>	Health education – structured
<i>Provider:</i>	Professional , Peer Must be able to demonstrate competence. Must receive at least 8 hours of updated HIV prevention training per year.
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group – approximately five to 20 individuals
<i>Target Population:</i>	Individuals who are at high risk of acquiring or transmitting HIV infection.
<i>Other:</i>	Cultural competence/proficiency; where and when delivered and how much, content and methods employed, consent/confidentiality considerations, etc.

Group Level Intervention – Comprehensive Health Programs (CHP) for Youth (CO)

Encompassed under Health Education/Risk Reduction

Subcategories of GLI:

Comprehensive Health Programs (CHP) for Youth – involve group sessions or workshops which address broad health topics such as HIV and STD prevention, nutrition, substance abuse prevention, mental and physical health, and suicide prevention. Such programs encourage research-based approaches to HIV prevention addressing the behavioral, race, ethnicity, and subpopulation priorities set for high risk children (age 0-12) and adolescents (age 13-19) as reflected in the CWT plan. This intervention is not intended for young adults (20-24). They involve a comprehensive health program (CHP) framework, ideally utilizing a curriculum previously funded under this category. CHP must include clear and measurable educational goals.

Includes goal of the intervention, target population, cultural competence/proficiency, where delivered, when delivered, how much, content and methods employed, qualifications of people to do this work, continuing education/ongoing training requirements, consent/confidentiality considerations, quality assurance, evaluation information, penalties for violating standards and other pertinent information.

- Goal of the Intervention: CHP programs encourage research-based approaches to HIV prevention meant to lead children and youth from behaviors that put them at risk for HIV infection to a wellness orientation.
- Target Population: CHP targets children (age 0-12) and high-risk adolescents (age 13-19) as reflected in the CWT plan. This intervention is not intended for young adults (20-24)
- Cultural competence/proficiency: ...
- Where Delivered: CHPs are delivered in schools or other settings convenient and accessible to members of the target audience (as determined through formative evaluation).
- When Delivered: ...
- How Much: CHP should be delivered in multiple sessions
- Content and Methods Employed: ...
- Qualifications of People to do this work: CHP must involve Health Dept and CBO staff and members of the targeted population as content experts. Providers of CHP should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means. Educators may be peers or professionals who are competent in regard to culture and other diversity and able to present the materials in an understanding and non-judgmental manner.
- Continuing Education/Ongoing Training Requirements: Providers of CHP must receive at least 8 hours of updated HIV prevention training per year.
- Consent/Confidentiality Considerations: ...
- Quality Assurance: ...
- Evaluation: ...
- Penalties for Violating Standards: ...
- Other: ...

<i>Duration/Dosage:</i>	Multiple sessions
<i>Venue:</i>	In schools or other setting convenient and accessible to members of the target audience.
<i>Mode:</i>	Health education – structured or semi-structured
<i>Provider:</i>	Professional and/or peer who are competent in regard to culture and other diversity. Must be able to demonstrate competence. Must receive at least 8 hours of updated HIV prevention training per year.
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	Children (ages 0-12) and high risk youth (ages 13-19)
<i>Other:</i>	Cultural competence/proficiency, where and when delivered, content and methods employed, consent/confidentiality considerations, etc.

Single Session HIV Prevention Workshops (CT)

Encompassed under Group Level Interventions – Interventions involving small to medium sized group of intervention participants, and a leader who is either a peer or a non-peer.

Single session HIV prevention workshops involve a group of people, usually with some characteristics in common (e.g., they are from the same risk group, or same ethnic background, or same sexual orientation), who come together to learn about HIV prevention in a group for a single session. The health educator who leads the session can be with a peer or non-peer. These interventions are usually conducted in community settings like public health clinics, schools, or CBOs. Workshops teach HIV information, improve attitudes towards prevention, increase supportive norms for prevention, and teach behavioral skills for prevention. Workshops often involve group members sharing their experiences and learning from one another.

Does the intervention change behavior?

- When they include information, motivation, and behavioral skills content, single session interventions have increased safer sexual behavior in many populations, though in general, the longer an intervention lasts, the more behavioral change occurs. So multiple session interventions are typically more successful than single session interventions.
- It is easier to get people to participate in a one session intervention since it requires less of a time commitment.

With what populations is it successful in changing behavior?

- Single session interventions may be more practical in situation where the population is difficult to reach for multiple session interventions (e.g., homeless, runaways, IDUs not in treatment). Single session interventions have been successful with college women, African American adolescent and adult males.

<i>Duration/Dosage:</i>	Single Session
<i>Venue:</i>	Clinics, schools, community-based organizations
<i>Mode:</i>	Workshop – structured
<i>Provider:</i>	Peer, Non-peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	Difficult to reach populations such as: homeless, runaways, IDUs not in treatment; and College women, African-American adolescent and adult males
<i>Other:</i>	Teach behavioral skills

Multiple Session HIV Prevention Workshops (CT)

Encompassed under Group Level Interventions – Interventions involving small to medium sized group of intervention participants, and a leader who is either a peer or a non-peer.

Multiple session HIV prevention workshops involve a group of people, usually with some characteristics in common (e.g., they are from the same risk group, or same ethnic background, or same sexual orientation), who come together to learn about HIV prevention in a group for a series of sessions. The health educator who leads the sessions can be either a peer or a non-peer. These interventions are usually conducted in community settings like public health clinics, schools, or community-based organizations. Workshops teach HIV information, improve attitudes towards prevention, increase supportive norms for prevention, and teach behavioral skills for prevention. Workshops often involve group members sharing their experiences and learning from one another.

Does the intervention change behavior?

- When they include information, motivation, and behavioral skills content, multiple session HIV prevention workshops have consistently and successfully increased safer sexual and drug use behavior across almost all populations.

With what populations is it successful in changing behavior?

- Multiple session HIV prevention workshops have successfully changes risky sexual and drug use practices among MSM, IDU, heterosexual women, adolescents, seriously mentally ill patients, gay youth, and college students.

<i>Duration/Dosage:</i>	Multiple sessions
<i>Venue:</i>	Clinics, schools, community-based organizations
<i>Mode:</i>	Workshops – structured or semi-structured
<i>Provider:</i>	Peer, Non-peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	MSM, IDU, heterosexual women, adolescents, seriously mentally ill patients, gay youth, and college students.
<i>Other:</i>	When they include information, motivation, and behavioral skills content, multiple session HIV prevention workshops have consistently and successfully increased safer sexual and drug use behavior across almost all populations.

Support Groups/Self-Help Groups/Clubs (CT)

Encompassed under Group Level Interventions – Interventions involving small to medium sized group of intervention participants, and a leader who is either a peer or a non-peer.

Support Groups/Self-Help Groups/Clubs are often small groups where individuals from the same gender, race, HIV risk group, or interests come together with a counselor to give advice and support one another for various purposes, including HIV risk reduction. These types of interventions generally do not have a set "curriculum" for what will be discussed.

Does the intervention change behavior? ...

With what populations is it successful in changing behavior?

- If they include the necessary components for successful behavior change, support groups, self-help groups, and clubs may be successful among adults and adolescent MSM or other populations. Unfortunately, such groups often do not include these components. In general, more specific group interventions that provide information about HIV/AIDS, attempt to increase motivation to be safe, and teach behavioral skills for HIV prevention are more successful than support groups without a curriculum.

Duration/Dosage:

Venue:

Mode: Counseling -semi-structured or minimally structured

Provider: Professional, Paraprofessional

Outcome: Behavioral

Level: Group

Target Population:

Other: In general, more specific group interventions that provide information about HIV/AIDS, attempt to increase motivation to be safe, and teach behavioral skills for HIV prevention are more successful than support groups without a curriculum.

Programs in Prisons (CT)

Encompassed under Community Level Interventions – These are interventions that try to change HIV risk behavior by changing community norms (and sometimes even the laws) of a community to support HIV prevention.

Programs in prisons are simply individual or group level interventions that take place in prisons. Prisons provide a good opportunity to get access to high risk individuals for interventions.

Does The Intervention Change Behavior?...

With What Population Is It Successful In Changing Behavior?

- One published study showed that an HIV prevention programs was successful with incarcerated women.

This intervention included in both ILI and GLI

Duration/Dosage:

Venue: Jail/prison

Mode:

Provider:

Outcome: Behavioral

Level: Individual, Group

Target Population: High-risk incarcerated individuals

Other: Individual and group level interventions that take place in prisons.

Couples Counseling (CT)

Encompassed under ILI – Interventions that target one person. In individual level interventions, one person (e.g., an HIV test counselor) is doing an HIV prevention intervention with another single individual (e.g., the person being tested).

Couples counseling involves incorporating both members of a couple into HIV risk reduction counseling sessions. Couples involved in couple level HIV risk reduction counseling are usually serodiscordant (one HIV+ and one HIV-), though research has also been done with couples counseling with serodiscordant couples and couples whose HIV status is unknown.

Does Intervention Change Behavior?...

With What Populations Is It Successful In Changing Behavior?

- Couples counseling has shown success with heterosexual couples. Couples HIV risk reduction is not relevant for long-term monograms relationships where both partners are known to be HIV-. But for newer relationships HIV prevention counseling might be useful, and partners can learn skills that might be used in later relationships.

Duration/Dosage:

Venue:

Mode: Counseling – semi-structured

Provider:

Outcome: Behavioral

Level: Couple

Target Population: Serodiscordant and seroconcordant couples

Other:

Group Level Intervention (DC)

From "Guidance and Standards for HIV Prevention Interventions"

Group Level Interventions consist of health educational and risk-reduction counseling that shift the delivery of service from individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide-range of skills, information, education, and support.

Some providers may consider general education activities to be group-level interventions. However, for the purposes of CDC reporting, GLI does not include "one-shot" educational presentations or lectures that lack a skills component.

Interventions that focus on groups as a target for HIV prevention and education may be structured to encourage the initiation and maintenance of safer behaviors, to provide interpersonal skills training, and/or to sustain appropriate behavior change. As with individual

counseling, the intervention may be delivered by a peer or a non-peer. Programs usually include information about condom use, negotiation of safer sexual behaviors and risk-reduction strategies for IDUs. Unlike CTRPN and individual interventions, group interventions may target those at low risk for HIV/AIDS as well as those at high risk, An example of group-level interventions is psycho-educational skills-building groups."

Includes:

1. Standards for Psycho-Educational Skills-Building Groups
2. Other considerations
3. Using Support Groups for HIV Prevention (from CDC Guidelines for HERR activities, March 1995)

Duration/Dosage:

Venue:

Mode: Health education – structured or semi-structured
Counseling – semi-structured

Provider: Peer, Non-peer

Outcome: Behavioral

Level: Group – varying sizes

Target Population: Target those at low risk for HIV/AIDS as well as those at high risk

Other: Includes a skills component

Psycho-Educational Skills Building Groups (DC)

From "Guidance and Standards for HIV Prevention Interventions"

Group Level Interventions consist of health educational and risk-reduction counseling that shift the delivery of service from individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide-range of skills, information, education, and support.

Some providers may consider general education activities to be group-level interventions. However, for the purposes of CDC reporting, GLI does not include "one-shot" educational presentations or lectures that lack a skills component.

Interventions that focus on groups as a target for HIV prevention and education may be structured to encourage the initiation and maintenance of safer behaviors, to provide interpersonal skills training, and/or to sustain appropriate behavior change. As with individual counseling, the intervention may be delivered by a peer or a non-peer. Programs usually include information about condom use, negotiation of safer sexual behaviors and risk-reduction strategies for IDUs. Unlike CTRPN and individual interventions, group interventions may target those at low risk for HIV/AIDS as well as those at high risk, An example of group-level interventions is psycho-educational skills-building groups."

Includes:

1. Standards for Psycho-Educational Skills-Building Groups:

Psycho-Educational Skills Building Groups are based on the Health Belief Model – which identifies the key elements of decision making, such as a person’s perception of susceptibility, perceived severity of the illness, and the perceived barriers to prevention – and on Social Cognitive Theory – which views learning as a social process influence by interactions with other people.

Individuals participate in multiple-session group workshops. They attend anywhere from 4-12 sessions – for a total of 12-24 hours – that are designed to increase their ability to initiate and sustain safer-sex, risk reduction and healthy behaviors. Workshop topics usually build on each other from session to session. Multiple sessions provide an opportunity to go into greater depth about HIV risk reduction issues and strategies, providing and enhanced opportunity for behavior change.

Psycho-education skills building programs include the following essential components:

- Interventions are conducted at locations and times that are convenient and safe for the target population.
- Sessions are facilitated by a trained facilitator or professional in a manner that is culturally and linguistically appropriate for the target population. ...
- The sessions incorporate practical, useful skills-building exercises or demonstrations based on the needs of the target population. ...

2. Other considerations

3. Using Support Groups for HIV Prevention (from CDC Guidelines for HERR activities, March 1995)

<i>Duration/Dosage:</i>	4-12 sessions for a total of 12-24 hours
<i>Venue:</i>	Locations and times that are convenient and safe for the target population.
<i>Mode:</i>	Workshops – structured
<i>Provider:</i>	Professional, Paraprofessional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group – varying sizes
<i>Target Population:</i>	Target those at low risk for HIV/AIDS as well as those at high risk
<i>Other:</i>	Includes a skills component Workshop topics usually build on each other from session to session.

HERR Small Group Counseling (HO)

This intervention brings individuals together to learn about HIV/AIDS, discuss safer sex, and participate in educational activities. Groups meet in community settings for single or multiple sessions. They vary in terms of goals, participants, and the characteristics of facilitators. The most important attribute of small group interventions is that they emphasize collective experiences, encouraging members to learn from each other (Kalichman, 1998).

Also included in Comprehensive Plan.

<i>Duration/Dosage:</i>	Single or multiple sessions
<i>Venue:</i>	Community settings
<i>Mode:</i>	Counseling – semi-structured
<i>Provider:</i>	Varies
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	

Group Level Intervention (GLI) – Multiple Session Group Workshop (IA)

Description taken from the Taxonomy of HIV/AIDS Prevention Interventions from the Academy of Educational Development and the CDC's 2000 Evaluation Guidance (CDC, 1999) for the purpose of "making meaningful distinctions and choices among possible interventions.

A group level intervention is health education and risk reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide range of skills, information, education, and support. GLI provides small groups of individuals at high risk of acquiring or transmitting HIV infection with: educational interventions that promote and reinforce safer behaviors; interpersonal skills training and support in negotiation and maintaining safer sexual and needle-sharing behaviors; emphasis on the relationship between substance abuse and risky behaviors; educational materials; and referrals to appropriate services.

Many providers may consider general education activities to be group level interventions. However, for the purposes of this discussion, GLI does not include "one-shot" educational presentations or lectures that lack a skill component. Those types of activities should be included in the Health Communication/Public Information category."

Encompassed under Health Education/Risk Reduction: (p. 167-193)

... The goals of health education and risk reduction activities are to go beyond the provision of information to provide education and counseling that assists individuals in developing the skills,

abilities, and self-esteem to carry out behavior change (CDC, 1995). Health education and risk reduction interventions can be delivered at individual, group, community, or outreach levels. HE/RR activities can include counseling, workshops, educational programs and materials, presentations, and outreach activities. ...

Group level interventions shift the delivery of services from individuals to groups of varying sizes. Group-level interventions use peer or non-peer models involving a wide range of skills, information, and support.

1. Multiple Session Group Workshops – a series of workshops, groups or meetings introducing HIV issues and linking them to other life issues not easily or immediately understood as relating to HIV. Workshop topics usually build on each other from session to session. Groups may be closed or drop-in, mixed or serostatus-specific, structured or issue driven groups for risk reduction and psychosocial support. Multiple sessions provide an opportunity to go into greater depth about risk reduction issues and strategies, and this format provides enhanced opportunity for behavior change. The intervention can draw people in with other (not directly HIV-related) activities. Groups can be held in vans or held as before/after bar groups.
 - a. Demonstrated effectiveness
 - b. Suggested Uses
2. School Based Programs
3. Out-of-School Based Programs

<i>Duration/Dosage:</i>	Multiple
<i>Venue:</i>	Vans or before/after bar groups
<i>Mode:</i>	Health education – structured or semi-structured Counseling – semi-structured or minimally structured
<i>Provider:</i>	Peer, Non-peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group – varying sizes
<i>Target Population:</i>	Individuals at high risk Composition may be characteristic-specific or mixed
<i>Other:</i>	Includes skills component

Group Level Intervention (GLI) – School Based Programs (IA)

Description taken from the Taxonomy of HIV/AIDS Prevention Interventions from the Academy of Educational Development and the CDC's 2000 Evaluation Guidance (CDC, 1999) for the purpose of "making meaningful distinctions and choices among possible interventions.

A group level intervention is health education and risk reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer

models involving a wide range of skills, information, education, and support. GLI provides small groups of individuals at high risk of acquiring or transmitting HIV infection with: educational interventions that promote and reinforce safer behaviors; interpersonal skills training and support in negotiation and maintaining safer sexual and needle-sharing behaviors; emphasis on the relationship between substance abuse and risky behaviors; educational materials; and referrals to appropriate services.

Many providers may consider general education activities to be group level interventions. However, for the purposes of this discussion, GLI does not include "one-shot" educational presentations or lectures that lack a skill component. Those types of activities should be included in the Health Communication/Public Information category."

Encompassed under Health Education/Risk Reduction: (p. 167-193)

... The goals of health education and risk reduction activities are to go beyond the provision of information to provide education and counseling that assists individuals in developing the skills, abilities, and self-esteem to carry out behavior change (CDC, 1995). Health education and risk reduction interventions can be delivered at individual, group, community, or outreach levels. HE/RR activities can include counseling, workshops, educational programs and materials, presentations, and outreach activities....

Group level interventions shift the delivery of services from individuals to groups of varying sizes. Group-level interventions use peer or non-peer models involving a wide range of skills, information, and support.

1. Multiple Session Group Workshops
2. School Based Programs – When the four curricula identified by the CDC as being effective are compared with curricula without positive behavioral results, the effective curricula share several characteristics. This may be linked to their success, while ineffective curricula lack one or more of these characteristics. These characteristics were first published by a panel of experts selected by CDC (Kirby et al., 1994) and subsequently updated by Kirby (1997). These characteristics reflect different aspects of effective instructional methods.

The nine characteristics that effective programs share include the following:

1. Effective programs focused on reducing one or more sexual behaviors that lead to unintended pregnancy.
2. The behavioral goals, teaching methods, and materials were appropriate to the age, sexual experience, and culture of students.
3. Effective programs were based upon theoretical approaches that have been demonstrated to be effective in influencing other health-related risky behaviors.
4. Effective programs lasted a sufficient length of time to complete important activities adequately.
5. Effective programs employed a variety of teaching methods designed to involve the participants and have them personalize the information.

6. Effective programs provided basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse.
7. Effective programs included activities that address social pressures on sexual behaviors. These activities took a variety of forms, for example, one curriculum addressed media influences.
8. Effective programs provided modeling and practice of communication, negotiation, and refusal skills.
9. Effective programs selected teachers or peers who believed in the program they were implementing and then provided training for those individuals.

3. Out-of-School Based Programs

<i>Duration/Dosage:</i>	Multiple
<i>Venue:</i>	Schools
<i>Mode:</i>	Health education – structured
<i>Provider:</i>	Professionals (teachers) and peers
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	In-school youth
<i>Other:</i>	Includes a skills component

Group Level Intervention (GLI) – Out-of-School Based Programs (IA)

Definition taken from the Taxonomy of HIV/AIDS Prevention Interventions from the Academy of Educational Development and the CDC's 2000 Evaluation Guidance (CDC, 1999) for the purpose of "making meaningful distinctions and choices among possible interventions.

A group level intervention is health education and risk reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide range of skills, information, education, and support. GLI provides small groups of individuals at high risk of acquiring or transmitting HIV infection with: educational interventions that promote and reinforce safer behaviors; interpersonal skills training and support in negotiation and maintaining safer sexual and needle-sharing behaviors; emphasis on the relationship between substance abuse and risky behaviors; educational materials; and referrals to appropriate services.

Many providers may consider general education activities to be group level interventions. However, for the purposes of this discussion, GLI does not include "one-shot" educational presentations or lectures that lack a skill component. Those types of activities should be included in the Health Communication/Public Information category.

Encompassed under Health Education/Risk Reduction: (p. 167-193)

... The goals of health education and risk reduction activities are to go beyond the provision of information to provide education and counseling that assists individuals in developing the skills, abilities, and self-esteem to carry out behavior change (CDC, 1995). Health education and risk reduction interventions can be delivered at individual, group, community, or outreach levels. HE/RR activities can include counseling, workshops, educational programs and materials, presentations, and outreach activities. ...

Group level interventions shift the delivery of services from individuals to groups of varying sizes. Group-level interventions use peer or non-peer models involving a wide range of skills, information, and support.

Includes:

1. Multiple Session Group Workshops
2. School Based Programs
3. Out-of-School Based Programs – the term "out-of-school" refers to adolescents not participating in a traditional secondary educational setting, but regularly participating in an organized treatment or alternative educational setting. This includes incarcerated youth, youth in mental health facilities, and youth in alternative high school programs.

<i>Duration/Dosage:</i>	Multiple
<i>Venue:</i>	Treatment or alternative educational setting (e.g., youth detention centers, mental health facilities, alternative high school programs).
<i>Mode:</i>	Health education – structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	Youth in non-traditional school or treatment settings (e.g., incarcerated youth, youth in mental health facilities, and youth in alternative high school programs).
<i>Other:</i>	Includes a skills component

Group Level Intervention (ID)

Health Education/Risk Reduction counseling with a skills component provided to more than one person at a time, and involves more than one interaction.

<i>Duration/Dosage:</i>	More than one interaction
<i>Venue:</i>	
<i>Mode:</i>	Health education – semi-structured Counseling – semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	Includes skills component.

Group Prevention & Support – Workshops (IL)

Group Prevention & Support refers to structured, planned interventions designed to help participants avoid HIV/STD, reduce risk behaviors, or maintain risk reduction practices. Examples of group prevention programs may be one-time events or part of a series. They may be conducted by peers-- trained, self-identified members of the targets population--and/or trained health educators who are familiar with the needs of the target population.

Group prevention and support programs may take place in any setting that is accessible to the target population. Successful group programs are often organized in sites where groups already meet or congregate. Examples of appropriate settings for group programs include mental health centers, substance abuse treatment programs, youth centers, correctional facilities, waiting rooms, private homes or social gatherings. Food, child care, bus tokens, and incentives may increase participation.

Group programs are guided by measurable objectives that specify the beliefs, skills or behaviors that participants will be encouraged to adopt.

Includes:

A. Types of Group Programs:

- Workshops encourage the active participation of group members in activities and discussions relevant to the program objectives. Workshops use role plays, problem solving activities, brainstorming, and other structured activities. Participation usually does not involve personal disclosure. Although facilitators may provide necessary information and feedback, the focus is participant involvement. In workshops, trained facilitators attempt to bring knowledge, skills, and ideas out of the group.
- Presentations ...
- Prevention support groups ...
- Events ...

B. *Quality Assurance tool provided.*

<i>Duration/Dosage:</i>	One-time or part of a series
<i>Venue:</i>	Appropriate settings for group programs include mental health centers, substance abuse treatment programs, youth centers, correctional facilities, waiting rooms, private homes or social gatherings.
<i>Mode:</i>	Workshops – structured or semi-structured
<i>Provider:</i>	Professional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	Trained facilitators attempt to bring knowledge, skills and ideas out of the group.

Group Prevention & Support – Presentations (IL)

Group Prevention & Support refers to structured, planned interventions designed to help participants avoid HIV/STD, reduce risk behaviors, or maintain risk reduction practices. Examples of group prevention programs may be one-time events or part of a series. They may be conducted by peers-- trained, self-identified members of the targets population--and/or trained health educators who are familiar with the needs of the target population.

Group prevention and support programs may take place in any setting that is accessible to the target population. Successful group programs are often organized in sites where groups already meet or congregate. Examples of appropriate settings for group programs include mental health centers, substance abuse treatment programs, youth centers, correctional facilities, waiting rooms, private homes or social gatherings. Food, child care, bus tokens, and incentives may increase participation.

Group programs are guided by measurable objectives that specify the beliefs, skills or behaviors that participants will be encouraged to adopt.

Includes:

A. Types of Group Programs:

- Workshops ...
- Presentations provide prevention information and demonstrate skills for an audience. In contrast to workshops, presentations focus most attention on the educator(s). Presentations may be appropriate when time is limited, or when learners lack the maturity, knowledge, or skills to be more actively involved. Because they require only basic facilitation skills, presentations may be suitable for volunteers or less experienced staff.
- Prevention support groups ...
- Events ...

B. *Quality Assurance tool provided.*

<i>Duration/Dosage:</i>	One-time or part of a series
<i>Venue:</i>	Appropriate settings for group programs include mental health centers, substance abuse treatment programs, youth centers, correctional facilities, waiting rooms, private homes or social gatherings.
<i>Mode:</i>	Presentations – structured
<i>Provider:</i>	Professional, Peer May be suitable for volunteers or less experienced staff
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	May be appropriate when time is limited or when learners lack the maturity, knowledge, or skills to be more actively involved.

Group Prevention & Support – Prevention support groups (IL)

Group Prevention & Support refers to structured, planned interventions designed to help participants avoid HIV/STD, reduce risk behaviors, or maintain risk reduction practices. Examples of group prevention programs may be one-time events or part of a series. They may be conducted by peers-- trained, self-identified members of the targets population--and/or trained health educators who are familiar with the needs of the target population.

Group prevention and support programs may take place in any setting that is accessible to the target population. Successful group programs are often organized in sites where groups already meet or congregate. Examples of appropriate settings for group programs include mental health centers, substance abuse treatment programs, youth centers, correctional facilities, waiting rooms, private homes or social gatherings. Food, child care, bus tokens, and incentives may increase participation.

Group programs are guided by measurable objectives that specify the beliefs, skills or behaviors that participants will be encouraged to adopt.

Includes:

A. Types of Group Programs:

- Workshops ...
- Presentations ...
- Prevention support groups involve participants who have identified HIV/STD prevention needs, and who often share a similar background or culture. Support programs encourage appropriate disclosure and learning from others' successes and struggles with risk reduction behaviors. Support programs may be open (people can join any time) or closed (the same group meets for a set period of time). Group

support programs may include structured discussion, educational activities, and opportunities for individual sessions with a prevention case manager.

- Events ...

B. Quality Assurance tool provided.

<i>Duration/Dosage:</i>	One-time or part of a series
<i>Venue:</i>	Appropriate settings for group programs include mental health centers, substance abuse treatment programs, youth centers, correctional facilities, waiting rooms, private homes or social gatherings.
<i>Mode:</i>	Health education – semi-structured Counseling – semi-structured
<i>Provider:</i>	Professional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	May be open (people can join any time) or closed (the same group meets for a set period of time) Support groups encourage disclosure and learning of RR behavior.

Group Prevention & Support – Events (II)

Group Prevention & Support refers to structured, planned interventions designed to help participants avoid HIV/STD, reduce risk behaviors, or maintain risk reduction practices. Examples of group prevention programs may be one-time events or part of a series. They may be conducted by peers-- trained, self-identified members of the targets population--and/or trained health educators who are familiar with the needs of the target population.

Group prevention and support programs may take place in any setting that is accessible to the target population. Successful group programs are often organized in sites where groups already meet or congregate. Examples of appropriate settings for group programs include mental health centers, substance abuse treatment programs, youth centers, correctional facilities, waiting rooms, private homes or social gatherings. Food, child care, bus tokens, and incentives may increase participation.

Group programs are guided by measurable objectives that specify the beliefs, skills or behaviors that participants will be encouraged to adopt.

Includes:

A. Types of Group Programs:

- Workshops ...
- Presentations ...
- Prevention support groups ...
- Events deliver prevention messages, model skills, and promote peer support for safe behaviors in informal, often fun, settings. Examples include team contests "dating games," or skits with prevention themes.

B. *Quality Assurance tool provided.*

<i>Duration/Dosage:</i>	One-time or part of a series
<i>Venue:</i>	Appropriate settings for group programs include mental health centers, substance abuse treatment programs, youth centers, correctional facilities, waiting rooms, private homes or social gatherings.
<i>Mode:</i>	Event – structured or semi-structured
<i>Provider:</i>	Professional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	

Group Level Intervention (KS)

Encompassed under Health Education and Risk Reduction (HE/RR)

Implement HE/RR programs that are tailored to reach persons infected or at high risk of becoming HIV infected by using interventions that are:

1. based in scientific theory or program experience;
2. developed to reduce the risk of primary and secondary infection;
3. culturally, linguistically age and gender appropriate; and
4. sensitive to sexual identity.

Group Level Interventions shift the delivery of services to groups of varying sizes

- In a group setting provide on-going education and support which reinforce safer behaviors and provide interpersonal skills training in negotiating and sustaining appropriate behavior change.
- Provide group sessions that
 1. are based on empowerment theory
 2. are culturally, linguistically, age, and gender appropriate;
 3. conduct peer-to-peer, education and support; and
 4. are staffed by individuals that reflect the at-risk population being served.

(Types of group level interventions include group level counseling, single session group workshops, and multiples session group workshops. Rationale for recommendations, with brief literature review, of each type included.)

<i>Duration/Dosage:</i>	On-going
<i>Venue:</i>	
<i>Mode:</i>	Health education – semi-structured Counseling – semi-structured
<i>Provider:</i>	Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group – varying sizes
<i>Target Population:</i>	Individuals infected with or at high risk of becoming infected with HIV.
<i>Other:</i>	Includes skills component Culturally, linguistically, age, and gender appropriate

School Based Efforts for Youth (KS)

Provide school based programs that use the basic philosophy recommended by Buckingham, Doyen, and Main, 1995, are theoretically-based, adhere to sound instructional strategies and are recommended by students in the Kansas school system.

- Provide prevention programs that allow youth to integrate what they have learned into their own experience, using real life situations and peers to model and reinforce desired behaviors.
- All programs should be skills-based and help to develop self-efficacy."

Rationale for recommendation, with brief literature review, included.

Duration/Dosage:

Venue: Schools

Mode: Health education – structured

Provider:

Outcome: Behavioral

Level:

Target Population: Youth

Other: All programs should be skills-based and help to develop self-efficacy.

Community Awareness Sessions (LA)

One time interaction with groups in community settings.

CDC Intervention Level: Group Level Intervention

Theoretical Basis: Transtheoretical model (Stages of change)

Target Persons: Racial/ethnic minorities, Sexually active females, males who have sex with males, youth, substance users

Sites: Churches, beauty shops, schools (cosmetology schools, trade schools, high schools, universities, etc.), community centers, law enforcement facilities, homeless shelters, and other locations where target populations may be reached

Key Elements:

- Present HIV/AIDS information to group using approved curriculum.
- Focus on establishing trust and building skills.
- Make referrals for free condoms; STD, HIV and Substance Abuse Treatment; HIV Counseling, Testing and Referral; needle exchange and/or pharmacies which sell needles; and other appropriate referrals.

- Utilize appropriate small media (Information and risk-reduction guidance disseminated through print materials such as pamphlets, posters, and other literature; and audio visual messages through electronic message boards, video taped messages, etc.) to reinforce the outreach workers message.
- Supplemental activities may include providing condoms and bleach kits to gatekeepers, placing posters in identified key areas, offering HIV and STD testing events, referring individuals for adjunct services on a mobile unit (van or RV).

Recommended Training: HIV/AIDS 101, American Red Cross Basic Fundamentals and Starter Facts

Evaluation Methods: Knowledge, Attitudes, Behavior and Belief Survey before and after intervention.

Expected Outcomes:

- Increased awareness.
- Increased information-seeking behavior.
- Build rapport and recognition.
- Condoms more accessible.
- Improved acceptance of condoms through increased knowledge and changed attitudes.
- Improved acceptance of new needles through increased knowledge and changed attitudes.
- Behavior change (increase condom use, decrease needle sharing, decrease drug use).

Implemented by: Trained staff or volunteers. May be implemented through a peer education program.

Also includes:

1. *Addresses High Priority Needs*
2. *Addresses Community/Cultural Norms & Values*
3. *Outcome Effectiveness*
4. *Accessible to the Target Populations*
5. *Intervention Feasibility and Cost-Effectiveness*
6. *Sources*

<i>Duration/Dosage:</i>	One time interaction
<i>Venue:</i>	Churches, beauty shops, shelters, schools, etc. and other locations where target populations may be reached.
<i>Mode:</i>	Health education – structured or semi-structured Material Distribution
<i>Provider:</i>	Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users
<i>Other:</i>	Includes skills building. Use approved curriculum.

Peer Led Multiple Small Group Sessions (LA)

Multiple sessions using an established/approved curriculum focusing on skill building in order to reduce risk for HIV/STD. Sessions are led by peer educators.

CDC Intervention Level: Group Level

Theoretical Basis: Theory of Reasoned Action, Social Learning Theory

Target Persons: Racial/ethnic minorities, Sexually active females, males who have sex with males, youth, substance users

Sites: Schools (cosmetology schools, trade schools, high schools, universities), after school programs, churches, community centers, job corps, shelter, bars, clinics, jails and other locations.

Key Elements:

- Trained peer leaders conduct sessions.
- The use of an established/approved curriculum. Approval of curriculum will be based on consistency of implementation at specific locations as well as norms and values of the target population.
- Curriculum must include interactive activities e.g. role-playing, group discussion, skits, etc.
- Curriculum must be designed in multiple session format that builds upon previous sessions with a focus on skill- building including: improved communication, increased self-esteem, and risk reduction skills.
- Provide referrals as needed. (HIV and STD screening may be provided on site when appropriate).
- Provide literature and condoms (when appropriate).
- Peer educators may need to be continuously recruited and trained.
- Peers may need additional emotional support.

- Incentives such as food, transportation, etc. may be required to obtain participants.

Recommended Training: HIV/AIDS 101, Curriculum specific training, HIV Counseling and Testing, Behavior Theory Training

Evaluation Methods: Pre and Post intervention questionnaires

Expected Outcomes:

- Improved perception of risk
- Improved intention to practice safer behaviors
- Decrease in unsafe behaviors

Implemented by: Trained CBO staff, volunteers (peer or non-peer). May be implemented through a peer education program.

Also includes:

1. *Addresses High Priority Needs*
2. *Addresses Community/Cultural Norms & Values*
3. *Outcome Effectiveness*
4. *Accessible to the Target Populations*
5. *Intervention Feasibility and Cost-Effectiveness*
6. *Sources*

<i>Duration/Dosage:</i>	Multiple Sessions
<i>Venue:</i>	Schools, after school programs, churches, community centers, job corps, shelter, bars, clinics, jails and other locations.
<i>Mode:</i>	Health education – structured
<i>Provider:</i>	Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users
<i>Other:</i>	Use established/approved curriculum. Focuses on skill building

Non-Peer Led Multiple Small Group Sessions (LA)

Multiple sessions led by non-peer professionals using an established/approved curriculum focusing on skill building in order to reduce risk for HIV/STD.

CDC Intervention Level: Group Level

Theoretical Basis: Theory of Reasoned Action, Social Learning Theory

Target Persons: Racial/Ethnic minorities, Sexually active females, males who have sex with males, youth, substance users

Sites: Schools (cosmetology schools, trade schools, high schools, universities), after school programs, churches, community centers, job corps, shelter, bars, clinics, jails and other locations.

Key Elements:

- Trained non-peer professionals conduct the sessions.
- The use of an established/approved curriculum. Approval of curriculum will be based on consistency of implementation at specific locations as well as norms and values of the target population.
- Curriculum must include interactive activities e.g. role-playing, group discussion, skits, etc.
- Curriculum must be designed in multiple session format that builds upon previous sessions with a focus on skill- building including: improved communication, increased self-esteem, and risk reduction skills.
- Provide referrals as needed. (HIV and STD screening may be provided on site when appropriate).
- Provide literature and condoms (when appropriate).
- Incentives such as food, transportation, etc. may be required to obtain participants.

Recommended Training: HIV/AIDS 101, Curriculum specific training, HIV Counseling and Testing, Behavior Theory Training

Evaluation Methods: Pre and Post intervention questionnaires

Expected Outcomes:

- Improved perception of risk
- Improved intention to practice safer behaviors
- Decrease in unsafe behaviors

Implemented by: Trained CBO staff, volunteers (peer or non-peer). May be implemented through a peer education program.

Also includes:

1. *Addresses High Priority Needs*
2. *Addresses Community/Cultural Norms & Values*
3. *Outcome Effectiveness*

4. *Accessible to the Target Populations*
5. *Intervention Feasibility and Cost-Effectiveness*
6. *Sources*

<i>Duration/Dosage:</i>	Multiple sessions
<i>Venue:</i>	Schools, after school programs, churches, community centers, job corps, shelter, bars, clinics, jails and other locations
<i>Mode:</i>	Health education – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users
<i>Other:</i>	Use established/approved curriculum. Focuses on skill building

Small-Group Education and Skills Development Trainings (MA)

Small-group sessions are a particularly effective means of delivering risk reduction information, building personal skills (such as condom use or negotiation with partners), and creating a sense of peer support for behavior change. The predominant model is to have a health educator or other health professional convene a group of willing participants recruited from clinical services, street/community outreach, public notice, or direct referral. Generally meeting in groups of four to fifteen members, small group sessions often follow a standard curriculum, usually covering the basics of HIV transmission, options for risk reduction, and special issues peculiar to the population (e.g. many gay male groups will discuss the relative riskiness of oral sex, while a women's session will often discuss how to negotiate condom use with an unwilling male partner). The very ability to target information to homogeneous group recommends these interventions. The small size also allows questions and particular concerns to be raised and discussed, making the intervention immediately relevant and responsive to members. More recently developed models may not begin with a focus on HIV prevention, but will address broader community issues and personal needs of clients. Also, the reliance on the formally trained health professional is often reduced through the use of indigenous educators, peer leaders, and popular education models that place the construction of the "curriculum" and the gathering of needed information in the hands of community members, who then interpret and utilize the information in their own terms and using their own voices.

Duration/Dosage:

Venue:

Mode: Health education – structured

Provider: Professional, Peer

Outcome: Behavioral

Level: Group – approx. 4-15 members

Target Population:

Other: Includes skills building component.

Follows a standardized curriculum.

Small/Large Group (MD)

Health communications, health education, and risk reduction interventions for groups which provide peer education and support, as well as promote and reinforces safe behaviors and provide interpersonal skills training in negotiating and sustaining appropriate behavior change.

Small group included with GLI; Large group with HC/PI

Duration/Dosage:

Venue:

Mode: Health education – semi-structured

Provider: Peer

Outcome: Behavioral

Level: Group

Target Population:

Other: Includes skills component

Group Level Intervention (ME)

Group level interventions both professionally led and peer led including:

- a. Behavior Change, Risk Reduction/Harm Reduction counseling
- b. Skills Training
- c. Secondary Prevention Efforts

Provides education and support in group settings to promote and reinforce safer behaviors and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change to persons at increased risk of becoming infected or, if already infected, or transmitting the virus to others.

Encompassed under CPG taxonomy primary category 'HIV Risk Reduction and Education'.

Duration/Dosage:

Venue:

Mode: Health education – semi-structured
Counseling – semi-structured and minimally structured

Provider: Professional, Peer

Outcome: Behavioral

Level: Group

Target Population: Persons at increased risk of becoming infected or already infected.

Other: Includes skills training

Group Level Prevention Counseling (MI)

Multi-session health education and risk-reduction counseling provided to groups of varying sizes (two or more participants). The focus of this intervention is to assess risk reduction needs of clients and assist them in making plans for individual behavior change.

Duration/Dosage: Multiple sessions

Venue:

Mode: Health education – structured or semi-structured
Counseling – structured or semi-structured

Provider:

Outcome: Behavioral

Level: Group – varying sizes of two or more individuals

Target Population:

Other:

Group Health Education/Risk Reduction (MI)

The focus of this intervention is on helping participants develop or enhance specific skills to engage in risk reducing practices and must include client demonstration of skills. The expectation is this intervention is that all participants will participate in skills-building activities and demonstrate attainment of these skills.

Duration/Dosage:

Venue:

Mode: Health education – structured

Provider:

Outcome: Behavioral

Level: Group

Target Population:

Other: Includes skills building

Must include client demonstration of skills

Group Level Education (MN)

Based on the work of Holtgrave et al.

Group level education including condom use training, negotiation of safer sexual behavior, risk reduction strategies for IDUs, other psychosocial issues, and referrals implemented by 1) peers, 2) a non-peer, or 3) through a social support group.

Duration/Dosage:

Venue:

Mode: Health education – structured or semi-structured

Counseling – semi-structured or minimally structured

Provider: Peer, Non-peer

Outcome: Behavioral

Level: Group

Target Population:

Other: Includes skills component

Group Level Intervention (MO)

Group level interventions encompass workshops and group counseling on risk reduction with an incorporated skill building component. Some examples of group level interventions include workshops on safer sex skills negotiation, risk reduction techniques, house parties in which empowerment and safer sex negotiation skills are taught. Multi session group level interventions tend to have a greater impact on behavior change because of ability to reinforce learned skills in risk reduction behavior. Group level interventions also seem to be more effective when they not only address issues regarding HIV but also holistic issues that tend to affect individuals which then place them at increased risk for HIV infection.

<i>Duration/Dosage:</i>	Multiple sessions recommended
<i>Venue:</i>	
<i>Mode:</i>	Workshops – structured Counseling – semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	Includes skills building component

Group Education Sessions – One Time (NC)

Prevention education for a group of individuals where there is only one session conducted with that particular group, such as single session home parties or risk reduction workshops. This is often a prescheduled activity.

Persons learn and retain information when it is presented more than one time. This strategy is an attempt to have multiple encounters with the same individuals to affect behavior change.

<i>Duration/Dosage:</i>	One time
<i>Venue:</i>	Homes, etc.
<i>Mode:</i>	Health education – structured or semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	

Group Education Sessions – Series (NC)

Prevention education for a group of individuals where there is more than one session conducted with that particular group, such as a series of home parties or risk reduction workshops with the same group. This is often a prescheduled activity.

Persons learn and retain information when it is presented more than one time. This strategy is an attempt to have multiple encounters with the same individuals to affect behavior change.

<i>Duration/Dosage:</i>	More than one session with same group
<i>Venue:</i>	Homes, etc.
<i>Mode:</i>	Health education – structured or semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	Often a prescheduled activity

Group Education Sessions – One Time (NH)

- One-time only education for a group.
- May be offered in the home of a person in the group using a "fun" format.
- May involve education about HIV or practice of skills to reduce risk (e.g. condom negotiation).

Overall Premises to be Considered in All Interventions

1. All interventions need to explicitly define a population to be served and the steps to reach that population.
2. All interventions must have explicitly defined HIV prevention goals (e.g., reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required data collection will be more limited than for individual and group level interventions due to the nature of the work.)
6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.
7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

<i>Duration/Dosage:</i>	One time
<i>Venue:</i>	May be in a home of group member
<i>Mode:</i>	Health education – semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	May include practice of skills

Group Education Sessions – Series (NH)

1. Planned and structured group education programs (usually 4-8 sessions) with specific goals.
2. Usually designed to help people change HIV risk behavior and often based on plans which have been shown to be effective.
3. Led by professionals or peers who have attended train-the trainer programs.

Overall Premises to be Considered in All Interventions

1. All interventions need to explicitly define a population to be served and the steps to reach that population.
2. All interventions must have explicitly defined HIV prevention goals (e.g., reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required data collection will be more limited than for individual and group level interventions due to the nature of the work.)
6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.
7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

<i>Duration/Dosage:</i>	4-8 sessions
<i>Venue:</i>	
<i>Mode:</i>	Health education – structured
<i>Provider:</i>	Professional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	

Support Groups (NH)

- Usually weekly groups made of people with a shared concern (e.g., HIV+, partners of HIV+, HIV- gay men)
- Led by a licensed professional (e.g. mental health counselor, LADAC)
- Designed to help people make behavior changes with group support."

Overall Premises to be Considered in All Interventions

1. All interventions need to explicitly define a population to be served and the steps to reach that population.
2. All interventions must have explicitly defined HIV prevention goals (e.g., reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required data collection will be more limited than for individual and group level interventions due to the nature of the work.)
6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.
7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

<i>Duration/Dosage:</i>	Usually weekly
<i>Venue:</i>	
<i>Mode:</i>	Counseling – minimally structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	Comprised of people with shared concerns.

Small Group Interventions (NV)

A small group (arbitrarily defined by Freudenberg (1995) as groups consisting of less than 20 members) of a gathering of two or more individuals meeting together for a common purpose. Small groups can be led by a health professional or peer-led. Among other things, small groups can be used as a forum to present information, motivate behavior change, teach problem-solving, communications, and assertiveness training skills, clarify values, train volunteers and provide emotional and social support.

Also includes advantages and disadvantages of intervention, and demonstrated effectiveness and implications.

<i>Duration/Dosage:</i>	
<i>Venue:</i>	
<i>Mode:</i>	Health education – minimally structured Counseling – minimally structured
<i>Provider:</i>	Professional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group – 2 or more, less than 20 members
<i>Target Population:</i>	
<i>Other:</i>	

Group Level Intervention (SC)

Encompassed under HE/RR

... shift delivery of service from individual to groups of varying sizes. Group level interventions provide education and support in group settings to promote and reinforce safer behaviors and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change to persons at increased risk of becoming infected or, if already infected, or transmitting the virus to

others. The content of the group session should be consistent with the format, i.e. groups can meet one time or on an ongoing basis. One-time sessions can provide participants an opportunity to hear and learn from one another's experiences, role play with peers, and offer and receive support. Ongoing sessions may offer stronger social influence with potential for developing emergent norms that can support risk reduction. A group level intervention can include more tailored individual level interventions with some of the group members.

Risk reduction programs provide counseling interventions provided by peers or professionals to groups, families, or couples to promote/reinforce safe behavior. Risk reduction programs should include interpersonal and skills training for clients in negotiating and sustaining appropriate behaviors changes, such as delaying sexual involvement, avoiding unsafe sex practices, negotiating safer sex, and avoiding sharing needles or learning how to clean needles.

<i>Duration/Dosage:</i>	One-time or on-going
<i>Venue:</i>	
<i>Mode:</i>	Health education – structured or semi-structured Counseling – semi-structured or minimally structured
<i>Provider:</i>	Professional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group – of varying sizes
<i>Target Population:</i>	Women at risk, youth at risk, school age youth, drug users, MSM, and incarcerated individuals
<i>Other:</i>	Includes interpersonal and skills training for clients Can include more tailored individual level interventions with some of the group members.

Group Level Intervention (TX)

Group level intervention shifts the delivery of service from individual to groups of varying sizes. Applicants must refer to the appropriate Regional Action Plan (RAP) for the list of priority group level interventions. Group activities must take place in the settings outlined in the RAPs, including areas where members of targeted populations congregate, or in areas where high risk behavior by target populations takes place. These activities are typically performed by peer laypersons or paraprofessional staff. Peers are defined as members of the target populations or trained persons who are sensitive to the issues affecting that population.

- a. Health Education and Risk Reduction (HERR) Activities
 1. Health education and risk reduction categorized a wide range of individual-level and group-level HIV prevention activities. Group-Level (HERR) activities include promoting and reinforcing safer behaviors and providing interpersonal skills training in negotiating and sustaining appropriate behavior change with persons at increased risk of becoming infected or, if already infected, of transmitting the virus to others.

- Prevention staff must provide materials to encourage clients to engage in safer behavior and refer clients to more intensive prevention interventions when appropriate. The distribution of all prevention materials, including condoms, must be accompanied with personalized messages.
2. The role of prevention staff in group-level interventions is to facilitate dialogue among participants regarding their individual thoughts, feelings and risks of HIV infection. An HIV/AIDS 101 lecture style presentation is not an acceptable intervention. Appropriate topics for discussion may include negotiating risk reduction with partners, substance use and abuse issues, and assertiveness training. Information regarding the full range of risk-reduction options should be discussed so that participants can formulate appropriate and individualized risk reduction plans. Group sizes should be small enough to foster participation, allow for questions and answers, and individualized attention. Prevention staff should also facilitate linkages to other referral services to meet client-identified needs in including prevention counseling, substance abuse assessment and treatment, and STD diagnosis and treatment.
 3. Applicants must refer to the appropriate RAP for the list of specific priority group-level HERR activities. Priority group HERR activities may include safer sex workshops, drug relapse prevention workshops and condom or bleach kit demonstrations. Group HERR activities must take place in areas identified in the RAPs, including areas where targeted populations congregate and areas where high risk activities by target populations take place.

Holtgrave, Valdessari & West Taxonomy in Comprehensive Plan – Appendix 3 ... HE/RR by peer or non-peer counselor (similar to program requirements)

Duration/Dosage:

Venue: Areas where target population congregate

Mode: Health education – structured or semi-structured

Provider: Paraprofessional, Peer

Outcome: Behavioral

Level: Group

Target Population:

Other:

Group Level Intervention (VA)

Encompassed under Category II Health Education/Risk Reduction.

Providing education to two or more individuals in a group setting which includes formal/informal assessments and a skills building component. May include HIV/STD awareness, primary and secondary prevention education, and referral. Health education and risk reduction intervention shifts the delivery of service from individual to groups of varying sizes. Group level

education does not include "one-shot" educational presentations or lectures that lack a skills building component.

<i>Duration/Dosage:</i>	More than one
<i>Venue:</i>	
<i>Mode:</i>	Counseling – structured or semi-structured Health education – structured or semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	
<i>Level:</i>	Group – two or more individuals of varying sizes
<i>Target Population:</i>	
<i>Other:</i>	Includes a skills building component

Risk Reduction Counseling (VI)

Risk reduction counseling provides counseling and health education to individuals that are at high risk for HIV infection. The intervention promotes and reinforces safe behavior. Risk reduction counseling is interactive and assists clients in building the skills and abilities to implement change. Strategies used in risk reduction counseling include role-play, group discussion and counseling, interpersonal and negotiation skills.

<i>Duration/Dosage:</i>	
<i>Venue:</i>	
<i>Mode:</i>	Counseling – semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	High risk individuals
<i>Other:</i>	Includes skills building

Group Level Intervention (GLI) (WI)

Level of Intensity: Intervention/Interaction (staff interact with client on an intensive and usually repeated basis.)

This includes ... Risk reduction counseling with a skills building component provided to more than 1 person at a time, usually multi-session.

This does not include ... "1-shot" educational presentations; lectures.

Group level interventions can have a variety of formats, ranging from closed groups with a fixed number of sessions to open ongoing groups. The minimum number of hours and meetings needed vary with the population, but some literature indicates that four hours is a minimum in order to yield any change behavior. While groups usually take place face-to-face, they can be conducted by conference call or computer to accommodate barriers to distance, inability to travel due illness, and reluctance to disclose HIV status or sexual or drug-using behaviors.

In addition to determining a format for group, facilitators can take a few key steps to make the group sessions successful. First, peer input and perhaps peer co-facilitation can allow the group to identify and define some of its own needs and goals and increase the facilitator's credibility with group. The facilitator should take steps to create a comfortable, safe environment for participants, including marketing the group in such a way that the focus is on relationship-building skills or self-confidence, not HIV prevention which can intimidate some individuals. Finally, facilitators should collect pre- and post-session assessments of knowledge, attitudes, and behaviors and surveys of client satisfaction to guide future program development.

Includes:

- *Scientific Basis*
- *Resources*

<i>Duration/Dosage:</i>	Closed w/fixed number of sessions; Open/ongoing sessions Usually more than one session 4 hour min. recommended
<i>Venue:</i>	Usually take place face-to-face, but may be conducted by conference call or computer to accommodate barriers to distance or illness Comfortable, safe environment
<i>Mode:</i>	Counseling – semi-structured Health education – semi-structured
<i>Provider:</i>	Professional, Peer (independently or as co-facilitator)
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	Includes skills building component Collection of pre- and post-session assessments of knowledge, attitudes, and behaviors and surveys of client satisfaction to guide future program development.

Outreach

The Number of Intervention Characteristics by Each Outreach Intervention

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Outreach	AK		✓	✓	✓	✓	✓	✓	✓	7
Outreach – Contact	AK	✓	✓	✓	✓	✓	✓	✓	✓	8
Outreach – Encounter	AK	✓	✓	✓	✓	✓	✓	✓	✓	8
Street and Community Outreach	CA	✓	✓	✓	✓	✓	✓		✓	7
Condoms, Other Barriers, and Bleach Demonstration and Distribution	CA		✓	✓		✓	✓			4
Natural Opinion Leaders	CA			✓	✓	✓	✓			4
Street/Community Outreach	CH		✓	✓		✓	✓		✓	5
Outreach	CO	✓	✓	✓	✓	✓	✓	✓	✓	8
Peer or Non-Peer Outreach	CT		✓	✓	✓	✓	✓	✓	✓	7
Natural Opinion Leaders	CT		✓		✓	✓		✓	✓	5
Outreach	DC		✓	✓	✓	✓	✓	✓	✓	7
HERR Street & Community Outreach	HO		✓	✓	✓	✓	✓		✓	6
Outreach – Peer Education	IA		✓	✓	✓	✓	✓		✓	6
Outreach – Endorsements/Testimonials by Opinion Leaders	IA		✓	✓	✓	✓	✓		✓	6
Outreach – Street Outreach	IA	✓	✓	✓	✓	✓	✓		✓	7
Outreach – Condoms, Latex Barriers, Bleach Distribution	IA		✓	✓	✓	✓	✓		✓	6
Outreach – Access to Sterile Injection Equipment	IA	✓	✓	✓	✓	✓	✓	✓	✓	8
Outreach	ID		✓	✓			✓		✓	4
Street Outreach	IL		✓	✓	✓	✓	✓		✓	6

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Community Outreach	IL		✓	✓	✓	✓	✓			5
Condom Availability	LA		✓	✓	✓	✓	✓	✓	✓	7
Street Outreach	LA	✓	✓	✓	✓	✓	✓	✓	✓	8
Venue-Based Outreach	LA	✓	✓	✓	✓	✓	✓	✓	✓	8
Popular Opinion Leader Intervention	LA	✓	✓	✓	✓	✓	✓	✓	✓	8
Street Outreach	MA		✓	✓	✓	✓	✓	✓	✓	7
Community Outreach	MA		✓	✓	✓	✓	✓	✓	✓	7
Public Sex Environment Outreach	MA		✓	✓		✓	✓	✓	✓	6
Peer-Driven Interventions	MA			✓	✓	✓		✓	✓	5
Latex and Reality Condom Distribution	MA			✓				✓	✓	3
Bleach Kit Distribution	MA			✓		✓	✓	✓	✓	5
Outreach Interventions	ME		✓	✓		✓	✓			4
Outreach	MN		✓	✓	✓	✓				4
Outreach Level Interventions	MO		✓	✓	✓	✓	✓	✓	✓	7
Street and Community Outreach	NC		✓	✓		✓	✓		✓	5
Peer/Natural Opinion Leader Programs	NC		✓	✓	✓	✓	✓	✓	✓	7
Street and Community Outreach	NH		✓	✓		✓		✓	✓	5
Peer/Natural Opinion Leader Programs	NH		✓		✓	✓		✓	✓	5
Street Outreach	NV		✓	✓	✓	✓	✓	✓		6
Condom Distribution Program	NV		✓	✓		✓	✓	✓		4

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Street and Community Level Outreach	OK	✓	✓	✓	✓	✓	✓		✓	7
Peer Led Interventions	OK	✓	✓	✓	✓	✓	✓		✓	7
Street and Community Outreach Programs	TN		✓	✓	✓	✓		✓		5
Condom Distribution	TX			✓		✓				2
Basic Street/Community Outreach	VA			✓		✓	✓		✓	4
Intensive Street/Community Outreach	VA	✓	✓	✓		✓	✓		✓	6
Collaborative Street/Community Outreach	VA		✓	✓		✓	✓		✓	5
Facilitative Street/Community Outreach	VA	✓	✓	✓		✓	✓		✓	6
Street Outreach	VI		✓	✓	✓	✓		✓		5
Outreach	WI	✓	✓	✓	✓	✓		✓	✓	7
TOTAL (N = 49)		14	43	47	34	47	39	26	39	289

✓ - Indicates that evidence of the intervention characteristic was found in reviewing the FY 2001 Cooperative Agreement Applications and Comprehensive Plans and Web sites. Definitions or guidelines addressing these elements may exist in other documentation not reviewed for this study.

Outreach – Listing of Evidence by Intervention Characteristic

Duration/Dosage:

	Intervention Name	Evidence of Intervention Characteristic:
AK	Outreach – Contact	Usually brief Sustained and regular presence in community
AK	Outreach – Encounter	Brief or lengthy, single or multiple
CA	Street and Community Outreach	Consistent and continuous, not sporadic
CO	Outreach	Consistent and on-going contact
IA	Outreach – Street Outreach	Needs to be consistent and continuous, not just sporadic visits
IA	Outreach – Access to Sterile Injection Equipment	Repeated
LA	Venue-Based Outreach	Revisit the same locations (at least 1x/month)
LA	Street Outreach	During hours when target population is most accessible Outreach must be conducted on a regular, on-going basis in assigned target areas Maintain the same locations (at least 1x/month).
LA	Popular Opinion Leader Intervention	Multiple sessions
OK	Street and Community Level Outreach	Consistent and continuous
OK	Peer Led Interventions	Consistent and continuous
VA	Facilitative Street/Community Outreach	Multiple occasions
VA	Intensive Street/Community Outreach	Multiple occasions
WI	Outreach	Consistent and continuous Intensity not as high as for individual level interventions

Venue:

	Intervention Name	Evidence of Intervention Characteristic:
AK	Outreach	Community – Specific areas frequented by persons who engage in risk behavior
AK	Outreach – Contact	Community – Specific areas frequented by persons who engage in risk behavior
AK	Outreach – Encounter	Outreach or other setting, or over the phone
CA	Street and Community Outreach	Community – areas where high-risk people congregate
CA	Condoms, Other Barriers, and Bleach Demonstration and Distribution	Community – areas where high-risk people congregate
CH	Street/Community Outreach	High-risk individuals' neighborhoods or areas where they congregate
CO	Outreach	On the street or in malls, parks, bars or other community settings outside of classrooms, workshops or clinics
CT	Peer or Non-Peer Outreach	In environment of target group
CT	Natural Opinion Leaders	Community
DC	Outreach	Areas where clients typically congregate
HO	HERR Street & Community Outreach	Community environments, such as neighborhoods, streets, bars, etc.
IA	Outreach – Peer Education	Neighborhood or areas where target population congregates
IA	Outreach – Endorsements/Testimonials by Opinion Leaders	Client's neighborhood or areas where clients congregate
IA	Outreach – Street Outreach	Informal sites where persons engaged in high-risk activities congregate, such as streets, bars, parks, shooting galleries, bathhouses, beauty parlors, etc.
IA	Outreach – Condoms, Latex Barriers, Bleach Distribution	Areas where people at risk for HIV congregate
IA	Outreach – Access to Sterile Injection Equipment	Community or street-based
ID	Outreach	Places where priority population congregates

IL	Street Outreach	Streets in a neighborhood or community, or places outside of a traditional health care or agency setting
IL	Community Outreach	Community settings outside traditional health care or agency settings
LA	Condom Availability	Office of Public Health clinics, drug treatment centers, mental health clinics, businesses (bars, liquor stores, housing developments, private physicians offices) in high risk areas and other areas where the target populations congregate
LA	Street Outreach	Street settings in identified high risk areas
LA	Venue-Based Outreach	Bars, sex clubs, public sex environments, beauty salons, barber shops, clinics and other venues in identified high risk areas where members of the target populations gather for social interactions or services.
LA	Popular Opinion Leader Intervention	Bars, community settings where target population congregates
MA	Street Outreach	In public areas (i.e., streets)
MA	Community Outreach	In public areas (i.e., streets, health fairs, street fairs, festivals, etc.)
MA	Public Sex Environment Outreach	Public sex environments (public parks, highway rest stops, etc.)
ME	Outreach Interventions	Street, community, public sex environments, institutions (outside a more traditional health care setting)
MN	Outreach	Non-agency sites where target populations gather
MO	Outreach Level Interventions	Informal sites where populations at risk are most likely to gather, such as bars, parks, bathhouses, beauty shops, coffee shops, streets, etc.
NC	Street and Community Outreach	Informal settings where people at risk naturally congregate
NC	Peer/Natural Opinion Leader Programs	Community

NH	Street and Community Outreach	Informal settings such as bars, festivals, parks, crack houses, public sex environments, homeless shelters, soup kitchens, etc. – focus on specific streets and neighborhoods where individuals who engage in risk behaviors are known to live or visit.
NH	Peer/Natural Opinion Leader Programs	Community
NV	Street Outreach	Street, shooting galleries, crack houses, etc.
NV	Condom Distribution Program	Health Facilities, Gay bars, Colleges, Night Clubs, Health fairs, etc.
OK	Street and Community Level Outreach	Anywhere outside a traditional, institutional health care setting that is easily, readily and regularly accessed by the designated client population.
OK	Peer Led Interventions	Anywhere outside a traditional, institutional health care setting that is easily, readily and regularly accessed by the designated client population.
TN	Street and Community Outreach Programs	Outside the traditional health care and drug treatment centers
VA	Basic Street/Community Outreach	Specified street or community
VA	Intensive Street/Community Outreach	Specified street or community
VA	Collaborative Street/Community Outreach	An identified and assessed area for the purpose of saturating the area with specific information
VA	Facilitative Street/Community Outreach	Specified street or community
VI	Street Outreach	Street
WI	Outreach	Location convenient to members of the target populations; gay bars, crack houses, etc.

Mode:

	Intervention Name	Evidence of Intervention Characteristic:
AK	Outreach	Outreach – minimally structured
AK	Outreach – Contact	Outreach – minimally structured Materials distribution
AK	Outreach – Encounter	Outreach – semi-structured

CA	Street and Community Outreach	Outreach
CA	Condoms, Other Barriers, and Bleach Demonstration and Distribution	Material distribution
CA	Natural Opinion Leaders	Health education
CH	Street/Community Outreach	Material/supply distribution Outreach – minimally structured
CO	Outreach	Outreach – semi-structured
CT	Peer or Non-Peer Outreach	Outreach – minimally structured Material/supply distribution
DC	Outreach	Outreach – minimally structured Material/supply distribution
HO	HERR Street & Community Outreach	Outreach – minimally structured
IA	Outreach – Peer Education	Outreach – minimally structured
IA	Outreach – Endorsements/Testimonials by Opinion Leaders	Health Communication/Public Information
IA	Outreach – Street Outreach	Outreach – semi-structured
IA	Outreach – Condoms, Latex Barriers, Bleach Distribution	Outreach – minimally or semi-structured
IA	Outreach – Access to Sterile Injection Equipment	Outreach – minimally or semi-structured
ID	Outreach	Outreach
IL	Street Outreach	Outreach – structured, semi-structured or minimally structured Material/supply distribution
IL	Community Outreach	Outreach – structured, semi-structured or minimally structured
LA	Condom Availability	Material/supply distribution
LA	Street Outreach	Outreach – structured or semi-structured Material/supply distribution
LA	Venue-Based Outreach	Multi-strategy education program
LA	Popular Opinion Leader Intervention	Outreach – minimally structured
MA	Street Outreach	Outreach – minimally structured Material/supply distribution

MA	Community Outreach	Outreach – minimally structured Material/supply distribution
MA	Public Sex Environment Outreach	Outreach – semi-structured or minimally structured
MA	Peer-Driven Interventions	Outreach – minimally structured
MA	Latex and Reality Condom Distribution	Material distribution
MA	Bleach Kit Distribution	Outreach – semi-structured Material/supply distribution
ME	Outreach Interventions	Outreach – semi-structured
MN	Outreach	Material/supply distribution Outreach – minimally structured
MO	Outreach Level Interventions	Outreach – semi-structured or minimally structured Material/supply distribution
NC	Street and Community Outreach	Outreach
NC	Peer/Natural Opinion Leader Programs	Health Communication/Public Information
NH	Street and Community Outreach	Outreach – semi-structured
NV	Street Outreach	Outreach – semi-structured or minimally structured
NV	Condom Distribution Program	Material/supply distribution
OK	Street and Community Level Outreach	Outreach – structured, semi-structured, or minimally structured
OK	Peer Led Interventions	Outreach – semi-structured or minimally structured Health education – structured, semi-structured, or minimally structured
TN	Street and Community Outreach Programs	Outreach
TX	Condom Distribution	Material/supply distribution
VA	Basic Street/Community Outreach	Outreach (contact)
VA	Intensive Street/Community Outreach	Outreach (encounters)
VA	Collaborative Street/Community Outreach	Outreach – structured
VA	Facilitative Street/Community Outreach	Outreach (encounter) – semi-structured
VI	Street Outreach	Outreach

WI Outreach Outreach – semi-structured

Provider:

	Intervention Name	Evidence of Intervention Characteristic:
AK	Outreach	Peer
AK	Outreach – Contact	Peer
AK	Outreach – Encounter	Professional, Paraprofessional, Peer
CA	Street and Community Outreach	Professional
CA	Natural Opinion Leaders	Peer
CO	Outreach	Professional, Peer
CT	Peer or Non-Peer Outreach	Peer, Non-Peer
CT	Natural Opinion Leaders	Peer
DC	Outreach	Paraprofessional, Peer
HO	HERR Street & Community Outreach	Peer, Non-Peer
IA	Outreach – Peer Education	Peer
IA	Outreach – Endorsements/Testimonials by Opinion Leaders	Peer
IA	Outreach – Street Outreach	Paraprofessional (non-peer), Peer
IA	Outreach – Condoms, Latex Barriers, Bleach Distribution	Professional
IA	Outreach – Access to Sterile Injection Equipment	Paraprofessional (non-peer), Peer
IL	Street Outreach	Paraprofessional, Peer
IL	Community Outreach	Paraprofessional, Peer
LA	Condom Availability	Professional
LA	Street Outreach	Professional, Paraprofessional, Peer
LA	Venue-Based Outreach	Professional, Paraprofessional, Peer
LA	Popular Opinion Leader Intervention	Professional, Paraprofessional, Peer
MA	Street Outreach	Peer
MA	Community Outreach	Peer
MA	Peer-Driven Interventions	Peer
MN	Outreach	Peer, Non peer
MO	Outreach Level Interventions	Peer

NC	Peer/Natural Opinion Leader Programs	Peers
NH	Peer/Natural Opinion Leader Programs	Trained Peers
NV	Street Outreach	Peer
OK	Street and Community Level Outreach	Peer
OK	Peer Led Interventions	Peer
TN	Street and Community Outreach Programs	Paraprofessional, Peer
VI	Street Outreach	Professional, Paraprofessional, Peer
WI	Outreach	Paraprofessional (near peer), Peer

Outcome:

Forty-six of the forty-seven interventions had outcome addressed in its definition, identified that outcome as behavioral. Information was the other outcome indicated.

	Intervention Name	Evidence of Intervention Characteristic:
IA	Outreach – Endorsements/Testimonials by Opinion Leaders	Information, Behavioral
NV	Condom Distribution Program	Information

Level:

	Intervention Name	Evidence of Intervention Characteristic:
AK	Outreach	Individual, Group, Community
AK	Outreach – Contact	Individual/Group
AK	Outreach – Encounter	Individual
CA	Street and Community Outreach	Individual
CA	Condoms, Other Barriers, and Bleach Demonstration and Distribution	Individual
CA	Natural Opinion Leaders	Group, Community
CH	Street/Community Outreach	Individual
CO	Outreach	Individual
CT	Peer or Non-Peer Outreach	Individual
DC	Outreach	Individual
HO	HERR Street & Community Outreach	Community
IA	Outreach – Peer Education	Individual, Group, Community

IA	Outreach – Endorsements/Testimonials by Opinion Leaders	Community
IA	Outreach – Street Outreach	Individual
IA	Outreach – Condoms, Latex Barriers, Bleach Distribution	Individual
IA	Outreach – Access to Sterile Injection Equipment	Community
ID	Outreach	Individual, Group
IL	Street Outreach	Individual
IL	Community Outreach	Community
LA	Condom Availability	Community
LA	Street Outreach	Individual, Group, Community
LA	Venue-Based Outreach	Individual, Group (small and large), Community
LA	Popular Opinion Leader Intervention	Individual, Group, Community
MA	Street Outreach	Individual
MA	Community Outreach	Group, Community
MA	Public Sex Environment Outreach	Individual, Group
MA	Bleach Kit Distribution	Individual
ME	Outreach Interventions	Individual, Group
MO	Outreach Level Interventions	Individual
NC	Street and Community Outreach	Individual, Community
NC	Peer/Natural Opinion Leader Programs	Community
NV	Street Outreach	Individual
NV	Condom Distribution Program	Community
OK	Street and Community Level Outreach	Individual, Small Group, Community
OK	Peer Led Interventions	Group, Community
VA	Basic Street/Community Outreach	Individual
VA	Intensive Street/Community Outreach	Individual
VA	Collaborative Street/Community Outreach	Individual
VA	Facilitative Street/Community Outreach	Individual

Target Population:

	Intervention Name	Evidence of Intervention Characteristic:
AK	Outreach	MSM; heterosexual women with partners at high-risk
AK	Outreach – Contact	High-risk youth, commercial sex workers, non-gay-identified MSM, IDU, female sex partners of IDU, and heterosexual adults.
AK	Outreach – Encounter	High-risk youth, commercial sex workers, non-gay-identified MSM, IDU, female sex partners of IDU, and heterosexual adults.
CO	Outreach	Individuals at high-risk for getting or spreading HIV
CT	Peer or Non-Peer Outreach	MSM, IDUs, other drug users, at-risk youth
CT	Natural Opinion Leaders	MSM and low-income women Possibly minority high school students
DC	Outreach	High-risk individuals
IA	Outreach – Access to Sterile Injection Equipment	Injection drug users
LA	Condom Availability	Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users.
LA	Street Outreach	Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users.
LA	Venue-Based Outreach	Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users.
LA	Popular Opinion Leader Intervention	Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users.
MA	Street Outreach	Individuals at perceived risk of HIV
MA	Community Outreach	Individuals at perceived risk of HIV
MA	Public Sex Environment Outreach	MSM
MA	Peer-Driven Interventions	IDUs
MA	Latex and Reality Condom Distribution	Men, Women, MSM
MA	Bleach Kit Distribution	IDUs
MO	Outreach Level Interventions	IDUs (but not limited to this population)

NC	Peer/Natural Opinion Leader Programs	IDUs, Racial and ethnic minorities, teens, MSM
NH	Street and Community Outreach	Individuals who engage in risk behavior.
NH	Peer/Natural Opinion Leader Programs	MSM, Minorities
NV	Street Outreach	Hard-to-reach populations including IDUs, homeless people, CSWs, runaway youth
TN	Street and Community Outreach Programs	High-risk individuals, HIV positive individuals
VI	Street Outreach	High-risk individuals
WI	Outreach	High-risk individuals

Other:

Intervention Name		Evidence of Intervention Characteristic:
AK	Outreach	Peer educators commit to conversing about risk reduction with specified number of peers. Risk reduction workshops for the opinion leaders and HIV prevention events implemented by the POLs.
AK	Outreach – Contact	Minimally, provides risk reduction info and supplies. Ideally facilitates personal risk perception and risk assessment. Provides skills training.
AK	Outreach – Encounter	Minimally, provides risk reduction info and supplies. Ideally facilitates personal risk perception and risk assessment. Provides skills training.
CA	Street and Community Outreach	Staff deliverers must be respected, trusted, credible, open, friendly, dedicated, non-judgmental or non-threatening.
CH	Street/Community Outreach	Street/community outreach cannot be funded as a stand-alone intervention (i.e., as the only intervention in a program) but must be coupled with 1 or more of the other HPPG approved interventions

CO	Outreach	<p>Outreach involves one-on-one contacts which include the distribution of materials, referrals and educational discussions on sexual-risk, needle-sharing behaviors, and the overall relationship between substance abuse and risky behavior.</p> <p>The distribution of materials by itself is not considered outreach</p> <p>Outreach workers strive to help clients develop skills and motivation to adopt and maintain safer behaviors over time.</p>
CT	Peer or Non-Peer Outreach	<p>Outreach workers ... support positive attitudes and norms regarding HIV prevention, teach behavioral skills for HIV prevention, ...</p>
CT	Natural Opinion Leaders	<ol style="list-style-type: none"> 1. nominated by peers, 2. trained to give HIV info., 3. support pro-HIV prevention norms, behaviors and attitudes 4. may train peers in behavioral skills.
DC	Outreach	<p>Also provide referrals to prevention, substance abuse, or early intervention programs.</p>
HO	HERR Street & Community Outreach	<p>Outreach itself does not have to be a standard form of intervention, but a variety of interventions that share a set of techniques and characteristics.</p> <p>Some outreach interventions provide information, some provide counseling, and some provide both (Kalichman, 1998).</p>
IA	Outreach – Peer Education	<p>Provide motivation, knowledge, risk reduction materials, and referrals to services that support behavior change.</p> <p>These individuals are trained in HIV/AIDS, peer counseling, outreach, and the issues of the population groups which are difficult to reach with HIV information alone.</p>
IA	Outreach – Endorsements/Testimonials by Opinion Leaders	<p>Provide motivation, knowledge, risk reduction materials, and referrals to services that support behavior change.</p>

IA	Outreach – Street Outreach	<p>Provide motivation, knowledge, risk reduction materials, and referrals to services that support behavior change.</p> <p>Involves a broad ranges of models may be highly interactive and engaging, or they may involve only a cursory risk message and delivery of referral information.</p>
IA	Outreach – Condoms, Latex Barriers, Bleach Distribution	<p>Provide motivation, knowledge, risk reduction materials, and referrals to services that support behavior change.</p>
IA	Outreach – Access to Sterile Injection Equipment	<p>Provide motivation, knowledge, risk reduction materials, and referrals to services that support behavior change.</p> <p>A limited opportunity for one-on-one health education and/or risk reduction intervention may occur in this context, as may a chance to help link an infected person to HIV care services.</p>
ID	Outreach	<p>Educational intervention</p> <p>For more than the purpose of counseling and testing.</p>
IL	Street Outreach	<p>Intervention within a community outreach program.</p>
LA	Condom Availability	<p>Condoms must be available at no-cost.</p> <p>Condoms should be placed in locations which are visible and accessible to clients.</p> <p>Promotion of condom distribution and consistent condom use through signs, posters & brochures.</p> <p>No direct contact with client required.</p>
LA	Street Outreach	<p>Face-to-face educational interaction</p>
LA	Venue-Based Outreach	<p>Conducted in high risks areas during hours when target population(s) are accessible.</p> <p>Multi-strategy education program;</p> <p>Should include an environmental/structural component.</p> <p>Outreach activities respect spirit of venue.</p> <p>Includes a combination of face-to-face, small group, and large group interactions.</p>

LA	Popular Opinion Leader Intervention	<p>Uses an establish/approved curriculum focusing on skill building in order to reduce risk for HIV/STD.</p> <p>Intervention location staff should be trained to identify popular opinion leaders.</p>
MA	Street Outreach	<p>Not considered by providers to be an endpoint intervention, rather an initial intervention that should lead to, and therefore must formally linked to more intensive and sustained prevention efforts.</p> <p>Workers need to be well trained and familiar with a wide array of allied services, from drug treatment to domestic violence intervention programs</p>
MA	Community Outreach	<p>Not considered by providers to be an endpoint intervention, rather an initial intervention that should lead to, and therefore must formally linked to more intensive and sustained prevention efforts.</p>
MA	Public Sex Environment Outreach	<p>Also attempt to recruit some men into more intensive interventions held elsewhere.</p>
MA	Peer-Driven Interventions	<p>Utilize active injection drug users to design more intensive levels of risk reduction activities than street outreach activities afford, and to involve active users in the recruitment of members of their social networks into these interventions.</p>
MA	Latex and Reality Condom Distribution	<p>A cornerstone of prevention activities at every level of intervention and for every population at sexual risk of infection</p> <p>Linked to skills building instruction, social supports, and community norms that encourage condom use, the act of making them available to clients is a welcome and important component in a complete HIV prevention program.</p>

MA	Bleach Kit Distribution	<p>The goal of this component is to assist IDUs in initiating or maintaining safer injection practices by providing immediate access and modeling of the technique of cleaning needles and syringes prior to sharing.</p> <p>Packaged kits contain small bottles of bleach and water for cleaning injection drug equipment along with instructions for their uses, clean metal cups to be used as "cookers", alcohol wipes for cleaning the skin prior to injection , and other RR items...</p>
MO	Outreach Level Interventions	<p>Can be very interactive with educators providing basic prevention strategies or it can be in the form of information dissemination.</p> <p>Outreach workers should be sensitive to and respectful of cultural diversity among the most high risk populations.</p>
NC	Street and Community Outreach	Provides referrals and prevention materials.
NC	Peer/Natural Opinion Leader Programs	Share information and promote risk reduction in leader's own community.
NH	Street and Community Outreach	Workers educate clients on safer sex environments.
NH	Peer/Natural Opinion Leader Programs	<p>Programs train people who are leaders in an at-risk community.</p> <p>Peer leaders may also begin to build a "culture" which promotes safer behavior.</p>
OK	Street and Community Level Outreach	Street and community outreach programs are defined by their locus of activity and by the content of their offerings.
OK	Peer Led Interventions	<p>Have a shared identity with target group.</p> <p>Are same age range.</p> <p>Speak same "language".</p> <p>Are familiar with group's cultural nuances.</p> <p>Act as advocates and liaisons between agency and target group.</p>
VA	Basic Street/Community Outreach	Basic outreach can not expected to change behaviors in and of itself and should not be considered an intervention.

VA	Intensive Street/Community Outreach	The conditions of Basic outreach must be met.
VA	Facilitative Street/Community Outreach	The conditions of Basic and Intensive Street Outreach must be met.
VA	Collaborative Street/Community Outreach	Utilizes outreach workers from various agencies and other health care providers
WI	Outreach	<p>Outreach workers should be trained in the following areas: the principles of outreach, the harm reduction model, referral sources, confidentiality issues, and safety issues.</p> <p>Focuses on information dissemination, not on skills building and behavior change as with ILI. Includes needle exchange program.</p>

Jurisdictions' Definitions of Outreach

Outreach (AK)

Outreach done by opinion leaders in the community being outreached.

“Characteristics of Effective Interventions” and additional information such as applicable target populations, prevention goal, essential components, behavioral/social science and evidence for effectiveness for Street and community outreach included separately from definition.

Outreach by Popular Opinion Leaders (POLs)

- App. target populations: MSM; heterosexual women with partners at high risk
- Prevention Goal: Reduce unsafe sexual behaviors; Increase condom use
- Essential components: Identification and training of volunteer peer educators recruited from among opinion leaders of a community; Peer educators commit to conversing about risk reduction with a specific number of peers; Risk reduction workshops for the opinion leaders and HIV prevention events implemented by the POLs.
- Behavioral/social science theoretical basis: Theories of social influence and diffusion of innovation.

Duration/Dosage:

Venue: Community – Specific areas frequented by persons who engage in risk behavior

Mode: Outreach – minimally structured

Provider: Peer

Outcome: Behavioral

Level: Individual, Group, Community

Target Population: MSM; heterosexual women with partners at high risk

Other: Peer educators commit to conversing about risk reeduction with specified number of peers.

Risk reduction workshops for the opinion leaders and Hiv prevention events implemented by the POLs.

Outreach – Contact (AK)

Contact – Dispensing prevention information and materials, including community resource information. One-on-one exchange or one worker talking to a few of the target population. Usually brief. Information flow is predominately for outreach worker to person in the target population.

“Characteristics of Effective Interventions” and additional information such as applicable target populations, prevention goal, essential components, behavioral/social science and evidence for effectiveness for Street and community outreach included separately from definition.

Street and Community Outreach

- App. target populations: high-risk youth, commercial sex workers, non-gay-identified MSM, IDU, female sex partners of IDU, and heterosexual adults.
- Prevention Goal: Reduce unsafe sexual behaviors, increase condom use, and delay sexual activity; reduce use of unclean injection equipment, and increase clean syringe access and bleach cleaning; and increase HIV counseling and testing.
- Essential components: Paid or volunteer peer outreach workers, culturally and linguistically representative of the target population; sustained and regular presence in the community; focus efforts on specific areas of a community frequented by persons who engage in risk behavior; minimally, provides risk reduction info and supplies- condoms, lubricant, injection harm reduction equipment and information on HIV HE/RR and C/T resources; ideally facilitates personal risk perception and risk assessment; provides skills training – condom use, needle/syringe cleaning, communication skills; provides messages of peer and community support for safer behaviors; provides messages of peer and community support for safer behaviors; provides specific referral to more intensive risk reduction resources as appropriate.
- Behavioral/social science theoretical basis: Transtheoretical Model of Behavioral Change and common theoretical factors derived from Health Belief Model, Theory of Reasoned Action and Social Cognitive Learning Theory.

<i>Duration/Dosage:</i>	Usually brief Sustained and regular presence in community
<i>Venue:</i>	Community – Specific areas frequented by persons who engage in risk behavior
<i>Mode:</i>	Outreach – minimally structured Materials distribution
<i>Provider:</i>	Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual, Group
<i>Target Population:</i>	High-risk youth, commercial sex workers, non-gay-identified MSM, IDU, female sex partners of IDU, and heterosexual adults.
<i>Other:</i>	Minimally, provides risk reduction info and supplies Ideally facilitates personal risk perception and risk assessment Provides skills training

Outreach – Encounter (AK)

A dialogue between a worker and a member of the target population. Involves some disclosure of risk/concerns by the target person and, from the worker, some client risk reduction counseling or referral to specific risk reduction resources. The encounter may take place in an outreach setting (bar, street, drop-site, etc.) or elsewhere (office, home, treatment center, shelter, etc.) or over the phone, as a client initiated follow-up to an outreach or health education activity. Encounters may be brief or lengthy; single or multiple interactions with the same client; spontaneous or prearranged.

“Characteristics of Effective Interventions” and additional information such as applicable target populations, prevention goal, essential components, behavioral/social science and evidence for effectiveness for Street and community outreach included separately from definition.

Street and Community Outreach

- App. target populations: high-risk youth, commercial sex workers, non-gay-identified MSM, IDU, female sex partners of IDU, and heterosexual adults.
- Prevention Goal: Reduce unsafe sexual behaviors, increase condom use, and delay sexual activity; reduce use of unclean injection equipment, and increase clean syringe access and bleach cleaning; and increase HIV counseling and testing.
- Essential components: Paid or volunteer peer outreach workers, culturally and linguistically representative of the target population; sustained and regular presence in the community; focus efforts on specific areas of a community frequented by persons who engage in risk behavior; minimally, provides risk reduction info and supplies- condoms, lubricant, injection harm reduction equipment and information on HIV HE/RR and C/T resources; ideally facilitates personal risk perception and risk assessment; provides skills training – condom use, needle/syringe cleaning, communication skills; provides messages of peer and community support for safer behaviors; provides messages of peer and community support for safer behaviors; provides specific referral to more intensive risk reduction resources as appropriate.
- Behavioral/social science theoretical basis: Transtheoretical Model of Behavioral Change and common theoretical factors derived from Health Belief Model, Theory of Reasoned Action and Social Cognitive Learning Theory.

<i>Duration/Dosage:</i>	Brief or lengthy, single or multiple
<i>Venue:</i>	Outreach or other setting, or over the phone
<i>Mode:</i>	Outreach – semi-structured
<i>Provider:</i>	Professional, Paraprofessional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	High-risk youth, commercial sex workers, non-gay-identified MSM, IDU, female sex partners of IDU, and heterosexual adults.
<i>Other:</i>	Minimally, provides risk reduction info and supplies Ideally facilitates personal risk perception and risk assessment Provides skills training

Street and Community Outreach (CA)

Under 'Program Category 1: Individual-Level Interventions'. Definition based upon a review of the literature.

Street and community outreach includes education and counseling at sites where community members informally congregate such as streets, bars, parks, shooting galleries, bathhouses, beauty parlors, etc.

Information from literature review on outcome effectiveness also provided. ... "To be effective, the presence of outreach workers needs to be consistent and continuous, not just sporadic visits" (Johnson, et al., 1990; Stephens, et al., 1993; Dorfman, et al., 1992).

<i>Duration/Dosage:</i>	Consistent and continuous, not sporadic
<i>Venue:</i>	Community – areas where high-risk people congregate
<i>Mode:</i>	Outreach
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	Staff deliverers must be respected, trusted, credible, open, friendly, dedicated, non-judgemental or non-threatening.

Condoms, Other Barriers, and Bleach Demonstration and Distribution (CA)

Under 'Program Category 1: Individual-Level Interventions'. Definition based upon a review of the literature.

This intervention includes the demonstration and distribution of condoms, bleach and risk reduction barriers and provision of referrals in areas where high-risk people congregate. Limited one-on-one health education or risk reduction may be offered.

Information from literature review on outcome effectiveness also provided.

Duration/Dosage:

Venue: Community – areas where high-risk people congregate

Mode: Material distribution

Provider:

Outcome: Behavioral

Level: Individual

Target Population:

Other:

Natural Opinion Leaders (CA)

Under 'Program Category 3: Community-Level Interventions'. Definition based upon a review of the literature.

This strategy uses natural opinion leaders, such as celebrities, to heighten people's interests in learning more about HIV transmission.

Information from literature review on outcome effectiveness is provided.

Duration/Dosage:

Venue:

Mode: Health education

Provider: Peer

Outcome: Behavioral

Level: Group, Community

Target Population:

Other:

Street/Community Outreach (CH)

Describes:

- I. Minimum Criteria
 - A. Face to face interactions with a high-risk individuals in their neighborhood or area(s) where they congregate
 - B. Outreach usually includes distribution of risk reduction supplies (e.g., condoms, bleach kits, lubricant, literature, etc.) and information regarding other available prevention services
 - C. Street/community Outreach cannot be funded as a stand-alone intervention (i.e., as the only intervention in a program) but must be coupled with 1 or more of the other HPPG approved interventions
- II. Quality Assurance Measures
 - A. Agency has signed Memorandums of Agreement (MOAs) with local bars, bookstores, bath houses etc. where they perform outreach activities
 - B. Agency has a written field safety protocol
 - C. Agency has a written outreach schedule
- III. Data Requirements
 - A. In an effort to better document service delivery citywide, all CDPH prevention funded agencies will be required to collect and submit the following data for each intervention used in their program. Data will be submitted to CDPH scan forms (provided by CDPH). This information will be used to improve the quality and effect of HIV prevention projects in Chicago.
 1. Type of agency
 2. Risk population
 3. Client demographics
 4. Setting
 5. Number of interventions
 6. Staffing
 7. Expenditures

What Works in Prevention?

Key factors of Successful Interventions and Programs:

- I. Services are:
 - D. delivered in a culturally appropriate and culturally sensitive manner
 - E. easily accessed
 - F. voluntary
- II. Target Population is:
 - A. clearly defined and with a proven need of HIV prevention services.
- III. Goals and Objectives of the Program are:
 - A. clearly defined, time-phased, and measurable.
- IV. Interventions are:
 - A. based on sound behavioral research
 - B. well planned, implemented, monitored and evaluated
 - C. created (whenever possible) with input from target population

- D. focused on reducing specific behaviors and address skill levels, attitudes, and behaviors that influence high risk activities (i.e., how to use condoms appropriately, how to clean injection equipment, and reinforcing positive attitudes about condom use)
- E. vehicles for demonstrating, reinforcing, and promoting positive behaviors
- V. Agencies have:
 - A. the ability to maintain multiple contacts with participants
 - B. the ability to document service delivery (i.e., develop and maintain survey questionnaires, client assessment forms, etc.)
 - C. a strong referral and follow-up system exists (formal, established, and written with signed memorandums of agreement)
 - D. the ability and desire to collaborate with other organizations
 - E. policies that conform with prevailing local, state and federal laws regarding client confidentiality
 - F. staff with necessary academic background or experience in a human-services-related field (i.e., social work, psychology, nursing, counseling, or health education); and case management and assessment techniques
 - G. staff that are knowledgeable about HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change.
- VI. How Do We Assure Quality?
 - A. Minimum Quality Assurance Standards
- VII. Services are:
 - A. offered in a safe environment. The agency should be clean, neat, well ventilated, and clutter free
- VIII. Interventions are:
 - A. whenever possible, implemented/delivered by individuals representative of the target population
- IX. Agencies have:
 - A. Policies and Procedure Manual. This manual must contain all intervention protocols, policies, and procedures of the services being delivered
 - B. current collaborative linkages within community and, when possible, should participate in one or more Community Planning Groups
 - C. staff that are familiar with available community resources
 - D. staff that are trained in the implementation of program intervention(s). All trainings must be documented in staff folders. The agency should promote and encourage continuing educational trainings.
 - E. grievance procedures in place and a method for informing clients of this process. Proof of client receipt should be documented in client charts
 - F. policies on staff safety (on site and off site)
 - G. a relationship with local authorities (police) such that the program is well known in the community
 - H. regular assessments of clients satisfaction through periodic client satisfaction surveys
 - I. regular management/supervisors meetings with program staff to discuss project and status progress towards stated outcomes

Duration/Dosage:

Venue: High-risk individuals' neighborhoods or areas where they
congregate

Mode: Material/supply distribution
Outreach – minimally structured

Provider:

Outcome: Behavioral

Level: Individual

Target Population:

Other: Street/community outreach cannot be funded as a stand-
alone intervention (i.e., as the only intervention in a
program) but must be coupled with 1 or more of the other
HPPG approved interventions

Outreach (CO)

Encompassed under Health Education/Risk Reduction – Subcategory of ILI

Outreach programs seek to change behavior by providing motivation, knowledge, risk reduction materials, and referrals to services that support behavior change. Such programs access at-risk individuals on the street, or in malls, parks, bars, or other community settings. The distribution of materials by itself is not considered outreach.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their programs flow from and is consistent with social and behavioral theory and research relevant to HIV risk reduction.

- Goal of the Intervention: Outreach seeks to lower risk behavior in individuals by providing motivation, knowledge, risk reduction materials, and referrals to services that support behavior change.
- Target Population: Outreach is directed towards a clearly defined target population of individuals at high-risk for getting or spreading HIV. Such population are further characterized by gender, age, race, ethnicity, risk behavior, physical or mental disability, and/or geographic location.
- Cultural competence/proficiency: ...
- Where Delivered: Outreach programs access at-risk individuals on the street, or in malls, parks, bars or other community settings (outside classroom, workshop or clinic) where members of the target audience are likely to be located (as identified through formative evaluation); the provider goes out to the client making the intervention accessible to the community.

- When Delivered: Outreach occurs at times when members of the target population are likely to be present (as identified through formative evaluation)
- How Much: Outreach strives for consistency and on-going contact and reinforcement with individuals
- Content and Methods Employed: ...Outreach involves one-on-one contacts which include the distribution of materials, referrals and educational discussions on sexual-risk, needle-sharing behaviors, and the overall relationship between substance abuse and risky behavior. The distribution of materials by itself is not considered outreach. Outreach workers strive to help clients develop skills and motivation to adopt and maintain safer behaviors over time. ...
- Qualifications of People to do this work: Outreach workers are usually peers or have extensive experience working with the target group(s), are knowledgeable about available resources, and are able to refer clients to them.

Outreach workers speak the same language as the clients.

Providers of outreach should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

The peers or professionals providing outreach must be competent to regard culture and other diversity and able to present the materials in an understandable and non-judgemental manner.

- Continuing Education/Ongoing Training Requirements:
- Consent/Confidentiality Considerations: ...
- Quality Assurance: ...
- Evaluation: ...
- Penalties for Violating Standards: ...
- Other: ...

<i>Duration/Dosage:</i>	Consistent and on-going contact
<i>Venue:</i>	On the street or in malls, parks, bars or other community settings outside of classrooms, workshops or clinics
<i>Mode:</i>	Outreach – semi-structured
<i>Provider:</i>	Professional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	Individuals at high-risk for getting or spreading HIV
<i>Other:</i>	<p>Outreach involves one-on-one contacts which include the distribution of materials, referrals and educational discussions on sexual-risk, needle-sharing behaviors, and the overall relationship between substance abuse and risky behavior.</p> <p>The distribution of materials by itself is not considered outreach.</p> <p>Outreach workers strive to help clients develop skills and motivation to adopt and maintain safer behaviors over time.</p>

Peer or Non-Peer Outreach (CT)

What is it?

- Outreach is when members of a particular group are contacted in their own environment (e.g., on the street, in drug use settings) by either other members of their group (peers) or people who are not part of their group (non-peers). These outreach workers give out HIV information, support positive attitudes and norms regarding HIV prevention, teach behavioral skills for prevention, and endorse safer sexual and drug behavior. Often outreach workers will distribute materials and supplies, such as new needles, bleach kits, or condoms. The discussions are usually informal, but appear highly effective.

Does the intervention change behavior? ...

- Studies have shown that outreach is successful at inducing safer sexual and drug use practices
- Outreach may be slightly easier and more effective for peers, as long as they are trusted members of the community; but non-peers can eventually gain the trust required to be successful.
- Though the intervention occurs at an individual level, there appear to be community-wide changes in norms as a result of outreach, where community norms become more positive towards HIV risk reduction.

With what populations is it successful in changing behavior?

- Outreach is especially useful with those populations that do not go to group interventions offered at public health departments or community-based organizations. It is also effective

with populations who are part of stigmatized groups who might not identify their risk status to public health professionals (e.g., MSM, IDUs, other drug users, at-risk youth).

Duration/Dosage:

Venue: In environment of target group

Mode: Outreach – minimally structured
Material/supply distribution

Provider: Peer, Non-Peer

Outcome: Behavioral

Level: Individual

Target Population: MSM, IDUs, other drug users, at-risk youth

Other: Outreach workers ... support positive attitudes and norms regarding HIV prevention, teach behavioral skills for HIV prevention, ...

Natural Opinion Leaders (CT)

What is it?

- Natural opinion leaders are people who are nominated as leaders of a particular social group, and are then trained to provide HIV prevention information, motivation and sometimes behavioral skills to the other members of the group. There are four basic steps to natural opinion leader interventions:
 1. Opinion leaders are nominated by their peers as people who are popular and respected, and then they are recruited to participate;
 2. Opinion leaders are trained to give HIV prevention information to their peers;
 3. Opinion leaders support pro-HIV prevention norms and behaviors, and this positive attitude and sense of support for HIV prevention spreads throughout the social group going from friend to friends; and
 4. Opinion leaders may train their peers in behavioral skills (e.g., how to negotiate safer sex with a partner).

Does the intervention change behavior?

- Natural opinion leaders interventions have successfully increased safer behavior and decreased risk behavior in populations of MSM and women living in low-income housing developments.
- In order to be successful, natural opinion leader interventions have to be done in close-knit communities where people have a lot of contact. Also, the people picked up as natural opinion leaders must be popular and respected in their peer group or community.

With what populations is it successful in changing behavior?

- Natural opinion leader interventions have been successful with MSM and women living in low-income housing developments. There is currently a natural opinion leaders intervention being evaluated with inner-city minority high school students

Duration/Dosage:

Venue: Community

Mode:

Provider: Peer

Outcome: Behavioral

Level:

Target Population: MSM and low-income women;
Possibly minority high school students

Other:

1. Nominated by peers.
2. Trained to give HIV info.
3. Support pro-HIV prevention norms, behaviors and attitudes.
4. May train peers in behavioral skills.

Outreach (DC)

Outreach interventions are generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate (e.g. bars, parks, shooting galleries). Outreach usually includes distribution of condoms, barriers, bleach and educational materials. Includes peer opinion leaders models.

Street outreach programs aim to encounter clients in their own community who are unlikely to be receiving important HIV prevention services. This strategy usually targets individuals at informal sites where persons engaged in high-risk activities congregate and includes the distribution of condoms, bleaching kits and literature. Outreach workers -- who may be trained peers or non-peers--also provide referrals to prevention, substance abuse, or early intervention programs.

Includes:

1. Standards: Agencies that provide street and community outreach will frequently engage peer educators to conduct intervention activities. This method provides an opportunity for individuals to perceive themselves as empowered by helping persons in their communities and social networks, thus supporting their own health enhancing practices. Street outreach programs include the following essential components:
 - Face-to-face outreach interventions in community settings at appropriate times of the day/night, week and year;

- Education on HIV transmission and on substance abuse/harm reduction that is provided in face-to-face interactions and promote the client's current prevention needs, whether these are for no interaction, prevention materials only, basic information, referrals to or on-the-spot case management or counseling on HVI test results;
- Distribution of male and female condoms and barriers, bleaching kits, and culturally and linguistically appropriate written information on the correct use of condoms and bleaching kits;
- Referrals to prevention, substance abuse or early intervention programs, as well as to services that can provide support in maintaining the client's seronegative status, such as: *mental health services, *housing and shelter services, *support groups for HIV-negative individuals.
- Establishing the educators and the agency they represent as resources for the community regarding HIV, STDs, substance abuse and support for other issues.

Also includes sections on:

2. *CDC Guidelines on Outreach (from "Guidelines for HERR activities, March 1995).*
3. *Using Peers in HIV Prevention Interventions*
4. *CDC Guidelines for Programs Using Peer Educators (from "Guidelines for HERR activities, March 1995).*
5. *Sample-Field Safety Protocol for Outreach Workers*

Duration/Dosage:

Venue: Areas where clients typically congregate

Mode: Outreach – minimally structured

Material/supply distribution

Provider: Paraprofessional, Peer

Outcome: Behavioral

Level: Individual

Target Population: High-risk individuals

Other: Also provide referrals to prevention, substance abuse, or early intervention programs.

HERR Street & Community Outreach (HO)

These intervention programs are defined by the location and nature of the prevention activities. They may involve the participation of peer and non-peer activity leaders. Outreach interventions take place in the community environment and target people who otherwise may not receive HIV prevention messages. Conducting community outreach interventions involves taking prevention activities to neighborhoods, streets, bars, or any other place where the target community gets together. The outreach itself does not have to be a standard form of intervention, but a variety of interventions that share a set of techniques and characteristics. Community outreach does not impose a formal structure of activities on the target population because it occurs in the client's

own terms. It is based on the face-to-face contact between the outreach worker and the community members. Some outreach interventions provide information, some provide counseling, and some provide both (Kalichman, 1998).

Duration/Dosage:

Venue: Community environments, such as neighborhoods, streets, bars, etc.

Mode: Outreach – minimally structured

Provider: Peer, Non-Peer

Outcome: Behavioral

Level: Community

Target Population:

Other: Outreach itself does not have to be a standard form of intervention, but a variety of interventions that share a set of techniques and characteristics.

Some outreach interventions provide information, some provide counseling, and some provide both (Kalichman, 1998).

Outreach – Peer Education (IA)

Description taken from the Taxonomy of HIV/AIDS Prevention Interventions from the Academy of Educational Development and the CDC's 2000 Evaluation Guidance (CDC, 1999) for the purpose of making meaningful distinctions and choices among possible interventions.

Outreach is HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate. Outreach programs seek to change individuals behavior by providing motivation, knowledge, risk reduction materials, and referrals to services that support behavior change. Such programs access at-risk individuals on the street, or in malls, parks, bars, or other community settings. Outreach is directed towards a clearly defined target population of individuals at high-risk for getting or spreading HIV. Such populations are further characterized by gender, age, race, ethnicity, risk behavior, physical or mental disability, and or geographic locations. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Peer opinion leader models are included in this category.

Encompassed under Health Education/Risk Reduction:

.... The goals of health education and risk reduction activities are to go beyond the provision of information to provide education and counseling that assists individuals in developing the skills, abilities, and self-esteem to carry out behavior change (CDC, 1995). Health education and risk

reduction interventions can be delivered at individual, group, community, or outreach levels. HE/RR activities can include counseling, workshops, educational programs and materials, presentations, and outreach activities. ...

Street and community outreach programs are defined by their locus of activity and by the content of their offerings. Both have important subcategories of peer and non-peer models.

- I. Peer Education – Peer education involves services provided by individuals who are recruited from a target population. These individuals are trained in HIV/AIDS, peer counseling, outreach, and the issues of the population groups which are difficult to reach with HIV information alone. The peer model can draw on established social networks to disseminate information. Peer providers are a direct link to members of the target population who do not normally present at primary channels such as counseling and testing sites (Edelstein and Gonyer, 1993). Peer educators can be used in individual, group, and community level interventions. ...
 - A. Demonstrated effectiveness
 - B. Suggested uses
 1. Advantages and Strengths
 - a. Peer education is a strategy that is generally applicable to all populations
 - b. Peer education is especially suited for populations who do not initially perceive themselves to be at risk
 2. Considerations ...
- II. Endorsements/Testimonials by Opinion Leaders ...
- III. Street Outreach ...
- IV. Condoms, Latex Barriers, Bleach Distribution ...
- V. Access to sterile Injection Equipment ...

Duration/Dosage:

Venue: Neighborhood or areas where target population congregates

Mode: Outreach – minimally structured

Provider: Peer

Outcome: Behavioral

Level: Individual, Group, Community

Target Population:

Other: Provide motivation, knowledge, risk reduction materials, and referrals to services that support behavior change.

These individuals are trained in HIV/AIDS, peer counseling, outreach, and the issues of the population groups which are difficult to reach with HIV information alone.

Outreach – Endorsements/Testimonials by Opinion Leaders (IA)

Description taken from the Taxonomy of HIV/AIDS Prevention Interventions from the Academy of Educational Development and the CDC's 2000 Evaluation Guidance (CDC, 1999) for the purpose of making meaningful distinctions and choices among possible interventions.

Outreach is HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate. Outreach programs seek to change individuals behavior by providing motivation, knowledge, risk reduction materials, and referrals to services that support behavior change. Such programs access at-risk individuals on the street, or in malls, parks, bars, or other community settings. Outreach is directed towards a clearly defined target population of individuals at high-risk for getting or spreading HIV. Such populations are further characterized by gender, age, race, ethnicity, risk behavior, physical or mental disability, and or geographic locations. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Peer opinion leader models are included in this category.

Encompassed under Health Education/Risk Reduction:

.... The goals of health education and risk reduction activities are to go beyond the provision of information to provide education and counseling that assists individuals in developing the skills, abilities, and self-esteem to carry out behavior change (CDC, 1995). Health education and risk reduction interventions can be delivered at individual, group, community, or outreach levels. HE/RR activities can include counseling, workshops, educational programs and materials, presentations, and outreach activities. ...

Street and community outreach programs are defined by their locus of activity and by the content of their offerings. Both have important subcategories of peer and non-peer models.

- I. Peer Education ...
- II. Endorsements/Testimonials by Opinion Leaders – Opinion leaders are key people who are recognized as influential and charismatic members of a community or communities. These individuals are seen as models whose opinions and behaviors are likely to influence the opinions and behaviors of a target population. An opinion leader is a member of the community who is particularly popular or respected by other members of the community. An opinion leader may be viewed as representing her/his community in the entertainment field, sports, government/politics, academia, business, popular culture, community work, etc.
 - A. Demonstrated effectiveness
 1. As a strategy for preventing HIV infections, however, the usefulness of high profile natural opinion leaders such as Magic Johnson may be limited. Natural opinion leaders, due to their widespread visibility, can be instrumental in increasing awareness and knowledge of HIV/AIDS and related prevention services but not necessarily effecting behavior change.
 - B. Suggested uses
 1. Advantages and Strengths ...

- 2. Considerations ...
- III. Street Outreach ...
- IV. Condoms, Latex Barriers, Bleach Distribution ...
- V. Access to sterile Injection Equipment ...

Duration/Dosage:

Venue: Client's neighborhood or areas where clients congregate

Mode: Health Communication/Public Information

Provider: Peer

Outcome: Information

Behavioral

Level: Community

Target Population:

Other: Provide motivation, knowledge, risk reduction materials, and referrals to services that support behavior change.

Outreach – Street Outreach (IA)

Description taken from the Taxonomy of HIV/AIDS Prevention Interventions from the Academy of Educational Development and the CDC's 2000 Evaluation Guidance (CDC, 1999) for the purpose of making meaningful distinctions and choices among possible interventions.

Outreach is HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate. Outreach programs seek to change individuals behavior by providing motivation, knowledge, risk reduction materials, and referrals to services that support behavior change. Such programs access at-risk individuals on the street, or in malls, parks, bars, or other community settings. Outreach is directed towards a clearly defined target population of individuals at high-risk for getting or spreading HIV. Such populations are further characterizes by gender, age, race, ethnicity, risk behavior, physical or mental disability, and or geographic locations. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Peer opinion leader models are included in this category.

Encompassed under Health Education/Risk Reduction:

.... The goals of health education and risk reduction activities are to go beyond the provision of information to provide education and counseling that assists individuals in developing the skills, abilities, and self-esteem to carry out behavior change (CDC, 1995). Health education and risk reduction interventions can be delivered at individual, group, community, or outreach levels. HE/RR activities can include counseling, workshops, educational programs and materials, presentations, and outreach activities. ...

Street and community outreach programs are defined by their locus of activity and by the content of their offerings. Both have important subcategories of peer and non-peer models.

- I. Peer Education ...
- II. Endorsements/Testimonials by Opinion Leaders ...
- III. Street Outreach – Street outreach refers to HIV prevention education and counselign that is delivered at informal sites where persons engaged in high-risk activities congregate, such as streetsm bars, parks, shooting galleries, bathhouses, beauty parlors, etc. The strategy involves a broad ranges of models from occasional condom drops to the long-term placement of highly skilled workers in the community. Street outreach programs may be highly interactive and engaging, or they may involve only a cursory risk message and delivery of referral information. Some outreach programs strive to develop long-term relationships with individuals on the streets, thus the service is repeatedly delivered to an individual over time.
 - ...
 - A. Demonstrated effectiveness ...studies have found that increased exposure over time results in more significant behavioral chnages (Stephens, et al., 1993). ...presence of outreach workers needs to be consistent and continuous, not just sporadic visits (Johnson, et al., 1990; Stephens, et al., 1993; Dorfman, et al., 1992). ...
- IV. Condoms, Latex Barriers, Bleach Distribution ...
- V. Access to sterile Injection Equipment ...

<i>Duration/Dosage:</i>	Needs to be consistent and continuous, not just sporadic visits
<i>Venue:</i>	Informal sites where persons engaged in high-risk activities congregate, such as streets, bars, parks, shooting galleries, bathhouses, beauty parlors, etc.
<i>Mode:</i>	Outreach – semi-structured
<i>Provider:</i>	Paraprofessional (non-peer), Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	Provide motivation, knowledge, risk reduction materials, and referrals to services that support behavior change. Involves a broad ranges of models may be highly interactive and engaging, or they may involve only a cursory risk message and delivery of referral information.

Outreach – Condoms, Latex Barriers, Bleach Distribution (IA)

Description taken from the Taxonomy of HIV/AIDS Prevention Interventions from the Academy of Educational Development and the CDC's 2000 Evaluation Guidance (CDC, 1999) for the purpose of making meaningful distinctions and choices among possible interventions.

Outreach is HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate. Outreach programs seek to change individuals behavior by providing motivation, knowledge, risk reduction materials, and referrals to services that support behavior change. Such programs access at-risk individuals on the street, or in malls, parks, bars, or other community settings. Outreach is directed towards a clearly defined target population of individuals at high-risk for getting or spreading HIV. Such populations are further characterized by gender, age, race, ethnicity, risk behavior, physical or mental disability, and or geographic locations. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Peer opinion leader models are included in this category.

Encompassed under Health Education/Risk Reduction:

.... The goals of health education and risk reduction activities are to go beyond the provision of information to provide education and counseling that assists individuals in developing the skills, abilities, and self-esteem to carry out behavior change (CDC, 1995). Health education and risk reduction interventions can be delivered at individual, group, community, or outreach levels. HE/RR activities can include counseling, workshops, educational programs and materials, presentations, and outreach activities. ...

Street and community outreach programs are defined by their locus of activity and by the content of their offerings. Both have important subcategories of peer and non-peer models.

- I. Peer Education ...
- II. Endorsements/Testimonials by Opinion Leader ...
- III. Street Outreach ...
- IV. Condoms, Latex Barriers, Bleach Distribution – Through this strategy, health workers distribute bleach, condoms, and latex barriers, demonstrate their use, and provide referrals in areas where people at risk for HIV congregate. Limited opportunities for one-on-one health education or risk reduction are offered by this strategy that, by definition, focuses on behavioral change.
- V. Access to sterile Injection Equipment ...

Duration/Dosage:

Venue: Areas where people at risk for HIV congregate

Mode: Outreach – minimally or semi-structured

Provider: Professional

Outcome: Behavioral

Level: Individual

Target Population:

Other: Provide motivation, knowledge, risk reduction materials, and referrals to services that support behavior change.

Outreach – Access to Sterile Injection Equipment (IA)

Description taken from the Taxonomy of HIV/AIDS Prevention Interventions from the Academy of Educational Development and the CDC's 2000 Evaluation Guidance (CDC, 1999) for the purpose of making meaningful distinctions and choices among possible interventions.

Outreach is HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate. Outreach programs seek to change individuals behavior by providing motivation, knowledge, risk reduction materials, and referrals to services that support behavior change. Such programs access at-risk individuals on the street, or in malls, parks, bars, or other community settings. Outreach is directed towards a clearly defined target population of individuals at high-risk for getting or spreading HIV. Such populations are further characterized by gender, age, race, ethnicity, risk behavior, physical or mental disability, and or geographic locations. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Peer opinion leader models are included in this category.

Encompassed under Health Education/Risk Reduction:

.... The goals of health education and risk reduction activities are to go beyond the provision of information to provide education and counseling that assists individuals in developing the skills, abilities, and self-esteem to carry out behavior change (CDC, 1995). Health education and risk reduction interventions can be delivered at individual, group, community, or outreach levels. HE/RR activities can include counseling, workshops, educational programs and materials, presentations, and outreach activities. ...

Street and community outreach programs are defined by their locus of activity and by the content of their offerings. Both have important subcategories of peer and non-peer models.

- I. Peer Education ...
- II. Endorsements/Testimonials by Opinion Leaders ...
- III. Street Outreach ...

IV. Condoms, Latex Barriers, Bleach Distribution ...

V. Access to sterile Injection Equipment – Needle exchange programs provide sterile needles to injection drug users. Needle exchange programs are community or street-based. Within this intervention framework, prevention workers distribute clean needles (syringes) and other supplies to individuals who use needles to inject drug, usually in exchange for used needles. They also provide referrals to HIV-related services in areas where persons involved in high-risk behaviors congregate. A limited opportunity for one-on-one health education and/or risk reduction intervention may occur in this context, as may a chance to help link an infected person to HIV care services. Needle exchange programs focus specifically on behavior change related to needle usage and less on sexual behaviors. Needle exchange programs are designed to reach individuals on a repeated basis. ...

A. Demonstrated effectiveness

<i>Duration/Dosage:</i>	Repeated
<i>Venue:</i>	Community or street-based
<i>Mode:</i>	Outreach – minimally or semi-structured
<i>Provider:</i>	Paraprofessional (non-peer), Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Community
<i>Target Population:</i>	Injection drug users
<i>Other:</i>	Provide motivation, knowledge, risk reduction materials, and referrals to services that support behavior change. A limited opportunity for one-on-one health education and/or risk reduction intervention may occur in this context, as may a chance to help link an infected person to HIV care services.

Outreach (ID)

Educational interventions conducted face-to-face in places where priority population congregates, for more than the purpose of counseling and testing.

Duration/Dosage:

Venue: Places where priority population congregates

Mode: Outreach

Provider:

Outcome:

Level: Individual, Group

Target Population:

Other: Educational intervention

For more than the purpose of counselign and testing

Street Outreach (IL)

Street outreach specifically refers to the individual level (one-on-one) interactions within a community outreach program. As the name implies, street outreach involves moving throughout a particular neighborhood or community, usually on foot, to deliver risk reduction interventions and supplies. Many communities, particularly in rural areas, do not find street outreach to be appropriate or feasible. In these areas, individual outreach is most often conducted in non-street community settings, such as those listed above.

The CDC defines three types of street and community outreach.

1. Active Street & Community Outreach involves moving throughout a particular neighborhood setting (e.g., a park, bar, shelter) to identify and engage clients in face-to-face interactions. The level of outreach interaction ranges from providing basic risk reduction information and supplies (condoms, bleach kits) to highly individualized risk assessment, education, and assistance accessing local services.
2. Fixed Site Outreach involves interaction with individuals from a specific place such as a table, van or storefront. Outreach specialists set up a station in areas expected to have high traffic from members of the target population.
3. Drop Off Site Outreach delivers risk reduction materials and supplies to volunteers for distribution when the outreach specialist is not there. Volunteers may be recruited to give free condoms or bleach kits to their peers (for example, other drug users or sex workers). Or store managers, bar owners or social service agencies may volunteer to display posters, brochures, or free condoms for their patrons. Outreach staff maintain the stock and provide any necessary training for volunteers.

Side text: There are many possible types of outreach strategies. Communities should plan street and community outreach activities that best address local needs, with input from members of the target population.

Also includes a Quality Assurance Tool for Street & Community Outreach.

Duration/Dosage:

Venue: Streets in a neighborhood or community, or places outside of a traditional health care or agency setting

Mode: Outreach – structured, semi-structured or minimally structured

Material/supply distribution

Provider: Paraprofessional, Peer

Outcome: Behavioral

Level: Individual

Target Population:

Other: intervention within a community outreach program

Community Outreach (IL)

Community outreach refers to a broad range of direct HIV prevention interventions that take place outside of traditional health care or agency settings. Community outreach delivers prevention messages, risk reduction supplies, education, and referrals in settings that are easily and regularly frequented by members of the targeted population. Outreach demonstrates an agency's willingness to go to the community rather than wait for the community to come to it. Examples of community outreach settings include street corners, laundromats, parks, shelters, bars, currency exchanges, fast food restaurant, bus stops, and drug houses. Prevention outreach may also occur in and around outreach testing sites.

The CDC defines three types of street and community outreach.

1. Active Street & Community Outreach involves moving throughout a particular neighborhood setting (e.g., a park, bar, shelter) to identify and engage clients in face-to-face interactions. The level of outreach interaction ranges from providing basic risk reduction information and supplies (condoms, bleach kits) to highly individualized risk assessment, education, and assistance accessing local services.
2. Fixed Site Outreach involves interaction with individuals from a specific place such as a table, van or storefront. Outreach specialists set up a station in areas expected to have high traffic from members of the target population.
3. Drop Off Site Outreach delivers risk reduction materials and supplies to volunteers for distribution when the outreach specialist is not there. Volunteers may be recruited to give free condoms or bleach kits to their peers (for example, other drug users or sex workers). Or store managers, bar owners or social service agencies may volunteer to display posters, brochures, or free condoms for their patrons. Outreach staff maintain the stock and provide any necessary training for volunteers.

Side text: There are many possible types of outreach strategies. Communities should plan street and community outreach activities that best address local needs, with input from members of the target population.

Also includes a Quality Assurance Tool for Street & Community Outreach.

Duration/Dosage:

Venue: Community settings outside traditional health care or agency settings

Mode: Outreach – structured, semi-structured or minimally structured

Provider: Paraprofessional, Peer

Outcome: Behavioral

Level: Community

Target Population:

Other:

Condom Availability (LA)

Increase access to condoms through distribution of no cost condoms in high-risk areas.

CDC Intervention Level: Community Level

Theoretical Basis: Social Marketing Theory

Target Persons: Racial/Ethnic minorities, Sexually active females, Males who have sex with males, Youth, Substance users

Sites: Office of Public Health clinics; drug treatment centers; mental health clinics; businesses (bars, liquor stores, housing developments, private physicians offices) in high risk areas (as defined in regional plans); gay bars; hourly rate motels; crack houses; shooting galleries; houses of prostitution; community health centers; CBOs; gay bars; hourly rate motels; crack houses; shooting galleries; houses of prostitution; community health centers; CBOs; and law enforcement facilities; youth clubs; recreational centers and other places where the target populations congregate.

Key Elements:

- Make condoms available as widely as possible through a variety of locations.
- Condoms should be placed in locations which are visible and accessible to clients/customers.
- Promotion of condom distribution and consistent condom use through signs, posters and brochures.
- Condoms must be available at no-cost

- Differs from individual-level interventions in that it requires no direct contact with client.

Recommended Training: HIV/AIDS 101, HIV Prevention Counseling and Testing, Street and Community Outreach

Evaluation Methods: Analysis of the following survey data: 1) OPH Clinic survey, 2) BRFSS telephone survey, 3) Street outreach survey statewide, 4) Site observation survey: Operation Protect Site Observation Surveys, 5) Clinic accessibility survey, 6) Customer survey: Operation Protect Customer Survey

Additional data collected: 1) Condom outlet density: Operation Protect Outlets per capita and per square mile by parish, 2) Condom density: condoms distributed per capita by parish, 3) Gonorrhea rates by parish.

Expected Outcomes:

- Changing norms in condom acceptability and use.
- Increase self-reported condom use.
- Decreased STD rates.

Implemented by: Public health staff, outreach staff, prevention counseling staff, HIV/STD prevention staff

Includes:

1. Addresses High Priority Needs
2. Addresses Community/Cultural Norms & Values
3. Outcome Effectiveness
4. Accessible to the Target Populations
5. Intervention Feasibility and Cost-Effectiveness
6. Sources

Duration/Dosage:

Venue: Office of Public Health clinics, drug treatment centers, mental health clinics, businesses (bars, liquor stores, housing developments, private physicians offices) in high risk areas and other areas where the target populations congregate

Mode: Material/supply distribution

Provider: Professional

Outcome: Behavioral

Level: Community

Target Population: Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users

Other: Condoms must be available at no-cost.
Condoms should be placed in locations which are visible and accessible to clients.
Promotion of condom distribution and consistent condom use through signs, posters & brochures.
No direct contact with client required.

Street Outreach (LA)

Face-to-face educational interaction with high risk persons to decrease high risk behaviors in street settings

CDC Intervention Level: Street and Community Outreach

Theoretical Basis: Transtheoretical Model (Stages of Change)

Target Persons: Racial/Ethnic minorities, Sexually active females, Males who have sex with males, Youth, Substance users

Sites: Street setting in identified high risk areas, including neighborhoods with high STD/HIV rates and neighborhoods in which drugs and sex are sold.

Key Elements:

- Conducted in high risk areas during hours when target population is most accessible (generally non-traditional).
- Must adhere to established safety protocols.
- Talk to people about HIV/STD risk; increase knowledge and awareness; discuss modification of specific behaviors (e.g. anal sex among men who have sex with men,

needle sharing among IDU); outreach workers are encouraged to be open and available to clients needs.

- Provide condoms, bleach kits and/or needle coupons.
- Maintain the same locations (at least 1x/month).
- Partner with appropriate organizations/agencies to establish systems of referrals for free condoms; STD, HIV and Substance Abuse Treatment; HIV Counseling, Testing and Referral; STD Screening and Treatment; needle exchange and/or pharmacies which sell needles; and other appropriate referrals.
- Utilize appropriate small media (Information and risk-reduction guidance disseminated through print materials such as pamphlets, posters, and other literature; and audio visual messages through electronic messages boards, video taped messages, etc.) to reinforce the outreach worker's message.
- Practice harm reduction counseling with substance users.
- Educate clients about proper disposal of used syringes.
- Supplemental activities may include providing condoms and bleach kits to gatekeepers, placing posters in identified key areas, offering HIV and STD testing events, referring individuals for adjunct services on a mobile unit (van or RV).

Recommended Training: HIV/AIDS 101, HIV Prevention Counseling and Testing Training, Street and Community Outreach Training, Harm Reduction Training, STD Training, OSHA Universal Precautions Training

Evaluation Methods:

- Analysis of Street Outreach survey data to track: Condom use at last sex over time, contact with outreach workers, and type of condom used
- Needle coupon tracking

Expected Outcomes:

- Increase condom accessibility
- Increase access to new needles
- Improve acceptance of condoms
- Improve acceptance of sterile needles
- Facilitate positive behavior change (increased condom use, decrease needle sharing, decrease drug use)

Implemented by: Trained outreach workers; and trained HIV/STD prevention staff

Includes:

1. Addresses High Priority Needs ... The extent to which outreach addresses an individual's HIV prevention needs depends ...
2. Addresses Community/Cultural Norms & Values ...
 - a. ... Outreach must be conducted on a regular, on-going basis in assigned target areas.
...
 - b. ... In order to be culturally competent when targeting racial and ethnic minorities, street and community outreach in Louisiana has employed workers that are often indigenous to the communities they serve. ... foster cultural competence by hiring

- and training outreach workers that are intimately aware of the community's behaviors, attitudes, beliefs, and barriers.
3. Outcome Effectiveness
 4. Accessible to the Target Populations
 5. Intervention Feasibility and Cost-Effectiveness
 6. Sources

<i>Duration/Dosage:</i>	During hours when target population is most accessible Outreach must be conducted on a regular, on-going basis in assigned target areas Maintain the same locations (at least 1x/month).
<i>Venue:</i>	Street settings in identified high risk areas
<i>Mode:</i>	Outreach – structured or semi-structured Material/supply distribution
<i>Provider:</i>	Professional, Paraprofessional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual, Group, Community
<i>Target Population:</i>	Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users
<i>Other:</i>	Face-to-face educational interaction

Venue-Based Outreach (LA)

Multi-strategy educational programs targeting high risk persons in a particular venue to increase health promoting behaviors and to decrease high risk behaviors.

CDC Intervention Level: Street and Community Outreach

Theoretical Basis: Theory of Reasoned Action & Social Network/Social Support Theory

Target Persons: Racial/Ethnic minorities, Sexually active females, Males who have sex with males, Youth, Substance users

Sites: Bars, sex clubs, public sex environments, beauty salons, barber shops, clinics and other venues in identified high risk areas where members of the target populations gather for social interactions or services.

Key Elements:

- Conducted in venues in high risk areas during hours when target population (s) are most accessible.
- Re-visit the same locations (at least 1x/month).

- Should include multiple strategies (such as condom blitz, safer sex party, posters & other environmental items, information table, encounters).
- Outreach activities are designed and performed primarily by individuals who are members of target audience.
- Events planning groups represent the diversity of the community (ies) targeted for educational and prevention.
- Outreach activities respect the operating conditions at, and contribute to the spirit of, the venue/event.
- Includes a combination of face-to-face, small group, and large group interactions.
- Make referrals for free condoms; STD, HIV and Substance Abuse Treatment; HIV Counseling, Testing and Referral; STD Screening and Treatment; needle exchange and/or pharmacies which sell needles; and other appropriate referrals.

Recommended Training: HIV/AIDS 101, HIV Prevention Counseling and Testing Training, Street and Community Outreach Training, Harm Reduction Training, STD Training

Evaluation Methods:

- Survey to determine condom use at last sex over time.
- Survey to look at social norm and behavioral changes.
- Six-month follow-up survey to determine behavior changes among venue clientele.

Expected Outcomes:

- Condoms more accessible
- Contribute to the development of a social norm favoring risk reducing and health promoting behaviors
- Venue patron engagement and/or satisfaction
- Personalization of HIV issues and the epidemic
- Increased motivation to participate in HIV prevention activities
- Behavior change (increase condom use, decrease needle-sharing, decrease drug use, increased HIV testing, increased STD screening).

Implemented by: Trained outreach workers; and trained HIV/STD prevention staff

Includes:

1. Addresses High Priority Needs
2. Addresses Community/Cultural Norms & Values
3. Outcome Effectiveness
4. Accessible to Target Population
5. Intervention Feasibility and Cost-Effectiveness
6. Sources

<i>Duration/Dosage:</i>	Revisit the same locations (at least 1x/month)
<i>Venue:</i>	Bars, sex clubs, public sex environments, beauty salons, barber shops, clinics and other venues in identified high risk areas where members of the target populations gather for social interactions or services.
<i>Mode:</i>	Multi-strategy education program
<i>Provider:</i>	Professional, Paraprofessional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual, Group (small and large), Community
<i>Target Population:</i>	Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users
<i>Other:</i>	<p>Conducted in high risk areas during hours when target pop(s) are accessible.</p> <p>Multi-Strategy education program</p> <p>Should include an environmental/structural component.</p> <p>Outreach activities respect spirit of venue.</p> <p>Includes a combination of face-to-face, small group, and large group interactions.</p>

Popular Opinion Leader Intervention (LA)

Multiple sessions using an established/approved curriculum focusing on skill building in order to reduce risk for HIV/STD.

CDC Intervention Level: Individual, Group and Community Levels

Theoretical Basis: Diffusion of Innovations

Target Persons: Racial/Ethnic minorities, Sexually active females, Males who have sex with males, Youth, Substance users

Sites: Bars, community settings where target population congregates

Key Elements:

- The intervention occurs in social settings.
- A survey should be administered to clientele at the intervention location to assess demographic
- Information, HIV risk behavior knowledge, perception of social norms concerning the acceptability of using risk reduction precautions, and personal sexual behavior over the past 2 months.
- Intervention location staff should be trained to identify popular opinion leaders.

- Popular opinion leaders should be recruited from intervention location staff nominations.
- Popular opinion leaders should be educated on HIV/AIDS risk reduction.
- HIV educational materials should be displayed in the intervention location.
- Posters with symbols should be displayed in the intervention location.
- Popular opinion leaders should wear buttons with symbols corresponding to posters.
- Popular opinion leaders should have conversations about safer sex practices with clientele of the intervention site.

Recommended Training: HIV/AIDS 101, Training of Trainers in Popular Opinion Leader intervention

Evaluation Methods:

- Impact: Baseline and periodic surveys of target population members
- Process: Access points, know the community, opinion leader training, intervention (intensity and duration including opinion leaders reports of the number of conversations), sustaining the intervention, cost of the intervention.

Expected Outcomes:

1. Create community norms and social supports that help individuals avoid risk.
2. Community members practice safer behaviors.

Implemented by: Trained CBO staff and volunteers (peer). May be implemented through a peer education program.

Includes:

1. Addresses High Priority Needs
2. Addresses Community/Cultural Norms & Values
3. Outcome Effectiveness
4. Accessible to Target Population
5. Intervention Feasibility and Cost-Effectiveness
6. Sources

<i>Duration/Dosage:</i>	Multiple sessions
<i>Venue:</i>	Bars, community settings where target population congregates
<i>Mode:</i>	Outreach – minimally structured
<i>Provider:</i>	Professional, Paraprofessional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual, Group, Community
<i>Target Population:</i>	Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users
<i>Other:</i>	Uses an establish/approved curriculum focusing on skill building in order to reduce risk for HIV/STD. Intervention location staff should be trained to identify popular opinion leaders.

Street Outreach (MA)

In traditional street outreach, prevention workers seek out individuals at perceived risk of HIV infection in public areas and deliver risk reduction information and materials/devices and make referrals to allied services. This approach is useful in reaching individuals who will not ordinarily access more formal prevention interventions or who do not perceive themselves to be at risk of infection. Historically conceptualized as a subset of individual interventions, and utilized to bring information and risk reduction devices to IDUs, street outreach has been adapted to the needs of sex workers, street youth, and the homeless. Its particular value has been in its capacity to create trusting relationships between persons at risk and members of the prevention community. When these programs are best implemented, outreach workers are socially close to clients (e.g. addicts in recovery for IDUs) and apparently fit into the environments they serve. Increasingly street outreach is not considered by providers to be an end-point intervention, rather an initial intervention that should lead to, and therefore must formally linked to more intensive and sustained prevention efforts, such as group education or counseling and testing. Therefore, outreach workers need to be well trained and familiar with a wide array of allied services, from drug treatment to domestic violence intervention programs.

<i>Duration/Dosage:</i>	
<i>Venue:</i>	In public areas (i.e., streets)
<i>Mode:</i>	Outreach – minimally structured Material/supply distribution
<i>Provider:</i>	Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	Individuals at perceived risk of HIV
<i>Other:</i>	Not considered by providers to be an endpoint intervention, rather an initial intervention that should lead to, and therefore must formally linked to more intensive and sustained prevention efforts. Workers need to be well trained and familiar with a wide array of allied services, from drug treatment to domestic violence intervention programs

Community Outreach (MA)

Community outreach is related to street outreach, but expands upon the potential locations of activity. It delivers risk reduction information and materials/devices to clients in the community settings they frequent, and therefore manifests itself in a greater variety of settings. For example, some providers utilize festivals, street fairs, and health fairs as opportunities to access members of prioritized cultural communities. Others engage clients in their socializing locations, such as programs like the outreach teams which frequents gay bars and health clubs in order to reach a broader range of men than would otherwise attend their formal risk reduction workshops and seminars. Since these programs create a presence of prevention activity among large congregations of community members, they have elements of group- and community-level interventions.

<i>Duration/Dosage:</i>	
<i>Venue:</i>	In public areas (i.e., streets, health fairs, street fairs, festivals, etc.)
<i>Mode:</i>	Outreach – minimally structured Material/supply distribution
<i>Provider:</i>	In public areas (i.e., streets)
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group, Community
<i>Target Population:</i>	Individuals at perceived risk of HIV
<i>Other:</i>	Not considered by providers to be an endpoint intervention, rather an initial intervention that should lead to, and therefore must formally linked to more intensive and sustained prevention efforts.

Public Sex Environment Outreach (MA)

A Component of outreach activity specifically directed toward certain men who have sex with men acknowledges that particular public parks, highway rest stops, and other public environments serve as points for men to meet and have sex. Given that anonymous or surreptitious sexual encounters are less likely to be fully negotiated in terms of risk reduction, outreach workers attempt to discreetly engage men in these settings and to deliver risk reduction information and materials/devices. The level of contact in these settings can vary from quick hand-off of condoms and other risk reduction materials to group conversations prompted by members of the team. While the goal of these interventions is to deliver condoms and information to men at the time and place where they may need them, they also attempt to build community norms around safer sexual practices and even to recruit some men into more intensive interventions held elsewhere.

<i>Duration/Dosage:</i>	
<i>Venue:</i>	Public sex environments (public parks, highway rest stops, etc.)
<i>Mode:</i>	Outreach – semi-structured or minimally structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual, Group
<i>Target Population:</i>	MSM
<i>Other:</i>	Also attempt to recruit some men into more intensive interventions held elsewhere.

Peer-Driven Interventions (MA)

Peer-driven interventions utilize active injection drug users to design more intensive levels of risk reduction activities than street outreach activities afford, and to involve active users in the recruitment of members of their social networks into these interventions. At the initial point of involvement active users may be compensated with cash or other incentives, such as food vouchers or public transportation tokens. These interventions have been successful in terms of accessing previously hidden users and bringing them into the program, and building a sense of self-efficacy among peer recruiters. These peers often begin to participate in the program for its intrinsic value to them as allied prevention workers, which in some cases results in a discernable movement in their stage of behavior change.

Duration/Dosage:

Venue:

Mode: Outreach – minimally structured

Provider: Peer

Outcome: Behavioral

Level:

Target Population: IDUs

Other: Utilize active injection drug users to design more intensive levels of risk reduction activities than street outreach activities afford, and to involve active users in the recruitment of members of their social networks into these interventions.

Latex and Reality Condom Distribution (MA)

The distribution of condoms is a cornerstone of prevention activities at every level of intervention and for every population at sexual risk of infection (including those whose primary risk is IDU related). Historically distribution by the Department and by providers was limited to latex condoms for use by men. Since the approval of the Reality women's condom by the U.S. Food and Drug Administration, this women-controlled device has become a standard component of materials distribution for programs targeting women's sexual risk. Further, some programs that prioritize men who have sex with men have also included the Reality condom (sometimes dubbed the "internal condom") for use in anal intercourse. While in and of itself condom distribution is not an effective intervention in terms of behavior change, when linked to skills building instruction, social supports, and community norms that encourage condom use, the act of making them available to clients is a welcome and important component in a complete HIV prevention program. Recent published evidence suggests that the presence of condom availability programs in schools positively influences risk reduction practices for the entire student body.

Duration/Dosage:

Venue:

Mode: Material/supply distribution

Provider:

Outcome:

Level:

Target Population: Men, Women, MSM

Other: A cornerstone of prevention activities at every level of intervention and for every population at sexual risk of infection.

Linked to skills building instruction, social supports, and community norms that encourage condom use, the act of making them available to clients is a welcome and important component in a complete HIV prevention program.

Bleach Kit Distribution (MA)

In this intervention, packaged kits containing small bottles of bleach and water for cleaning injection drug equipment along with instruction for their use, clean metal cups to be used as "cookers", alcohol wipes for cleaning the skin prior to injection, and other risk reduction items (such as condoms) are assembled and distributed to clients in the context of street outreach, peer driven interventions, and small group education. The goal of this component is to assist IDUs in initiating or maintaining safer injection practices by providing immediate access and modeling of the technique of cleaning needles and syringes prior to sharing.

Duration/Dosage:

Venue:

Mode: Outreach – semi-structured
Material distribution

Provider:

Outcome: Behavioral

Level: Individual

Target Population: IDUs

Other: The goal is to assist IDUs in initiating or maintaining safer injection practices by providing immediate access and modeling of the technique of cleaning needles and syringes prior to sharing.

Packaged kits contain small bottles of bleach and water for cleaning injection drug equipment along with instructions for their uses, clean metal cups to be used as "cookers", alcohol wipes for cleaning the skin prior to injection, and other RR items...

Outreach Interventions (ME)

Under HE/RR:

- A. Health Education/Risk Reduction
 - 1. Individual Level Interventions
 - 2. Group Level Interventions
 - 3. Outreach Interventions including those appropriate for individuals and groups at the following locations:
 - a. Street
 - b. Community
 - c. Public sex environments
 - d. Institutions
 - 4. Community Level Interventions

Outreach is a prevention activity conducted outside a more traditional health care setting for the purpose of providing other education and risk reduction/harm reduction services or referrals.

Duration/Dosage:

Venue: Street, community, public sex environments, institutions
(outside a more traditional health care setting)

Mode: Outreach – semi-structured

Provider:

Outcome: Behavioral

Level: Individual, Group

Target Population:

Other:

Outreach (MN)

Outreach provided at non-agency sites where target population gathers – e.g., the streets, bars, beaches, buses, laundromats, drop-in centers, homeless shelters, etc. Condoms, bleach access to sterile injection equipment, referrals, brief risk reduction education, and educational materials are provided, either by a peer or a non peer.

(Based on the work of Holtgrave et al.)

Duration/Dosage:

Venue: Non-agency sites where target populations gather

Mode: Material/supply distribution

Outreach – minimally structured

Provider: Peer, Non-peer

Outcome: Behavioral

Level:

Target Population:

Other:

Outreach Level Interventions (MO)

Outreach interventions encompass a number of interventions geared to behavior change within a large number of individuals. Peer outreach programs using peer educators as the vehicle to disseminate information to larger numbers of people has shown to be an effective way to elicit behavior change. Within Missouri's peer outreach programming, it was found that behavior changes are most likely to occur if an individual perceives their own personal HIV related risks directly resulting from engaging in conversations and educational sessions with peers or gatekeepers of groups to which they are affiliated with.

Street and community outreach encompasses counseling and education provided at informal sites where populations at risk are most likely to gather. Such places targeted in Missouri are bars, parks, bathhouses, beauty shops, coffee shops, streets, etc. Street and community outreach can be very interactive with educators providing basic prevention strategies or it can be in the form of information dissemination through brochures, literature, condom and safer sex kit distribution. Street and community outreach is best conducted by outreach workers who are sensitive to and respectful of cultural diversity among the most high risk populations. Trust can therefore be established and the outreach worker will be viewed as someone from whom information is accurately and sensitively provided. Street and community outreach is the type of intervention that best serves populations without means of transportation or other barriers/obstacles that prevent them from seeking services from a clinic or doctor's office.

The Center for AIDS prevention studies at UCSF lists community outreach as the effective approach leading to changed behaviors among IDUs. Kansas City and St. Louis have the most significant IDU population and therefore have a planned number of street and community outreach interventions targeted at reducing the risk of IDUs for HIV infection. ...

Duration/Dosage:

Venue: Informal sites where populations at risk are most likely to gather, such as bars, parks, bathhouses, beauty shops, coffee shops, streets, etc.

Mode: Outreach – semi-structured or minimally structured
Material/supply distribution

Provider: Peer

Outcome: Behavioral

Level: Individual

Target Population: IDUs (but not limited to this population)

Other: Can be very interactive with educators providing basic prevention strategies or it can be in the form of information dissemination.

Outreach workers should be sensitive to and respectful of cultural diversity among the most high risk populations.

Street and Community Outreach (NC)

Education/counseling in informal settings where people at risk naturally congregate, such as bars, parks, festivals, crack houses, and on the street.

Street and community outreach – reaches persons at high risk and provides them information one-on-one, and/or in community settings. High risk individuals are also provided prevention materials and referrals to other services, if needed.

Duration/Dosage:

Venue: Informal settings where people at risk naturally congregate

Mode: Outreach

Provider:

Outcome: Behavioral

Level: Individual, Community

Target Population:

Other: Provides referrals and prevention materials.

Peer/Natural Opinion Leader Programs (NC)

Training peers and natural community leaders with the specific intention that they will share prevention information and promote risk reduction in their community, such as the faith initiative, or working with youth educators, bartenders, barbers, and beauticians, and lay health advisors.

This strategy elicits leaders in the community at risk to provide information to others in their specific (i.e., IDU, adolescents) area/community.

Duration/Dosage:

Venue: Community

Mode: Health Communication/Public Information

Provider: Peers

Outcome: Behavioral

Level: Community

Target Population: IDUs, racial and ethnic minorities, teens, MSM

Other: Share information and promote risk reduction in leader's own community.

Street and Community Outreach (NH)

- Outreach workers meet people at risk in informal settings such as bars, festivals, parks, crack houses, public sex environments, homeless shelters, soup kitchens, etc.
- Workers educate clients on safer sex and needle-sharing in brief conversations and by handing out written information. Outreach workers also distribute condoms, bleach kits, etc. and refer clients to other needed services such as counseling and testing or substance abuse treatment.

- Street outreach projects focus on specific streets and neighborhoods where individuals who engage in risk behaviors are known to live or visit.

Overall Premises to be Considered in All Interventions:

1. All interventions need to explicitly define a population to be served and the steps to reach that population.
2. All interventions must have explicitly defined HIV prevention goals (e.g. reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required data collection will be more limited than for individual and group level interventions due to the nature of the work.)
6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.
7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

Duration/Dosage:

Venue: Informal settings such as bars, festivals, parks, crack houses, public sex environments, homeless shelters, soup kitchens, etc. – focus on specific streets and neighborhoods where individuals who engage in risk behaviors are known to live or visit.

Mode: Outreach – semi-structured

Provider:

Outcome: Behavioral

Level:

Target Population: Individuals who engage in risk behavior.

Other: Workers educate clients on safer sex environments.

Peer/Natural Opinion Leader Programs (NH)

- Programs that train people who are leaders in an at-risk community.
- Trained peer leaders are expected to work with members of their communities on risk reduction.
- Peer leaders may also begin to build a "culture" which promotes safer behavior."

Overall Premises to be Considered in All Interventions:

1. All interventions need to explicitly define a population to be served and the steps to reach that population.
2. All interventions must have explicitly defined HIV prevention goals (e.g. reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required data collection will be more limited than for individual and group level interventions due to the nature of the work.)
6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.
7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

Duration/Dosage:

Venue: Community

Mode:

Provider: Trained Peers

Outcome: Behavioral

Level:

Target Population: MSM, Minorities

Other: Programs train people who are leaders in an at-risk community.

Peer leaders may also begin to build a "culture" which promotes safer behavior.

Street Outreach (NV)

Street outreach is an AIDS prevention strategy used to access hard-to-reach populations who are unlikely to utilize programs based on health facilities, drug treatment programs, community organizations or other facilities. Some of these hard-to-reach populations include injection drug users (IDUs), homeless people, commercial sex workers (CSWs), and runaway youth. In contrast with traditional helping models in which clients seek out the helper, outreach workers seek out the target population on their own turf – street corners where drugs are sold, shooting galleries and crack houses, etc. Outreach workers are generally similar to their target audience (I.e., former IDUs or CSWs), which makes them appear more credible and trustworthy in the eyes of their target audience.

Outreach workers engage in a variety of activities, including providing specific information on HIV transmission and methods of risk reduction, referring clients to HIV testing/counseling services or drug treatment programs, and distributing and demonstrating the use of condoms or bleach kits. These activities contribute to the goals of influencing social norms on drug use and sexual behavior, introducing accurate information about HIV/AIDS into existing social networks within the target population, and providing the community with role-models of people who have successfully transformed their lives.

Also includes advantages and disadvantages of intervention, and demonstrated effectiveness and implications.

Duration/Dosage:

Venue: Street, shooting galleries, crack houses, etc.

Mode: Outreach – semi-structured or minimally structured

Provider: Peer

Outcome: Behavioral

Level: Individual

Target Population: Hard-to-reach populations including IDUs, homeless people, CSWs, runaway youth

Other:

Condom Distribution Program (NV)

Throughout the United States, AIDS groups have distributed free condoms at health facilities, gay bars, night clubs, colleges, health fairs, and other events. The goals of these condom campaigns are to increase people's awareness of the benefits of condom use in the prevention of AIDS and other sexually transmitted diseases (STDs), increase the availability of condoms and the acceptability of the use, teach people the correct use of condoms, and help people to learn to negotiate the use of condoms with their sexual partners.

Also includes section on advantages, disadvantages, and demonstrated effectiveness and implications.

Duration/Dosage:

Venue: Health Facilities, Gay bars, Colleges, Night Clubs, Health fairs, etc.

Mode: Material/supply distribution

Provider:

Outcome: Information

Level: Community

Target Population:

Other:

Street and Community Level Outreach (OK)

(Information of Street and Community Level Outreach taken from Guidelines for Health Education and Risk Reduction Activities, US Dept of Health and Human Services, Public Health Service, April 1995, unless otherwise cited)

Street and community outreach programs are defined by their locus of activity and by the content of their offerings. These programs reach persons at high risk, individually or in a small group, on the street or in community settings. The program staff provide them with prevention messages, information materials, and other services and assist persons in obtaining other prevention and care services. (CDC, 1998 Application Guidance)

Outreach demonstrates an agency's willingness to go to the community rather than wait for the community to come to it. Often, agencies enlist and train peer educators to conduct the outreach activities....

Street and community outreach can be described as an activity conducted outside a more traditional, institutional health care setting for the purposes of providing direct health education and risk reduction services or referrals. ... To determine the setting, an agency need only decide that the setting is easily, readily and regularly accessed by the designated client population. ...

Street outreach commonly involves specialists moving throughout a particular neighborhood or community to deliver risk reduction information and materials. ...

Workshops and presentations are typical activities of community outreach. Because they follow lecture formats, they can be highly structured health education and risk reduction intervention efforts. ...

Street and community – or venue-based – outreach entails a one-on-one interaction between an outreach worker and a client. Ideally, a pair or small team of outreach workers works within the

same venue at the same time. Outreach may occur in a variety of locations, including in the street, in homes, at dance clubs, in churches, temples or synagogues, in schools, at sporting events, at gyms, at county fairs.... Interaction with clients may include distribution of prevention materials, such as condoms; assessment of a client's needs; behavioral risk assessments; health education and risk reduction information; and referral and dialogue about a client's HIV-related concerns. Venue-based outreach may involve one-time interventions or be part of a long-term relationship between counseling and testing programs and at-risk communities (Connecting with Hard-to-Reach Clients, Barbara Adler, MFCCI in Focus Supplement Volume 13, Number 1, December 1997).

Venue-based outreach is most effective when it is consistent, continuous, and performed by someone who is a member of the targeted community. ...

- A. Peer led
- B. Non-peer led
- C. Street counseling and risk reduction
- D. Condom distribution and promotion
- E. Serilization kits for IDU's
- F. Referrals into individual/group level interventions, HIV counseling/testing, STD/TB screening, and other medical and social support services

<i>Duration/Dosage:</i>	Consistent and continuous
<i>Venue:</i>	Anywhere outside a traditional, institutional health care setting that is easily, readily and regularly accessed by the designated client population.
<i>Mode:</i>	Outreach – structured, semi-structured, or minimally structured
<i>Provider:</i>	Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual, Small Group, Community
<i>Target Population:</i>	
<i>Other:</i>	Street and community outreach programs are defined by their locus of activity and by the content of their offerings.

Peer Led Interventions (OK)

Encompassed under Street and Community Level Outreach:

Information of Street and Community Level Outreach taken from Guidelines for Health Education and Risk Reduction Activities, US Dept of Health and Human Services, Public Health Service, April 1995, unless otherwise cited)

Street and community outreach programs are defined by their locus of activity and by the content of their offerings. These programs reach persons at high risk, individually or in a small group, on the street or in community settings. The program staff provide them with prevention messages, information materials, and other services and assist persons in obtaining other prevention and care services. (CDC, 1998 Application Guidance)

Outreach demonstrates an agency's willingness to go to the community rather than wait for the community to come to it. Often, agencies enlist and train peer educators to conduct the outreach activities....

Street and community outreach can be described as an activity conducted outside a more traditional, institutional health care setting for the purposes of providing direct health education and risk reduction services or referrals. ... To determine the setting, an agency need only decide that the setting is easily, readily and regularly accessed by the designated client population. ...

Street outreach commonly involves specialists moving throughout a particular neighborhood or community to deliver risk reduction information and materials. ...

Workshops and presentations are typical activities of community outreach. Because they follow lecture formats, they can be highly structured health education and risk reduction intervention efforts. ...

Street and community – or venue-based – outreach entails a one-on-one interaction between an outreach worker and a client. Ideally, a pair or small team of outreach workers works within the same venue at the same time. Outreach may occur in a variety of locations, including in the street, in homes, at dance clubs, in churches, temples or synagogues, in schools, at sporting events, at gyms, at county fairs.... Interaction with clients may include distribution of prevention materials, such as condoms; assessment of a client's needs; behavioral risk assessments; health education and risk reduction information; and referral and dialogue about a client's HIV-related concerns. Venue-based outreach may involve one-time interventions or be part of a long-term relationship between counseling and testing programs and at-risk communities (Connecting with Hard-to-Reach Clients, Barbara Adler, MFCCI in Focus Supplement Volume 13, Number 1, December 1997)

Venue-based outreach is most effective when it is consistent, continuous, and performed by someone who is a member of the targeted community. ...

A. Peer led

1. Agencies that provide street and community outreach will frequently engage peer educators to conduct intervention activities. Peer education implies a role-model method of education in which trained, self-identified members of the client population provide HIV/AIDS education to their behavioral peers. This approach provides an opportunity for individuals to perceive themselves as empowered by helping persons in their communities and social networks, thus supporting their own health enhancing practices. At the same time, the use of peer educators sustains

intervention efforts in the community long after the professional service providers are gone. Effective peer educators:

- a. Have a shared identity with the targeted community or group.
- b. Are within the same age range as the targeted community or group.
- c. Speak the same "language" as the community or group.
- d. Are familiar with the group's cultural nuances and are able to convey these norms and values to the agency.
- e. Act as an advocate, serving as a liaison between the agency and the targeted community or group.

Peer education can be very powerful, if it is applied appropriately. The peer educator not only teaches a desired risk reduction practice but s/he models it. Peer educators demonstrate behaviors that can influence the community norms in order to promote HIV/AIDS risk reduction within networks. They are better able to inspire and encourage their peers to adopt health-seeking behaviors because they are able to share common weakness, strengths, and experiences. (Guidelines for Health Education and Risk Reduction Activities, U.S. Department of Health and Human Services, Public Health Service, April 1995)". ...

- B. Non-peer led
- C. Street counseling and risk reduction
- D. Condom distribution and promotion
- E. Sterilization kits for IDU's
- F. Referrals into individual/group level interventions, HIV counseling/testing, STD/TB screening, and other medical and social support services

<i>Duration/Dosage:</i>	Consistent and continuous
<i>Venue:</i>	Anywhere outside a traditional, institutional health care setting that is easily, readily and regularly accessed by the designated client population.
<i>Mode:</i>	Outreach – semi-structured or minimally structured Health education – structured, semi-structured, or minimally structured
<i>Provider:</i>	Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group, Community
<i>Target Population:</i>	
<i>Other:</i>	Have a shared identity with target group. Are same age range; Speak same "language". Are familiar with group's cultural nuances. Act as advocates and liaisons between agency and target group.

Street and Community Outreach Programs (TN)

Encompassed under ...

2. Category II. Health Education/Risk Reduction (HE/RR). HE/RR is used to described organized efforts to reach individuals at an increased risk of becoming HIV infected or, if already infected, from transmitting the virus to others. This category focuses on activities ranging from individual case management to broad community based interventions. ...
- C. Street and community outreach programs" are defined according to the scope of activity and by the content of their offerings. Both have important sub categories of peer and non-peer models. Street outreach programs for HIV prevention are designed to deliver HIV prevention messages, materials, and referral services to high-risk individuals outside of traditional health care and drug treatment clinics.

Duration/Dosage:

Venue: Outside the traditional health care and drug treatment centers

Mode: Outreach

Provider: Paraprofessional, Peer

Outcome: Behavioral

Level:

Target Population: High-risk individuals, HIV positive individuals

Other: .

Condom Distribution (TX)

All TDH-funded HIV prevention programs are expected to make available TDH purchased male condoms. These condoms are to be considered a "starter set" and clients are encouraged to incorporate future condom purchases into their lifestyle and budget. Prevention projects may request budgetary funds to purchase other safer sex materials such as water-based lubricants, female condoms and vaginal contraceptive film.

Duration/Dosage:

Venue:

Mode: Material/supply distribution

Provider:

Outcome: Behavioral

Level:

Target Population:

Other:

Basic Street/Community Outreach (VA)

Encompassed under ... Category II. Health Education/Risk Reduction:

- E. Street and Community Outreach – The screening and engaging of individuals for the purpose of delivering primary/secondary prevention education, materials and/or referrals, usually within a specified location and/or community.
 - 1. Basic Street/Community Outreach – Consists primarily of contacts during which outreach workers engage in brief conversations, providing information, literature, condoms, referrals, etc. This type of outreach is important for establishing rapport within a community and building trust with individuals. It can be used as a method

for bringing clients into other services such as intensive street outreach, counseling and testing, prevention case management, home health parties, and peer education groups. Basic outreach can not expected to change behaviors in and of itself and should not be considered an intervention.

2. Intensive Street/Community Outreach
3. Facilitative Street/Community Outreach
4. Collaborative Street/Community Outreach

Duration/Dosage:

Venue: Specified street or community

Mode: Outreach (contact)

Provider:

Outcome: Behavioral

Level: Individual

Target Population:

Other: Basic outreach can not expected to change behaviors in and of itself and should not be considered an intervention.

Intensive Street/Community Outreach (VA)

Encompassed under... Category II. Health Education/Risk Reduction:

- E. Street and Community Outreach – The screening and engaging of individuals for the purpose of delivering primary/secondary prevention education, materials and/or referrals, usually within a specified location and/or community.
1. Basic Street/Community Outreach
 2. Intensive Street/Community Outreach – Includes ongoing encounters in which outreach workers spend extended periods of time with clients, assess risks, make plans with clients for behaviors change, and provide referrals. The outreach worker and client meet on multiple occasions. Outreach workers may verify follow-up on referrals and bring individuals into other services. Both process and outcome evaluation should be used in assessing this type of outreach (The conditions of Basic outreach must be met.)
 3. Facilitative Street/Community Outreach
 4. Collaborative Street/Community Outreach

<i>Duration/Dosage:</i>	Multiple occasions
<i>Venue:</i>	Specified street or community
<i>Mode:</i>	Outreach (encounters)
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	The conditions of Basic outreach must be met.

Facilitative Street/Community Outreach (VA)

Encompassed under... Category II. Health Education/Risk Reduction:

- E. Street and Community Outreach – The screening and engaging of individuals for the purpose of delivering primary/secondary prevention education, materials and/or referrals, usually within a specified location and/or community.
 - 1. Basic Street/Community Outreach
 - 2. Intensive Street/Community Outreach
 - 3. Facilitative Street/Community Outreach – Street outreach workers facilitate client’s entrance into services and verify follow through. (The conditions of Basic and Intensive Street Outreach must be met.)
 - 4. Collaborative Street/Community Outreach

<i>Duration/Dosage:</i>	Multiple occasions
<i>Venue:</i>	Specified street or community
<i>Mode:</i>	Outreach (encounters) – semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	The conditions of Basic and Intensive Street Outreach must be met.

Collaborative Street/Community Outreach (VA)

Encompassed under ... Category II. Health Education/Risk Reduction:

- E. Street and Community Outreach – The screening and engaging of individuals for the purpose of delivering primary/secondary prevention education, materials and/or referrals, usually within a specified location and/or community.
1. Basic Street/Community
 2. Intensive Street/Community Outreach
 3. Facilitative Street/Community Outreach

 4. Collaborative Street/Community Outreach – An outreach effort that utilizes outreach workers from various agencies and other health care providers to participate in a tabling or stroll of an already identified and assessed area for the purpose of saturating the area with specific information (e.g., a major syphilis outbreak has occurred in a residential area, the health department will be providing on-site testing, outreach workers would be pivotal in disseminating information and directions about testing).

Duration/Dosage:

Venue: An identified and assessed area for the purpose of saturating the area with specific information

Mode: Outreach – structured

Provider:

Outcome: Behavioral

Level: Individual

Target Population:

Other: Utilizes outreach workers from various agencies and other health care providers

Street Outreach (VI)

Street outreach is an HIV prevention strategy carried out on the streets that targets high-risk individuals. It is an intervention usually conducted by outreach workers, peer educators and health educators. This intervention aims to provide prevention information, education and to provide referrals for counseling and testing, risk reduction counseling, and PCM for the target population. The concept of outreach demonstrates an organization's willingness to take services to the target population.

Duration/Dosage:

Venue: Street

Mode: Outreach

Provider: Professional, Paraprofessional, Peer

Outcome: Behavioral

Level:

Target Population: High-risk individuals

Other:

Outreach (WI)

Level of Intensity: Contact

This includes ... Educational interventions conducted face-to-face in places where clients congregate, includes needle exchange

This does not include ... Lectures or group educational presentations; Outreach solely for the purposes of counselign and testing (CTS)

Outreach is most effective when it is continuous, consistent, and performed by someone indigenous to the community targeted. The success of outreach is critically dependent on the skills of the outreach workers, who should not only be peers or near peers of the community, but also viewed as credible, open, dedicated, non-threatening, and non-judgmental. Additionally, outreach workers should be trained in the following areas: the principles of outreach, the harm reduction model, referral sources, confidentiality issues, and safety issues. Finally, outreach work collaboratively with gatekeepers to minimize interference. Gatekeepers are those individuals that manage the operations in the setting, such as bartenders or bar owners, park police, housing site managers, methadone maintenance providers, and correctional facility managers.

Outreach is set apart from many other interventions by virtue of location and intensity of the intervention. This intervention is delivered at a location of convenience to members of the target population, rather than asking them to come to a clinic for services. Examples of outreach locations are streets, drug using settings ("shooting galleries" and "crack houses"), gay bars, public sex environments such as parks and waysides (for men engaging in anonymous sexual encounters with other men), homeless shelters, public housing single room occupancies, methadone maintenance programs, and correctional settings. This level of intensity of Outreach is not as high as that of an Individual Level Intervention (ILI). Outreach focuses on information dissemination, not on skills building and behavior change as with ILI.

Needle exchange programs (NEPs) are one type of outreach. ...

Includes:

- *Scientific Basis*
- *Resources*

<i>Duration/Dosage:</i>	Consistent and continuous Intensity not as high as for individual level intervention
<i>Venue:</i>	Location convenient to members of the target populations; gay bars, crack houses, etc.
<i>Mode:</i>	Outreach – semi-structured
<i>Provider:</i>	Paraprofessional (near peer), Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	
<i>Target Population:</i>	High-risk individuals
<i>Other:</i>	Outreach workers should be trained in the following areas: the principles of outreach, the harm reduction model, referral sources, confidentiality issues, and safety issues. Focuses on information dissemination, not on skills building and behavior change as with individual level interventions. Includes needle exchange program.

Prevention Case Management (PCM)

The Number of Intervention Characteristics by Each Prevention Case Management (PCM) Intervention

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Prevention Case Management (PCM)	AK	✓	✓	✓	✓	✓	✓			6
Prevention Case Management	CA			✓	✓	✓	✓			4
Prevention Case Management	CH	✓	✓	✓		✓	✓		✓	6
Prevention Case Mgmt	CO	✓	✓	✓	✓	✓	✓	✓	✓	8
HIV Prevention Case Management	CT		✓	✓		✓	✓	✓		5
Prevention Case Management (PCM)	IA	✓		✓	✓	✓	✓	✓		6
Prevention Case Management	ID			✓	✓		✓	✓	✓	5
Prevention Case Management (PCM)	IL	✓	✓	✓	✓	✓	✓	✓		7
HIV Prevention Case Management	LA	✓	✓	✓	✓	✓	✓	✓		7
Prevention Case Management	MO			✓		✓	✓			3
Prevention Case Management	NH	✓		✓	✓	✓	✓	✓	✓	7
Prevention Case Management	NV			✓			✓	✓		3
Case Management	NY						✓			1
HIV Prevention Case Management	OK						✓	✓	✓	3

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Prevention Case Management	TN	✓		✓		✓				3
Prevention Case Management	TX	✓		✓	✓	✓	✓	✓	✓	7
Prevention Case Management	VA	✓		✓		✓	✓	✓		5
Prevention Case Management	VI	✓		✓		✓	✓	✓		5
Prevention Case Management	WI	✓		✓		✓	✓		✓	5
TOTAL (N = 19)		12	6	17	9	15	18	12	7	96

✓- Indicates that evidence of the intervention characteristic was found in reviewing the FY 2001 Cooperative Agreement Applications and Comprehensive Plans and Web sites. Definitions or guidelines addressing these elements may exist in other documentation not reviewed for this study.

Prevention Case Management (PCM) – Listing of Evidence by Intervention Characteristic

Duration/Dosage:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Prevention Case Mgmt (PCM)	Multiple
CH	Prevention Case Mgmt	On-going
CO	Prevention Case Mgmt	Multiple sessions, until one or more of criteria have been met to signal that case closure should occur.
IA	Prevention Case Mgmt (PCM)	Intensive and repeated Multiple sessions
IL	Prevention Case Mgmt (PCM)	Intensive and on-going
LA	HIV Prevention Case Management	Multiple sessions
NH	Prevention Case Mgmt	A series of counseling sessions
TN	Prevention Case Mgmt	On-going
TX	Prevention Case Mgmt	Intensive and on-going Multiple sessions
VA	Prevention Case Mgmt	On-going
VI	Prevention Case Mgmt	Long-term
WI	Prevention Case Mgmt	Intensive On-going

Venue:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Prevention Case Mgmt (PCM)	Health care facility/clinic
CH	Prevention Case Mgmt	Health care facility/clinic
CO	Prevention Case Mgmt	Variety of settings
CT	HIV Prevention Case Management	Public health setting such as an STD clinic or HIV testing center
IL	Prevention Case Mgmt (PCM)	Client's home, CBO, clinic, institutional setting
LA	HIV Prevention Case Management	CBOs, STD clinics, health centers, drug treatment centers, HIV clinics

Mode:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Prevention Case Mgmt (PCM)	Case management – minimally structured
CA	Prevention Case Mgmt	Case management – structured
CH	Prevention Case Mgmt	Case management – structured
CO	Prevention Case Mgmt	Case management – structured
CT	HIV Prevention Case Management	Case management – structured
IA	Prevention Case Mgmt (PCM)	Case management – structured
ID	Prevention Case Mgmt	Case management – minimally structured Counseling – structured
IL	Prevention Case Mgmt (PCM)	Case management – structured
LA	HIV Prevention Case Management	Case management – structured
MO	Prevention Case Mgmt	Case management – semi-structured
NH	Prevention Case Mgmt	Case management – structured
NV	Prevention Case Mgmt	Case management – minimally structured
TN	Prevention Case Mgmt	Counseling – semi-structured
TX	Prevention Case Mgmt	Case management – structured
VA	Prevention Case Mgmt	Case management – semi-structured
VI	Prevention Case Mgmt	Case management – semi-structured
WI	Prevention Case Mgmt	Case management – structured

Provider:

Nine of the nineteen prevention case management interventions addressed provide in its definition. All nine stated the provider needed to be a ‘professional’.

Outcome:

All fifteen prevention case management interventions identified the anticipated outcome as ‘behavioral’.

Level:

Of the eighteen prevention case management interventions addressing level, all indicated the level to be ‘individual’. One jurisdiction (IL) also included ‘couples’ as a level for prevention case management.

Target Population:

	Intervention Name:	Evidence of Intervention Characteristic:
CO	Prevention Case Mgmt	Persons (regardless of HIV status) who are having, or who are likely to have, difficulty initiating and sustaining safer sexual and drug use behaviors and to improve client's skills in accessing community resources that support behavior change.
CT	HIV Prevention Case Management	Homeless, seriously mentally ill, substance abusers, and those living in poverty.
IA	Prevention Case Mgmt (PCM)	HIV positive persons High-risk HIV negative persons
ID	Prevention Case Mgmt	HIV Seropositive and high risk seronegative MSMs
IL	Prevention Case Mgmt (PCM)	High-risk for HIV/STD
LA	HIV Prevention Case Management	Substance users who are HIV negative and at extremely high risk to become infected or are HIV infected and likely to transmit to others.
NH	Prevention Case Mgmt	HIV positive individuals High-risk or high-risk HIV negative individuals
NV	Prevention Case Mgmt	HIV positive and high-risk individuals
OK	HIV Prevention Case Management	High-risk individuals
TX	Prevention Case Mgmt	HIV positive and high-risk individuals
VA	Prevention Case Mgmt	Persons having or likely to have difficulty initiating or sustaining practices to reduce or prevent HIV infection.
VI	Prevention Case Mgmt	High-risk individuals

Other:

	Intervention Name:	Evidence of Intervention Characteristic:
CH	Prevention Case Management	PCM files must contain the following information: <ul style="list-style-type: none">• client contact information,• client contact notes,• documentation of receipt by client of client rights and responsibilities,• confidentiality statement, etc.
CO	Prevention Case Mgmt	Includes skills building
ID	Prevention Case Mgmt	Standards outlined in CDC HIV Prevention Case Management Guidance will be followed.
NH	Prevention Case Mgmt	All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. All interventions must show evidence that they are based on sound behavioral science theory. All interventions need to explicitly define a population to be served and the steps to reach that population. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
OK	HIV Prevention Case Management	Should compliment ongoing HIV prevention services such as HIV antibody counseling, testing, referral, and partner counseling and referral services, and early medical intervention programs.
TX	Prevention Case Mgmt	Protocols for client engagement and related follow-up must be developed, such as requiring a minimum number of follow-up contacts within a specified time period. Prevention case managers must meet on a regular basis with clients to monitor their changing needs and their progress in meeting HIV behavioral risk-reduction objectives.

WI Prevention Case Mgmt

All PCM providers should comply with PCM guidelines for client charting, clinical supervision, criteria for eligible clients, creation of risk-reduction plans, size of client load, and a process for evaluating the strategy.

Jurisdictions' Definitions of Prevention Case Management (PCM)

Prevention Case Management (PCM) (AK)

Multiple, one-on-one sessions for intensive risk reduction counseling for HIV positive persons having difficulty initiating or sustaining practices that reduce or prevent HIV transmission, and HIV negative persons (or unknown serostatus) at high risk of HIV infection, following the CDC HIV Prevention Case Management Guidelines, Sept. 1997, provided by, or under the supervision of a mental health professional or clinical MSW

<i>Duration/Dosage:</i>	Multiple
<i>Venue:</i>	Health care facility/clinic
<i>Mode:</i>	Case management – minimally structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	

Prevention Case Management (CA)

Program Category 1: Individual-Level Interventions

Individual level interventions provide information, risk assessment, and risk reduction counseling to assist individuals to learn about transmission and risk behaviors, make plans for individual behavior change and ongoing appraisal of their own behaviors, and to facilitate linkages to resources to support behavior changes. The common denominator of these strategies is their focus on one-on-one interactions between provider and individual.

Definition based upon a review of the literature:

1. HIV Antibody Counseling, Testing, and Partner Referral
2. Education, Information, and Referral Hotlines
3. Street and Community Outreach
4. Individual Peer Education
5. On-site Risk Reduction Education and Counseling
6. Prevention Case Management – Prevention case management involves identification, coordination and delivery of primary and secondary HIV prevention services. It is intensive, individualized support to assist persons to remain seronegative or to reduce the risk of HIV transmission to others.

7. Needle Exchange Programs
8. Condoms, Other Barriers, and Bleach Demonstration and Distribution

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue:

Mode: Case management – structured

Provider: Professional

Outcome: Behavioral

Level: Individual

Target Population:

Other:

Prevention Case Management (CH)

Describes:

I. Minimum Criteria

- A. A client centered intervention with fundamental goal of promoting the adoption of HIV risk reduction behaviors
- B. Intended for persons with multiple, complex problems and risk reduction needs (e.g., substance abuse, financial, medical, psychological, etc.) having or likely to have difficulty, initiating, or sustaining behaviors that reduce or prevent HIV transmission
- C. A client developed, written, prevention plan is created
- D. Offers intensive ongoing prevention education, support, monitoring, and service brokerage

II. Quality Assurance Measures

- A. PCM files are updated within 24 hours of client contact
- B. PCM files must contain the following information:
 1. client contact information,
 2. client contact notes,
 3. documentation of receipt by client of client rights and responsibilities,
 4. confidentiality statement,
 5. grievance procedures,
 6. client referrals, and follow-ups

III. Data Requirements

- A. In an effort to better document service delivery citywide, all CDPH prevention funded agencies will be required to collect and submit the following data for each intervention used in their program. Data will be submitted to CDPH scan forms (provided by CDPH). This information will be used to improve the quality and effect of HIV prevention projects in Chicago.
 1. Type of agency

2. Risk population
3. Client demographics
4. Setting
5. Number of interventions
6. Staffing
7. Expenditures
8. Number of sessions (total & # of clients receiving 1-2-3-4-5 or more sessions)
9. Pre/Post HIV/AIDS Risk Assessment Measurement (CDPH tool)
10. Pre/Post HIV/AIDS Knowledge Assessment Measurement (CDPH tool)

What Works in Prevention?

Key factors of Successful Interventions and Programs

- I. Services are:
 - A. delivered in a culturally appropriate and culturally sensitive manner
 - B. easily accessed
 - C. voluntary
- II. Target Population is:
 - A. clearly defined and with a proven need of HIV prevention services
- III. Goals and Objectives of the Program are:
 - A. clearly defined, time-phased, and measurable
- IV. Interventions are:
 - A. based on sound behavioral research
 - B. well planned, implemented, monitored and evaluated
 - C. created (whenever possible) with input from target population
 - D. focused on reducing specific behaviors and address skill levels, attitudes, and behaviors that influence high risk activities (i.e., how to use condoms appropriately, how to clean injection equipment, and reinforcing positive attitudes about condom use)
 - E. vehicles for demonstrating, reinforcing, and promoting positive behaviors
- V. Agencies have:
 - A. the ability to maintain multiple contacts with participants
 - B. the ability to document service delivery (i.e., develop and maintain survey questionnaires, client assessment forms, etc.)
 - C. a strong referral and follow-up system exists (formal, established, and written with signed memorandums of agreement)
 - D. the ability and desire to collaborate with other organizations
 - E. policies that conform with prevailing local, state and federal laws regarding client confidentiality
 - F. staff with necessary academic background or experience in a human-services-related field (i.e., social work, psychology, nursing, counseling, or health education); and case management and assessment techniques
 - G. staff that are knowledgeable about HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change.
- VI. How Do We Assure Quality?
 - A. Minimum Quality Assurance Standards
- VII. Services are:

A. offered in a safe environment. The agency should be clean, neat, well ventilated, and clutter free

VIII. Interventions are:

A. whenever possible, implemented/delivered by individuals representative of the target population

IX. Agencies have:

A. Policies and Procedure Manual. This manual must contain all intervention protocols, policies, and procedures of the services being delivered

B. current collaborative linkages within community and, when possible, should participate in one or more Community Planning Groups

C. staff that are familiar with available community resources

D. staff that are trained in the implementation of program intervention(s). All trainings must be documented in staff folders. The agency should promote and encourage continuing educational trainings.

E. grievance procedures in place and a method for informing clients of this process. Proof of client receipt should be documented in client charts

F. policies on staff safety (on site and off site)

G. a relationship with local authorities (police) such that the program is well known in the community

H. regular assessments of clients satisfaction through periodic client satisfaction surveys

I. regular management/supervisors meetings with program staff to discuss project and status progress towards stated outcomes"

Duration/Dosage:

On-going

Venue:

Health care facility/clinic

Mode:

Case management – structured

Provider:

Outcome:

Behavioral

Level:

Individual

Target Population:

Other:

PCM files must contain the following information:

- client contact information,
- client contact notes,
- documentation of receipt by client of client rights and responsibilities,
- confidentiality statement, etc.

Prevention Case Management (CO)

HIV Prevention Case Management (HIV/PCM) involves one-on-one client assessment of HIV risk behavior and other psychosocial and health needs for an individual and their support systems. HIV/PCM concentrates on primary prevention (preventing HIV transmission) and secondary interventions (advocating for early medical intervention to prevent or delay the onset of symptoms in HIV infected clients). HIV/PCM is intended for clients with HIV infection as well as those without HIV infection who engage in unsafe behaviors who have a poor prognosis for changing behaviors without this intervention.

HIV/PCM includes an intensive, client-centered care plan to achieve the individual's goals in the area of risk-reduction education, counseling, and referral to other social/medical services. Participation is always voluntary, confidential, and based on a client-centered care plan to achieve the individuals goals.

HIV/PCM services are not intended to be a substitute for medical case management, extended social services, long-term psychological care nor should HIV/PCM duplicate Ryan White CARE Act case management services for people living with HIV.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their programs flow from and is consistent with social and behavioral theory and research relevant to HIV risk reduction.

- Goal For the Intervention: HIV/PCM's primary goal is to prevent and stop the spread of HIV.
- Target Population: HIV/PCM is intended for persons (regardless of HIV status) who are having, or who are likely to have, difficulty initiating and sustaining safer sexual and drug use behaviors and to improve client's skills in accessing community resources that support behavior change. Therefore, PCM is intended for target persons at greatest risk of transmitting or acquiring HIV whose needs are not being effectively served and whose behavior is not influenced by less intensive HIV prevention interventions, such as individual-level strategies, group-level strategies, or HIV counseling and testing.

Persons who are to be targeted for PCM shall include those who maintain unsafe behaviors as well as those who would have poor prognosis for changing behaviors without this intervention, including those who are: cognitively or developmentally disabled, chronically mentally ill, substance abusers, have multiple sexually transmitted diseases (STD), and those who have chronically dysfunctionally lives.

- Cultural Competence/Proficiency: ...
- Where Delivered: HIV/PCM is carried out in a variety of settings appropriate to the clients needs.
- When Delivered: HIV/PCM is carried out at a time of day appropriate to the clients needs.
- How Much: HIV/PCM is intended to be carried out over multiple sessions. HIV/PCM continues until one or more criteria have been met to signal that case closure should occur.

The following are criteria for closure of open cases:

1. The client verbally refuses services.
 2. The case manager's attempt to meet with the client have been largely and/or completely unsuccessful.
 3. The client is lost to intervention when they have moved to another state or without any locating information.
 4. The client dies.
 5. The client successfully changes their behavior and has had no relapses after 12-18 months.
 6. The client's situation or environment is dangerous to the prevention case manager.
 7. The client is categorized as "unable to locate" after 6 months of good faith efforts by using all available resources. These may include Post Office, homeless shelter, jails, Department of Motor Vehicles, Internet, phone record searches, and medical records.
 8. The client is not successful in changing their unsafe risk behaviors after repeated efforts by prevention case management; and is determined to be danger to public health. At this point the client may be referred to a state or local health department for further action (see Part 4, regarding public health orders).
- **Methods Employed:**
HIV/PCM should be delivered in a client-centered manner, that is, tailored to the behavior, circumstances, and special needs of a person.

HIV/PCM is an ongoing one-on-one professional relationship which is comprehensive (i.e., includes all aspects of health). Participation is voluntary and confidential. Identification and participation can be either client-driven or generated by agency activity.

Based on the literature, the ideal is a maximum case load size of 20-30 open, active cases at any given time.

Psycho social assessment is an essential component of HIV/PCM. Ongoing psycho social assessment shall include, but not be limited to the following; sexual history; drug history; HIV risk assessment; current knowledge and attitudes about safer sex and safer needle use behaviors; assessment of stage of behavior change; guardianship status; presence of literacy/learning problems and/or developmental disability; criminal and/or legal involvement; mental health history; support systems/resources including Ryan White case management; relevant medical history; cultural and religious considerations; adherence to HIV-related treatment; STD history; and strengths and competencies.

HIV/PCM includes an intensive, client-centered care plan to achieve the individual's goals in the areas of risk-reduction education, counseling, and referral to other social/medical services. Client must participate in the development of a case plan to the extent of their abilities. Client HIV/PCM records must contain a copy of the voluntary informed consent document and the Prevention Plan showing the client's or guardian signature. Minimum elements of a care plan: risk/harm reduction plan or counseling, accessing community resources, increasing or learning assertiveness skills, improving hygiene skills, increasing or learning negotiating skills, treatment plan for medical, dental, and family planning,

educational process on HIV/AIDS and other STDs and referrals to appropriate treatment or resources (substance abuse, mental health). The Prevention Plan must address efforts to ensure that a PCM client is medically evaluated for STDs at regular intervals regardless of symptom status. In identifying HIV risk reduction behavioral objectives, behavior change must be included in the Prevention Plan. For persons living with HIV and receiving anti-retroviral or other drug therapies, the Prevention Plan must address issues of adherence.

The process for making referrals includes:

- helping the client define their priorities,
 - discussing and offering options, offering referrals,
 - making referrals to known and trusted services,
 - assessing whether your suggested referral works for the client,
 - facilitating an active referral,
 - developing a follow-up plan after giving the referral.
- Qualifications of the People Who DO HIV/PCM:
In terms of education, a person performing HIV/PCM must, at a minimum, have either a B.S./B.A. degree in human services or behavioral sciences OR a B.S./B.A. degree in another field (not human services or behavioral sciences) and one year work related experience.
In addition, a HIV/PCM must have ongoing clinical supervision by a licensed mental health professional, (i.e., Licensed Clinical Social Worker, Licensed Mental Health Counselor, Psychiatrist, Licensed Clinical Psychologist, Licensed Marriage and Family Counselor and/or Psychiatric Nurse).

Providers of HIV/PCM should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

Those providing HIV/PCM must be competent in regard to culture and other diversity and able to present the materials in an understandable and non-judgmental manner.

- Continuing Education/Ongoing Training Requirements: Providers of HIV/PCM must receive at least 16 hours of updated HIV prevention training per year.
- Consent/Confidentiality Consideration: ...
- Quality Assurance: ...
- Evaluation: ...
- Penalties for Violating Standards: ...
- Other: ...

<i>Duration/Dosage:</i>	Multiple sessions, until one or more of criteria have been met to signal that case closure should occur.
<i>Venue:</i>	Variety of settings
<i>Mode:</i>	Case management – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	Persons (regardless of HIV status) who are having, or who are likely to have, difficulty initiating and sustaining safer sexual and drug use behaviors and to improve client's skills in accessing community resources that support behavior change.
<i>Other:</i>	Includes skills building

HIV Prevention Case Management (CT)

Encompassed under ILI – Interventions that target one person. In individual level interventions, one person (e.g., an HIV test counselor) is doing an HIV prevention intervention with another single individual (e.g., the person being tested).

Prevention case management is intensive, individual counseling for HIV risk reduction that usually takes place in a public health setting like an STD clinic or HIV testing center. The Patient is identified as at-risk, and then receives client-centered counseling that combines parts of traditional case management like support services and referrals, but with a focus on HIV risk reduction. The patient receives a series of follow-up sessions which are intended to encourage long-term behavior change. PCM for seropositives focuses on helping them change behavior so they do not infect others; PCM for seronegatives focuses on helping them change behavior so they do not become infected themselves.

Does The Intervention Change Behavior?

- Prevention case management is a new program. As yet, there are no published studies of the effectiveness of prevention case management for behavioral risk reduction.
- The few outcome studies that exist measure whether or not the people who would most benefit from prevention case management have access to it, and how much prevention case management costs.

With what Populations is it successful in changing Behavior?

- Prevention case management seems to be best suited for individuals who have very complex adverse life circumstances, which make less intensive behavior change interventions less likely to work. In addition to people who have great difficulty changing behavior, it would seem to be best suited for populations such as the homeless, seriously mentally ill, substance abusers, and those living in poverty."

Duration/Dosage:

Venue: Public health setting such as an STD clinic or HIV testing center

Mode: Case management – structured

Provider:

Outcome: Behavioral

Level: Individual

Target Population: Homeless, seriously mentally ill, substance abusers, and those living in poverty.

Other:

Prevention Case Management (PCM) (IA)

Includes description from the Taxonomy of HIV/AIDS Prevention Interventions from the Academy of Educational Development and the CDC's 2000 Evaluation Guidance (CDC, 1999) for the purpose of "making meaningful distinctions and choices among possible interventions".

Encompassed under Health Education/Risk Reduction:

Using the taxonomy originally proposed by Holtgrave, et al., 1994, the following interventions will be included under the broad category of Health Education and Reduction (HE/RR): individual-level intervention, prevention case management, group level intervention, and outreach. HE/RR describes organized efforts to reach persons at increased risk of becoming HIV infected or, if already infected, of transmitting the virus to others. The goals of health education and risk reduction activities are to go beyond the provision of information to provide education and counseling that assists individuals in developing the skills, abilities, and self-esteem to carry out behavior change (CDC, 1995). Health education and risk reduction interventions can be delivered at individual, group, community, or outreach levels. HE/RR activities can include counseling, workshops, educational programs and materials, presentations, and outreach activities.

PCM is a client-centered HIV prevention activity with fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is intended for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission, or re-infection. As a hybrid of HIV risk-reduction counseling and traditional case management, PCM provides intensive, on-going, individualized prevention counseling, support, and service brokerage. This HIV prevention activity addresses the relationship between HIV risk and other issues such as substance abuse, STD treatment, mental health, and social and cultural factors.

Prevention case management offers service in a repeated, intensive manner in order to promote and support ongoing safer behavior. Priorities for PCM services should be given to HIV seropositive persons having likely to have difficulty initiating or sustaining practices that reduce

or prevent HIV transmission and re-infection. For HIV seropositive persons, PCM involves the coordination of primary and secondary prevention interventions in close collaboration with Ryan White CARE Act case management providers. Further, PCM ensures the provision of other medical and psychosocial services affecting risk behavior, including STD and substance abuse treatment services.

HIV seronegative persons or those of unknown HIV serostatus – either

1. engaging in high-risk behavior within communities with moderate to high seroprevalence rate of HIV infection or
2. otherwise at heightened risk of infection – may also be appropriate for PCM.

Includes seven essential components of PCM:

1. Client recruitment
2. Screening and assessment (comprehensive assessment of HIV and STD risk, medical and psychosocial service needs – including STD evaluation and treatment, and substance abuse treatment);
3. Development of a client-centered "Prevention Plan";
4. Multiple – session HIV risk reduction counseling;
5. Active coordination of services with follow-up;
6. Monitoring and reassessment of clients' needs, risks, and progress; and
7. Discharge from PCM upon attainment and maintenance of risk-reduction goals (HIV Prevention Case Management, "Guidance" CDC, September 1997).

Also includes: Demonstrated effectiveness.

<i>Duration/Dosage:</i>	Intensive and repeated Multiple sessions
<i>Venue:</i>	
<i>Mode:</i>	Case management – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	HIV positive persons High-risk HIV negative persons
<i>Other:</i>	

Prevention Case Management (ID)

Client-centered Health Education/Risk Reduction counseling with a case management component.

This intervention is an intensive client-centered prevention activity which assists HIV seropositive, as well as very high risk seronegative persons, in adopting risk-reduction behaviors. The service is intended for MSMs with multiple, complex HIV risk-reduction needs, having difficulty initiating or sustaining practices that reduce or prevent HIV transmission. These persons in need highly individualized and intensive support and counseling, and substantial psychosocial interpersonal skills training. Trained counselors assess a client's knowledge about risk, perceived personal vulnerability, behavior change intention, self-efficacy, skill level, reinforcement of behavior change efforts, and environmental barriers. Prevention case management also assists individuals with accessing needed medical, psychological, social services.

Prevention case management has seven components: recruitment; screening and assessment; development of prevention plan; multiple session risk-reduction counseling; coordination of services with follow-up; monitoring and reassessment of clients' needs, risks, and progress; and case closure upon attainment of goals.

The STD/AIDS Program anticipates that HIV prevention providers in at least two health districts will build their capacity to implement prevention case management. These organizations will develop service protocols, identify qualified staff, and develop prevention case management plans specific to their district's prevention needs and resources. Standards outlined in CDC HIV Prevention Case Management Guidance will be followed.

Duration/Dosage:

Venue:

Mode: Case management – minimally structured
Counseling – structured, minimally structured

Provider: Professional

Outcome:

Level: Individual

Target Population: HIV seropositive and high-risk seronegative MSMs

Other: Standards outlined in CDC HIV Prevention Case Management Guidance will be followed.

Prevention Case Management (PCM) (IL)

Overview

Prevention case management is an intensive, ongoing, and individualized service designed to help:

- uninfected clients remain seronegative, or
- HIV positive clients avoid HIV transmission to others or re-infection.

PCM is intended for persons at high risk for HIV/STD who have or are likely to have difficulty initiating and sustaining safe behaviors. Services are always voluntary and are provided with client's informed consent.

PCM may be carried out in a variety of settings, including a client's home, community based organization, clinic, or institutional setting.

Components of a PCM Program: PCM involves:

- a comprehensive HIV/STD risk assessment, including an assessment of the variables that influence client risk taking;
- a comprehensive assessment of psychosocial and medical service needs, as well as barriers to accessing these services;
- the development of a client case plan with realistic, time-phased, and measurable objectives for client risk reduction;
- the development of a plan to obtain necessary psychosocial and medical services – such as housing, drug treatment, job training, and HIV/STD prevention and treatment services – through referrals, case manager assistance, and follow-up;
- multiple individual or couples risk reduction counseling sessions; monitoring of client progress toward his or her risk reduction plan at each session; and
- one-on-one support and reinforcement of client behavior changes.

PCM Service Providers-

- PCM is provided by professionals who are knowledgeable about community services, familiar with the needs of the target population, and skilled in ongoing individual or couples' risk reduction counseling. Prevention case managers usually have an academic background or special training in counseling and psychosocial assessment (e.g. social work, drug and alcohol treatment counseling, or nursing).

Relationship to Other Services

- PCM should not duplicate Ryan White CARE Act case management services for persons living with HIV. Many communities have trained Ryan White case managers to effectively integrate the additional components of PCM into their existing services. PCM services are not intended as substitutes for medical case management, extended social services, or long-term psychosocial care.

<i>Duration/Dosage:</i>	Intensive and On-going
<i>Venue:</i>	Client's home, CBO, clinic, institutional setting
<i>Mode:</i>	Case management – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual, Couple
<i>Target Population:</i>	High-risk for HIV/STD
<i>Other:</i>	

HIV Prevention Case Management (LA)

Description:

...is a client-centered HIV prevention activity with fundamental goal of promoting the adoption and maintenance of HIV risk reduction behaviors by clients with multiple, complex problems and risk reduction needs.

CDC Intervention Level: Individual Level Intervention

Theoretical Basis: Theory of Reasoned Action

Target Population: Substance users who are HIV negative and at extremely high risk to become infected or are HIV infected and likely to transmit to others.

Sites: CBOs, OPH STD clinics; HIV ambulatory care clinics and early interventions sites; community health centers, drug treatment clinics.

Key Elements:

Client recruitment and enrollment/screening for eligibility and willingness to participate.

- Assessment of HIV, STD and substance abuse risks, along with medical and psychosocial needs.
- Development of a client-centered risk reduction plan that is specific, time-phased, realistic and achievable.
- Multiple sessions of HIV risk reduction counseling with same client.
- Actively assist clients in securing services to appropriate referral sites.
- Monitoring and reassessing clients' needs and progress.
- Client discharge from PCM upon attainment and maintenance of risk- reduction goals.
- Practice harm reduction counseling with substance users.
- This intervention can be enhanced by couples.
- This intervention could be incorporated into a care plan for HIV infected clients.
- Appropriate referrals must be made (mental health clinics, substance abuse clinics, etc.).

Recommended Training: HIV/AIDS 101, HIV Prevention Counseling and Testing, Annual HIV Update, Social Service/Compliance Update, Harm Reduction Training, Behavior Theory Training.

Evaluation Methods...

Expected Outcomes: Prevent the transmission or acquisition of HIV; increase condom use; decrease needle sharing.

Implemented by: Trained staff including Ryan White case managers.

Includes:

1. Addresses High Priority Needs
2. Addresses Community/Cultural Norms & Values
3. Outcome Effectiveness
4. Accessible to the Target Populations
5. Intervention Feasibility and Cost-Effectiveness
6. Sources

<i>Duration/Dosage:</i>	Multiple sessions
<i>Venue:</i>	CBOs, STD clinics, health centers, drug treatment centers, HIV clinics
<i>Mode:</i>	Case management – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	Substance users who are HIV negative and at extremely high-risk to become infected or are HIV infected and likely to transmit to others.
<i>Other:</i>	

Prevention Case Management (MO)

Prevention Case Management includes client-centered HIV prevention activities offered in conjunction with traditional care case management which links HIV positive individuals to care and other community services. The fundamental goal is the promotion, adoption, and maintenance of reduced HIV risk behaviors along with linkages to care. This represents a holistic approach by ensuring access to care which should increase the quality of health outcomes, while reducing the potential for secondary infections which is a primary public health prevention outcome.

<i>Duration/Dosage:</i>	
<i>Venue:</i>	
<i>Mode:</i>	Case management – semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	

Prevention Case Management (NH)

- Offered by a licensed mental health professional for people who are HIV positive or at significantly increased risk.
- Client and counselor identify reasons the client is engaging in risky behavior and develop a step-by-step plan to allow the client to reduce risks. In a series of counseling sessions the counselor and client work together to put the plan into action.
- Client may be referred to other services such as substance abuse treatment, supported housing, job search assistance, etc."

Overall Premises to be Considered in All Interventions:

1. All interventions need to explicitly define a population to be served and the steps to reach that population.
2. All interventions must have explicitly defined HIV prevention goals (e.g. reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required data collection will be more limited than for individual and group level interventions due to the nature of the work.)
6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.
7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

<i>Duration/Dosage:</i>	A series of counseling sessions
<i>Venue:</i>	
<i>Mode:</i>	Case management – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	HIV positive individuals High-risk HIV negative individuals
<i>Other:</i>	All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. All interventions must show evidence that they are based on sound behavioral science theory. All interventions need to explicitly define a population to be served and the steps to reach that population. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.

Prevention Case Management (NV)

Transmission of HIV can be prevented through HIV-prevention case management (HIVCM). HIVCM is a strategy that can be used both to prevent HIV positive individuals from infecting others, and to help prevent high-risk individuals from getting HIV. It is a one-on-one client service specifically designed to assist both at-risk and HIV-infected persons in receiving services that will prevent or reduce behaviors that result in further spread of the virus, delay the onset of AIDS and improve the client's health status. This approach supports prevention goals through the provision of risk-reduction information and the reinforcement of safer behaviors (CDC, 1993).

Demonstrated effectiveness and implications...

Duration/Dosage:

Venue:

Mode: Case management – minimally structured

Provider:

Outcome:

Level: Individual

Target Population: HIV positive and high-risk individuals

Other:

Case Management (NY)

Ccoordination of an individual's care to get the best results for the most reasonable expenditure.

Duration/Dosage:

Venue:

Mode:

Provider:

Outcome:

Level: Individual

Target Population:

Other:

HIV Prevention Case Management (OK)

Encompassed under Health Education/Risk Reduction.

Individuals who need more intensive individualized support may be candidates for HIV Prevention Case Management (PCM). PCM is an individual level intervention directed at persons who need highly individualized support, including substantial psychosocial, interpersonal skills training, and other support to remain seronegative or to reduce the risk of HIV transmission to others. HIV prevention case management services are not intended to be substitutes for medical case management or extended social services.

Prevention case management services should compliment ongoing HIV prevention services such as HIV antibody counseling, testing, referral, and partner counseling and referral services, and early medical intervention programs. Coordination with HIV counseling and testing clinics, STD clinics, TB testing sites, substance abuse treatment programs, and other health services agencies and organizations is essential to successfully recruiting or referring HIV positive or persons at high risk who are appropriate for this type of intervention. (CDC Application Guidelines, 1998)

Duration/Dosage:

Venue:

Mode:

Provider:

Outcome:

Level: Individual

Target Population: High-risk individuals

Other: Should compliment ongoing HIV prevention services such as HIV antibody counseling, testing, referral, and partner counseling and referral services, and early medical intervention programs.

Prevention Case Management (TN)

Taken from section: Interventions and Target Populations Prioritized by the TCPG.

PCM is client-centered HIV prevention activity with fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex risk-reduction needs. This relatively new intervention is a mixture of traditional case management services with intensive, ongoing, and individualized prevention counseling. Other type of support for the individual, include services brokering, is also an important aspect of this intervention."

Taken from heading: Criteria for Selecting Interventions:

...The interventions Workgroup also evaluates interventions based upon several specific factors which include:

1. the intervention has been demonstrated to be acceptable to the target population norms and values;
2. evidence exists to show the effectiveness of the intervention in averting or reducing high-risk behavior within the target population;
3. evidence exists to show cost effectiveness;
4. the intervention addresses a demonstrated high priority need;
5. the knowledge from existing social and behavioral science has been applied.

As previously mentioned, each of the interventions was adapted from the list of scientifically-tested prevention programs reviewed by Holtgrave, et al., (1995) as well as those interventions reported in the CDC's Compendium of HIV Prevention Interventions with Evidence of Effectiveness. In addition, interventions which do not fit into the CDC's guidance for interventions are given consideration providing they meet the criteria detailed above.

<i>Duration/Dosage:</i>	On-going
<i>Venue:</i>	
<i>Mode:</i>	Counseling – semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	
<i>Target Population:</i>	
<i>Other:</i>	

Prevention Case Management (TX)

1. Prevention Case Management (PCM) provides intensive, ongoing, individualized prevention counseling and referrals to other appropriate social services. PCM is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is the most intensive individual level intervention and is intended for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission, or reinfection. This HIV prevention activity addresses the relationship between HIV risk and other issues such as substance use/abuse, STD treatment, mental health, and social and cultural factors. PCM services may be provided to targeted populations only if PCM is indicated in the RAPs as a priority intervention. Any reference to intensive, ongoing prevention counseling with referral services or professional level counseling in the RAPs must be provided through this PCM model.
2. PCM services should complement other HIV prevention services such as HIV prevention counseling and partner elicitation, partner notification and early medical intervention programs. A strong relationship with STD clinics, TB testing sites, substance abuse treatment programs, and other health service agencies is essential to successfully recruiting or referring persons at high risk who are appropriate for this type of intervention. Programs without solid linkages to other HIV prevention, medical or social services are discouraged from considering a PCM program.
3. PCM should be offered to both HIV-infected and seronegative persons who continue to practice risky behaviors as indicated in the RAPs. However, PCM is not indicated for all regions in the RAPs. PCM provides an ongoing, sustained relationship with the client in order to assume multiple-session HIV risk reduction counseling and access to service referrals.
4. PCM consists of seven essential components. Each component is listed below with the minimum set of standards for each component. PCM programs may not contract out any of the seven program elements. Applicants may obtain additional PCM guidance in the HIV Prevention Case Management Guidance, September 1997 available from the CDC National AIDS Clearinghouse at (800) 458- 5231.

- **Client Recruitment and Engagement**
Protocols for client engagement and related follow-up must be developed, such as requiring a minimum number of follow-up contacts within a specified time period.
- **Screening and Assessment**
PCM program staff must develop screening procedures to identify persons at highest risk for acquiring or transmitting HIV and who are appropriate clients for PCM. All persons screened for PCM, including those who are not considered to be appropriate for PCM, must be offered counseling by the prevention case manager and referrals relevant to their needs. Thorough and comprehensive assessment instrument(s) must be obtained or developed to assess HIV, STD, and substance abuse risks and their medical and psychosocial needs. All PCM clients must participate in a thorough client-centered assessment of their HIV, STD, and substance abuse risks and their medical and psychosocial needs. Case managers must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must assure the client of confidentiality.
- **Development of a Client-Centered Prevention Plan**
For each PCM client, a written prevention plan must be developed, with client participation, which specifically defines HIV risk-reduction behavioral objectives and strategies for change. For persons living with HIV and receiving antiretroviral or other drug therapies, the prevention plan must address issues of adherence. The prevention plan must address efforts to ensure that a PCM client is medically evaluated for STDs at regular intervals regardless of symptoms status. For clients with substance abuse problems, the prevention plan must address referral to appropriate drug and/or alcohol treatment. Clients must sign off on the mutually negotiated prevention plan to ensure their participation and commitment. Client files that include individual prevention plans must be maintained in a locked file cabinet to ensure confidentiality.
- **HIV Risk-Reduction Counseling**
PCM provides multiple-session HIV reduction counseling aimed at meeting identified behavioral objectives must be provided to all PCM clients. Training and quality assurance for staff must be provided to ensure effective identification of HIV risk behaviors and appropriate application of risk-reduction strategies. Clients who are not aware of their HIV antibody status must receive information regarding the potential benefits of knowing their HIV status. Clients must be provided education about the increased risk of HIV transmission associated with other STDs and about the prevention of these other STDs. PCM program staff must develop a protocol for assisting HIV seropositive clients in confidentially notifying partners themselves or eliciting names and locating information for local health department notification and referring them to PCM and/or prevention counseling and testing services. For persons receiving treatment for opportunistic infections and/or antiretroviral therapy(ies), counseling to support adherence to treatments/therapies must be provided.
- **Coordination of Services with Active Follow-up**
Formal and informal agreements, such as memoranda of understanding or qualified service organization agreements (QSOA), must be established with relevant service providers to ensure availability and access to key services referrals. A standardized written referral process for the PCM program must be established. Explicit protocols for structuring relationships and communication between case managers or counselors in

different organizations is required to avoid duplication of services, for example, how to transfer or co-manage PCM clients with Ryan White CARE Act case management. Communication about an individual client with others providers is dependent upon the obtainment of written, informed consent from the client. A referral tracking system must be maintained. Annual assessment of relevant community providers with current referral and access information must be maintained. A mechanism to provide clients with emergency psychological or medical services must be established.

- Monitoring and Reassessment of Client's Needs and Progress
Prevention case managers must meet on a regular basis with clients to monitor their changing needs and their progress in meeting HIV behavioral risk-reduction objectives. Individuals meetings with a client must be reflected in the client's confidential progress notes. A protocol must be established for defining minimum, active efforts to retain clients. That protocol should specify when clients are to be made "inactive."
 - Discharge from PCM Upon Attainment and Maintenance of Risk-Reduction Goals
A protocol for client discharge must be established.
5. Optimally, PCM involves referral to and not necessarily performance of the following services: substance abuse treatment, mental health counseling, STD diagnosis and treatment, women's health services, TB diagnosis and treatment, and other primary health care services. PCM services are not intended to be a substitute for extended social services, medical case management or psychological care. Specific PCM services may include skills building, individual counseling, couples counseling, crisis management, resource procurement, and preparation for referral of partners.
 6. At a minimum, a physician, registered nurse, or Masters of Social Work should be on the Board of Directors and oversee activities of case managers who do not hold professional licensure. All PCM intake assessments and services must be performed by individuals with appropriate training and skills. For example, any substance abuse assessment and counseling must be performed by a Licensed Chemical Dependency Counselor or other professional with the appropriate licensure. At minimum, PCM case managers must successfully complete the Texas HIV Prevention Counseling and Partner Elicitation training and be trained in the basic philosophy and techniques of case management. Project staff must be supervised and evaluated by individuals with appropriate professional license/credentials and experience in supervising intensive interventions activities with the population(s) targeted by the project. PCM staff must be provided written job descriptions and opportunities for regular, constructive feedback. All staff must be knowledgeable of confidentiality laws and agency confidentiality policies and procedures.
 7. An explicit protocol for structuring relationships with Ryan White CARE Act case management providers must be established and should detail how to transfer and/or share clients. PCM must not duplicate Ryan White CARE Act case management for persons living with HIV, but may be integrated into these services.
 8. Clear procedure and protocol manuals for the PCM program must be developed to ensure effective delivery of PCM services and minimum standards of care. Written quality assurance protocols must be developed and included in procedure and protocol manuals.

Client PCM records must contain a copy of the voluntary informed consent document and the prevention plan showing the client's signature.

Holtgrave, Valdessari & West Taxonomy in Comprehensive Plan – Appendix 3 ... PCM not listed.

<i>Duration/Dosage:</i>	Intensive and on-going Multiple sessions
<i>Venue:</i>	
<i>Mode:</i>	Case management – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	HIVpositive and high-risk individuals
<i>Other:</i>	Protocols for client engagement and related follow-up must be developed, such as requiring a minimum number of follow-up contacts within a specified time period. Prevention case managers must meet on a regular basis with clients to monitor their changing needs and their progress in meeting HIV behavioral risk-reduction objectives.

Prevention Case Management (VA)

Encompassed under Category II: Health Education/Risk Reduction.

Prevention Case Management (PCM)

A client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple complex problems and risk-reduction needs. PCM is indicated for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission, or re-infection. As a hybrid of HIV risk-reduction counseling and traditional case management, PCM provides intensive, on-going, individualized prevention counseling, support, and service brokerage. This HIV prevention intervention addresses the relationship between HIV risk and other issues such as substance abuse, STD treatment, mental health, and social and cultural factors. Priority for PCM services should be given to HIV seropositive persons.

<i>Duration/Dosage:</i>	On-going
<i>Venue:</i>	
<i>Mode:</i>	Case management – semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	Persons having or likely to have difficulty initiating or sustaining practices to reduce or prevent HIV infection.
<i>Other:</i>	

Prevention Case Management (VI)

Prevention case management is a long-term prevention strategy that has been successful with individuals who engage in high-risk behavior as well as HIV positive clients that continue with risky behavior. PCM involves the client in risk reduction counseling to initiate behavior change to prevention of HIV transmission or reinfection with virus. The stages of change behavior model is used in PCM to monitor each client's progress. PCM also facilitates referral services for the client's medical and psychological needs that affect health and ability to change HIV risk taking behavior.

<i>Duration/Dosage:</i>	Long-term
<i>Venue:</i>	
<i>Mode:</i>	Case management – semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	High-risk individuals
<i>Other:</i>	

Prevention Case Management (WI)

HIV Prevention Case Management (PCM) combines individual risk reduction counseling with an individualized case plan developed by client and service provider and implementation of the plan including referrals. PCM concentrates on providing prevention education and risk reduction counseling through intensive one-on-one, client-centered interaction. This intervention assists persons in remaining seronegative, reducing the possibility for transmission with other sexually transmitted infections, and preventing transmission for HIV-positive persons to others. Ideally, PCM builds and reinforces client self-efficacy skills, which facilitate sustained risk management.

PCM providers should deliver the following five services to clients:

1. assessment of HIV risk behavior;
2. development of a case plan in which the client actively participates;
3. implementation of the plan through follow-up and referral;
4. ongoing HIV risk-reduction counseling;
5. advocacy for clients services.

This client-centered focus may assist providers in reaching individuals who have difficulty complying with health promotion regimens or who need flexibility to accommodate their individual situations and needs.

Includes:

- Scientific Basis

Extensive evidence has supported the efficacy of comprehensive and intensive prevention programs. PCM is able to assist an individual in addressing all of the potential risk factors that can lead to unsafe behavior. In addition, personal efficacy for changing or maintaining behaviors, which can be built through PCM, is one of the strongest predictors of low sexual risk-taking. (Stall RD, Coates TJ, Hoff C. Behavioral risk reduction for HIV infection among gay and bisexual men. *Am Psychol* 1988; 43:878-85. Kelly JA. *Changing HIV Risk Behaviors: Practical Strategies*. New York (NY): The Guilford Press; 1995.)

- Resources

All PCM providers should comply with PCM guidelines for client charting, clinical supervision, criteria for eligible clients, creation of risk-reduction plans, size of client load, and a process for evaluating the strategy... .

Duration/Dosage:

Intensive

On-going

Venue:

Mode:

Case management – structured

Provider:

Outcome:

Behavioral

Level:

Individual

Target Population:

Other:

All PCM providers should comply with PCM guidelines for client charting, clinical supervision, criteria for eligible clients, creation of risk-reduction plans, size of client load, and a process for evaluating the strategy.

Partner Counseling and Referral Services (PCRS)

The Number of Intervention Characteristics by Each Partner Counseling and Referral Service (PCRS) Intervention

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Partner Notification	AK			✓	✓	✓	✓			4
Partner Counseling and Referral Services	CO	✓	✓	✓	✓	✓	✓	✓	✓	8
Partner Notification	CT			✓	✓	✓	✓	✓	✓	6
Partner Counseling and Referral Services (PCRS)	IA			✓		✓	✓	✓		4
Partner Counseling and Referral Services	ID			✓		✓	✓			3
Partner Counseling and Referral Services (PCRS)	IL	✓	✓	✓	✓	✓	✓	✓	✓	8
Partner Counseling and Referral Services	LA		✓	✓	✓	✓	✓	✓	✓	7
TOTAL (N = 7)		2	3	7	5	7	7	5	4	40

✓- Indicates that evidence of the intervention characteristic was found in reviewing the FY 2001 Cooperative Agreement Applications and Comprehensive Plans and Web sites. Definitions or guidelines addressing these elements may exist in other documentation not reviewed for this study.

Partner Counseling & Referral Services (PCRS) – Listing of Evidence by Intervention Characteristic

Duration/Dosage:

	Intervention Name:	Evidence of Intervention Characteristic:
CO	Partner Counseling and Referral Services	One or more sessions, with the number of sessions and duration of services based on client need and PCRS provider assignment.
IL	Partner Counseling and Referral Services (PCRS)	On-going and Comprehensive

Venue:

	Intervention Name:	Evidence of Intervention Characteristic:
CO	Partner Counseling and Referral Services	A variety of settings appropriate to client need
IL	Partner Counseling and Referral Services (PCRS)	Confidential or anonymous settings
LA	Partner Counseling and Referral Services	All sites which identify HIV infected individuals and/or diagnosis individuals with AIDS

Mode:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Partner Notification	Counseling – minimally structured Biomedical – minimally structured
CO	Partner Counseling and Referral Services	Counseling – structured Health education – semi-structured
CT	Partner Notification	Counseling – semi-structured
IA	Partner Counseling and Referral Services (PCRS)	Counseling – structured Biomedical – minimally structured
ID	Partner Counseling and Referral Services	Counseling – semi-structured Biomedical – minimally structured

IL	Partner Counseling and Referral Services (PCRS)	Counseling – structured Biomedical – minimally structured
LA	Partner Counseling and Referral Services	Counseling – structured Biomedical – semi-structured

Provider:

All five of the interventions referencing criteria or standards for providers indicated providers of PCRS should be professional.

Outcome:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Partner Notification	Biomedical
CO	Partner Counseling and Referral Services	Biomedical Behavioral
CT	Partner Notification	Behavioral
IA	Partner Counseling and Referral Services (PCRS)	Biomedical Behavioral
ID	Partner Counseling and Referral Services	Behavioral Biomedical
IL	Partner Counseling and Referral Services (PCRS)	Behavioral Biomedical
LA	Partner Counseling and Referral Services	Behavioral

Level:

Seven prevention case management interventions addressed level. All indicated the level to be ‘individual’. Partner Counseling and Referral Services (CO) also included ‘couples’ as a level for prevention case management.

Target Population:

	Intervention Name:	Evidence of Intervention Characteristic:
CO	Partner Counseling and Referral Services	People who test positive for HIV or have been diagnosed as having AIDS, sex and needle-sharing partners of HIV/AIDS clients, perinatally exposed children and other individuals at increased risk of acquiring HIV infection.
CT	Partner Notification	Individuals who test HIV positive and their partners
IA	Partner Counseling and Referral Services (PCRS)	Sex and needle-sharing partners of HIV positive individuals
IL	Partner Counseling and Referral Services (PCRS)	Sex and needle-sharing partners of HIV positive individuals
LA	Partner Counseling and Referral Services	MSM, females, youth, substance users, ethnic minorities

Other:

	Intervention Name:	Evidence of Intervention Characteristic:
CO	Partner Counseling and Referral Services	<p>PCRS provider will contact and interview clients at the earliest appropriate time (~65-74% of clients are interviewed within 7 days).</p> <p>Sex and needle-share partners will be counseled at the earliest appropriate opportunity (~70-80% within 7 days).</p> <p>A consent form for testing specified by the CDPHE or a CDPHE approved equivalent must be used by all contracted PCRS providers.</p>
CT	Partner Notification	Individuals involved in partner notification must be fully informed of the risks involved, must have complete confidentiality, and must be allowed enough time to consider whether or not they want to notify their partners.

IL Partner Counseling and Referral Services (PCRS)

Delivered in four ways:

1. Provider referral
2. Client referral
3. Contract referral
4. Dual referral.

LA Partner Counseling and Referral Services

Compliance with LA sanitary code which requires a good faith effort to notify the spouses and non-spouse sex partners of their exposure to HIV and offer HIV testing.

Interview and counsel HIV positive individuals to identify their sexual and needle-sharing partners.

Jurisdictions' Definitions of Partner Counseling & Referral Services (PCRS)

Partner Notification (AK)

Voluntary services to notify named sexual and needle-sharing partners to HIV positive individuals of their HIV exposure, and to provide risk reduction counseling, HIV testing, and other appropriate services/referrals per CDC HIV Partner Counseling and Referral Services [Guidelines].

Duration/Dosage:

Venue:

Mode: Counseling – minimally structured

Biomedical – minimally structured

Provider: Professional

Outcome: Biomedical

Level: Individual

Target Population:

Other:

Partner Counseling and Referral Services (CO)

Partner counseling and referral (PCRS) is a service offered to people infected with HVI and other STDs and describes index clients and health department efforts to notify persons of a possible exposure to HIV. The goal of PCRS is to stop the unintentional spread of HIV by providing risk reduction education to persons who are infected and to those at risk of infection. It involves a confidential discussion between the index client and a trained health professional about the patient's risk, the course of the infection, options for health care follow-up, measures to reduce the risk of disease transmission, and at risk sexual and needle sharing partners and how these partners will be notified of exposure. The index client may decline to be interviewed or to name partners. Index clients may choose to notify their partners without health department assistance (client referral), have the health department notify partners (provider referral) or elect a combination approach in which the index client and health department are both involved in the notification of partners. PCRS services are integrally linked to other HIV prevention interventions which support the movement of index clients and their partners toward the practice of safer behaviors.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their programs flow from and is consistent with social and behavioral theory and research relevant to HIV risk reduction.

- **Goal of the Intervention:** The goal of PCRS is to stop the unintentional spread of HIV by persons who are infected by negotiating a client-centered risk reduction plan and by providing referrals to medical and other prevention services. Additionally, it is the goal of PCRS to help those who are at risk of infection gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment options, and other prevention services.
- **Target Population:** People who test positive for HIV or have been diagnosed as having AIDS, sex and needle-sharing partners of HIV/AIDS clients, perinatally exposed children and other individuals at increased risk of acquiring HIV infection.

In conjunction with CDPHE, the PCRS provider will develop standards and criteria defining which clients will be eligible for PCRS. The eligibility criteria should be evaluated annually based on client needs, disease trends, and new treatments available for HIV.

- **Cultural competence/proficiency:** ...
- **Where Delivered:** PCRS is carried out in a variety of settings appropriate to client needs.
- **When Delivered:** Once the facility or private medical doctor has given permission for PCRS follow-up the PCRS provider will contact and interview clients at the earliest appropriate time (at CDPHE, 65-74% of the clients are interviewed within 7 days of assignment). When the client utilizes PCRS for the referral of sex and needle-share partners, a client-centered plan will be developed for the proper timing and method of referral (client, provider or dual referral). As the plan allows, the sex and needle-share partners of clients will be counseled at the earliest appropriate opportunity (At CDPHE, 70-80% if sex and needle-share partners are offered PCRS within 7 days of assignment).
- **How Much:** PCRS is typically conducted in one or more sessions, with the number of sessions and duration of services based on client need and PCRS provider assignment.
- **Methods Employed:** ...PCRS involves a one-on-one confidential client-centered discussion between the index client and health professional trained in PCRS. At a minimum the discussion includes conveying information regarding confidentiality, that PCRS is voluntary and at times an emotional process. PCRS services include: ... Index clients who elect to notify their partners shall be given the opportunity to notify their partners within a period of time not to exceed six weeks. ...

All PCRS providers will perform services in accordance with Section 8 SPOUSAL NOTIFICATION of Public Law 104-146 (Spousal Notification requirement of the Ryan White CARE Reauthorization Act of 1996). PCRS providers may use the CDC-approved procedures developed by CDPHE or may develop their own procedures to ensure compliance with this law. ...

Also includes: Referrals to Other HIV Services and Methods for Serving Public Health Orders.

- **Qualifications of People to do this Work:**
 - Individual Training Requirements:

1. All persons performing PCRS will have completed a course concerning partner counseling and referral services and also the course Introduction to Sexually Transmitted Disease Intervention or its equivalent as specified by the CDPHE.
 2. All persons providing PCRS will have completed the HVI Prevention Counseling course or an equivalent of not less than 16 hours of training approved by the CDPHE.
 3. All persons providing PCRS will attend training opportunities as offered to provide culturally competent services to appropriate address situation involving: domestic violence, people with disabilities, people who are deaf or hard of hearing or people who are mono-lingual Spanish-speaking.
- Agency Requirements:
1. All contracted agencies must be able to provide field testing and pre- and posttest counseling to all clients requesting counseling and testing.
 2. All PCRS providers when performing HIV pretest prevention and risk reduction counseling will: a) conduct a risk assessment, b) discuss and develop a risk reduction plan based on the risk assessment, c) fully and legibly complete for each person tested the HIV 1 Serology lab slip.
 3. All PCRS providers when performing HIV posttest prevention and risk reduction counseling will: a) inform clients in person of positive test results, b) make reasonable effort to provide results to persons who test negative, c) explain the significance of both positive and negative test results, d) discuss and/or modify the client-centered risk reduction plan, e) refer clients who test positive for follow-up medical and counseling services as needed.
 4. All PCRS providers performing HIV pre- and posttest counseling will have protocols addressing the following issues that may arise during the counseling session: Suicide, domestic violence, PCRS provider safety and confidentiality.
 5. A consent form for testing specified by the CDPHE or a CDPHE approved equivalent must be used by all contracted PCRS providers.
- Continuing Education/Ongoing Training Requirements: All persons providing PCRS services will have a minimum of eight hours of relevant HIV/STD or allied health services continuing education annually, approved by the CDPHE.
 - Consent/Confidentiality Considerations: (Includes sub-sections on: Consent, Confidentiality, and Information Sharing)
 - Quality Assurance: ...
 - Evaluation: ...
 - Penalties for Violating Standards: ...
 - Other: ...

<i>Duration/Dosage:</i>	One or more sessions, with the number of sessions and duration of services based on client need and PCRS provider assignment.
<i>Venue:</i>	A variety of settings appropriate to client need
<i>Mode:</i>	Counseling – structured Health education – semi-structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Biomedical Behavioral
<i>Level:</i>	Individual, Couple
<i>Target Population:</i>	People who test positive for HIV or have been diagnosed as having AIDS, sex and needle-sharing partners of HIV/AIDS clients, perinatally exposed children and other individuals at increased risk of acquiring HIV infection.
<i>Other:</i>	PCRS provider will contact and interview clients at the earliest appropriate time (~65-74% of clients are interviewed within 7 days). Sex and needle-share partners will be counseled at the earliest appropriate opportunity (~70-80% within 7 days). A consent form for testing specified by the CDPHE or a CDPHE approved equivalent must be used by all contracted PCRS providers.

Partner Notification (CT)

Encompassed under ILI – Interventions that target one person. In individual level interventions, one person (e.g., an HIV test counselor) is doing an HIV prevention intervention with another single individual (e.g., the person being tested).

Partner notification is a public health strategy for locating and informing past sexual and drug use partners of individuals who have tested HIV positive. It involves asking the HIV + partner to disclose the names of people they may have put at risk through drug use or sexual behavior. These people are then contacted by public health professionals and informed that they are at potential risk for infection. To protect the HIV+ person's confidentiality, when public health professionals notify partners they must keep the name of the HIV+ person concealed.

Does The Intervention Change Behavior?

- Some research suggests that HIV positive patients often do not inform drug use or sexual partners that they may be at risk, so notification by public health professionals may be more reliable

- There is little data on the effectiveness of partner notification, though one study found that individuals notified of their potential exposure thought that notification was the right thing to do. In addition, most of those contacted (90% cited in one study) seek HIV testing and counseling.
- External review by the CDC found partner notification programs sometimes fail to adhere to codes of conduct and professionalism, and considered some programs to be harmful to HIV prevention.
- Sometimes the HIV positive person may risk physical or psychological abuse or abandonment as a result of their partners being notified.

With What Population Is It Successful In Changing Behavior?

- Individuals involved in partner notification must be fully informed of the risks involved, must have complete confidentiality, and must be allowed enough time to consider whether or not they want to notify their partners. Heterosexual women who test HIV positive may be at particular risk for abuse from male partners as a result of partner notification.

Duration/Dosage:

Venue:

Mode: Counseling – semi-structured

Provider: Professional

Outcome: Behavioral

Level: Individual

Target Population: Individuals who test HIV positive and their partners

Other: Individuals involved in partner notification must be fully informed of the risks involved, must have complete confidentiality, and must be allowed enough time to consider whether or not they want to notify their partners.

Partner Counseling and Referral Services (PCRS) (IA)

Includes description from the Taxonomy of HIV/AIDS Prevention Interventions from the Academy of Educational Development and the CDC's 2000 Evaluation Guidance (CDC, 1999) for the purpose of "making meaningful distinctions and choices among possible interventions".

Partner counseling and referral to appropriate services is essential for ensuring that sex and needle-sharing partners of HIV-infected persons are notified about their risk and offered HIV prevention counseling, testing and referrals. Partner counseling and referral is a primary prevention service with the following objectives:

1. to confidentially inform partners of their possible exposure to HIV;
2. to provide partners with client-centered prevention counseling that assists and supports them in their efforts to reduce their risks of acquiring HIV or, if infected, of transmitting HIV infection; and

3. to minimize or delay disease progression by identifying HIV infection partners as early as possible in the course of their HIV infection and assisting them in obtaining appropriate prevention, medical, and other support services."

Includes:

1. *Demonstrated Effectiveness*
2. *Suggested Uses*
 - a. *Advantages and Strengths*

Duration/Dosage:

Venue:

Mode: Counseling – structured
Biomedical – minimally structured

Provider:

Outcome: Biomedical
Behavioral

Level: Individual

Target Population: Sex and needle-sharing partners of HIV positive individuals

Other:

Partner Counseling and Referral Services (ID)

A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV and gain access to counseling, testing, treatment and other prevention services.

Duration/Dosage:

Venue:

Mode: Counseling – semi-structured
Biomedical – minimally structured

Provider:

Outcome: Behavioral
Biomedical

Level: Individual

Target Population:

Other:

Partner Counseling and Referral Services (PCRS) (IL)

Partner Counseling and Referral Services are ongoing and comprehensive activities to reach, support, and serve sex and needle-sharing partners of HIV infected persons. PCRS should be offered at the earliest appropriate time after a person's diagnosis in confidential or anonymous settings. Services are available throughout any HIV- infected person's life, if and when future partners are exposed to HIV infection.

1. PCRS activities include:
 - Confidentiality and voluntary client participation in making a plan to notify sex and needle sharing partners
 - Counseling and support for persons who choose to notify their own partner, including assistance deciding if, how, to whom, and when to disclose their infection
 - Client and/or confidential provider activities to inform partners of possible exposure to HIV
 - Client-centered prevention counseling for sex and needle sharing partners so they can avoid HIV and STD infections or, if already infected, can prevent transmission to others
 - Referrals and assistance accessing HIV services (testing, medical evaluation, treatment), drug treatment, social services, and support.
2. PCRS may be delivered in four ways:
 - Provider referral – the PCRS provider locates and notifies exposed sex or needle-sharing partners
 - Client referral – the client takes full responsibility for notifying partners
 - Contract referral – the provider allows the infected person a certain amount of time to notify his or her partners and, if client is unable to do so, the provider follows through with notifying the partners
 - Dual referral – the provider and client notify partners together
3. PCRS are offered by certain qualified, trained health care personnel, as specified by Illinois law. These include physicians and public health department staff. Private physicians and others HIV service providers should refer clients to publicly funded PCRS sites. Non-health department personnel--such as case managers and community based prevention providers--should provide counseling and support for only client referral. Contact IDPH for more information about PCRS policies.

<i>Duration/Dosage:</i>	On-going and Comprehensive
<i>Venue:</i>	Confidential or anonymous settings
<i>Mode:</i>	Counseling – structured Biomedical – minimally structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral Biomedical
<i>Level:</i>	Individual
<i>Target Population:</i>	Sex and needle-sharing partners of HIV positive individuals
<i>Other:</i>	Delivered in four ways: <ol style="list-style-type: none"> 1. Provider referral 2. Client referral 3. Contract referral 4. Dual referral.

Partner Counseling and Referral Services (LA)

Intervention:

Trained counselors provide counseling to HIV infected and/or AIDS diagnosed persons, elicit names of sex and needle sharing partners. Partners are notified of their risk, counseled to reduce risk and offered HIV testing."

CDC Intervention Level: Individual Level Intervention.

Key Elements:

- Compliance with Louisiana Sanitary Code which requires a good faith effort to notify the spouses and non-spouse sex partners of their exposure to HIV and offer HIV testing.
- Interview and counsel HIV-infected and/or AIDS diagnosed persons to identify their sexual and needle-sharing partners.
- Confidentially locate and counsel these partners regarding their risk and ways to decrease risk.
- Offer and provide HIV testing and/or referral for partners.
- In compliance with federal requirements, a good faith effort is made to notify all spouses within the past ten years.

Recommended Training:

HIV/AIDS 101, HIV Prevention Counseling and Testing, Annual HIV Update, Field Safety, Partner Notification Training , Crisis Intervention Training

Evaluation Methods...

Expected Outcomes: Increased condom use; decreased needle sharing; decreased number of partners; increased knowledge of serostatus of partners.

Implemented by: STD Disease Intervention Specialists, in coordination with HIV testing sites; physicians, trained health care professionals

Includes:

1. Addresses High Priority Needs
2. Addresses Community/Cultural Norms and Values
3. Outcome Effectiveness
4. Accessible to the Target Populations
5. Intervention Feasibility and Cost-Effectiveness
6. Sources

Duration/Dosage:

Venue: All sites which identify HIV infected individuals and/or diagnosis individuals with AIDS

Mode: Counseling – structured
Biomedical – semi-structured

Provider: Professional

Outcome: Behavioral

Level: Individual

Target Population: MSM, females, youth, substance users, ethnic minorities

Other: Compliance with LA sanitary code which requires a good faith effort to notify the spouses and non-spouse sex partners of their exposure to HIV and offer HIV testing.
Interview and counsel HIV positive individuals to identify their sexual and needle-sharing partners.

Health Communication/ Public Information (HC/PI)

The Number of Intervention Characteristics by Each Health Communication/Public Information Intervention

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Health Communication/Public Information	AK		✓	✓			✓			3
Education, Information and Referral Hotlines	CA			✓		✓	✓			3
Speakers Bureaus	CA	✓	✓	✓	✓	✓	✓			6
Group Presentations	CA	✓		✓	✓	✓	✓		✓	6
Social Marketing (3)	CA		✓	✓		✓	✓			4
Media Relations (3)	CA		✓	✓		✓	✓			4
Public Events (3)	CA		✓	✓		✓	✓			4
Social Marketing (4)	CA		✓	✓		✓	✓			4
Media Relations (4)	CA		✓	✓		✓	✓			4
Public Events (4)	CA		✓	✓		✓	✓			4
Health Communication/Public Information (HC/PI)	CH	✓	✓	✓		✓	✓			5
Community Level/Social Marketing	CH	✓	✓	✓	✓	✓	✓			6
Public Information	CO	✓	✓	✓	✓	✓	✓	✓		7
Hotlines and Telephone Counseling (Including TDD)	CT			✓	✓	✓	✓			4
Media Campaigns	CT			✓		✓	✓	✓		4
Social marketing	CT			✓		✓	✓	✓		3

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Health Communication/Public Information – Electronic Media	DC			✓		✓	✓			3
Health Communication/Public Information – Print Media	DC			✓		✓	✓			3
Health Communication/Public Information – Hotline	DC			✓		✓				2
Health Communication/Public Information – Clearinghouse	DC			✓		✓	✓	✓		4
Health Communication/Public Information – Presentations/Lectures	DC	✓		✓		✓	✓			4
Public Information	DC			✓		✓	✓		✓	4
Health Communications & Public Information	HO			✓		✓	✓			3
Electronic and Print Media	IA			✓		✓	✓	✓		4
Targetable and Mass Media	IA			✓		✓	✓	✓		4
Education, Information, and Referral Hotlines	IA			✓		✓	✓	✓		4
Presentations/Lectures	IA	✓		✓		✓	✓	✓	✓	6
Health Communications/Public Information	ID			✓		✓				2
Public Information/Social Marketing	IL			✓		✓	✓	✓		4

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Public Information Programs	KS			✓		✓	✓	✓		4
Media Campaign	LA			✓	✓	✓	✓	✓		5
Targeted Public Information Efforts	MA	✓		✓		✓	✓			4
Public Information	MD			✓		✓	✓	✓	✓	5
Small/Large Group	MD			✓	✓	✓	✓		✓	5
Health Communication and Public Information	MI			✓		✓				2
Mass Media	MN			✓						1
Education, Information, and Referral Hotlines	MO			✓		✓				2
Health Communication/Public Information	MO	✓		✓		✓	✓			4
Telephone Hotline	NC			✓						1
Media Events	NC			✓			✓			2
Telephone Hotline and Counseling	NH			✓		✓	✓			3
Media Events	NH			✓			✓		✓	3
Large Group Interventions	NV		✓	✓	✓	✓	✓			5
Educational Materials	NV			✓		✓				2
Mass Media	NV			✓		✓	✓			3
AIDS Hotlines	NV			✓	✓	✓	✓		✓	5
Health Communication/Public Information	OK			✓		✓	✓		✓	4
Social Marketing	OK					✓	✓			2
Public Information	SC					✓	✓			2
Media	SD			✓		✓	✓		✓	4

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL L
Hotlines/Clearinghouses	SD			✓		✓				2
Endorsements/Testimonials By Opinion Leaders	SD				✓	✓				2
Social Marketing	SD			✓		✓				2
Mass Media	TN	✓		✓		✓			✓	4
Other Media	TN			✓		✓		✓		3
Social Marketing	TN					✓	✓		✓	3
Endorsements/Testimonials	TN			✓		✓				2
Hotline/Clearinghouses	TN			✓		✓		✓	✓	4
Targeted Public Information	TX		✓	✓		✓	✓			4
Presentations/Lectures	VA	✓		✓		✓				3
Health/Community Fairs	VA		✓	✓		✓	✓			5
Mass Media	VA			✓		✓	✓	✓		4
Hotlines	VA			✓		✓	✓	✓		4
Clearinghouse	VA					✓	✓	✓		3
Social Marketing	VA			✓		✓	✓		✓	4
Social Marketing	VI			✓		✓				2
Health Communication/Public Information – Media	WI			✓		✓	✓			3
Health Communication/Public Information – AIDS/HIV Information Hotline	WI			✓			✓		✓	3
Health Communication/Public Information – HIV Awareness Initiatives	WI		✓			✓	✓	✓		4

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Health Communication/Public Information – HIV Lectures	WI			✓		✓				2
Health Communication/Public Information	WY			✓			✓	✓		3
TOTAL (N = 70)		11	15	65	11	64	52	3	14	248

✓- Indicates that evidence of the intervention characteristic was found in reviewing the FY 2001 Cooperative Agreement Applications and Comprehensive Plans and Web sites. Definitions or guidelines addressing these elements may exist in other documentation not reviewed for this study.

Health Communication/Public Information – Listing of Evidence by Intervention Characteristic

Duration/Dosage:

	Intervention Name:	Evidence of Intervention Characteristic:
CA	Speakers Bureaus	One time
CA	Group Presentations	Short one-time or longer carefully targeted
CH	Community Level/Social Marketing	Consistently
CH	Health Communication/Public Information (HC/PI)	Single session
CO	Public Information	Repeated messages implemented over a longer term
DC	Health Communication/Public Information – Presentations/Lectures	One-shot
IA	Presentations/Lectures	One-time
MA	Targeted Public Information Efforts	Long-term
MO	Health Communication/Public Information	One-shot
TN	Mass Media	Short time period
VA	Presentations/Lectures	One-shot

Venue:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Health Communication/Public Information	Public sex environments
CA	Speakers Bureaus	Schools, work sites, clubs, treatment clinics, etc.
CA	Social Marketing (3)	Community
CA	Media Relations (3)	Community
CA	Public Events (3)	Public meetings or events
CA	Social Marketing (4)	Community
CA	Media Relations (4)	Community
CA	Public Events (4)	Public meetings or events

CH	Health Communication/Public Information (HC/PI)	Community
CH	Community Level/Social Marketing	Community
CO	Public Information	Key locations (as determined by formative evaluation)
NV	Large Group Interventions	Schools, colleges, prison, workplaces, etc.
TX	Targeted Public Information	Areas where the target population gathers
VA	Health/Community Fairs	Health/Community Fairs, Public events
WI	Health Communication/Public Information (HC/PI) – HIV Awareness Initiatives	Community

Mode:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Health Communication/Public Information	Health Communication/Public Information
CA	Education, Information and Referral Hotlines	Hotline
CA	Speakers Bureaus	Presentation
CA	Group Presentations	Presentation
CA	Social Marketing (3)	Media
CA	Media Relations (3)	Media
CA	Public Events (3)	Media
		Health education
CA	Social Marketing (4)	Media
CA	Media Relations (4)	Media
CA	Public Events (4)	Material/supply distribution
		Health education
CH	Health Communication/Public Information (HC/PI)	Health Communication/Public Information
CH	Community Level/Social Marketing	Social marketing
CO	Public Information	Health Communication/Public Information
CT	Media Campaigns	Media
CT	Social marketing	Media

CT	Hotlines and Telephone Counseling (Including TDD)	Hotline
DC	Health Communication/Public Information – Electronic Media	Media
DC	Health Communication/Public Information – Print Media	Media
DC	Health Communication/Public Information – Hotline	Hotline
DC	Health Communication/Public Information – Clearinghouse	Media
DC	Health Communication/Public Information – Presentations/Lectures	Presentation Health education – structured, semi- structured
DC	Public Information	Media
HO	Health Communications & Public Information	Media
IA	Electronic and Print Media	Media
IA	Targetable and Mass Media	Media
IA	Education, Information, and Referral Hotlines	Hotlines
IA	Presentations/Lectures	Workshop Presentation
ID	Health Communications/Public Information	Media Presentations Hotlines
IL	Public Information/Social Marketing	Media
KS	Public Information Programs	Media
LA	Media Campaign	Media
MA	Targeted Public Information Efforts	Media
MD	Public Information	Media
MD	Small/Large Group	Health education – semi-structured
MI	Health Communication and Public Information	Presentations
MN	Mass Media	Media Hotlines

MO	Education, Information, and Referral Hotlines	Hotlines
MO	Health Communication/Public Information	Presentation Media
NC	Media Events	Media
NC	Telephone Hotline	Hotline
NH	Telephone Hotline and Counseling	Hotlines Counseling – structured
NH	Media Events	Media
NV	Large Group Interventions	Presentation – structured
NV	Educational Materials	Material/supply distribution
NV	Mass Media	Media
NV	AIDS Hotlines	Hotlines
OK	Health Communication/Public Information	Media; Hotlines, Public events
SD	Media	Media
SD	Hotlines/Clearinghouses	Hotlines
SD	Social Marketing	Media
TN	Mass Media	Media
TN	Other Media	Media
TN	Endorsements/Testimonials	Media
TN	Hotline/Clearinghouses	Hotline Media
TX	Targeted Public Information	Media Hotlines
VA	Presentations/Lectures	Presentation
VA	Health/Community Fairs	Media
VA	Mass Media	Media
VA	Hotlines	Hotlines
VA	Social Marketing	Media
VI	Social marketing	Media
WI	Health Communication/Public Information (HC/PI) – Media	Media

WI	Health Communication/Public Information (HC/PI) – AIDS/HIV Information Hotline	Hotline
WI	Health Communication/Public Information (HC/PI) – HIV Lectures	Presentations
WY	Health Communication/Public Information	Media

Provider:

	Intervention Name:	Evidence:
CA	Speakers Bureaus	Paraprofessional
CA	Group Presentations	Professional, Peer
CH	Community Level/Social Marketing	Peer
CO	Public Information	Professional, Peer
CT	Hotlines and Telephone Counseling (Including TDD)	Professional, Paraprofessional
LA	Media Campaign	Professional, Paraprofessional
MD	Small/Large Group	Peer
NV	Large Group Interventions	Professional – specially trained speaker
NV	AIDS Hotlines	Professional, Paraprofessional
SD	Endorsements/Testimonials By Opinion Leaders	Peer

Outcome:

Of the 64 different health communication/public information interventions addressing outcomes in the definition, 56 indicated the anticipated outcome as ‘behavioral’. Seven reported outcomes as information and one jurisdiction’s intervention aimed for structural outcomes.

	Intervention Name:	Evidence of Intervention Characteristic:
DC	Health Communication/Public Information – Presentations/Lectures	Information
MI	Health Communication and Public Information	Information
NH	Telephone Hotline and Counseling	Information
NV	Educational Materials	Information
NV	Mass Media	Information

NV	AIDS Hotlines	Information
SD	Hotlines/Clearinghouses	Information
WI	Health Communication/Public Information (HC/PI) – HIV Awareness Initiatives	Behavioral Structural

Level:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Health Communication/Public Information	Community
CA	Education, Information and Referral Hotlines	Individual
CA	Speakers Bureaus	Group
CA	Group Presentations	Group
CA	Social Marketing (3)	Community
CA	Public Events (3)	Community
CA	Media Relations (3)	Group, Community
CA	Social Marketing (4)	Group, Community
CA	Public Events (4)	Community
CA	Media Relations (4)	Community
CH	Health Communication/Public Information (HC/PI)	Community
CH	Community Level/Social Marketing	Community
CO	Public Information	Community
CT	Hotlines and Telephone Counseling (Including TDD)	Individual
CT	Media Campaigns	Community
DC	Health Communication/Public Information – Electronic Media	Community
DC	Health Communication/Public Information – Print Media	Community
DC	Health Communication/Public Information – Clearinghouse	Community
DC	Health Communication/Public Information – Presentations/Lectures	Group

DC	Public Information	Community
HO	Health Communications & Public Information	Community
IA	Electronic and Print Media	Community
IA	Targetable and Mass Media	Community
IA	Education, Information, and Referral Hotlines	Community
IA	Presentations/Lectures	Group
IL	Public Information/Social Marketing	Individual, Community
KS	Public Information Programs	Community
LA	Media Campaign	Community
MA	Targeted Public Information Efforts	Community
MD	Public Information	Community
MD	Small/Large Group	Group
MO	Health Communication/Public Information	Community ("large number of people")
NC	Media Events	Community
NH	Telephone Hotline and Counseling	Individual
NH	Media Events	Community
NV	Large Group Interventions	Group – 20 or more members
NV	Mass Media	Community
NV	AIDS Hotlines	Individual
OK	Health Communication/Public Information	Community
OK	Social Marketing	Community
SC	Public Information	Community
SD	Media	Community
TN	Social Marketing	Community
TX	Targeted Public Information	Community
VA	Health/Community Fairs	Community
VA	Mass Media	Community
VA	Hotlines	Community
VA	Clearinghouse	Community

VA	Social Marketing	Community
WI	Health Communication/Public Information (HC/PI) – Media	Community
WI	Health Communication/Public Information (HC/PI) – AIDS/HIV Information Hotline	Individual
WI	Health Communication/Public Information (HC/PI) – HIV Awareness Initiatives	Community
WY	Health Communication/Public Information	Community

Target Population:

	Intervention Name:	Evidence of Intervention Characteristic:
CO	Public Information	General public as well as specific populations.
CT	Media Campaigns	People who can see and hear Youth (gay and non-gay)
CT	Social marketing	Youth, CSW
DC	Health Communication/Public Information – Clearinghouse	General public as well as high risk populations.
IA	Electronic and Print Media	General public as well as specific populations.
IA	Targetable and Mass Media	General public as well as specific populations.
IA	Education, Information, and Referral Hotlines	General public as well as specific populations.
IA	Presentations/Lectures	General public as well as specific populations.
IL	Public Information/Social Marketing	At-risk communities
KS	Public Information Programs	Persons at high risk
LA	Media Campaign	Racial/Ethnic minorities, Sexually active females, Males who have sex with males, Youth, Substance users
MD	Public Information	General public
TN	Hotline/Clearinghouses	General public and high-risk populations.

TN	Other Media	A narrow segment of a broad population.
VA	Health/Community Fairs	General public and/or high risk populations.
VA	Mass Media	Public or targeted populations
VA	Hotlines	General public and high-risk individuals.
VA	Clearinghouse	General public as well as high-risk populations.
WI	Health Communication/Public Information (HC/PI) – HIV Awareness Initiatives	Educators, employers, health care providers, etc.
WY	Health Communication/Public Information	General public and policy makers

Other:

	Intervention Name:	Evidence of Intervention Characteristic:
CA	Group Presentations	Target skills training an/or emphasize the erotic appeal of safer sex...
DC	Public Information	Community representatives must be involved in planning and developing public information activities to ensure community "buy in."
IA	Presentations/Lectures	Includes skills building
MD	Small/Large Group	Includes skills component
Nh	Media	Delivery of prevention information without face-to-face education
NV	AIDS Hotlines	Staffed by operators who are trained to provide callers with information, counseling, and referrals.
OK	Health Communication/Public Information	Public information programs should use multiple approaches to motivate an involve people and communities.
SD	Media Events	Messages must be strong to compete for the public's attention Messages are most effective when they are emotionally or intellectually engaging.
TN	Mass Media	Messages should address the prevention needs of the specific community.

TN	Social Marketing	Utilizes techniques adapted from commercial marketing to identify specific audiences called segments.
TN	Hotline/Clearinghouses	Interactive
VA	Social Marketing	Techniques adapted from commercial marketing to identify specific audiences called segments, identify their perceived needs, and then construct a program of services, support and communication to meet those perceived needs.
WI	Health Communication/Public Information (HC/PI) – AIDS/HIV Information Hotline	Confidential and anonymous.

Jurisdictions' Definitions of Health Communication/ Public Information

Health Communication/Public Information (AK)

Targeted – Selected use of broadcast or print media, health fairs, or hotlines, accessed primarily by the target population. Example: safer sex posters in gay bars and adult bookstores.

Duration/Dosage:

Venue: Public sex environments

Mode: Health Communication/Public Information

Provider: Media

Outcome:

Level: Community

Target Population:

Other:

Education, Information and Referral Hotlines (CA)

Program Category 1: Individual-Level Interventions

Individual level interventions provide information, risk assessment, and risk reduction counseling to assist individuals to learn about transmission and risk behaviors, make plans for individual behavior change and ongoing appraisal of their own behaviors, and to facilitate linkages to resources to support behavior changes. The common denominator of these strategies is their focus on one-on-one interactions between provider and individual.

Definition based upon a review of the literature:

1. HIV Antibody Counseling, Testing, and Partner Referral
2. Education, Information, and Referral Hotlines – Education, information and referral hotlines toll-free telephone hotlines, which provide information, education and referrals to callers.
3. Street and Community Outreach
4. Individual Peer Education
5. On-site Risk Reduction Education and Counseling
6. Prevention Case Management
7. Needle Exchange Programs
8. Condoms, Other Barriers, and Bleach Demonstration and Distribution

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue:

Mode: Hotline

Provider:

Outcome: Behavioral

Level: Individual

Target Population:

Other:

Speakers Bureaus (CA)

Program Category 2: Group-Level Interventions

Group level interventions provide education and risk reduction support groups to promote and reinforce safer behaviors, and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change. The common denominator of these strategies is their focus on group.

1. Speakers Bureaus – Speakers bureaus provide presentation by a trained volunteer of a one-time education seminar at a site where the audience regularly meets, including schools, work sites, clubs, treatment clinics, etc.
2. Group Presentations
3. Multi-Session Group
4. Group Peer Education

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage: One time

Venue: Schools, work sites, clubs, treatment clinics, etc.

Mode: Presentation

Provider: Paraprofessional

Outcome: Behavioral

Level: Group

Target Population:

Other:

Group Presentations (CA)

Program Category 2: Group-Level Interventions

Group level interventions provide education and risk reduction support groups to promote and reinforce safer behaviors, and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change. The common denominator of these strategies is their focus on group.

1. Speakers Bureaus
2. Group Presentations – Group presentations offer an opportunity to learn about risk assessment, gain risk reduction skills such as condom usage or condom negotiation, or develop motivation to maintain safer sex practices. Groups may be led by trained peer facilitators or professional health educators.
3. Multi-Session Group
4. Group Peer Education

Outcome effectiveness and/or cost effectiveness provided for each intervention.

<i>Duration/Dosage:</i>	Short one-time or longer carefully targeted
<i>Venue:</i>	
<i>Mode:</i>	Presentation
<i>Provider:</i>	Professional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	Target skills training an/or emphasize the erotic appeal of safer sex...

Social Marketing (3) (CA)

Program Category 3: Community-Level Interventions

Community-level interventions seek to reduce risk behaviors by changing attitudes, norms and behaviors through health communications, social (prevention) marketing, community mobilization and community-wide events. The common denominator of these strategies is their focus on community/group identity.

1. Social Marketing – Social marketing can include advertising using billboards, television, radio, and bus placards which seek to increase knowledge or change norms or behaviors.
2. Media Relations
3. Public Events
4. Natural Opinion Leader
5. Community Mobilization

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue: Community

Mode: Media

Provider:

Outcome: Behavioral

Level: Group, Community

Target Population:

Other:

Media Relations (3) (CA)

Program Category 3: Community-Level Interventions

Community-level interventions seek to reduce risk behaviors by changing attitudes, norms and behaviors through health communications, social (prevention) marketing, community mobilization and community-wide events. The common denominator of these strategies is their focus on community/group identity.

1. Social Marketing
2. Media Relations – Media relations involve activities to gain in-depth media coverage about issues related to HIV prevention or risk reduction
3. Public Events
4. Natural Opinion Leader
5. Community Mobilization

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue: Community

Mode: Media

Provider:

Outcome: Behavioral

Level: Group, Community

Target Population:

Other:

Public Events (3) (CA)

Program Category 3: Community-Level Interventions

Community-level interventions seek to reduce risk behaviors by changing attitudes, norms and behaviors through health communications, social (prevention) marketing, community mobilization and community-wide events. The common denominator of these strategies is their focus on community/group identity.

1. Social Marketing
2. Media Relations
3. Public Events – Public meetings or events offer community booths or other displays where printed information and referrals are offered. Limited opportunity for one-on-one health education of risk reduction may be offered.
4. Natural Opinion Leader
5. Community Mobilization

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue: Public meetings or events

Mode: Media
Health education

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Social Marketing (4) (CA)

Program Category 4: Public Information Programs

Public information programs are provided for the general public to dispel myths about HIV transmission, support volunteerism, reduce discrimination toward individuals with HIV/AIDS, and promote support for strategies and interventions that contribute to HIV prevention. The major distinction between public information programs and community-level intervention is the extent to which the focus is on risk behavior.

1. Social Marketing – Social marketing can include advertising using billboards, television, radio, and bus placards that seek to dispel myths, support volunteerism, reduce discrimination, and promote programs or strategies and interventions that contribute to HIV prevention.
2. Media Relations
3. Public Events

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue: Community

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Public Events (4) (CA)

Program Category 4: Public Information Programs

Public information programs are provided for the general public to dispel myths about HIV transmission, support volunteerism, reduce discrimination toward individuals with HIV/AIDS, and promote support for strategies and interventions that contribute to HIV prevention. The major distinction between public information programs and community-level intervention is the extent to which the focus is on risk behavior.

1. Social Marketing
2. Media Relations
3. Public Events – Public meetings or events offer community booths or other displays where printed information and referrals are offered. The focus is on dispelling myths, volunteerism, reducing discrimination, or promoting programs or strategies that contribute to HIV prevention.

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue: Public meetings or events

Mode: Material/supply distribution

Health education

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Media Relations (4) (CA)

Program Category 4: Public Information Programs

Public information programs are provided for the general public to dispel myths about HIV transmission, support volunteerism, reduce discrimination toward individuals with HIV/AIDS, and promote support for strategies and interventions that contribute to HIV prevention. The major distinction between public information programs and community-level intervention is the extent to which the focus is on risk behavior.

1. Social Marketing
2. Media Relations – Media relations involve activities to gain in-depth coverage about issues such as myths, volunteerism, discrimination, or education programs and strategies that contribute to HIV prevention.
3. Public Events

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue: Community

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Health Communication/Public Information (HC/PI) (CH)

Describes:

I. Minimum Criteria

- A. The delivery of planned HIV/AIDS prevention messages to target audiences through electronic media, print media, hotlines, clearinghouses, and presentations/lectures, for the purpose of building support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services
- B. Single session presentations and lectures, that do not contain a skills component, belong in this category
- C. Health Communication/Public Information cannot be funded as a stand-alone intervention (i.e., as the only intervention in a program) but must be coupled with 1 or more of the other HPPG approved interventions.

II. Quality Assurance Measures

- A. Agency has demonstrated the ability to access non-traditional communication networking (i.e., word of mouth through specific groups)
- B. Agency has demonstrated the ability to disseminate public information in electronic, print, or other types of media

III. Data Requirements

- A. In an effort to better document service delivery citywide, all CDPH prevention funded agencies will be required to collect and submit the following data for each intervention used in their program. Data will be submitted to CDPH scan forms (provided by CDPH). This information will be used to improve the quality and effect of HIV prevention projects in Chicago.
 - 1. Type of agency
 - 2. Risk population
 - 3. Client demographics
 - 4. Setting
 - 5. Number of interventions
 - 6. Staffing
 - 7. Expenditures
 - 8. Client demographics are not required for this intervention
 - 9. Type of HC/PI Intervention (e.g., presentation, hotlines, print media, etc)

What Works in Prevention?

Key factors of Successful Interventions and Programs:

- I. Services are:
 - A. delivered in a culturally appropriate and culturally sensitive manner
 - B. easily accessed
 - C. voluntary
- II. Target Population is:
 - A. clearly defined and with a proven need of HIV prevention services.
- III. Goals and Objectives of the Program are:
 - A. clearly defined, time-phased, and measurable.
- IV. Interventions are:
 - A. based on sound behavioral research
 - B. well planned, implemented, monitored and evaluated
 - C. created (whenever possible) with input from target population
 - D. focused on reducing specific behaviors and address skill levels, attitudes, and behaviors that influence high risk activities (i.e., how to use condoms appropriately, how to clean injection equipment, and reinforcing positive attitudes about condom use)
 - E. vehicles for demonstrating, reinforcing, and promoting positive behaviors
- V. Agencies have:
 - A. the ability to maintain multiple contacts with participants
 - B. the ability to document service delivery (i.e., develop and maintain survey questionnaires, client assessment forms, etc.)
 - C. a strong referral and follow-up system exists (formal, established, and written with signed memorandums of agreement)
 - D. the ability and desire to collaborate with other organizations

- E. policies that conform with prevailing local, state and federal laws regarding client confidentiality
 - F. staff with necessary academic background or experience in a human-services-related field (i.e., social work, psychology, nursing, counseling, or health education); and case management and assessment techniques
 - G. staff that are knowledgeable about HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change.
- VI. How Do We Assure Quality?
- A. Minimum Quality Assurance Standards
- VII. Services are:
- A. offered in a safe environment. The agency should be clean, neat, well ventilated, and clutter free
- VIII. Interventions are:
- A. whenever possible, implemented/delivered by individuals representative of the target population
- IX. Agencies have:
- A. Policies and Procedure Manual. This manual must contain all intervention protocols, policies, and procedures of the services being delivered
 - B. current collaborative linkages within community and, when possible, should participate in one or more Community Planning Groups
 - C. staff that are familiar with available community resources
 - D. staff that are trained in the implementation of program intervention(s). All trainings must be documented in staff folders. The agency should promote and encourage continuing educational trainings.
 - E. grievance procedures in place and a method for informing clients of this process. Proof of client receipt should be documented in client charts
 - F. policies on staff safety (on site and off site)
 - G. a relationship with local authorities (police) such that the program is well known in the community
 - H. regular assessments of clients satisfaction through periodic client satisfaction surveys
 - I. regular management/supervisors meetings with program staff to discuss project and status progress towards stated outcomes

Duration/Dosage: Single session

Venue: Community

Mode: Health Communication/Public Information

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Community Level/Social Marketing (CH)

Describes:

- I. Minimum Criteria
 - A. A systems approach that seeks to influence specific behaviors using social networks (e.g., sex workers, IDUs, MSMs, transgender, etc.) to consistently deliver HIV risk-reduction interventions
 - B. Seeks to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups
 - C. Examples include: community mobilizations and community wide events
 - D. CL/SM cannot be funded as a stand-alone intervention (i.e., as the only intervention in a program) but must be coupled with 1 or more of the other (e.g., Individual, Group, PCM, HIV Prevention Counseling, Testing and Referral, Targeted STD Outreach Screening & Referral) HPPG approved interventions.
- II. Quality Assurance Measures
 - A. Staff providing interventions should be recruited from the targeted population
 - B. Agency demonstrates the ability to access target population
 - C. Agency demonstrates the ability to work within target population
- III. Data Requirements
 - A. In an effort to better document service delivery citywide, all CDPH prevention funded agencies will be required to collect and submit the following data for each intervention used in their program. Data will be submitted to CDPH scan forms (provided by CDPH). This information will be used to improve the quality and effect of HIV prevention projects in Chicago.
 1. Type of agency
 2. Risk population
 3. Client demographics
 4. Setting
 5. Number of interventions
 6. Staffing
 7. Expenditures
 8. Type of CL/SM intervention (marketing, etc.) is required

What Works in Prevention?

Key factors of Successful Interventions and Programs:

- I. Services are:
 - A. delivered in a culturally appropriate and culturally sensitive manner
 - B. easily accessed
 - C. voluntary
- II. Target Population is:
 - A. clearly defined and with a proven need of HIV prevention services.
- III. Goals and Objectives of the Program are:
 - A. clearly defined, time-phased, and measurable.
- IV. Interventions are:

- A. based on sound behavioral research
 - B. well planned, implemented, monitored and evaluated
 - C. created (whenever possible) with input from target population
 - D. focused on reducing specific behaviors and address skill levels, attitudes, and behaviors that influence high risk activities (i.e., how to use condoms appropriately, how to clean injection equipment, and reinforcing positive attitudes about condom use)
 - E. vehicles for demonstrating, reinforcing, and promoting positive behaviors
- V. Agencies have:
- A. the ability to maintain multiple contacts with participants
 - B. the ability to document service delivery (i.e., develop and maintain survey questionnaires, client assessment forms, etc.)
 - C. a strong referral and follow-up system exists (formal, established, and written with signed memorandums of agreement)
 - D. the ability and desire to collaborate with other organizations
 - E. policies that conform with prevailing local, state and federal laws regarding client confidentiality
 - F. staff with necessary academic background or experience in a human-services-related field (i.e., social work, psychology, nursing, counseling, or health education); and case management and assessment techniques
 - G. staff that are knowledgeable about HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change.
- VI. How Do We Assure Quality?
- A. Minimum Quality Assurance Standards
- VII. Services are:
- A. offered in a safe environment. The agency should be clean, neat, well ventilated, and clutter free
- VIII. Interventions are:
- A. whenever possible, implemented/delivered by individuals representative of the target population
- IX. Agencies have:
- A. Policies and Procedure Manual. This manual must contain all intervention protocols, policies, and procedures of the services being delivered
 - B. current collaborative linkages within community and, when possible, should participate in one or more Community Planning Groups
 - C. staff that are familiar with available community resources
 - D. staff that are trained in the implementation of program intervention(s). All trainings must be documented in staff folders. The agency should promote and encourage continuing educational trainings.
 - E. grievance procedures in place and a method for informing clients of this process. Proof of client receipt should be documented in client charts
 - F. policies on staff safety (on site and off site)
 - G. a relationship with local authorities (police) such that the program is well known in the community
 - H. regular assessments of clients satisfaction through periodic client satisfaction surveys

- I. regular management/supervisors meetings with program staff to discuss project and status progress towards stated outcomes

<i>Duration/Dosage:</i>	Consistently
<i>Venue:</i>	Community
<i>Mode:</i>	Social marketing
<i>Provider:</i>	Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Community
<i>Target Population:</i>	
<i>Other:</i>	

Public Information (CO)

Public Information (PI) programs target general public as well as specific populations and seek to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination toward persons with HIV/AIDS or persons perceived to be at risk for HIV infection, promote support for strategies and interventions that contribute to HIV prevention in the community, and increase access to available services. Through the use of such promotional tactics, such as hotlines and the Internet, public information programs can lead to increased knowledge of HIV/AIDS facts, offer support and referrals, and may lead to behavior change.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their programs flow from and is consistent with social and behavioral theory and research relevant to HIV risk reduction.

- Goal For the Intervention: PI seeks to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination toward persons with HIV/AIDS or persons perceived to be at risk for HIV infection, promote support for strategies and intervention that contribute to HIV prevention in the community, and increase access to available services. PI programs can lead to increased knowledge of HIV/AIDS facts, offer support and referrals, and may lead to behavior change.
- Target Population: PI programs target the general public as well as specific populations. They target audiences based on needs identified through formative evaluation.
- Cultural Competence/Proficiency: ...
- Where Delivered: PI programs are implemented in key locations (as determined by formative evaluation)
- When Delivered: PI programs are implemented at times most appropriate for reaching a large portion of the target audience (as determined by formative evaluation).
- How Much: In general, public information campaigns with repeated messages implemented over a longer term are more effective.

- **Methods Employed:** Methods include one-on-one or group discussion, the creation and distribution of kits or materials (including condoms) and small media (such as brochures, posters, tapes, booklets, buttons, newspaper ads, and flyers); banners, table tops displays, and visible presence at community events; and the use of billboards, radio, television, and the Internet.

... When feasible, recipients of PI should also receive referrals, which should be made to known and trusted services.

- **Qualifications of the People Who DO HIV/PCM:** Programs are designed by a combination of professionals and peers. For public information programs to be effective community representatives must be involved in the planning and development of PI activities

Providers of PI should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

The peers or professionals providing PI must be competent in regard to culture and other diversity and able to present the materials in an understandable and non-judgmental manner.

- **Continuing Education/Ongoing Training Requirements:** Providers of PI must receive at least 8 hours of updated HIV prevention training per year.
- **Consent/Confidentiality Consideration:** ...
- **Quality Assurance:** ...
- **Evaluation:** ...
- **Penalties for Violating Standards:** ...
- **Other:** PI programs differ from community level interventions in their goals, degree of formative evaluation conducted, and level of saturation of the community. ...

<i>Duration/Dosage:</i>	Repeated messages implemented over a longer term
<i>Venue:</i>	Key locations (as determined by formative evaluation)
<i>Mode:</i>	Health Communication/Public Information
<i>Provider:</i>	Professional, Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Community
<i>Target Population:</i>	General public as well as specific populations
<i>Other:</i>	

Hotlines and Telephone Counseling (CT)

Encompassed under ILI – Interventions that target one person. In individual level interventions, one person (e.g., an HIV test counselor) is doing an HIV prevention intervention with another single individual (e.g., the person being tested).

AIDS Hotlines and telephone counseling are run by a number of different agencies including the CDC, state health departments, and community organizations. Operators are trained to answer questions about HIV and AIDS, and are often trained in basic counseling techniques. Most people who call AIDS hotlines ask questions about their own personal risk for acquiring HIV, and may be nervous or scared about recent behavior that may have placed them at risk. So, hotline workers and counselors must often help the caller deal with those fears, as well as providing them with the information they need.

Does the intervention change behavior?

- Hotlines are widely used. The National AIDS Hotline receives more than 3,000 calls per day.
- Whether or not phone counseling has any effect on HIV risk behavior or any other outcome measure has not been documented or evaluated.

With what populations is it successful in changing behavior?

- In order for hotlines and phone counseling lines to be successful, they must advertise services in the community they wish to reach, offer counseling in all languages used in the community, and include TDD services for the hearing impaired.

Duration/Dosage:

Venue:

Mode: Hotline

Provider: Professional, Paraprofessional

Outcome: Behavioral

Level: Individual

Target Population:

Other:

Media Campaigns (CT)

Encompassed under Community Level Interventions – These are interventions that try to change HIV risk behavior by changing community norms (and sometimes even the laws) of a community to support HIV prevention.

Media campaigns involve using different types of media like television, radio, magazines, newspapers, or billboards to promote HIV prevention. Public service announcements like the "America Responds to AIDS" campaign, are probably the most common type of media campaign.

Does the intervention change behavior?

- Media interventions can reach a large number of people quickly.
- It's most difficult to tailor the message to a particular group of people.

- A study of public service announcement showed that people could remember details of the commercial they saw, and were more likely to mention AIDS as an important issue.
- No evidence of media campaign actually changing HIV risk behavior.

With what populations is it successful in changing behavior?

- Media messages only work for those people who can see or hear them. So, for example, a program using commercials on television would not reach anyone who didn't have a television. Mass media messages seem to be especially successful with young people (gay or non-gay). While media campaigns can provide information and perhaps help in changing norms, it is difficult to use them to train behavioral skills, and there is no evidence that they change risky behavior.

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population: People who can see and hear; Youth (gay and non-gay)

Other:

Social Marketing (CT)

Encompassed under Community Level Interventions – These are interventions that try to change HIV risk behavior by changing community norms (and sometimes even the laws) of a community to support HIV prevention.

Social marketing combines behavioral science concepts and marketing concepts to develop HIV prevention programs for very specific target populations which are called the "audience". There are five key principles known as the Five P's. These are:

1. Product – what the intervention is "selling" to the audience, for example, condom use, abstinence, using clean needles,
2. Price – the cost to the audience members of doing the new behavior or using the product; this is like barriers in behavioral science,
3. Place – where will the new product be distributed, for example, putting condom machines in bathrooms at the mall,
4. Promotion – how the product is advertised, and
5. Positioning – how the product fits into the lifestyle of the audience.

Social marketing relies on a lot of survey and focus group research with the audience to develop a program that will be successful.

Does the intervention change behavior? ...

With what populations is it successful in changing behavior?

- Social marketing has been successful with young people and with commercial sex workers. It can be successful with any population that can participate in market research to develop a tailored social marketing campaign.

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level:

Target Population: Youth; Commercial sex workers

Other:

Electronic Media (DC)

Health Communications/Public Information is the delivery of HIV prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection how to obtain specific services. Health communications and public information can be delivered using the following means.

- Electronic Media: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, and infomercials which target a large-scale (city-, region-, statewide) audience.
- Print Media:
- Hotline:
- Clearinghouse:
- Presentations/Lectures:

Also includes CDC Guidelines for Workshops and Presentations

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Print Media (DC)

Health Communications/Public Information is the delivery of HIV prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection how to obtain specific services. Health communications and public information can be delivered using the following means.

- Electronic Media:
- Print Media: These formats reach a large-scale or nationwide audience. They include any printed materials, such as newspapers, magazines, pamphlets, and “environmental media” such as billboards and transportation signage.
- Hotline:
- Clearinghouse:
- Presentations/Lectures:

Also includes CDC Guidelines for Workshops and Presentations

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Hotline (DC)

Health Communications/Public Information is the delivery of HIV prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection how to obtain specific services. Health communications and public information can be delivered using the following means.

- Electronic Media:
- Print Media:
- Hotline: Telephone services offering up-to-date information and referral to local service, such as counseling, testing, and support groups
- Clearinghouse:
- Presentations/Lectures:

Also includes CDC Guidelines for Workshops and Presentations

Duration/Dosage:

Venue:

Mode: Hotline

Provider:

Outcome: Behavioral

Level:

Target Population:

Other:

Clearinghouse (DC)

Health Communications/Public Information is the delivery of HIV prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection how to obtain specific services. Health communications and public information can be delivered using the following means.

- Electronic Media:
- Print Media:
- Hotline:
- Clearinghouse: Interactive electronic outreach systems using telephones, mail, and Internet, Worldwide Web to provide a responsive information service to the general public as well as high-risk populations.
- Presentations/Lectures:

Also includes CDC Guidelines for Workshops and Presentations

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population: General public as well as high-risk populations

Other:

Presentations/Lectures (DC)

Health Communications/Public Information is the delivery of HIV prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection how to obtain specific services. Health communications and public information can be delivered using the following means.

- Electronic Media:
- Print Media:
- Hotline:
- Clearinghouse:
- Presentations/Lectures: These are information-only activities conducted in group settings; often called “one-shot” education interventions. Workshops and presentations are typical activities of community outreach. Because they usually follow lecture formats, they can be highly structured health education and risk reduction intervention efforts. While they support important opportunities to disseminate HIV/AIDS prevention information, their impact on behavior change is limited because they are usually single-encounter experiences. Although they provide crucial information that raises awareness and increases knowledge and may be a critical first step in the change process, the information alone is usually inadequate to sustain behavior change.

One example of this type of activity is Community Workshops and Presentations, which are one-shot activities in which participants are provided with basic information on HIV/AIDS.

Standards for Community Workshops and Presentations

In a workshop or presentation, audience participation is to be strongly encouraged. Time must be allotted, usually at the end of the presentation, for a question and answer session. However, some questions may be so pressing, or some participants so persistent, that the presenter will have to address some questions and concerns during the presentation.

Elements for successful Community Outreach presentation include:

1. Speakers who are members of the target population audience.
2. A comprehensive workshop/presentation curriculum.
3. Assurance that curricula provide for discussion of related issues.
4. Detailed workshop/presentation outlines.
5. Methods to assure that the audience is informed about workshop/presentation goals and objectives and that discussion of subject matter is facilitated.
6. Descriptions of skills building exercises relevant to the program’s objectives.
7. Referrals to agencies, hotlines and community information resources.

Also includes CDC Guidelines for Workshops and Presentations

<i>Duration/Dosage:</i>	One-shot
<i>Venue:</i>	
<i>Mode:</i>	Presentation Health education – structured, semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Information
<i>Level:</i>	Group
<i>Target Population:</i>	
<i>Other:</i>	

Public Information (DC)

Standards for Effective Public Information Programs include:

1. Public information activities must support other components of health education and risk reduction activities.
2. Target audiences for public information activities must be selected, based on needs identified through the community needs assessment.
3. Objectives for public information must be based on realistic assessment of what communications can be expected to contribute to prevention.
4. Messages must be based on the target audience's values, needs, and interests.
5. Messages and materials must be pretested with the target audience to assure understanding and relevance to their needs and interests.
6. Community representatives must be involved in planning and developing public information activities to ensure community "buy in."

Also includes CDC Guidelines for Public information (from "Guidelines for HERR activities, March 1995).

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other: Community representatives must be involved in planning and developing public information activities to ensure community "buy in."

Health Communications & Public Information (HO)

This category involves elements of large (TV, radio, newspaper) and small (pamphlets, brochures, handouts, etc.) media. It can be used to target a narrow segment of the population or to reach broad audiences within a city, a state, or a country. Activities vary by the size of the target group and the interactiveness of the medium being used. This intervention type is most effective among low risk individuals and it is useful to maintain and reinforce low risk behaviors (Holtgrave, Qualls, Curran, et al., 1995). It is also effective among those at high risk, when accompanied by more intensive face-to-face contact.

Also included in Comprehensive Plan.

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Electronic and Print Media (IA)

Health Communication and Public Information is the delivery of planned HIV/AIDS prevention messages through one or more channels to target audience to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection how to obtain specific services. HC/PI programs target the general public as well as specific populations and seek to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination towards persons with HIV/AIDS or persons perceived to be at risk for HIV infection, promote support for strategies and interventions that contribute to HIV prevention in the community, and increase access to available services. Through the use of promotional tactics, such as hotlines and the Internet, public information programs can lead to increased knowledge of HIV/AIDS facts, offer support and referrals, and may lead to behavior change.

Includes:

1. **Electronic Media:** Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, and infomercials which target a large-scale (city-, region-, statewide) audience.
2. **Print Media:** These formats reach a large-scale or nationwide audience. They include any printed materials, such as newspapers, magazines, pamphlets, and “environmental media” such as billboards and transportation signage.
3. **Hotline:** Telephone services offering up-to-date information and referral to local service, such as counseling, testing, and support groups
4. **Clearinghouse:** Interactive electronic outreach systems using telephones, mail, and Internet, Worldwide Web to provide a responsive information service to the general public as well as high-risk populations.

I. Electronic and Print Media

Media is a form of communication that can reach large numbers of people with motivational and educational messages. These messages can be designed to reach mass audiences, small and location-specific audiences, or culturally and communally specific audiences. Different types of media are listed:

- Large media can include television (documentaries, talk shows, commercials, PSAs, etc.) radio (PSAs, public talk shows, etc.), and print (newspapers, magazines, etc.)
- Small media can include materials development (brochures, pamphlets, fact sheets, posters, palm cards, videos, audio tapes, etc.)
- Other media can include billboard advertising, computer services (Internet, bulletin boards, etc.), and telephone services (hotlines, talk lines, etc.).

Large media campaigns often require a substantial amount of funds and many grassroots movement-type organizations cannot afford to sponsor them. Small media, however, can be very cost effective and affordable.

- A. Demonstrated effectiveness
- B. Suggested uses
 - 1. Advantages and Strengths
 - 2. Considerations
- II. Targetable and Mass Media
- III. Education, Information, and Referral Hotlines
- IV. Presentations/Lectures

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population: General public as well as specific populations

Other:

Targetable and Mass Media (IA)

Health Communication and Public Information is the delivery of planned HIV/AIDS prevention messages through one or more channels to target audience to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection how to obtain specific services. HC/PI programs target the general public as well as specific populations and seek to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination towards persons with HIV/AIDS or persons perceived to be at risk for HIV infection, promote support for strategies and interventions that contribute to HIV prevention in the community, and increase access to available services. Through the use of promotional tactics, such as hotlines and the Internet, public information programs can lead to increased knowledge of HIV/AIDS facts, offer support and referrals, and may lead to behavior change.

Includes:

1. Electronic Media: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, and infomercials which target a large-scale (city-, region-, statewide) audience.
2. Print Media: These formats reach a large-scale or nationwide audience. They include any printed materials, such as newspapers, magazines, pamphlets, and “environmental media” such as billboards and transportation signage.
3. Hotline: Telephone services offering up-to-date information and referral to local service, such as counseling, testing, and support groups

4. Clearinghouse: Interactive electronic outreach systems using telephones, mail, and Internet, Worldwide Web to provide a responsive information service to the general public as well as high-risk populations.

I. Electronic and Print Media

II. Targetable and Mass Media

Media can be divided into targetable and mass media forms. The difference has to do with the intended audiences – is it specific target group or is it the general public (or a set of people who do not identify or socialize with a group of others like them)?

A. Targetable Media – Suggested uses

1. Advantages and Strengths
2. Considerations

B. Mass Media – Suggested uses

1. Advantages and Strengths
2. Considerations

III. Education, Information, and Referral Hotlines

IV. Presentations/Lectures

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population: General public as well as specific populations

Other:

Education, Information, and Referral Hotlines (IA)

Health Communication and Public Information is the delivery of planned HIV/AIDS prevention messages through one or more channels to target audience to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection how to obtain specific services. HC/PI programs target the general public as well as specific populations and seek to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination towards persons with HIV/AIDS or persons perceived to be at risk for HIV infection, promote support for strategies and interventions that contribute to HIV prevention in the community, and increase access to available services. Through the use of promotional tactics, such as hotlines and the Internet, public information programs can lead to increased knowledge of HIV/AIDS facts, offer support and referrals, and may lead to behavior change.

Includes:

1. Electronic Media: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, and infomercials which target a large-scale (city-, region-, statewide) audience.
2. Print Media: These formats reach a large-scale or nationwide audience. They include any printed materials, such as newspapers, magazines, pamphlets, and “environmental media” such as billboards and transportation signage.
3. Hotline: Telephone services offering up-to-date information and referral to local service, such as counseling, testing, and support groups
4. Clearinghouse: Interactive electronic outreach systems using telephones, mail, and Internet, Worldwide Web to provide a responsive information service to the general public as well as high-risk populations.

I. Electronic and Print Media

II. Targetable and Mass Media

III. Education, Information, and Referral Hotlines

Toll-free HIV hotlines provide education, risk assessment and referral information to callers, related to either general HIV prevention, referral, and support, or for specializes AIDS-related referrals and counseling. The anonymity of hotline services fits the preferences of those who are too embarrassed, closeted, or frightened to receive services elsewhere. In most cases, hotlines serve as convenient access points to obtain needed information and referrals related to all aspects of HIV and AIDS. Hotlines can serve both as a crucial first link to other services, and as an information source for individuals who are geographically or physically isolated.

IV. Presentations/Lectures

Duration/Dosage:

Venue:

Mode: Hotlines

Provider:

Outcome: Behavioral

Level: Community

Target Population: General public as well as specific populations

Other:

Presentations/Lectures (IA)

Health Communication and Public Information is the delivery of planned HIV/AIDS prevention messages through one or more channels to target audience to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection how to obtain specific services. HC/PI programs target the general public as well as specific populations and seek to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination towards persons with HIV/AIDS or persons perceived to be at risk for HIV infection, promote support for strategies and interventions that contribute to HIV prevention in the community, and increase access to available services. Through the use of promotional tactics, such as hotlines and the Internet, public information programs can lead to increased knowledge of HIV/AIDS facts, offer support and referrals, and may lead to behavior change.

Includes:

1. **Electronic Media:** Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, and infomercials which target a large-scale (city-, region-, statewide) audience.
2. **Print Media:** These formats reach a large-scale or nationwide audience. They include any printed materials, such as newspapers, magazines, pamphlets, and “environmental media” such as billboards and transportation signage.
3. **Hotline:** Telephone services offering up-to-date information and referral to local service, such as counseling, testing, and support groups
4. **Clearinghouse:** Interactive electronic outreach systems using telephones, mail, and Internet, Worldwide Web to provide a responsive information service to the general public as well as high-risk populations.

I. Electronic and Print Media

II. Targetable and Mass Media

III. Education, Information, and Referral Hotlines

IV. Presentations/Lectures – A single session group workshop consists of a one-time, intensive session or gathering focusing on information about HIV (e.g., transmission and behavior change), motivational activities, and skills building. It may also touch on other relevant issues. This intervention can take a variety of forms such as involving impromptu groups, using vans as session sites, and before/after bar groups. The specific intervention is planned or requested, usually based on advertising or promotion of the availability of the service.

A. Demonstrated effectiveness

1. Advantages and Strengths
2. Considerations

<i>Duration/Dosage:</i>	One-time
<i>Venue:</i>	
<i>Mode:</i>	Workshop Presentation
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group
<i>Target Population:</i>	General public as well as specific populations
<i>Other:</i>	Includes skills building

Health Communications/Public Information (ID)

Use of electronic or print media, educational presentations or lectures, hotlines or clearinghouse to deliver planned prevention messages to support risk-reduction, provide information, increase awareness, or build support for safe behavior.

<i>Duration/Dosage:</i>	
<i>Venue:</i>	
<i>Mode:</i>	Media Presentations Hotlines
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	
<i>Target Population:</i>	
<i>Other:</i>	

Public Information/Social Marketing (IL)

Public information is a health communications intervention designed to influence the attitudes, behaviors, and knowledge of individuals and communities at risk."

Public information programs go beyond information dissemination. Typical purposes of public information programs are to:

- build community support for safer behaviors
- motivate individuals to make behaviors changes
- promote benefits of risk reduction
- encourage persons at risk to obtain services

- model ways to overcome barriers
- refute misconceptions that affect behaviors

Public information delivers planned messages to target audiences using one or more communication channels. These may include:

- mass media (television, radio, newspapers)
- small media (locally published newsletters, role model stories)
- printed materials (brochures, posters, wallet cards)
- hotlines
- promotional items (buttons, beverage napkins, temporary tattoos)

Public information programs use commercial marketing techniques to focus on the needs and wants of the consumer. The use of modern marketing principles to "sell" socially beneficial ideas, products, behaviors, and practices is called Social Marketing. Public information programs should be planned using social marketing approach, which is characterized by:

- audience research
- specific goals
- pretesting strategies and materials
- a marketing plan (considering price, product, promotion, place and other market factors)
- monitoring and alteration as needed
- community involvement

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Individual, Community

Target Population: At-risk communities

Other:

Public Information Programs (KS)

A. Fund public information programs and activities that increase community awareness, build general support for safe behavior, dispel myths about HIV/AIDS and reduce discrimination towards persons with living with HIV infection, address barriers to effective risk reduction programs and support efforts for personal risk reduction.

- Target public information programs to reach persons at high risk and difficult to reach with messages and material directed specifically at those populations.
- Ensure materials are accurate, culturally competent and developmentally appropriate, linguistically specific, and sensitive to sexual identity.

- Make HIV education and training available to public media personnel to foster effective distribution of HIV prevention messages.

B. Fund programs that promote community involvement in the community planning process and make available recommendations made by the communities most at risk for HIV infection in Kansas.

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population: Persons at high risk

Other:

Media Campaign (LA)

CDC Intervention Level – Community Level

Theoretical Basis – Social Marketing Theory

Target Persons – Racial/Ethnic minorities, Sexually active females, Males who have sex with males, Youth, Substance users

Key Elements: This intervention should be implemented consistently with elements of social marketing which follows:

- Identify information gaps and the marketing and message actions required for their solution.
- Establish priorities, select affordable efforts and set up a schedule.
- Pinpoint the target audience for each marketing/message action.
- Establish objectives for each target group and each marketing/message action.
- Design the marketing/message actions (PSA or paid, radio, TV, billboards, etc.)
- Test the marketing/message actions for acceptability, implementation, comprehension, believability, motivation, and conviction.
- Revise and retest the marketing/message actions as necessary.
- Construct the marketing/distribution and message/media patterns to achieve maximum target audience reach and message frequency.
- Funded materials must be approved by the OPH HIV Program Review Panel.
- Coordinate and harmonize with all ongoing related programs.
- Modify each marketing/message action according to evaluation findings.
- Conduct media advocacy workshops for HIV prevention providers.

Recommended Training: HIV/AIDS 101, course work in social marketing

Evaluation Methods –

- Focus groups, intercept interviews, and street surveys
- Track the impact of each marketing/message action through statewide hotline

Expected Outcomes

- Increased awareness of HIV prevention
- Increased use of prevention

Implemented by – HIV/AIDS Program and community based organizations.

Includes:

1. Addresses High Priority Needs
2. Addresses Community/Cultural Norms & Values
3. Outcome Effectiveness
4. Accessible to the Target Populations
5. Intervention Feasibility and Cost-Effectiveness
6. Sources

Duration/Dosage:

Venue:

Mode: Media

Provider: Professional, Paraprofessional

Outcome: Behavioral

Level: Community

Target Population: Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users

Other:

Targeted Public Information Efforts (MA)

Programs at every level of activity, including the state Department of Public Health, may be involved in the development of focused educational materials and public offerings. At the local level, these often take the form of pamphlets, brochures, posters, buttons, and fact sheets written with the linguistic needs and reading level of community members in mind, as well as utilizing themes and images that will appeal to them. Better resourced providers may mount long-term coordinated campaigns. Other communities make excellent use of television and radio programming and public service announcements. In all cases, the best public information efforts are planned using members of the priority population to test language, messages, and images. For some communities, telecommunications, the Internet and other electronic systems are providing new means of disseminating HIV prevention information.

Duration/Dosage: Long-term
Venue:
Mode: Media
Provider:
Outcome: Behavioral
Level: Community
Target Population:
Other:

Public Information (MD)

Public Information programs for general public, which seek to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination toward persons with HIV/AIDS, and promote support strategies and interventions that contribute to HIV prevention in the community.

A communication (public information) program is the delivery of planned messages through one or more channels to target audiences through the use of materials.

Duration/Dosage:
Venue:
Mode: Media
Provider:
Outcome: Behavioral
Level: Community
Target Population: General public
Other:

Small/Large Group (MD)

Health communications, health education, and risk reduction interventions for groups which provide peer education and support, as well as promote and reinforces safe behaviors and provide interpersonal skills training in negotiating and sustaining appropriate behavior change.

Also classified under Group Level Interventions.

Duration/Dosage:

Venue:

Mode: Health education – semi-structured

Provider: Peer

Outcome: Behavioral

Level: Group

Target Population:

Other: Includes skills component

Health Communication and Public Information (MI)

Health Communication/Public Information (e.g., AIDS 101 presentations, testimonials, lectures and similar presentations). Use of educational presentations, lectures, etc. to provide HIV prevention messages or information, increase awareness of HIV/AIDS or promote support for HIV/AIDS issues.

Duration/Dosage:

Venue:

Mode: Presentations

Provider:

Outcome: Information

Level:

Target Population:

Other:

Mass Media (MN)

Mass media through print, electronic, small media, social marketing, endorsements by opinion leaders, and hotlines/clearinghouses.

Duration/Dosage:

Venue:

Mode: Media
Hotlines

Provider:

Outcome:

Level:

Target Population:

Other:

Health Communication/Public Information (MO)

In Missouri, HC/PI level interventions take on the following characteristic; consist of one-shot lectures and or presentations designed to disseminate basic HIV/STD 101 prevention education. They are designed to reach a large number of people all at once. HC/PI level interventions in Missouri also encompass social marketing campaigns, advertising, PSA, and radio ads for prevention messages and/or services. Media and social marketing in general are influential in teaching about health risks associated with specific risk-taking behaviors. Unfortunately, funding for this type of intervention is limited and studies show that behavior change as a result of social marketing/media outreach happens only when a campaign extends over a longer period of time.

Duration/Dosage: One-shot

Venue:

Mode: Presentation
Media

Provider:

Outcome: Behavioral

Level: Community ("large number of people")

Target Population:

Other:

Education, Information, and Referral Hotlines (MO)

In Missouri there is one state funded HIV/STD prevention hotline. There is also the same type of hotline which is funded through a local St. Louis CBO. These toll-free hotlines provide education, risk assessment, and referral information to callers relating to general HIV/STD prevention, referral, and support. The hotlines are an anonymous way for callers to receive accurate information in order to better perceive their own risks in order to initiate behavior change. Primarily, the hotlines serve as access points to obtain needed information and referrals needed information to individuals who are either physically or geographically isolated from local services.

Duration/Dosage:

Venue:

Mode: Hotlines

Provider:

Outcome: Behavioral

Level:

Target Population:

Other:

Media Events (NC)

Using TV, radio, billboards, or newsletters to disseminate prevention information and messages to a particular community.

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome:

Level: Community

Target Population:

Other:

Telephone Hotline (NC)

A phone-based information and referral service.

Duration/Dosage:

Venue:

Mode: Hotline

Provider:

Outcome:

Level:

Target Population:

Other:

Telephone Hotline and Counseling (NH)

- Information and referrals offered on the phone by trained staff or volunteers (hotline) OR
- Formal educational or support programs offered by phone (counseling).

Overall Premises to be Considered in All Interventions:

1. All interventions need to explicitly define a population to be served and the steps to reach that population.
2. All interventions must have explicitly defined HIV prevention goals (e.g. reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required data collection will be more limited than for individual and group level interventions due to the nature of the work.)
6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.
7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

Duration/Dosage:

Venue:

Mode: Hotlines
Counseling – structured

Provider:

Outcome: Information

Level: Individual

Target Population:

Other:

Media Events (NH)

- Using TV, radio, billboards or newsletters to deliver prevention information and messages to a specific community without face-to face education."

Overall Premises to be Considered in All Interventions

1. All interventions need to explicitly define a population to be served and the steps to reach that population.
2. All interventions must have explicitly defined HIV prevention goals (e.g. reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required data collection will be more limited than for individual and group level interventions due to the nature of the work.)
6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.
7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome:

Level: Community

Target Population:

Other: Delivery of prevention information without face-to-face education.

Large Group Interventions (NV)

A large group (arbitrarily defined by Freudenberg (1995) as groups consisting of 20 or members) is a forum in which specially trained speakers present information on AIDS to a group of people assembled for that purpose. Large groups provide an efficient method for providing HIV/AIDS prevention in settings such as schools, colleges, correctional facilities, and workplaces. Intervention activities may include the presentation of information on the transmission and prevention of AIDS, skills demonstration, and question-and-answer sessions.

Also includes advantages and disadvantages of intervention, and demonstrated effectiveness and implications.

Duration/Dosage:

Venue: Schools, colleges, prison, workplaces, etc.

Mode: Presentation – structured

Provider: Professional – specially trained speaker

Outcome: Behavioral

Level: Group – 20 or more members

Target Population:

Other:

Educational Materials (NV)

Educational materials are items such as brochures, posters, videos, and slide shows that are used by AIDS prevention programs to provide information.

Also includes advantages and disadvantages of intervention, and demonstrated effectiveness and implication

Duration/Dosage:

Venue:

Mode: Material/supply distribution

Provider:

Outcome: Information

Level:

Target Population:

Other:

Mass Media (NV)

According to national public opinion polls, people in the United States learn more about AIDS from the mass media than from any other source (Freudenberg, 1989). No other channel of communication so infiltrates our society as television, radio, newspapers, and magazines. AIDS prevention organizations can utilize the media as a means of increasing awareness and knowledge about AIDS, and getting the message of prevention across.

Also includes advantages and disadvantages of intervention, and demonstrated effectiveness and implications.

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Information

Level: Community

Target Population:

Other:

AIDS Hotlines (NV)

Telephone hotlines provide people concerned about AIDS with a direct link to AIDS prevention organizations. Telephone hotlines are staffed by operators who are trained to provide callers with information, counseling, and referrals.

Also includes advantages and disadvantages of intervention, and demonstrated effectiveness and implications.

Duration/Dosage:

Venue:

Mode: Hotlines

Provider: Professional, Paraprofessional

Outcome: Information

Level: Individual

Target Population:

Other: Staffed by operators who are trained to provide callers with information, counseling, and referrals.

Health Communication/Public Information (OK)

Public information activities, alone do not represent a sufficient HIV prevention strategy. However, planning and implementing effective and efficient public information programs are essential to successful HIV/AIDS prevention efforts. As defined here, the purposes of public information programs are to:

- Build general support for safe behavior;
- To dispel myths about HIV/AIDS;
- To address barriers to effective risk reduction programs; and
- To support efforts for personal risk reduction.

CDC defines health communication as a "multi-disciplinary, theory-based practice designed to influence the knowledge, attitudes, beliefs, and behaviors of individuals and communities". Sound health communication practice is based on a combination of behavioral and communication sciences, health education, and social marketing. Current practice extends beyond information dissemination to include a variety of proactive strategies addressing both individual and societal change. A communication (public information) program is the delivery of planned messages through one or more channels to target audiences through use of material. Successful public information programs share a number of basic characteristics, which include:

- A person in charge who will manage the program well
- Activities planned to fit what the community and target audience need and want
- A variety of activities, including mass media, that can be directed over a period of time

- A measurable program objective or purpose
- A commitment to evaluation
- Efficient use of people and other resources.

Public information programs should use multiple approaches to motivate and involve people and communities. Using health communication methodologies, however, is not sufficient to guarantee change. Plans for creating sustained behavior change should include information/communications in combination with other prevention strategies. In this way, effective communications can significantly enable and contribute to change. Consumer-influenced messages and strategies are best achieved by a systematic approach involving research, planning, implementation, evaluation and feedback. In addition to planning, pretesting, and evaluating public information strategies, specific components of public information programs- -producing educational materials, working with the print and broadcast media, managing hotlines, and coordination special events should also be a part of the public information program.

Duration/Dosage:

Venue:

Mode: Media
Hotlines
Public events

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other: Public information programs should use multiple approaches to motivate and involve people and communities.

Social Marketing (OK)

Information in this section taken from "The Basics of Social Marketing" By David Barre. National Minority AIDS Council Technical Assistance Newsletter. May/June 1995 and CDC (1996) The Prevention Marketing Initiative: Applying Prevention Marketing).

Social Marketing has three key factors:

1. Thoroughly understanding how and why consumer segments (targets audiences) behave as they do.
2. Creating "beneficial relationships" (exchange an unhealthy behavior for a healthy one to get some perceived benefit) to influence audiences' behavior.
3. Strategically managing prevention programs by continuously monitoring and altering interventions as needed to stay relevant to target audiences.

HIV prevention Social Marketing combines those three elements of social marketing with a strong reliance on behavioral science within a community mobilization project. It offers a systematic way to design, deliver and evaluate HIV prevention education programs that are based on behavioral goals. (CDC Letter to AIDS Directors and Community Planning Group Co-Chairs, April 9, 1996).

Duration/Dosage:

Venue:

Mode:

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Public Information (SC)

The purpose of public information is to dispel myths about HIV transmission, support volunteerism for HIV prevention programs (i.e., outreach workers, peer educators, presenters), reduce discrimination toward individuals with HIV, and promote support for strategies and interventions that contribute to HIV prevention in the community. ...

Duration/Dosage:

Venue:

Mode:

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Media (SD)

Encompassed under Health Communication/Public Information

Public Information activities, alone, do not represent a sufficient HIV prevention strategy. However, planning and implementing effective and efficient public information programs are essential to successful HIV/AIDS prevention efforts. As defined here, the purpose of public information programs are to:

- Build general support for safe behavior;
- To dispel myths about HIV/AIDS;
- To address barriers to effective risk reduction programs; and
- To support efforts for personal risk reduction.

Includes standards, guidelines and Health Communication definition from CDC standards for health communication.

...Successful public information programs share a number of basic characteristics, which include:

- A person in charge who manages the program well.
- Activities planned to fit what the community and target audience need and want.
- A variety of activities, including mass media, that can be directed over a period of time to the target audience.
- A measurable program objective or purpose.
- A commitment to evaluation.
- Efficient use of people and other resources.

Media is a form of communication that can reach large numbers of people with motivational and educational messages. These messages can be designed to reach mass audiences, small and location-specific audiences, or culturally and communally specific audiences. Different types of media include:

- Large media can include television (documentaries, talk shows, commercials, PSAs, etc.),
- Small media can include materials development (brochures, pamphlets, fact sheets, posters, palm cards, videos, audiotapes, etc.).
- Other media can include billboard advertising, computer services (internet, bulletin boards, etc.), and telephones services (hotlines, talk lines, etc.).

Large media campaigns often require substantial amount of funds and many grassroots movement-type organization cannot afford to sponsor them. Small media, however, can be very cost-effective and affordable.

Media providers note the media messages must be strong to compete for the public's attention. Desensitization of the public from exposure to many strong messages, however is a counterbalancing concern. Providers note that messages are most effective when they are emotionally or intellectually engaging.

Includes: Evidence of Effectiveness.

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other: Messages must be strong to compete for the public's attention;
Messages are most effective when they are emotionally or intellectually engaging.

Hotlines/Clearinghouses (SD)

Encompassed under Health Communication/Public Information:

Public Information activities, alone, do not represent a sufficient HIV prevention strategy. However, planning and implementing effective and efficient public information programs are essential to successful HIV/AIDS prevention efforts. As defined here, the purpose of public information programs are to:

- Build general support for safe behavior;
- To dispel myths about HIV/AIDS;
- To address barriers to effective risk reduction programs; and
- To support efforts for personal risk reduction.

Includes standards, guidelines and Health Communication definition from CDC standards for health communication.

...Successful public information programs share a number of basic characteristics, which include:

- A person in charge who manages the program well.
- Activities planned to fit what the community and target audience need and want.
- A variety of activities, including mass media, that can be directed over a period of time to the target audience.
- A measurable program objective or purpose.
- A commitment to evaluation.
- Efficient use of people and other resources.

Toll-free HIV hotlines provide education, risk assessment, and referral information to callers, related either to general HIV prevention, referral, and support, or for specialized AIDS-related referrals or counseling. The anonymity of hotline services fits the preference of those who are too embarrassed, closeted, or frightened to receive services elsewhere. In most cases, hotlines serve as convenient access points to obtain needed information and referrals related to all aspects of HIV and AIDS. Hotlines can serve both as a crucial first link to other services, and as an information source for individuals who are geographically or physically isolated.

Duration/Dosage:

Venue:

Mode: Hotlines

Provider:

Outcome: Information

Level:

Target Population:

Other:

Endorsements/Testimonials By Opinion Leaders (SD)

Encompassed under Health Communication/Public Information:

Public Information activities, alone, do not represent a sufficient HIV prevention strategy. However, planning and implementing effective and efficient public information programs are essential to successful HIV/AIDS prevention efforts. As defined here, the purpose of public information programs are to:

- Build general support for safe behavior;
- To dispel myths about HIV/AIDS;
- To address barriers to effective risk reduction programs; and
- To support efforts for personal risk reduction.

Includes standards, guidelines and Health Communication definition from CDC standards for health communication.

...Successful public information programs share a number of basic characteristics, which include:

- A person in charge who manages the program well.
- Activities planned to fit what the community and target audience need and want.
- A variety of activities, including mass media, that can be directed over a period of time to the target audience.
- A measurable program objective or purpose.
- A commitment to evaluation.
- Efficient use of people and other resources.

Opinion leaders are key people who are recognized as influential and charismatic members of a community or communities. These individuals are seen as models whose opinions and behaviors are likely to influence the opinions and behaviors of a target population. An opinion leader is a member of the community who is particularly popular or respected by other members of the community. An opinion leader may be viewed as representing her/his community by other members of the community. An opinion leader may be viewed as representing her/his community in the entertainment field, sports, government/politics, academia, business, popular culture, community work, etc.

Includes: Evidence of Effectiveness

Duration/Dosage:

Venue:

Mode:

Provider: Peer

Outcome: Behavioral

Level:

Target Population:

Other:

Social Marketing (SD)

Encompassed under Health Communication/Public Information

Public Information activities, alone, do not represent a sufficient HIV prevention strategy. However, planning and implementing effective and efficient public information programs are essential to successful HIV/AIDS prevention efforts. As defined here, the purpose of public information programs are to:

- Build general support for safe behavior;
- To dispel myths about HIV/AIDS;
- To address barriers to effective risk reduction programs; and
- To support efforts for personal risk reduction.

Includes standards, guidelines and Health Communication definition from CDC standards for health communication.

...Successful public information programs share a number of basic characteristics, which include:

- A person in charge who manages the program well.
- Activities planned to fit what the community and target audience need and want.

- A variety of activities, including mass media, that can be directed over a period of time to the target audience.
- A measurable program objective or purpose.
- A commitment to evaluation.
- Efficient use of people and other resources.

(Information in this section taken from "The Basics of Social Marketing" by David Barre. National Minority AIDS Council Technical Assistance Newsletter. May/June 1995 and CDC (1996) The Prevention Marketing Initiative: Applying Prevention Marketing.)

Social marketing has three key factors:

1. Thoroughly understand how and why consumer segments (target audiences) behave as they do.
2. Creating "beneficial relationships" (exchanging in unhealthy behavior for a healthy one to get some perceived to stay relevant to target audiences.
3. Strategically managing prevention programs by continuously monitoring and altering interventions as needed to stay relevant to target audiences.

HIV prevention Social Marketing combines those three elements of social marketing with a strong reliance on behavioral science within a community mobilization project. It offers a systematic way to design, deliver and evaluate HIV prevention education programs that are based on behavioral goals. (CDC Letter to AIDS Directors and Community Planning Group Co-Chairs, April 1996)"

Focus groups and other client survey exercises ... (continues with methodology) ...

Basically, social marketing is the concept of utilized traditional marketing tools, used to sell consumer products, to "sell" healthy behaviors to target audiences. It is not just about developing a snazzy advertising campaign to promote condom use or AIDS testing. It is about developing the right advertising campaign to accomplish those goals. ...

Evidence of Effectiveness: ...

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level:

Target Population:

Other:

Mass Media (TN)

Taken from section: Description of interventions. Encompassed under Category III. Health Communication/Pubic Information.

Health Communication/Pubic Information includes electronic and print-mediated communication or communication of other forms designed to reach the public. It includes the use of a media to reach a narrow segment such as policy makers through news events, or a broad general public strategy to provide late-breaking news. This type of media can also reinforce existing attitudes and information, counteract misleading rumors, and reduce negative attitudes toward individuals living with HIV/AIDS."

"Mass media" refers to the use of print, radio and television to communicate with specific populations. It includes public service announcements, news broadcasts, infomercials, magazines, newspapers, billboards, etc., which reach a large scale audience in a short period of time. The messages seek to help people modify sexual behavior associated with transmission in order to eliminate or reduce potential danger. Recent research indicates, however, that the messages should work to expand the range of health supportive sexual options people can enjoy as well as maximize the appeal of HIV prevention. However, guidelines couched in desexualized academic jargon should be translated into language of intimacy, passion, and sex (Taylor and Lourea, 1992). In addition, messages should address the prevention needs of the specific community served (Holtgrave, Qualls, Curan, Valdiserri, Guinan, and Parra, 1995).

<i>Duration/Dosage:</i>	Short time period
<i>Venue:</i>	
<i>Mode:</i>	Media
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	
<i>Target Population:</i>	
<i>Other:</i>	Messages should address the prevention needs of the specific community.

Other Media (TN)

Taken from section: Description of interventions. Encompassed under Category III. Health Communication/Pubic Information.

Health Communication/Pubic Information includes electronic and print-mediated communication or communication of other forms designed to reach the public. It includes the use of a media to reach a narrow segment such as policy makers through news events, or a broad general public strategy to provide late-breaking news. This type of media can also reinforce

existing attitudes and information, counteract misleading rumors, and reduce negative attitudes toward individuals living with HIV/AIDS."

"Other media" includes events, theater, pamphlets, posters, etc., which reach fewer people but are typically targeted as reinforcements or reminders for a narrow segment of a broad population.

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level:

Target Population: A narrow segment of a broad population

Other:

Social Marketing (TN)

Taken from section: Description of interventions. Encompassed under Category III. Health Communication/Pubic Information.

Health Communication/Pubic Information includes electronic and print-mediated communication or communication of other forms designed to reach the public. It includes the use of a media to reach a narrow segment such as policy makers through news events, or a broad general public strategy to provide late-breaking news. This type of media can also reinforce existing attitudes and information, counteract misleading rumors, and reduce negative attitudes toward individuals living with HIV/AIDS."

"Social marketing" is a form of community-level intervention which utilizes techniques adapted from commercial marketing to identify specific audiences called segments. Of great importance is the identification of their perceived needs. Once identified, programs, services support and communication is developed to meet the perceived needs of the segments. At times, specific products such as condoms and condom access are identified as a need. Other times, the need may be for negotiation skills and social support for delaying sexual initiation, etc.

Duration/Dosage:

Venue:

Mode:

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other: Utilizes techniques adapted from commercial marketing to identify specific audiences called segments.

Endorsements/Testimonials (TN)

Taken from section: Description of interventions. Encompassed under Category III. Health Communication/Pubic Information.

Health Communication/Pubic Information includes electronic and print-mediated communication or communication of other forms designed to reach the public. It includes the use of a media to reach a narrow segment such as policy makers through news events, or a broad general public strategy to provide late-breaking news. This type of media can also reinforce existing attitudes and information, counteract misleading rumors, and reduce negative attitudes toward individuals living with HIV/AIDS."

"Endorsements/Testimonials" highlight the importance of celebrities in HIV/AIDS education

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level:

Target Population:

Other:

Hotline/Clearinghouses (TN)

Taken from section: Description of interventions. Encompassed under Category III. Health Communication/Pubic Information.

Health Communication/Pubic Information includes electronic and print-mediated communication or communication of other forms designed to reach the public. It includes the use

of a media to reach a narrow segment such as policy makers through news events, or a broad general public strategy to provide late-breaking news. This type of media can also reinforce existing attitudes and information, counteract misleading rumors, and reduce negative attitudes toward individuals living with HIV/AIDS."

"Hotline/Clearinghouses" are interactive electronic outreach systems that use telephones, mail, and computer technology to provide a responsive information service to the general public and high-risk populations.

Duration/Dosage:

Venue:

Mode: Hotline
Media

Provider:

Outcome: Behavioral

Level:

Target Population: General public and high-risk populations

Other: Interactive

Targeted Public Information (TX)

Targeted Public Information (TPI) includes electronic, print and broadcast media communication or other forums designed to reach targeted populations. The purposes of targeted public information funded through this RFP are 1) to build support for safe behaviors, 2) to address barriers to effective HIV prevention programs, 3) to support local efforts for personal risk reduction, and 4) to assist in informing persons at risk of HIV infection of how to obtain specific prevention and treatment services. Many of the 1999 Regional Action Plans include regionally-specific recommendations for targeted public information. Appropriate public information activities may include posters in gay bars and other gathering places, targeted mass media, community level messages, hotlines, social marketing, and public service announcements. Applicants may address only those activities specifically included in their RAP.

Holtgrave, Valdessari & West Taxonomy in Comprehensive Plan – Appendix 3 ... under HC/PI (similar)

Duration/Dosage:

Venue: Areas where the target population gathers

Mode: Media
Hotlines

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Presentations/Lectures (VA)

Category III Health Communications/Public Information – The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behaviors, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain services.

1. Presentations/Lectures – These are often information-only activities conducted in group settings; often called "one-shot or "AIDS 101" education interventions
2. Health/Community Fairs
3. Mass Media
4. Hotlines
5. Clearinghouse
6. Social marketing

Duration/Dosage: One-shot

Venue:

Mode: Presentation

Provider:

Outcome: Behavioral

Level:

Target Population:

Other:

Health/Community Fairs (VA)

Category III Health Communications/Public Information – The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behaviors, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain services.

1. Presentations/Lectures
2. Health/Community Fairs – To set up information tables or booths which may include interactive activities for the purpose of disseminating information verbally and written to the general public an/or high risk populations. Health/community fairs raise awareness and assist in building relationship within a community. May be used as a vehicle to recruit persons for other services/programs.
3. Mass Media
4. Hotlines
5. Clearinghouse
6. Social marketing

Duration/Dosage:

Venue: Health/Community Fairs, Public events

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population: General public an/or high-risk popuatlions.

Other:

Mass Media (VA)

Category III Health Communications/Public Information – The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behaviors, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain services.

1. Presentations/Lectures
2. Health/Community Fairs
3. Mass Media – Use of the media to reach the public or targeted populations (Includes television, radio, print, and the internet). The use of print, radio, television or the internet to advertise an event or agency should not be considered a mass media campaign.
4. Hotlines
5. Clearinghouse
6. Social marketing

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population: Public or targeted populations

Other:

Hotlines (VA)

Category III Health Communications/Public Information – The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behaviors, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain services.

1. Presentations/Lectures
2. Health/Community Fairs
3. Mass Media
4. Hotlines – Interactive electronic outreach systems using telephones, computers and mail to provide a responsive information service to the general public as well as high-risk populations.
5. Clearinghouse
6. Social marketing

Duration/Dosage:

Venue:

Mode: Hotlines

Provider:

Outcome: Behavioral

Level: Community

Target Population: General public and high risk individuals

Other:

Clearinghouse (VA)

Category III Health Communications/Public Information – The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behaviors, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain services.

1. Presentations/Lectures
2. Health/Community Fairs
3. Mass Media
4. Hotlines
5. Clearinghouse – Interactive electronic outreach systems using telephones, mail, and the internet to provide a responsive information service to the general public as well as high-risk populations.
6. Social marketing

Duration/Dosage:

Venue:

Mode:

Provider:

Outcome: Behavioral

Level: Community

Target Population: General public as well as high-risk populations.

Other:

Social Marketing (VA)

Category III Health Communications/Public Information – The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behaviors, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain services.

1. Presentations/Lectures
2. Health/Community Fairs
3. Mass Media
4. Hotlines
5. Clearinghouse
6. Social marketing – Social marketing is a form of community level intervention which uses techniques adapted from commercial marketing to identify specific audiences called segments, identify their perceived needs, and then construct a program of services, support and communication to meet those perceived needs.

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other: Techniques adapted from commercial marketing to identify specific audiences called segments, identify their perceived needs, and then construct a program of services, support and communication to meet those perceived needs..

Social Marketing (VI)

Social marketing uses commercial marketing techniques to initiate voluntary change among people for their own benefit and for the benefit of the community. Social marketing can be used to develop a media campaign. It involves looking at problems from the perspective of the target population; it also examines the audiences perceived beliefs, perceived benefits and barriers to change a behavior.

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level:

Target Population:

Other:

Media (WI)

Encompassed under Health Communication/Public Information

Level of Intensity: Contact

This includes ... Use of electronic or print media, educational presentations or lectures, hotlines, or clearinghouses to deliver planned prevention messages to support risk reduction, provide information, increase awareness, or build support for safe behavior.

This does not include ... Group interventions with a skills building component (GLI)

There are four types or health communication/public information interventions.

1. Media

This category include print, radio, television and other media to deliver messages to help promote healthy behavior change. Public health media campaigns have been very successful with some sectors of the public in a number of areas of health promotion, including increased seat belt use, declines in smoking, and reductions in drunk driving.

Media in this case, may be used to reach a recommended risk population or the general population.

2. AIDS/HIV Information Hotlines

3. HIV Awareness Initiatives

4. HIV Lectures

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

AIDS/HIV Information Hotline (WI)

Encompassed under Health Communication/Pubic Information

Level of Intensity: Contact

This includes ... Use of electronic or print media, educational presentations or lectures, hotlines, or clearinghouses to deliver planned prevention messages to support risk reduction, provide information, increase awareness, or build support for safe behavior.

This does not include ... Group interventions with a skills building component (GLI)

There are four types or health communication/public information interventions.

1. Media :

2. AIDS/HIV Information Hotlines

A hotline is a confidential telephone service that provides information, support, and referral to anonymous callers. Hotlines can serve large geographic areas and reach a diverse and

sometimes isolated population. Hotlines often depend heavily on volunteer staff to function. It is crucial that volunteers and paid staff receive initial and ongoing training to remain knowledgeable about HIV and referral resources.

Includes Scientific Basis from CDC National AIDS Hotline, American Social Health Association, personal correspondence, 1997.

3. HIV Awareness Initiatives
4. HIV Lectures

Duration/Dosage:

Venue:

Mode: Hotline

Provider:

Outcome:

Level: Individual

Target Population:

Other: Confidential and anonymous.

HIV Awareness Initiatives (WI)

Encompassed under Health Communication/Public Information

Level of Intensity: Contact

This includes ... Use of electronic or print media, educational presentations or lectures, hotlines, or clearinghouses to deliver planned prevention messages to support risk reduction, provide information, increase awareness, or build support for safe behavior.

This does not include ... Group interventions with a skills building component (GLI)

There are four types of health communication/public information interventions.

1. Media :
2. AIDS/HIV Information Hotlines
3. HIV Awareness Initiatives

Providing employers, educators, health care providers and the general population with information regarding state and federal anti-discrimination laws and accurate information about HIV/AIDS can decrease discrimination against people with HIV disease. HIV awareness initiatives seek to improve social conditions for and decrease discrimination against people with HIV disease. They are important because they may affect members of targeted communities engaging in risk behaviors. HIV awareness interventions can use a range of strategies and can be used in combination with other interventions.

Successful HIV awareness interventions will:

- solicit input from members of affected populations;
- Challenge stereotypes;
- Offer more constructive approaches to communities that experience discrimination.

Some examples of HIV awareness interventions are:

- speakers bureaus of HIV-positive people to dispel myths about people with HIV;
- consultation with schools and youth-serving agencies;
- collaboration with youth-serving agencies to enhance the awareness of diverse populations of youth among their clientele;
- media positively highlighting persons with HIV infection or persons at risk for HIV infection;
- workplace HIV awareness programs that dispel myths regarding workplace exposures to HIV.

Includes Scientific Basis

4. HIV Lectures

Duration/Dosage:

Venue: Community

Mode:

Provider:

Outcome: Behavioral

Structural

Level: Community

Target Population: Educators, employers, health care providers, etc.

Other:

Health Communication/Public Information (HC/PI) – HIV Lectures (WI)

Encompassed under Health Communication/Public Information

Level of Intensity: Contact

This includes ... Use of electronic or print media, educational presentations or lectures, hotlines, or clearinghouses to deliver planned prevention messages to support risk reduction, provide information, increase awareness, or build support for safe behavior.

This does not include ... Group interventions with a skills building component (GLI)

There are four types of health communication/public information interventions.

1. Media :
2. AIDS/HIV Information Hotlines
3. HIV Awareness Initiatives
4. HIV Lectures

HIV prevention education serves to achieve one or both of the following goals:

1. changes knowledge about HIV transmission and
2. change attitudes about persons with HIV and groups disproportionately affected by HIV.

Such presentations focusing on information dissemination lack sufficient dose and intensity to be effective in changing behavior and to qualify as group level interventions. However, they dispel myths about people with HIV and build a relationship with an agency thereby enabling repeated, more intensive interventions. For example, trained teen peers who disseminate information to their peers, without learning the risk of the participants and without confirming that the participant can demonstrate a risk reduction skill, provide HC/PI.

Duration/Dosage:

Venue:

Mode: Presentations

Provider:

Outcome: Behavioral

Level:

Target Population:

Other:

Health Communication/Public Information (WY)

This category includes all forms of electronic, and print-mediated communications designed to reach the public. Often it includes the targeted use of media to reach a narrow segment such as policy makers, or a broad general public strategy to educate the public on misinformation, existing attitudes and rumors.

Duration/Dosage:

Venue:

Mode: Media

Provider:

Outcome:

Level: Community

Target Population: General public and policy makers

Other:

Biomedical Interventions

The Number of Intervention Characteristics by Each Biomedical Intervention

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Targeted STD Outreach, Screening and Referral	CH	✓	✓	✓	✓	✓	✓	✓	✓	8
Methadone Maintenance	CT			✓	✓	✓				3
Targeted STD Screening & Treatment	IL		✓	✓	✓	✓	✓	✓		6
Access to STD Diagnosis and Treatment	KS		✓	✓		✓				3
STD Screening and Treatment	LA		✓	✓	✓	✓	✓	✓	✓	7
STD CTRPN	NC			✓		✓				2
STD Testing, Treatment and Prevention Counseling	NH			✓		✓		✓	✓	4
TOTAL (N = 7)		1	4	7	3	7	4	4	3	33

✓- Indicates that evidence of the intervention characteristic was found in reviewing the FY 2001 Cooperative Agreement Applications and Comprehensive Plans and Web sites. Definitions or guidelines addressing these elements may exist in other documentation not reviewed for this study.

Biomedical Interventions

Duration/Dosage:

	Intervention Name:	Evidence of Intervention Characteristic:
CH	Targeted STD Outreach, Screening and Referral	Regular access

Venue:

	Intervention Name:	Evidence of Intervention Characteristic:
CH	Targeted STD Outreach, Screening and Referral	Non-medical setting
IL	Targeted STD Screening & Treatment	Fixed, Satellite, or Outreach --Medical or Nonmedical
KS	Access to STD Diagnosis and Treatment	Settings where the diseases are prevalent & populations congregate
LA	STD Screening and Treatment	Clinics, Schools, Prisons, bars, high-rate (STD & HIV) communities

Mode:

	Intervention Name:	Evidence of Intervention Characteristic:
CH	Targeted STD Outreach, Screening and Referral	Outreach – minimally structured (see Outreach) ; Biomedical – semi-structured or structured
CT	Methadone Maintenance	Biomedical
IL	Targeted STD Screening & Treatment	Biomedical – structured
KS	Access to STD Diagnosis and Treatment	Biomedical – semi-structured
LA	STD Screening and Treatment	Biomedical – structured
NC	STD CTRPN	Biomedical – minimally structured
NH	STD Testing, Treatment and Prevention Counseling	Biomedical – minimally structured

Provider:

The 3 intervention definitions addressing provider, noted that he or she should be a professional in order to conduct a biomedical intervention.

Outcome:

All the seven of these interventions indicated a biomedical outcome. One also anticipated behavioral outcomes.

	Intervention Name:	Evidence of Intervention Characteristic:
CT	Methadone Maintenance	Behavioral Biomedical

Level:

Four biomedical interventions specifically stated the intervention is to be implemented on an individual level.

Target Population:

	Intervention Name:	Evidence of Intervention Characteristic:
CH	Targeted STD Outreach, Screening and Referral	Persons at high-risk for HIV infection
CT	Methadone Maintenance	Heroin users
IL	Targeted STD Screening & Treatment	High-risk individuals and HIV positive individuals
LA	STD Screening and Treatment	MSM, Females, Youth, Substance users, Ethnic minorities
NH	STD Testing, Treatment and Prevention Counseling	High-risk populations

Other:

	Intervention Name:	Evidence of Intervention Characteristic:
CH	Targeted STD Outreach, Screening and Referral	Must be in compliance with Health Department policies, guidelines, protocols, and performance standards; Staff regularly participate in STD update trainings Targeted STD Outreach, Screening and Referral cannot be funded as a stand-alone intervention (i.e., as the only intervention in a program) but must be coupled with 1 or more of the other HPPG approved interventions.
IL	Targeted STD Screening & Treatment	All HIV prevention programs should provide STD prevention messages, counseling, and referrals to clients, as outlined in IDPH training and quality assurance standards. HIV prevention counseling and testing should be offered to High-risk persons.
LA	STD Screening and Treatment	Compliance with LA ACT 1065 Confidential, not anonymous Coordinate with outreach
NH	STD Testing, Treatment and Prevention Counseling	All interventions need to explicitly define a population to be served and the steps to reach that population.

Jurisdictions' Definitions of Biomedical Interventions

Targeted STD Outreach, Screening and Referral (CH)

Describes:

- I. Minimum Criteria
 - A. To establish or expand STD screening in non-medical settings (e.g., drop-in sites, treatment facilities, community centers, etc.) where persons at high-risk for HIV infection and curable STDs are encouraged and can be treated efficiently
 - B. Provide or assure regular access to STD screening/clinical care
 - C. Must be delivered by qualified and trained medical staff
 - D. Must be in compliance with Health Department policies, guidelines, protocols, and performance standards
 - E. Targeted STD Outreach, Screening and Referral cannot be funded as a stand-alone intervention (i.e., as the only intervention in a program) but must be coupled with 1 or more of the other HPPG approved interventions.
- II. Quality Assurance Measures
 - A. Staff regularly participate in STD update trainings
- III. Data Requirements
 - A. In an effort to better document service delivery citywide, all CDPH prevention funded agencies will be required to collect and submit the following data for each intervention used in their program. Data will be submitted to CDPH scan forms (provided by CDPH). This information will be used to improve the quality and effect of HIV prevention projects in Chicago.
 1. Type of agency
 2. Risk population
 3. Client demographics
 4. Setting
 5. Number of interventions
 6. Staffing
 7. Expenditures
 8. Number of individuals screening positive for STDs

What Works in Prevention?

Key factors of Successful Interventions and Programs:

- I. Services are:
 - A. delivered in a culturally appropriate and culturally sensitive manner
- II. easily accessed
 - A. voluntary
 - B. Target Population is:
 - C. clearly defined and with a proven need of HIV prevention services.
- III. Goals and Objectives of the Program are:
 - A. clearly defined, time-phased, and measurable.
- IV. Interventions are:
 - A. based on sound behavioral research
 - B. well planned, implemented, monitored and evaluated

- C. created (whenever possible) with input from target population
 - D. focused on reducing specific behaviors and address skill levels, attitudes, and behaviors that influence high risk activities (i.e., how to use condoms appropriately, how to clean injection equipment, and reinforcing positive attitudes about condom use)
 - E. vehicles for demonstrating, reinforcing, and promoting positive behaviors
- V. Agencies have:
- A. the ability to maintain multiple contacts with participants
 - B. the ability to document service delivery (i.e., develop and maintain survey questionnaires, client assessment forms, etc.)
 - C. a strong referral and follow-up system exists (formal, established, and written with signed memorandums of agreement)
 - D. the ability and desire to collaborate with other organizations
 - E. policies that conform with prevailing local, state and federal laws regarding client confidentiality
 - F. staff with necessary academic background or experience in a human-services-related field (i.e., social work, psychology, nursing, counseling, or health education); and case management and assessment techniques
 - G. staff that are knowledgeable about HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change.
- VI. How Do We Assure Quality?
- A. Minimum Quality Assurance Standards
- VII. Services are:
- A. offered in a safe environment. The agency should be clean, neat, well ventilated, and clutter free
- VIII. Interventions are:
- A. whenever possible, implemented/delivered by individuals representative of the target population
- IX. Agencies have:
- A. Policies and Procedure Manual. This manual must contain all intervention protocols, policies, and procedures of the services being delivered
 - B. current collaborative linkages within community and, when possible, should participate in one or more Community Planning Groups
 - C. staff that are familiar with available community resources
 - D. staff that are trained in the implementation of program intervention(s). All trainings must be documented in staff folders. The agency should promote and encourage continuing educational trainings.
 - E. grievance procedures in place and a method for informing clients of this process. Proof of client receipt should be documented in client charts
 - F. policies on staff safety (on site and off site)
 - G. a relationship with local authorities (police) such that the program is well known in the community
 - H. regular assessments of clients satisfaction through periodic client satisfaction surveys
 - I. regular management/supervisors meetings with program staff to discuss project and status progress towards stated outcomes

<i>Duration/Dosage:</i>	Regular access
<i>Venue:</i>	Non-medical setting
<i>Mode:</i>	Outreach – minimally structured (see Outreach) Biomedical – semi-structured or structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Biomedical
<i>Level:</i>	Individual
<i>Target Population:</i>	Persons at high-risk for HIV infection
<i>Other:</i>	Must be in compliance with Health Department policies, guidelines, protocols, and performance standards Staff regularly participate in STD update trainings Targeted STD Outreach, Screening and Referral cannot be funded as a stand-alone intervention (i.e., as the only intervention in a program) but must be coupled with 1 or more of the other HPPG approved interventions.

Targeted STD Screening & Treatment (IL)

Encompassed under ILI – Interventions that target one person. In individual level interventions, one person (e.g., an HIV test counselor) is doing an HIV prevention intervention with another single individual (e.g., the person being tested).

Methadone maintenance is a drug treatment program for heroin addicts, where patients are given doses of the drug methadone. Methadone is a substitute for heroin, prevents withdrawal symptoms. Though methadone controls cravings for heroin, it does not give the same "high" as heroin. Also, one dose of methadone can control cravings for an entire day, whereas individuals must inject heroin every few hours to control cravings. The goal of methadone maintenance is to get people out of the heroin "lifestyle", where the majority of their time is spent finding more drugs. Getting them off the streets allows them to seek counseling, rehabilitation and even employment. Once a person's life is stabilized they may, or may not, try to gradually get off of methadone. Most methadone treatment programs have counseling and other services to help patients in their recovery.

Does The Intervention Change Behavior? ...

With What Populations Is It Successful In changing Behavior?

Methadone maintenance is successful at reducing both injection drug use and sexual HIV risk behavior across gender and racial/ethnic category.

Duration/Dosage:

Venue: Fixed, Satellite, or Outreach --Medical or Nonmedical

Mode: Biomedical

Provider:

Outcome: Behavioral

Biomedical

Level: Individual

Target Population: Heroin users

Other:

Targeted STD Screening & Treatment (IL)

Targeted STD Screening & Treatment is an important component of HIV prevention services for high risk populations. Early detection and treatment of curable STD is an effective strategy for preventing sexually transmitted HIV infection. Targeted STD screening and treatment, as an HIV prevention strategy, includes the following activities:

- Establish or expand STD in nonmedical and medical settings where persons at high risk for HIV infection and curable STD are encountered and can be treated efficiently. Examples of appropriate sites include correctional facilities, gay youth drop-in sites, drug treatment centers, and hospital emergency departments.
- Provide or assure regular STD screening in nonmedical and medical settings where persons at high risk for HIV infection and curable STD are encountered and can be treated efficiently. Examples of appropriate sites include correctional facilities, gay youth drop-in sites, drug treatment centers, and hospital emergency departments.
- Assess and ensure timely access to STD clinical care for target populations seeking medical services for STD symptoms.

Targeted STD screening and treatment may be delivered in fixed, satellite, or outreach sites that are suitable for STD service provision and accessible to target populations. (For descriptions of these types of sites, see the IDPH definition, "HIV Prevention Counseling and Testing.")

Targeted STD screening and treatment should be delivered by qualified and trained medical staff employed by public or private health care providers. Nonmedical and community based HIV prevention providers may coordinate, promote, and refer to targeted STD services.

Includes:

1. Targeted STD Service Providers – Targeted STD screening and treatment should be delivered by qualified and trained medical staff employed by public or private health care providers. Nonmedical and community based HIV prevention providers may coordinate, promote, and refer to targeted STD services.

2. Relationship to Other Services

HIV prevention funds should not be used to duplicate STD services currently provided by local health departments or supplant other sources of STD funding. HIV prevention funds may be used to coordinate expanded STD screening, counseling, and treatment services for only those populations at high risk for HIV or already infected.

Communities should identify the most efficient strategy for delivering targeted STD screening and treatment, including the use of local health department STD clinics and staff...

All HIV prevention programs should provide STD prevention messages, counseling, and referrals to clients, as outlined in IDPH training and quality assurance standards. Similarly, all persons at high risk for STD or infected with STD should be offered HIV prevention counseling and testing. STD/HIV integration is expected of all funded programs and does not itself constitute targeted STD screening and treatment.

Duration/Dosage:

Venue: Fixed, Satellite, or Outreach --Medical or Nonmedical

Mode: Biomedical – structured

Provider: Professional

Outcome: Biomedical

Level: Individual

Target Population: High-risk individuals & HIV + individuals

Other: All HIV prevention programs should provide STD prevention messages, counseling, and referrals to clients, as outlined in IDPH training and quality assurance standards.
HIV prevention counseling and testing should be offered to High-risk persons.

Access to STD Diagnosis and Treatment (KS)

- A. Provide early detection and treatment of curable STD's by expanding screening and treatment programs for STDs in settings where the diseases are prevalent and populations congregate.
- B. Collaborate and coordinate HIV and STD prevention programs to ensure STD's are diagnosed and referred for treatment by offering onsite, diagnostic services and referrals for treatment of other STDs.

Duration/Dosage:

Venue: Settings where the diseases are prevalent & populations congregate

Mode: Biomedical – semi-structured

Provider:

Outcome: Biomedical

Level:

Target Population:

Other:

STD Screening and Treatment (LA)

Description – Prevention of HIV transmission through identification and treatment of STDs which operate as "cofactors". The STDs of a particular importance are curable STDs: syphilis, gonorrhea, chlamydia, and trichomonas. Of these, gonorrhea and chlamydia are the most common and the most easily identified with laboratory tests. These diseases usually cause no symptoms, therefore programs must rely heavily on screening of asymptomatic persons.

CDC Intervention Level – Individual Level Intervention.

Theoretical Basis – Biologic and epidemiologic evidence that STD treatment reduces HIV transmission.

Target Persons – Racial/Ethnic Minorities, Sexually Active Females, Males who have Sex with Males, Youth, Substance Users

Key Elements:

- Identification of a site which can reach a large number of persons at high risk for STDs (chlamydia or gonorrhea prevalence at least 3% and/or HIV prevalence at least 1%) during accessible hours.
- Screening for syphilis, gonorrhea and/or chlamydia.
- Systems must be put in place to store and transport specimens.
- Testing must be confidential (not anonymous).
- Persons found to have STDs must be contacted for their results and have ready access to treatment.
- Appropriate referrals must be provided for clients and their partners (ex: condom availability sites, local CBOs, Partner Counseling and Referral Services, etc)
- Education of providers and staff to the reason for intervention and plans for treatment is necessary.
- Sexual risk-reduction messages must also be included.
- Compliance with Louisiana ACT 1065 enabling minors (13 and older) to obtain screening treatment for venereal disease without parental consent.
- Coordinate with outreach.

Evaluation Methods – Rates of STDs (especially gonorrhea); STD reinfection rates.

Expected Outcomes –

- Decreased prevalence of STDs in screened populations;
- High proportion of persons who have STDs will be treated.

Implemented by -

- STD Disease Intervention Specialists; nurse; physicians; and trained outreach staff.

Includes:

1. Addresses High Priority Needs
2. Addresses Community/Cultural Norms & Values
3. Outcome Effectiveness
4. Accessible to the Target Populations
5. Intervention Feasibility and Cost-Effectiveness
6. Sources

Duration/Dosage:

Venue: Clinics, Schools, Prisons, bars, high-rate (STD & HIV) communities

Mode: Biomedical – Structured

Provider: Professional

Outcome: Biomedical

Level: Individual

Target Population: MSM, Females, Youth, Substance users, Ethnic minorities

Other: Compliance with LA ACT 1065

Confidential, not anonymous

Coordinate with outreach

STD CTRPN (NC)

Testing and treatment of STDs as a method to decrease ability to transmit and become infected by HIV.

Duration/Dosage:

Venue:

Mode: Biomedical – minimally structured

Provider:

Outcome: Biomedical

Level:

Target Population:

Other:

STD Testing, Treatment and Prevention Counseling (NH)

Sexually transmitted disease testing and treatment for high risk populations to reduce the risk of HIV transmission.

Behavior change counseling is offered at the time of testing and/or treatment.

Overall Premises to be Considered in All Interventions:

1. All interventions need to explicitly define a population to be served and the steps to reach that population.
2. All interventions must have explicitly defined HIV prevention goals (e.g. reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required data collection will be more limited than for individual and group level interventions due to the nature of the work.)
6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.
7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

Duration/Dosage:

Venue:

Mode: Biomedical – minimally structured

Provider:

Outcome: Biomedical

Level:

Target Population: High risk populations

Other: All interventions need to explicitly define a population to be served and the steps to reach that population.

Community Level Interventions (CLI)

The Number of Intervention Characteristics by Each Community Level Intervention

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Public Events	CA		✓	✓		✓	✓			4
Community Mobilization	CA		✓	✓		✓	✓		✓	5
Population Level Intervention – Community Level Interventions	CO	✓	✓	✓	✓	✓	✓	✓	✓	8
Population Level Interventions – Community Identification Process	CO	✓	✓	✓	✓	✓	✓			6
School Curricula	CT		✓	✓		✓	✓	✓		5
HERR Community Level Interventions	HO		✓	✓		✓	✓		✓	5
Community-Level Interventions	IA		✓	✓	✓	✓	✓		✓	6
Other Community Level Interventions	ID		✓	✓		✓	✓	✓		5
Community Level Interventions	KS	✓	✓	✓		✓	✓	✓	✓	7
Community Mobilization	LA	✓	✓		✓	✓	✓	✓	✓	7
Community Building/Popular Education approaches:	MA		✓	✓	✓	✓	✓	✓	✓	7
Community Level Interventions	MD		✓	✓		✓	✓			4
Community Level Interventions	ME			✓		✓	✓			3
Community Level Interventions/Mobilizations	MN			✓		✓	✓	✓		4

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Community Intervention	NC		✓	✓			✓			3
Community Building Events	NH		✓	✓						2
Community Level Interventions	OK		✓	✓		✓	✓		✓	5
Community Mobilization	OK		✓	✓		✓	✓	✓	✓	6
Community Level Interventions	SC		✓	✓		✓	✓			4
Community Intervention and Mobilizations	SD		✓	✓		✓	✓			4
Community Level Interventions/Mobilizations	TN		✓	✓	✓		✓		✓	5
Community Level Interventions	TX		✓			✓	✓			3
Health/Community Fairs	VA		✓	✓			✓	✓	✓	5
Community Level Interventions	WI		✓	✓	✓	✓	✓	✓	✓	7
TOTAL (N = 24)		4	22	22	7	20	23	4	45	147

✓- Indicates that evidence of the intervention characteristic was found in reviewing the FY 2001 Cooperative Agreement Applications and Comprehensive Plans and Web sites. Definitions or guidelines addressing these elements may exist in other documentation not reviewed for this study.

Community Level Interventions (CLI) – Listing of Evidence by Intervention Characteristic

Duration/Dosage:

	Intervention Name:	Evidence of Intervention Characteristic:
CO	Population Level Intervention – Community Level Interventions	Saturation of environment on consistent and ongoing basis.
CO	Population Level Interventions – Community Identification Process	Until the goals of the study are complete
KS	Community Level Interventions	Ongoing
LA	Community Mobilization	Multiple sessions

Venue:

	Intervention Name:	Evidence of Intervention Characteristic:
CA	Public Events	Public meetings or events
CA	Community Mobilization	Community
CO	Population Level Intervention – Community Level Interventions	Community
CO	Population Level Interventions – Community Identification Process	Community
CT	School Curricula	Schools
HO	HERR Community Level Interventions	Community
IA	Community-Level Interventions (CLI)	Community
ID	Other Community Level Interventions	Community
KS	Community Level Interventions	Sites where target populations congregate, where at-risk behaviors take place, street and community settings
LA	Community Mobilization	Schools, community centers, churches, bars, etc.
MA	Community Building/Popular Education Approaches	Community
MD	Community Level Interventions (CLI)	Community wide events
NC	Community Interventionon	Community
NH	Community Building Events	Athletic events, alcohol and drug free environments

OK	Community Level Interventions	Community
OK	Community Mobilization	Community
SC	Community Level Interventions	Community
SD	Community Intervention and Mobilizations	Community
TN	Community Level Interventions/Mobilizations	Community
TX	Community Level Interventions	Community
VA	Health/Community Fairs	Health fairs and community fairs
WI	Community Level Interventions	Community

Mode:

	Intervention Name:	Evidence of Intervention Characteristic:
CA	Public Events	Material/supply distribution Health education
CA	Community Mobilization	Community Mobilization
CO	Population Level Intervention – Community Level Interventions	Health communication/Public Information Community Mobilization
CO	Population Level Interventions – Community Identification Process	Research
CT	School Curricula	Health education – semi-structured
HO	HERR Community Level Interventions	Counseling
IA	Community-Level Interventions (CLI)	Media Public events Community Mobilization
ID	Other Community Level Interventions	Media Policy Community Mobilization
KS	Community Level Interventions	Outreach Material distribution
MA	Community Building/Popular Education Approaches	Health Education

MD	Community Level Interventions (CLI)	Public events Media Community Mobilization
ME	Community Level Interventions	Media Community Mobilization
MN	Community Level Interventions/Mobilizations	Material Distribution
NC	Community Interventionon	Media
NH	Community Building Events	Helath Education Material/supply distribution
OK	Community Level Interventions	Outreach Media Community Mobilization.
OK	Community Mobilization	Community Mobilization
SC	Community Level Interventions	Media Community mobilization
SD	Community Intervention and Mobilizations	Media Community Mobilization
TN	Community Level Interventions/Mobilizations	Media Counseling Health Education
VA	Health/Community Fairs	Material Distribution Health communication/public information
WI	Community Level Interventions	Community Mobilization

Provider:

	<u>Intervention Name:</u>	<u>Evidence of Intervention Characteristic:</u>
CO	Population Level Interventions – Community Identification Process	Professional, Paraprofessional
CO	Population Level Intervention – Community Level Interventions	Peer
IA	Community-Level Interventions (CLI)	Professional Peer networks

LA	Community Mobilization	Professional or Peer
MA	Community Building/Popular Education approaches:	Peer
TN	Community Level Mobilization	Peer
WI	Community Level Interventions	Individuals who belong to the community

Outcome:

Fourteen of the definitions for community level interventions only specified behavioral outcomes. Structural outcomes were referenced in six of the intervention definitions; five of which also included behavioral outcomes.

	Intervention Name:	Evidence of Intervention Characteristic:
CO	Population Level Intervention – Community Level Interventions	Behavioral Structural
CO	Population Level Interventions – Community Identification Process	Structural
IA	Community-Level Interventions (CLI)	Behavioral Structural
OK	Community Mobilization	Political Social
SC	Community Level Interventions	Behavioral Structural Environmental
TX	Community Level Interventions	Behavioral Structural

Level:

Of the interventions addressing level, 21 of the 23 definitions stated the intervention is to be implemented at the community level.

	Intervention Name:	Evidence of Intervention Characteristic:
CA	Public Events	Group, Community
LA	Community Mobilization	Group, Community Level

Target Population:

	Intervention Name:	Evidence of Intervention Characteristic:
CO	Population Level Intervention – Community Level Interventions	A well defined community or target population that can be distinguished according to geography, ethnicity, sexual orientation, gender, age, behavior, or some self-defining criteria.
CT	School Curricula	School age children
ID	Other Community Level Interventions	MSM, IDUs or Women at-risk
KS	Community Level Interventions	MSM, IDUs and their partners, sexually active individuals
LA	Community Mobilization	Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users
MA	Community Building/Popular Education approaches:	Poor Latinos
MN	Community Level Interventions/Mobilizations	High and low risk individuals in a specific community
OK	Community Mobilization	Those at risk for HIV and those not at risk for HIV
VA	Health/Community Fairs	General public or high-risk populations
WI	Community Level Interventions	At-risk populations

Other:

	Intervention Name:	Evidence of Intervention Characteristic:
CA	Community Mobilization	The focus is not on the individual members of a community, but those who can influence individual members.
CO	Population Level Intervention – Community Level Interventions	Based upon research among community members and incorporate community input and involvement in program design, implementation, and evaluation.
HO	HERR Community Level Interventions	They differ from street and community outreach in that they are designed to reach a defined community with the intention of modifying social norms, attitudes and beliefs that influence the community's risk behaviors.

IA	Community-Level Interventions (CLI)	<p>Based upon research among community members and incorporate community input and involvement in program design, implementation, and evaluation.</p> <p>Ideally...utilize peer networks within community as a means of increasing the effectiveness of CLI and sustaining interventions efforts after professional and service providers are gone.</p>
KS	Community Level Interventions	HIV prevention planning through needs assessments open prevention community meetings, and on-going feedback in order to develop plans, minimize or eliminate barriers and ensure cultural responsiveness.
LA	Community Mobilization	<p>Prevention plans developed by community & placed in the community's hands to be sustained over time.</p> <p>All parties have equal standing and decisions are made by consensus.</p>
MA	Community Building/Popular Education Approaches	Community residents are engaged in a peer-led, non-authoritarian process of collective examination of their social, health, political, and economic conditions with goal of personal and communal transformation.
OK	Community Level Interventions	<p>Involve community members in the actual design and delivery.</p> <p>Aim to change community norms about high risk behaviors as well as modify individual behaviors.</p>
OK	Community Mobilization	Differs from community level interventions in that it generally targets persons who are not at risk for HIV as well as those who are at risk.
TN	Community Level Interventions/Mobilizations	May include aspects of other categories (e.g., peer, media or counseling), but the combination must be aimed explicitly at community norms.
VA	Health/Community Fairs	Information tables or booths with interactive activities.

WI Community Level Interventions

Should not be used in place of ILI, GLI or outreach.

Should build resiliency and gain a sense of support and community.

Jurisdictions' Definitions of Community Level Interventions (CLI)

Public Events (CA)

Program Category 3: Community-Level Interventions

Community-level interventions seek to reduce risk behaviors by changing attitudes, norms and behaviors through health communications, social (prevention) marketing, community mobilization and community-wide events. The common denominator of these strategies is their focus on community/group identity.

1. Social Marketing
2. Media Relations
3. Public Events – Public meetings or events offer community booths or other displays where printed information and referrals are offered. Limited opportunity for one-on-one health education or risk reduction may be offered.
4. Natural Opinion Leader
5. Community Mobilization

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue: Public meetings or events

Mode: Material/supply distribution

Health education

Provider:

Outcome: Behavioral

Level: Group, Community

Target Population:

Other:

Community Mobilization (CA)

Program Category 3: Community-Level Interventions

Community-level interventions seek to reduce risk behaviors by changing attitudes, norms and behaviors through health communications, social (prevention) marketing, community mobilization and community-wide events. The common denominator of these strategies is their focus on community/group identity.

1. Social Marketing
2. Media Relations
3. Public Events
4. Natural Opinion Leader
5. Community Mobilization – This strategy involves efforts to motivate a segment of a community or an entire community to engage in prevention activities – the focus is not on the individual members of a community, but those who can influence individual members.

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue: Community

Mode: Community Mobilization

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other: The focus is not on the individual members of a community, but those who can influence individual members.

Population Level Intervention – Community Level Interventions (CO)

Encompassed under Health Education/Risk Reduction – Subcategory of Population Level Intervention

Community Level Interventions (CLI) seek to change the attitudes, norms, and values as well as the social and environmental context of risk behaviors of an entire community, not simply individual members of the community. CLI are based upon research among community members and incorporate community input and involvement in program design, implementation, and evaluation. Ideally, CLI programs utilize peer networks within a community as a means of increasing the effectiveness of CLI and sustaining intervention efforts after professional service providers are gone. Effective community level interventions also may incorporate ILI and GLI activities.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their programs flow from and is consistent with social and behavioral theory and research relevant to HIV risk reduction.

- Goal of the Intervention: CLI seeks to change the attitudes, norms and values as well as the social and environmental context of risk behaviors of an entire community, not simply individual members of the community. They are meant to move the members of the community, incrementally, one step at a time, closer to healthier sexual and needle use behaviors.
- Target Population: The target audience is a well defined community or target population that can be distinguished according to geography, ethnicity, sexual orientation, gender, age, behavior, or some self-defining criteria.
- Cultural competence/proficiency: ...
- Where Delivered: Interventions are delivered in convenient and appropriate community settings (as determined by formative evaluation). Programs must be accessible to the target audience.
- When Delivered: Interventions are delivered at times that are appropriate to the target audience (as determined by formative evaluation).
- How Much: CLI are meant to saturate the environment on a consistent and ongoing basis with prevention messages.
- Content and Methods Employed: ... The content and methods of the intervention are based on the needs of the community as identified through formative evaluation. ... Based on research findings, messages are developed, and a selection of activities and materials are designed to relay the messages.

... These messages and prevention materials do this by changing the specific norms, values, beliefs and social and environmental factors within the community that promote the risky behaviors, and/or by reinforcing norms, values, beliefs and social and environmental factors within the community that promote healthier behaviors. ...

- Qualifications of People to do this work: Formal and informal community leaders and peer networks deliver the messages throughout the entire community by means of these various activities.

Providers of CLIS should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

The peers or professionals providing CLI must be competent in regard to culture and other diversity and able to present the materials in an understandable and non-judgmental manner.

- Continuing Education/Ongoing Training Requirements: Providers of CLI must receive at least 8 hours of updated HIV prevention training per year.
- Consent/Confidentiality Considerations: ...

- Quality Assurance: ...
- Evaluation: ...
- Penalties for Violating Standards: ...
- Other: ...

<i>Duration/Dosage:</i>	Saturation of environment on consistent and ongoing basis.
<i>Venue:</i>	Community
<i>Mode:</i>	Health Communication/Public Information Community Mobilization
<i>Provider:</i>	Peer
<i>Outcome:</i>	Behavioral Structural
<i>Level:</i>	Community
<i>Target Population:</i>	A well defined community or target population that can be distinguished according to geography, ethnicity, sexual orientation, gender, age, behavior, or some self-defining criteria.
<i>Other:</i>	Based upon research among community members and incorporate community input and involvement in program design, implementation, and evaluation.

Population Level Interventions – Community Identification Process (CO)

Encompassed under Health Education/Risk Reduction – Subcategory of Population Level Intervention

Community Identification Process (CIP) is designed to identify, qualitatively and quantitatively, baseline norms, values, shared meanings, and social and environmental circumstances that influence behavior within target populations. This knowledge is the foundation on which effective messages and strategies are built. Understanding where and when to access the community by learning about the social networks will enhance the ability to intervene most effectively.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their programs flow from and is consistent with social and behavioral theory and research relevant to HIV risk reduction.

- Goal of the Intervention: The community identification process is based on, and will result in, qualitative and quantitative analysis of baseline norms, values, shared meanings, and social and environmental circumstances that influence behavior within the target populations. Implementation of the research methods produces information about the target

audience, their risk behaviors, the context of their risk behaviors, and their views on appropriate content and delivery of HIV prevention interventions.

- Target Population: The target audience is a community or population that can be defined according to geography, ethnicity, sexual orientation, gender, age, behavior, or some self-defining criteria.
- Cultural competence/proficiency: ...
- Where Delivered: The research is carried out within community settings in locations that are acceptable and accessible to the target audience (as determined by formative evaluation).
- When Delivered: The research is carried out at times that are convenient to the target audience (as determined by formative evaluation).
- How Much: A combination of observations, interviews, surveys and focus groups are conducted until the goals of the study are complete.
- Content and Methods Employed: ...
- Qualifications of People to do this work: Data gathering involves skilled interviewers and observers, using the help of key members of the population to gain baseline information, access to the population, and "buy-in" from the population.

Providers of CIP should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

The peers or professionals providing CIP must be competent in regard to culture and other diversity and able to present the materials in an understandable and non-judgmental manner.

Researchers must have received formal training and/or training and technical assistance through CDPHE in how to select and utilize appropriate research methods, including the construction and implementation of interviews and survey design.

- Continuing Education/Ongoing Training Requirements: Providers of CIP must receive at updated training on topics relevant to their projects.
- Consent/Confidentiality Considerations: ...
- Quality Assurance: ...
- Evaluation: ...
- Penalties for Violating Standards: ...
- Other: ...

<i>Duration/Dosage:</i>	Until the goals of the study are complete
<i>Venue:</i>	Community
<i>Mode:</i>	Research
<i>Provider:</i>	Professional, Paraprofessional
<i>Outcome:</i>	Structural
<i>Level:</i>	Community
<i>Target Population:</i>	
<i>Other:</i>	

School Curricula (CT)

Encompassed under Community Level Interventions – These are interventions that try to change HIV risk behavior by changing community norms (and sometimes even the laws) of a community to support HIV prevention.)

School curricula are HIV education programs that are taught in schools. Currently, Connecticut schools must teach some type of HIV education, but each school has a great deal of latitude in deciding what type of program will be taught.

Does The Intervention Change Behavior?...

With What Populations Is It Successful In changing Behavior?

Messages used have to be appropriate to age level. So, in younger students programs could talk more about delaying intercourse, while programs for older students might focus more on condom use.

<i>Duration/Dosage:</i>	
<i>Venue:</i>	Schools
<i>Mode:</i>	Health Education – semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Community
<i>Target Population:</i>	School age children
<i>Other:</i>	

HERR Community Level Interventions (HO)

These interventions are designed to target specific geographic areas, neighborhoods or communities. They differ from street and community outreach in that they are designed to reach a defined community with the intention of modifying social norms, attitudes and beliefs that influence the community's risk behaviors. This type of intervention may involve components from other interventions (individual or small group counseling, etc.), which can be blended as part of a single prevention approach. The impact of this intervention on entire communities may have greater public health benefits for HIV prevention than the total number of individuals that may be reached through other face-to-face interventions.

Also included in Comprehensive Plan.

Duration/Dosage:

Venue: Community

Mode: Counseling

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other: They differ from street and community outreach in that they are designed to reach a defined community with the intention of modifying social norms, attitudes and beliefs that influence the community's risk behaviors.

Community-Level Interventions (CLI) (IA)

Includes description from the Taxonomy of HIV/AIDS Prevention Interventions from the Academy of Educational Development and the CDC's 2000 Evaluation Guidance (CDC, 1999) for the purpose of "making meaningful distinctions and choices among possible interventions".

Community-based approaches to behavior change provide information and skills on the community level to change behavior and encourage a supportive social environment through channels and methods that are indigenous to the community. Community-level efforts are also designed to create structures and systems that assist in the maintenance of healthy behaviors. These intervention are based on several theories including Social Learning Theory, the Health Belief Model and Diffusion Theory (Coates and Greenblat, 1990).

... seek to reduce risk behaviors by changing attitudes, norms, and behaviors through health communications, social (prevention) marketing, community mobilization, and community-wide events. The common denominator of these strategies is their focus on community and social group identity.

Includes:

1. Demonstrated Effectiveness
2. Suggested Uses
3. Speakers Bureaus
 - a. Demonstrated Effectiveness
 - b. Suggested Uses
4. Social Marketing
 - a. Suggested Uses
 - b. Demonstrated Effectiveness
5. Public Events

Duration/Dosage:

Venue: Community

Mode: Media
Public Events
Community Mobilization

Provider: Professional
Peer networks

Outcome: Behavioral
Structural

Level: Community

Target Population:

Other: Based upon research among community members and incorporate community input and involvement in program design, implementation, and evaluation.
Ideally...utilize peer networks within community as a means of increasing the effectiveness of CLI and sustaining interventions efforts after professional and service providers are gone.

Other Community Level Interventions (ID)

These may include social marketing campaigns, community-wide events, policy interventions, or structural interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole.

Duration/Dosage:

Venue: Community

Mode: Media

Policy

Community Mobilization

Provider:

Outcome: Structural

Behavioral

Level: Community

Target Population: MSM, IDUs or Women at-risk

Other:

Community Level Interventions (KS)

Encompassed under Health Education and Risk Reduction (HE/RR):

Implement HE/RR programs that are tailored to reach persons infected or at high risk of becoming HIV infected by using interventions that are:

1. based in scientific theory or program experience;
2. developed to reduce the risk of primary and secondary infection;
3. culturally, linguistically age and gender appropriate; and
4. sensitive to sexual identity.

Community Level Interventions are directed at changing community norms to increase community support of behaviors that reduce the risk of HIV infection.

- Increase the involvement of community members in HIV prevention program planning through needs assessments open prevention community meetings, and ongoing feedback in order to develop plans, minimize or eliminate barriers and ensure cultural responsiveness.
- Disseminate information concerning the impact of HIV/AIDS to Kansas communities, particularly as it relates to the impact HIV infection places upon families, the health care system, the economic cost to society due to lost future job productivity.
- Persuade community based programs which build on the strengths of a community's culture and inform community members of their important role in HIV prevention in their communities regardless of their own at-risk behaviors.
- Provide street and community outreach to deliver individual, group, and community interventions at sites where target populations congregate and at-risk behaviors take place, on the street, and/or in community settings.

<i>Duration/Dosage:</i>	Ongoing
<i>Venue:</i>	Sites where target populations congregate, where at-risk behaviors take place, street and community settings
<i>Mode:</i>	Outreach Material distribution
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Community
<i>Target Population:</i>	MSM, IDUs and their partners, sexually active individuals
<i>Other:</i>	HIV prevention planning through needs assessments open prevention community meetings, and on-going feedback in order to develop plans, minimize or eliminate barriers and ensure cultural responsiveness.

Community Mobilization (LA)

Description: Facilitated sessions to develop and implement a community-appropriate prevention strategy

CDC Intervention Level: Group and/or Community Level

Theoretical Basis: Empowerment Theory

Target Persons: Racial/Ethnic minorities, Sexually active females, Males who have sex with males, Youth, Substance users

Sites: Schools, community centers, churches, bars and other locations

Key Elements:

- Prevention plans are developed by the community and placed in the hands of the community so that it can be sustained over time.
- Discussions center on understanding HIV needs relative to other community needs that may require immediate attention.
- Staff facilitate work groups by focusing discussion(s) and sharing knowledge and skills with the community to help effect change.
- Community strengths and resources are identified and built upon so that behavior change sustains itself.
- Multiple planning sessions of approximately 6 weeks using needs, resources and action plan format.
- All parties have equal standing and decisions are made by consensus.
- Each community is characterized by a sense of identification and emotional connection to other members, common symbol systems, shared values and norms, mutual influence, common interests and commitment to meeting shared needs.

Recommended Training: HIV/AIDS 101, American Red Cross Basic Fundamentals and Starter Facts, Facilitator Training, Health Behavior Theory Training

Evaluation Methods:

- Pre and post surveys of community members risk behaviors.
- 6 month follow-up survey

Expected Outcomes:

- Changes in community norms.
- Increased community involvement.
- Decreased risky behaviors

Implemented by: Trained HAP and CBO staff. May be implemented through a peer education program.

Includes:

1. Addresses High Priority Needs
2. Addresses Community/Cultural Norms and Values
3. Outcome Effectiveness
4. Accessible to the Target Populations
5. Intervention Feasibility and Cost-Effectiveness
6. Sources

<i>Duration/Dosage:</i>	Multiple sessions
<i>Venue:</i>	Schools, community centers, churches, bars, etc.
<i>Mode:</i>	
<i>Provider:</i>	Professional , Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Group, Community Level
<i>Target Population:</i>	Racial/ethnic minorities, sexually active females, males who have sex with males, youth, substance users
<i>Other:</i>	Prevention plans developed by community and placed in the community's hands to be sustained over time. All parties have equal standing and decisions are made by consensus

Community Building/Popular Education Approaches: (MA)

Popular education approaches build on the traditions of politically informed adult literacy programs for the poor in Latin America. Community residents are engaged in a peer-led, non-authoritarian process of collective examination of their social, health, political, and economic conditions with the goal of personal and communal transformation. Through this examination,

concrete plans for community development and improvement are constructed. In the context of these discussion and community projects, HIV and relates concerns are explored and the group determines strategies for addressing HIV in the context of their community's life.

Duration/Dosage:

Venue: Community

Mode: Health Education

Provider: Peer

Outcome: Behavioral

Level: Community

Target Population: Poor Latinos

Other: Community residents are engaged in a peer-led, non-authoritarian process of collective examination of their social, health, political, and economic conditions with goal of personal and communal transformation.

Community Level Interventions (CLI) (MD)

Community Level Interventions (CLI) for populations at risk for HIV infection, which seek to reduce behaviors by changing attitudes, norms, and practices through health communication, prevention marketing, communicating mobilization/organization, and community wide events. CLI combines community organization and social marketing – a strategy that takes a systems approach. Its founding is an assumption that individuals make up large and small social networks or systems. CLIs target specific populations – not simply the community in general. The client populations have identified shared risk behaviors for HIV infection and also may be defined by race, gender or sexual orientation.

Duration/Dosage:

Venue: Community wide events

Mode: Media

Public Events

Community Mobilization

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Community Level Interventions (ME)

Community level interventions are aimed to reduce risky behaviors by changing attitudes, norms, and behaviors through health communication, social (prevention) marketing, community mobilization and organization, community wide events.

a. Community Building Efforts for Social Networks

Encompassed under CPG taxonomy primary category HIV Risk Reduction and Education.

Duration/Dosage:

Venue:

Mode: Media
Community Mobilization

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Community Level Interventions/Mobilizations (MN)

Community Level Interventions/Mobilizations (i.e., designed to change community norms, and targeting everyone within the specific community, and not necessarily the individuals at highest risk for HIV).

Accompanied by educational material dissemination, condom, bleach, and clean needle distribution or exchange, and encouragement of HIV antibody testing.

Duration/Dosage:

Venue:

Mode: Material Distribution

Provider:

Outcome: Behavioral

Level: Community

Target Population: High and low risk individuals in a specific community

Other:

Community Interventionon (NC)

Community intervtnions or social marketing programs are directed at the community not the individual. This strategy is an attempt to influence community norms and target specific racial/ethnic populations.

Duration/Dosage:

Venue: Community

Mode: Media

Provider:

Outcome:

Level: Community

Target Population:

Other:

Community Building Events (NH)

Social events which include HIV prevention education. Education could be a brief talk, the distribution of condoms or printed materials, etc. (Examples are social hours at an alcohol and drug free environment, group trips, athletic events, etc.).

Overall Premises to be Considered in All Interventions

1. All interventions need to explicitly define a population to be served and the steps to reach that population.
2. All interventions must have explicitly defined HIV prevention goals (e.g. reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required data collection will be more limited than for individual and group level interventions due to the nature of the work.)
6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.
7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

Duration/Dosage:

Venue: Athletic events, alcohol and drug free environments

Mode: Health Education

Material/supply Distribution

Provider:

Outcome:

Level:

Target Population:

Other:

Community Level Interventions (OK)

Community level interventions are those that:

1. target a given community (community often defined by sex, geography, risky behaviors, race/ethnicity, and/or sexual orientation);
2. involve community members in the actual design and delivery of the intervention; and
3. aim to change community norms about high risk behaviors as well as modify individual behaviors. (Holtgrave et al., 1994)

Community level interventions are directed at changing community norms to increase community support of behaviors known to reduce the risk for HIV infection and transmission. While individual and group level interventions also may be taking place within the community, interventions that target the community are unique in their purpose and are likely to lead to different strategies than other types of interventions. Community level interventions aim to reduce risky behaviors by changing attitudes, norms, and practices through community-based outreach, social (prevention) marketing, mass media (television, radio, newspapers, billboards) small media (newsletters, posters, flyers, and brochures) community organization, and community-wide events.

Includes – Evidence of Effectiveness.

Duration/Dosage:

Venue: Community

Mode: Outreach

Media

Community Mobilization.

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other: Involve community members in the actual design and delivery.

Aim to change community norms about high risk behaviors as well as modify individual behaviors.

Community Mobilization (OK)

The goal of community mobilization is to increase awareness and knowledge of HIV/AIDS issues and to provide a foundation for the greater participation of people in general in HIV prevention and service activities. This category differs from community level interventions in that it generally targets persons who are not at risk for HIV as well as those who are at risk. Furthermore, community mobilization may not be designed, at least originally, to change individual health behavior, but rather to create a social, political and/or institutional climate conducive to and receptive of developing effective prevention programs. (N. Corby and M. Jamner, (1996) “HIV Prevention Interventions: What Works and What Doesn't?” Center for Behavioral Research and Services, California State University)

Includes – Evidence of Effectiveness.

Duration/Dosage:

Venue: Community

Mode: Community Mobilization

Provider:

Outcome: Political

Social

Level: Community

Target Population: Those at risk for HIV and those not at risk for HIV.

Other: Differs from community level interventions in that it generally targets persons who are not at risk for HIV as well as those who are at risk.

Community Level Interventions (SC)

Community level interventions are directed at changing community norms, rather than the individual or group, to increase community support of the behaviors known to reduce the risk for HIV infection and transmission. While individual and group level interventions may be taking place within the community, interventions that target the community level are unique in their purpose and are likely to lead to different strategies than other types of interventions.

Community level interventions aim to reduce risky behaviors by changing attitudes, norms, and practices through health communication, social (prevention) marketing, community mobilization and organization, and community-wide events. The primary goals of these programs are to improve health status, to promote healthy behaviors, and to change factors that affect the health of community residents. The community may be defined in terms of a neighborhood, region, or some other geographic area to capture the social networks that may be located within those boundaries. These networks may be changing and overlapping, but should represent some degree of shared communications, activities, and interests. Community level interventions are designed to impact on the social norms or shared beliefs and values held by members of the community. Specific activities include:

- Identifying and describing (through needs assessments and ongoing feedback from the community) structural, environmental, behavioral, and psychosocial facilitators and barriers to risk reduction in order to develop plans to enhance facilitators and barriers to risk reduction in order to develop plans to enhance facilitators and minimize or eliminate barriers.
- Developing and implementing, with participation from the community, culturally competent, developmentally appropriate, linguistically specific, and sexual- identify-sensitive interventions to influence specific structural, environmental, behavioral, and psychosocial factors thought to promote risk reduction, including:
 1. Changing community norms about condom and contraceptive use, needle sharing, diagnosis and treatment of STDs, and other HIV risk reduction strategies through persuasive communications and role play.

2. Identifying and enlisting family, peer, and community networks.
3. Creating and mobilizing new networks of communication.
4. Providing opportunities to acquire skills in HIV risk reduction and in reinforcement of behavior change.
5. Involving community members as role models in locally developed small media (local newspapers, radio) to present information and persuasive messages about HIV risk reduction.
6. Persuading community members at risk to accept and use HV prevention measures.

Duration/Dosage:

Venue: Community

Mode: Media

Community Mobilization

Provider:

Outcome: Behavioral

Structural

Level: Community

Target Population:

Other:

Community Intervention and Mobilizations (SD)

Community-based approaches to behavior change provide information and skills on the community level to change behavior and encourage a supportive social environment through channels and methods that are indigenous to the community. Community-level efforts are also designed to create structures and systems that assist in the maintenance of healthy behaviors. These interventions are based on several theories including Social Learning Theory, the Health Belief Model, and Diffusion Theory (Coates and Greenblatt, 1990).

Community level interventions are those that:

1. target a given community (community often defined by sex, geography, risky behaviors, race/ethnicity, and/or sexual orientation);
2. involve community members in the actual design and delivery of the intervention; and
3. aim to change community norms about high risk behaviors as well as modify individual behaviors (Holtgrave et al., 1994).

Community level interventions are directed at changing community norms to increase community support of behaviors known to reduce the risk for HIV infection and transmission. While individual and group level interventions also may be taking place within the community, interventions that target the community are unique in their purpose and are likely to within the community, interventions that target the community are unique in their purpose and are likely to lead to different strategies than other types of interventions. Community level interventions aim

to reduce risky behaviors by changing attitudes, norms, and practices through community-based outreach, social (prevention) marketing, mass media (television, radio, newspaper, billboards) small media (newsletters, posters, flyers, and brochures) community organization, and community-wide events.

Includes – Evidence of Effectiveness

The goal of community mobilization is to increase awareness and knowledge of HIV/AIDS issues and to provide a foundation for the greater participation of people in general in HIV prevention and service activities. This category differs from community level interventions in that it generally targets persons who are not at risk for HIV as well as those who are at risk. Furthermore, community mobilization may not be designed, at least originally, to change individual health behavior, but rather to create a social, political and/or institutional climate conducive to and receptive of developing effective prevention programs. (N. Corby and M. Jamner, (1996) "HIV Prevention Interventions: What Works and What Doesn't? Center for Behavioral Research and Services, California State University)

Duration/Dosage:

Venue: Community

Mode: Media

Community Mobilization

Provider:

Outcome: Behavioral

Level: Community

Target Population:

Other:

Community Level Interventions/Mobilizations (TN)

Encompassed under Category II HE/RR.

Community level interventions/mobilizations are a distinct class of programs characterized by their scope and objectives. In these programs, the focus is upon altering social norms in a specified community (geographic or an identified subgroup) as a way to influence high risk behavior. Additionally, a community-level intervention may include aspects of other categories (e.g., peer, media or counseling), but the combination must be aimed explicitly at community norms. For example, one strategy might be to elect and educate workers in gay bars as 'peer health educators' and asked them to take prevention messages back to their communities. Experts have shown that this type of intervention can change community norms, self-reported risk and sexual behaviors (Kelly, Murphy, Sikkema, and Kalichman, 1993).

Duration/Dosage:

Venue: Community

Mode: Media

Counseling

Health Education

Provider: Peer

Outcome:

Level: Community

Target Population:

Other: May include aspects of other categories (e.g., peer, media or counseling), but the combination must be aimed explicitly at community norms.

Community Level Interventions (TX)

Community-level interventions are directed at the community, rather than the individual or a group, to increase community support of the behaviors known to reduce the risk for HIV infection and transmission. Community-level interventions aim to reduce risky behaviors by changing attitudes, norms, and practices through health communications, social (prevention) marketing, community mobilization and organization, and community-wide events. The primary goals of these programs are to improve health status, to promote healthy behaviors, and to change factors that affect the health of community residents.

Community-level interventions are designed to affect social norms or shared beliefs held by members of the community. The community may be defined in terms of a neighborhood, region, or some other geographic area, but only as a mechanism to capture the social networks that may be located within those boundaries. Community level interventions must be directed at members of targeted populations as outlined in the RAPs. ...

Holtgrave, Valdessari and West Taxonomy in Comprehensive Plan – Appendix 3 ... under HE/RR (no description); several components captured under HC/PI.

Duration/Dosage:

Venue: Community

Mode:

Provider:

Outcome: Structural

Behavioral

Level: Community

Target Population:

Other:

Health/Community Fairs (VA)

Encompassed under Category III Health Communications/Public Information

Health/Community Fairs

To set up information tables or booths which may include interactive activities for the purpose of disseminating information verbally and written to the general public and/or high-risk populations. Health/community fairs raise awareness and assist in building relationship within a community. May be used as a vehicle to recruit persons for other services/programs.

Duration/Dosage:

Venue: Health fairs and community fairs

Mode: Material Distribution

Health Communication/Public Information

Provider:

Outcome:

Level: Community

Target Population: General public or high-risk populations

Other: Information tables or booths with interactive activities.

Community Level Interventions (WI)

Community level interventions are designed to reach risk populations through individuals who are approaching the community to which they belong, in an effort to raise awareness of issues that influence risk reduction. In addition to raising awareness, the intervention should help individuals build resiliency and gain a sense of support and community. Ideally, community level interventions will change the attitudes among a risk population, which could result in behavior changes to reduce the risk of HIV infection.

Often community level interventions are recommended for difficult-to-reach risk populations, as a way to build trust in service providers and support among community members. Community level interventions should not be used in place of individual level interventions, group level interventions, or outreach to reach risk populations that already maintain a sense of community support and have solid knowledge of risk behaviors of their population. Service providers should be able to justify using a community level intervention over these those, due to the specific needs of the particular risk population.

Includes:

- *Scientific Basis*
- *Resources*

Duration/Dosage:

Venue: Community

Mode: Community Mobilization

Provider: Individuals who belong to the community

Outcome: Behavioral

Level: Community

Target Population: At-risk populations

Other: Should not be used in place of ILI, GLI or outreach.
Should build resiliency and gain a sense of support and community.

Counseling and Testing

The Number of Intervention Characteristics by Each Counseling and Testing Intervention

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Counseling and Testing	AK		✓	✓	✓	✓	✓			5
HIV Counseling, Testing and Partner Referral	CA			✓	✓	✓	✓			4
HIV Prevention Counseling, Testing and Referral	CH			✓	✓	✓	✓		✓	5
Counseling, Testing and Referral	CO	✓	✓	✓	✓	✓	✓	✓	✓	8
Counseling and Testing	CT	✓		✓		✓	✓			4
School-based Clinics for HIV Testing and Prevention	CT		✓	✓		✓	✓	✓		5
Counseling, Testing, Reporting and Partner Notification	HO			✓		✓	✓			3
Counseling, Testing, Referral (CTR)	IA		✓	✓	✓	✓	✓	✓		6
Counseling and Testing (C/T)	IL		✓	✓	✓	✓	✓	✓		6
HIV Counseling, Testing, Referral, and Partner Notification (CTRPN)	KS		✓	✓		✓	✓	✓	✓	6
Perinatal Transmission Prevention Activities	KS			✓		✓	✓		✓	5
HIV Counseling, Testing and Referral Services	LA		✓	✓	✓	✓	✓	✓		6
HIV Antibody Counseling and Testing	MA			✓		✓	✓			3

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Counseling, Testing and Referral (CTR)	MI			✓		✓				2
HIV Counseling and Testing	MN		✓							4
Non-Clinic Based HIV CTRPN	NH	✓	✓	✓	✓	✓	✓			6
Clinic Based HIV CTRPN (Counseling, Testing, Referral and Partner Notification)	NH	✓	✓	✓	✓	✓	✓	✓		7
Counseling, Testing, Referral and Partner Notification	NV			✓	✓	✓	✓	✓		5
Voluntary HIV Counseling & Testing	OK			✓	✓	✓	✓			4
Mobile Field Based Counseling and Testing	OK		✓	✓		✓	✓			4
Client-Centered Counseling	OK	✓		✓	✓	✓	✓			5
Voluntary HIV Counseling and Testing	SD			✓		✓	✓			3
Mobile Field- Based Counseling and Testing	SD		✓	✓	✓	✓				4
Counseling, Testing, Referral and Partner Notification	TN			✓		✓	✓	✓		4
HIV Counseling, Testing, Referral and Partner Notification (CTRPN)	VT			✓		✓	✓			3
Counseling and Testing Services (CTS)	WI	✓	✓	✓	✓	✓	✓			6

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Counseling, Testing, Referral and Partner Notification (CTRPN)	WY			✓			✓	✓	✓	4
TOTAL (N = 27)		6	13	26	14	25	24	4	3	454

✓ - Indicates that evidence of the intervention characteristic was found in reviewing the FY 2001 Cooperative Agreement Applications and Comprehensive Plans and Web sites. Definitions or guidelines addressing these elements may exist in other documentation not reviewed for this study.

Counseling and Testing – Listing of Evidence by Intervention Characteristic

Duration/Dosage:

	InterventionName:	Evidence of Intervention Characteristic:
CO	Counseling, Testing and Referral	Pretest: 20mins Posttest-negative: 10-15mins Posttest-positive: 60mins 2nd Posttest-positive: 60mins People are encourage to seek CTS services at the following points in their lives when they are engaging in behaviors that put them at risk for HIV infection (Every 6mos for those
CT	Counseling and Testing	Pre- and post test sessions (2)
NH	Non-Clinic Based HIV CTRPN	2 Sessions
NH	Clinic Based HIV CTRPN (Counseling, Testing, Referral and Partner Notification	2 sessions
OK	Client-Centered Counseling	Content and amount determined by client's level of knowledge
WI	Counseling and Testing Serivces (CTS)	Two sessions

Venue:

	InterventionName:	Evidence of Intervention Characteristic:
AK	Counseling and Testing	Outreach setting, clinic or agency office
CO	Counseling, Testing and Referral	Sites (e.g., clinics, CBOs), community, or through outreach (streets)
CT	School-based Clinics for HIV Testing and Prevention	Health care facility/clinic
IA	Counseling, Testing, Referral (CTR)	Safe environment
IL	Counseling and Testing (C/T)	Fixed, Satellite, and Outreach Sites
KS	HIV Counseling, Testing, Referral, and Partner Notification (CTRPN)	Private and public areas known to have high rates of HIV infection and a high number of HIV high-risk individuals

LA	HIV Counseling, Testing and Referral Services	DHH clinics, drug treatment ctrs, prisons, mobile units, CBOs, health ctrs
MN	HIV Counseling and Testing	HIV/STD C/T site, other clinic, community setting
NH	Non-Clinic Based HIV CTRPN	Locations where clients are likely to be in their day-to-day lives.
NH	Clinic Based HIV CTRPN (Counseling, Testing, Referral and Partner Notification)	Clinic
OK	Mobile Field Based Counseling and Testing	Mobile vans
SD	Mobile Field- Based Counseling and Testing	Mobile van
WI	Counseling and Testing Services (CTS)	Clinics, CBOs, Community health clinics, HDs, etc.

Mode:

The majority of counseling and testing interventions indicated having both counseling and biomedical modes, but the level of structure for each mode varied by the jurisdictions' definitions.

	InterventionName:	Evidence of Intervention Characteristic:
AK	Counseling and Testing	Counseling – minimally structured
CA	HIV Counseling, Testing and Partner Referral	Biomedical – semi-structured Counseling – structured
CH	HIV Prevention Counseling, Testing and Referral	Counseling – structured Biomedical – minimally structured
CO	Counseling, Testing and Referral	Counseling – structured Biomedical – structured
CT	School-based Clinics for HIV Testing and Prevention	Biomedical – minimally structured Material Distribution – minimally structured
CT	Counseling and Testing	Counseling – structured or semi-structured
HO	Counseling, Testing, Reporting and Partner Notification	Counseling – structured Biomedical – structured

IA	Counseling, Testing, Referral (CTR)	Counseling – structured Biomedical – structured
IL	Counseling and Testing (C/T)	Counseling – structure Biomedical – structured
KS	HIV Counseling, Testing, Referral, and Partner Notification (CTRPN)	Counseling – structured Biomedical – structured
KS	Perinatal Transmission Prevention Activities	Biomedical – minimally structured
LA	HIV Counseling, Testing and Referral Services	Counseling – structured Biomedical – minimally structured
MA	HIV Antibody Counseling and Testing	Counseling – minimally structured Biomedical – minimally structured
MI	Counseling, Testing and Referral (CTR)	Counseling- minimally structured Biomedical – minimally structured
NH	Non-Clinic Based HIV CTRPN	Biomedical – structured Counseling – structured
NH	Clinic Based HIV CTRPN (Counseling, Testing, Referral and Partner Notification)	Biomedical – structured Counseling – structured
NV	Counseling, Testing, Referral and Partner Notification	Counseling – semi-structured or minimally structured
OK	Mobile Field Based Counseling and Testing	Counseling – semi-structured Biomedical – structured
OK	Client-Centered Counseling	Counseling – structured
OK	Voluntary HIV Counseling and Testing	Counseling – semi-structured Biomedical – semi-structured
SD	Mobile Field- Based Counseling and Testing	Counseling – semi-structured Biomedical – semi- structured
SD	Voluntary HIV Counseling and Testing	Counseling – semi-structured Biomedical – semi – structured
TN	Counseling, Testing, Referral and Partner Notification	Biomedical – semi-structured Counseling – semi-structured

VT	HIV Counseling, Testing, Referral and Partner Notification (CTPRN)	Biomedical – minimally structure Counseling – minimally structured
WI	Counseling and Testing Services (CTS)	Counseling – structured; Biomedical – minimally structure Material distribution – semi- structured
WY	Counseling, Testing, Referral and Partner Notification (CTPRN)	Biomedical – minimally structured Counseling – minimally structured

Provider:

Fourteen of the 16 interventions with evidence of descriptions or standards for a provider, indicated that the provider of counseling and testing and referral services should be a professional. One jurisdiction also included trained volunteers in its definition and another described referred to the individual as a prevention provider.

	InterventionName:	Evidence of Intervention Characteristic:
LA	HIV Counseling, Testing and Referral Services	Professionals and trained volunteers
OK	Voluntary HIV Counseling and Testing	Prevention Provider

Outcome:

	InterventionName:	Evidence of Intervention Characteristic:
AK	Counseling and Testing	Biomedical
CA	HIV Counseling, Testing and Partner Referral	Biomedical Behavioral
CH	HIV Prevention Counseling, Testing and Referral	Behavioral Biomedical
CO	Counseling, Testing and Referral	Biomedical Behavioral
CT	School-based Clinics for HIV Testing and Prevention	Biomedical
CT	Counseling and Testing	Behavioral
HO	Counseling, Testing, Reporting and Partner Notification	Biomedical
IA	Counseling, Testing, Referral (CTR)	Behavioral

IL	Counseling and Testing (C/T)	Biomedical
KS	HIV Counseling, Testing, Referral, and Partner Notification (CTRPN)	Biomedical Behavioral
KS	Perinatal Transmission Prevention Activities	Biomedical
LA	HIV Counseling, Testing and Referral Services	Behavioral Biomedical
MA	HIV Antibody Counseling and Testing	Behavioral Biomedical
MI	Counseling, Testing and Referral (CTR)	Biomedical Behavioral
NH	Non-Clinic Based HIV CTRPN	Biomedical Behavioral
NH	Clinic Based HIV CTRPN (Counseling, Testing, Referral and Partner Notification)	Biomedical Behavioral
NV	Counseling, Testing, Referral and Partner Notification	Behavioral
OK	Mobile Field Based Counseling and Testing	Biomedical Behavioral
OK	Client-Centered Counseling	Behavioral
OK	Voluntary HIV Counseling and Testing	Biomedical Behavioral
SD	Mobile Field- Based Counseling and Testing	Behavioral Biomedical
SD	Voluntary HIV Counseling and Testing	Behavioral Biomedical
TN	Counseling, Testing, Referral and Partner Notification	Biomedical Behavioral
VT	HIV Counseling, Testing, Referral and Partner Notification (CTPRN)	Biomedical Behavioral
WI	Counseling and Testing Services (CTS)	Behavioral Biomedical

Level:

	InterventionName:	Evidence of Intervention Characteristic:
AK	Counseling and Testing	Individual
CA	HIV Counseling, Testing and Partner Referral	Individual
CH	HIV Prevention Counseling, Testing and Referral	Individual
CO	Counseling, Testing and Referral	Individual
CT	School-based Clinics for HIV Testing and Prevention	Community
CT	Counseling and Testing	Individual
HO	Counseling, Testing, Reporting and Partner Notification	Individual
IA	Counseling, Testing, Referral (CTR)	Individual
IL	Counseling and Testing (C/T)	Individual
KS	HIV Counseling, Testing, Referral, and Partner Notification (CTRPN)	Individual
KS	Perinatal Transmission Prevention Activities	Individual
LA	HIV Counseling, Testing and Referral Services	Individual
MA	HIV Antibody Counseling and Testing	Individual
NH	Non-Clinic Based HIV CTRPN	Individual
NH	Clinic Based HIV CTRPN (Counseling, Testing, Referral and Partner Notification)	Individual
NV	Counseling, Testing, Referral and Partner Notification	Individual
OK	Mobile Field Based Counseling and Testing	Individual
OK	Client-Centered Counseling	Individual
OK	Voluntary HIV Counseling and Testing	Individual
SD	Voluntary HIV Counseling and Testing	Individual
TN	Counseling, Testing, Referral and Partner Notification	Individual

VT	HIV Counseling, Testing, Referral and Partner Notification (CTPRN)	Individual
WI	Counseling and Testing Services (CTS)	Individual
WY	Counseling, Testing, Referral and Partner Notification (CTRPN)	Individual

Target Population:

	InterventionName:	Evidence of Intervention Characteristic:
CO	Counseling, Testing and Referral	Individuals with a history of one or more of the following: IDU, sex with a person with HIV/AIDS, sex with an MSM, sex with an IDU, an STD, exchanging money for drug or sex. Special emphasis in young MSM, people of color and women who engage in said behaviors
CT	School-based Clinics for HIV Testing and Prevention	Students
IA	Counseling, Testing, Referral (CTR)	High-risk individuals
IL	Counseling and Testing (C/T)	High-risk and HIV positive individuals
KS	HIV Counseling, Testing, Referral, and Partner Notification (CTRPN)	High-risk and HIV positive individuals
KS	Perinatal Transmission Prevention Activities	HIV high-risk pregnant women
LA	HIV Counseling, Testing and Referral Services	MSM, Females, Youth, Substance users, Ethnic minorities
NH	Clinic Based HIV CTRPN (Counseling, Testing, Referral and Partner Notification)	HIV positive individuals
NV	Counseling, Testing, Referral and Partner Notification	HIV positive individuals and their partners
TN	Counseling, Testing, Referral and Partner Notification	High-risk behavior individuals
WY	Counseling, Testing, Referral and Partner Notification (CTRPN)	MSM

Other:

	InterventionName:	Evidence of Intervention Characteristic:
CA	HIV Counseling, Testing and Partner Referral	<p>A good counseling and testing program will focus on enhancing and developing skills for behavior change</p> <p>Will conduct the session with full client participation; and</p> <p>Will link that individual to follow-up activities.</p>
CH	HIV Prevention Counseling, Testing and Referral	<p>Must be in compliance with Health Department policies, guidelines, protocols, and performance standards.</p> <p>HIV Prevention Counseling, Testing and Referral cannot be funded as a stand-alone intervention (i.e., as the only intervention in a program) but must be coupled with 1 or more of the other HPPG approved interventions.</p>
CO	Counseling, Testing and Referral	<p>Dosage: 6 weeks after high risk behavior; every six months until minimal risk behavior is achieved; Once a year for those who have achieved minimal risk behavior.</p> <p>2 critical components:1) client-centered (counseling is tailored to the behavior, circumstances, and special needs of a person) and 2) focus on personal risk assessment, development of a personalized action plan, and the decision to test.</p>
KS	Perinatal Transmission Prevention Activities	<p>Ensure that HIV-infected women and HIV-exposed infants have access to appropriate prevention interventions to reduce perinatal HIV transmission, and that HIV-infected women have access to appropriate treatment services.</p>

Jurisdictions' Definitions of Counseling and Testing

Counseling and Testing (AK)

Client centered HIV risk assessment and risk reduction counseling in the context of HIV testing. May take place in an outreach setting or in a clinic or agency office.

Duration/Dosage:

Venue: Outreach setting, clinic or agency office

Mode: Counseling – minimally structured

Provider: Professional

Outcome: Biomedical

Level: Individual

Target Population:

Other:

HIV Counseling, Testing and Partner Referral (CA)

Program Category 1: Individual-Level Interventions

Individual level interventions provide information, risk assessment, and risk reduction counseling to assist individuals to learn about transmission and risk behaviors, make plans for individual behavior change and ongoing appraisal of their own behaviors, and to facilitate linkages to resources to support behavior changes. The common denominator of these strategies is their focus on one-on-one interactions between provider and individual.

Definition based upon a review of the literature:

1. HIV Antibody Counseling, Testing, and Partner Referral – HIV counseling, testing and partner referral allows individuals to learn their serostatus and to receive prevention counseling and referral to other preventive, medical and social services. Testing is often done either anonymously (client tests without personal identifiers) or confidentially (patient must give consent to be tested; personal identifier used). The strongest programs include partner referral and support services for parents of infants and referral.

Scientific theory supports the belief that screening is much more effective when there are follow-up activities to reduce the continued spread of the virus. A good counseling and testing program will focus on enhancing and developing skills for behavior change; will conduct the session with the full client participation; and will link that individual to follow-up activities. According to the Institute for Health Policy Studies (1993), "Extending counseling and education interventions appear to provide substantial benefits in most settings.

2. Education, Information, and Referral Hotlines

3. Street and Community Outreach
4. Individual Peer Education
5. On-site Risk Reduction Education and Counseling
6. Prevention Case Management
7. Needle Exchange Programs
8. Condoms, Other Barriers, and Bleach Demonstration and Distribution

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue:

Mode: Biomedical – semi-structured

Counseling – structured

Provider: Professional

Outcome: Biomedical

Behavioral

Level: Individual

Target Population:

Other: A good counseling and testing program will focus on enhancing and developing skills for behavior change;
Will conduct the session with full client participation; and
Will link that individual to follow-up activities.

HIV Prevention Counseling, Testing and Referral (CH)

Describes:

- I. Minimum Criteria
 - A. Helps clients identify their risk(s) for acquiring or transmitting HIV
 - B. Negotiate a realistic HIV risk-reduction plan
 - C. Prepare a client to receive, understand, manage the test result
 - D. Allow the client to learn their HIV serostatus
 - E. Make referrals for additional medical and social services
 - F. Offer STD screening and treatment services
 - G. Offer Partner Counseling and Referral (PCR) services
 - H. Must be delivered by qualified and trained staff
 - I. Must be in compliance with Health Department policies, guidelines, protocols, and performance standards
 - J. HIV Prevention Counseling, Testing and Referral cannot be funded as a stand-alone intervention (i.e., as the only intervention in a program) but must be coupled with 1 or more of the other HPPG approved interventions.

II. Quality Assurance Measures

- A. Staff must have been trained in pre and post HIV test/counseling. This training must have been completed within the past 12 months (or received update training) through CDPH or IDPH

III. Data Requirements

- A. In an effort to better document service delivery citywide, all CDPH prevention funded agencies will be required to collect and submit the following data for each intervention used in their program. Data will be submitted to CDPH scan forms (provided by CDPH). This information will be used to improve the quality and effect of HIV prevention projects in Chicago.
 1. Type of agency
 2. Risk population
 3. Client demographics
 4. Setting
 5. Number of interventions
 6. Staffing
 7. Expenditures
 8. Number of clients who return for their results
 9. Number of clients who have received post test counseling

What Works in Prevention?

Key factors of Successful Interventions and Programs

I. Services are:

- A. delivered in a culturally appropriate and culturally sensitive manner
- B. easily accessed
- C. voluntary

II. Target Population is:

- A. clearly defined and with a proven need of HIV prevention services

III. Goals and Objectives of the Program are:

- A. clearly defined, time-phased, and measurable

IV. Interventions are:

- A. based on sound behavioral research
- B. well planned, implemented, monitored and evaluated
- C. created (whenever possible) with input from target population
- D. focused on reducing specific behaviors and address skill levels, attitudes, and behaviors that influence high risk activities (i.e., how to use condoms appropriately, how to clean injection equipment, and reinforcing positive attitudes about condom use)
- E. vehicles for demonstrating, reinforcing, and promoting positive behaviors

V. Agencies have:

- A. the ability to maintain multiple contacts with participants
- B. the ability to document service delivery (i.e., develop and maintain survey questionnaires, client assessment forms, etc.)

- C. a strong referral and follow-up system exists (formal, established, and written with signed memorandums of agreement)
 - D. the ability and desire to collaborate with other organizations
 - E. policies that conform with prevailing local, state and federal laws regarding client confidentiality
 - F. staff with necessary academic background or experience in a human-services-related field (i.e., social work, psychology, nursing, counseling, or health education); and case management and assessment techniques
 - G. staff that are knowledgeable about HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change.
- VI. How Do We Assure Quality?
- A. Minimum Quality Assurance Standards
- VII. Services are:
- A. offered in a safe environment. The agency should be clean, neat, well ventilated, and clutter free
- VIII. Interventions are:
- A. whenever possible, implemented/delivered by individuals representative of the target population
- IX. Agencies have:
- A. Policies and Procedure Manual. This manual must contain all intervention protocols, policies, and procedures of the services being delivered
 - B. current collaborative linkages within community and, when possible, should participate in one or more Community Planning Groups
 - C. staff that are familiar with available community resources
 - D. staff that are trained in the implementation of program intervention(s). All trainings must be documented in staff folders. The agency should promote and encourage continuing educational trainings.
 - E. grievance procedures in place and a method for informing clients of this process. Proof of client receipt should be documented in client charts
 - F. policies on staff safety (on site and off site)
 - G. a relationship with local authorities (police) such that the program is well known in the community
 - H. regular assessments of clients satisfaction through periodic client satisfaction surveys
 - I. regular management/supervisors meetings with program staff to discuss project and status progress towards stated outcomes"

Duration/Dosage:

Venue:

Mode: Counseling – structured
Biomedical – minimally structured

Provider: Professional

Outcome: Behavioral
Biomedical

Level: Individual

Target Population:

Other: Must be in compliance with Health Department policies, guidelines, protocols, and performance standards.
HIV Prevention Counseling, Testing and Referral cannot be funded as a stand-alone intervention (i.e., as the only intervention in a program) but must be coupled with 1 or more of the other HPPG approved interventions.

Counseling, Testing and Referral (CO)

HIV Prevention Counseling is a client-centered and harm reduction oriented exchange designed to support individuals in making behavior changes that will reduce their risk or acquiring or transmitting HIV and test to learn their HIV antibody status. There are two critical components to this definition. Client-centered means that counseling is tailored to the behavior, circumstances, and special needs of a person. Equally important is its focus on personal risk assessment, development of a personalized action plan, and the decision to test.

CTR programs must include general characteristics of successful HIV prevention programs, especially those described in behavioral and social science literature. Each provider must demonstrate how their program flows from and is consistent with social and behavioral theory and research relevant to HIV risk reduction.

- Goal of the Intervention:
 - to provide a convenient opportunity for persons to learn their current serostatus;
 - to allow such persons to receive client-centered and harm reduction oriented HIV prevention counseling to help initiate incremental behavior change to prevent the transmission or acquisition of HIV;
 - to help persons obtain client-centered, specific and facilitated referrals to receive additional medical care, prevention, psychosocial, and other needed services;
 - to provide prevention services and client-centered referrals for sex and needle-sharing persons.

The objectives of a brief HIV prevention counseling session is to assess actual and self-perceived HIV/STD risk, to help the participant recognize barriers to risk reduction, to

negotiate an acceptable and achievable risk-reduction plan, and to support patient-initiated behavior change.

- Target Population: Individuals who have a history of one or more of the following shall be considered to be at high/increased risk: injection drug use, sex with a person with HIV/AIDS, sex with a man who has sex with men, sex with an injection drug user, a sexually transmitted disease, exchanging money for drug or sex.

A special emphasis should be placed on members of the following groups who engage in high/increased behaviors: young men who have sex with men, people of color, women.

- Cultural competence/proficiency: ...
- Where Delivered: Possible sites for CTR services include counseling, testing, and referral locations, local health departments, community-based organizations, substance abuse treatment centers, sexually transmitted disease clinics, family planning clinics, public sex environments

During 2000, state-designated counseling and testing sites (CTS) will begin implementing their plan for providing testing services in the following three settings:

1. Site-based: Providing services at the agency during established business hours. Clients must come in for services.
2. Community-based: Services are provided in the community. Clients must still "come in" for testing however, testing has been taken into the community
3. Outreach: Services are provided "on the street" in areas of high morbidity and/or areas where individuals are engaging in high/increased risk behavior for HIV infection. Outreach testing does not require the client to "come in" – agencies are required to go where the clients are and offer testing services.

CDPHE strongly encourages agencies to develop a collaborative relationship with agencies within their area that have a relationship with access to individuals engaging in high/increased risk behavior for HIV infection.

- When Delivered: CTS is typically provided during business hours. Evening, weekend hours and walk-in services are strongly encouraged.

People are encouraged to seek CTS services at the following points in their lives when they are engaging in behaviors that put them at risk for HIV infection:

If never tested before, 6-weeks after a high/increased risk behavior. Every six-months for those engaged in a risk reduction plan who have not yet achieved minimal risk behavior. Once a year for those individuals who have successfully engaged in a risk reduction plan who have achieved minimal risk behavior and possibly retest for the support and positive reinforcement of that behavior change.

- Duration of the Intervention:
 - Pretest counseling, testing and referral (average 20 minutes)
 - Posttest:
 - negative (case by case basis/average 10-15 minutes)
 - positive (case by case basis/average 60 minutes)
 - Second post-test positive (case by case basis/average 60 minutes)

It is important to recognize that many clients may need multiple sessions to achieve optimal reduction in their risk behavior, I.e., minimal chance of HIV transmission. Such clients will need to be referred to intervention which include multiple sessions.

- Content and Methods Employed: (Includes sub-sections on: Intervention Methods; Standards for Giving Results; Make referral and provide support; Confidential and Anonymous Testing; and Specimen Collection)
- Qualifications of HIV Prevention Counselors: Colorado Board of Health Rules and Regulation Pertaining to the Reporting, Prevention, and Control of AIDS, HIV-Related Illness, and HIV Infection – Regulation #6 (A-1):

Counselors may be paid staff or volunteers. Whether paid staff or volunteers, all counselors (contracted) providing counseling, testing and referral services must have successfully completed the CDC course "Fundamentals of HIV Prevention Counseling" or an approved equivalent of not less than 16 hours. All equivalent need to be approved by the Colorado Department of Public Health and Environment STD/AIDS Technical Assistance and Training Program.

- Continuing Education/Ongoing Training Requirements: Colorado Board of Health Rules and Regulation Pertaining to the Reporting, Prevention, and Control of AIDS, HIV-Related Illness, and HIV Infection – Regulation #6 (A-2):

All counselors providing ten or more pre or posttest counseling sessions per calendar quarter (every 3 months) are required to attend one State approved continuing education course per year. Those Contractors which do not have any counselors providing ten or more pre or posttest counseling sessions per calendar quarter are required to have a minimum of one counselor per year attend a State approved HIV continuing education course.

- Consent/Confidentiality Considerations: ...
- Quality Assurance: ...
- Evaluation: ...
- Penalties for Violating Standards: ...
- Other: ...

<i>Duration/Dosage:</i>	<p>Pretest: 20mins;</p> <p>Posttest-negative: 10-15mins;</p> <p>Posttest-positive: 60mins;</p> <p>2nd Post-pos:60mins</p> <p>People are encourage to seek CTS services at the following points in their lives when they are engaging in behaviors that put them at risk for HIV infection (Every 6mos for thosewho have not reached minimal risk behavior).</p>
<i>Venue:</i>	Sites (e.g., clinics, CBOs), community, or through outreach (streets)
<i>Mode:</i>	<p>Counseling – structured</p> <p>Biomedical – structured</p>
<i>Provider:</i>	Professional
<i>Outcome:</i>	<p>Biomedical</p> <p>Behavioral</p>
<i>Level:</i>	Individual
<i>Target Population:</i>	Individuals with a history of one or more of the following: IDU, sex with a person with HIV/AIDS, sex with an MSM, sex with an IDU, an STD, exchanging money for drug or sex. Special emphasis in young MSM, people of colorand women who engage in said behaviors.
<i>Other:</i>	<p>Dosage: 6 weeks after high risk behavior; every six months until minimal risk behavior is achieved; Once a year for those who have achieved minimal risk behavior.</p> <p>2 critical components:</p> <ol style="list-style-type: none"> 1. client-centered (counseling is tailored to the behavior, circumstances, and special needs of a person) and 2. focus on personal risk assessment, development of a personalized action plan, and the decision to test.

Counseling and Testing (CT)

Encompassed under ILI – Interventions that target one person. In individual level interventions, one person (e.g., an HIV test counselor) is doing an HIV prevention intervention with another single individual (e.g., the person being tested).

Counseling and testing involves an individual voluntarily deciding to get an HIV test, and receiving pretest and posttest counseling. Testing can be either anonymous (I.e., the person's name is never asked for and results are given by code number) or confidential (i.e., the patient's name is associated with their result). Pretest counseling involves asking the patient about their past and current sexual and needle use risk behavior, and evaluating their risk exposure to HIV. Posttest counseling involves encouraging the patient to engage in safer sexual behavior, and to either stop needle use or make their needle use safer. In the case of an HIV positive test, patients are given options for treatment, and explanations of treatments. According to CDC guidelines, patients who test HIV positive should also receive a thorough mental health evaluation to determine suicidal potential, coping ability, and sources of social support.

Does the intervention change behavior? ...

With what populations is it successful in changing behavior?

- Counseling and testing appears to be most successful at changing behaviors with those who test HIV positive and with serodiscordant couples (where one partner is HIV positive and one is HIV negative). Some studies have shown that risky behavior may increase after a negative HIV test.

<i>Duration/Dosage:</i>	Pre- and post test sessions (2)
<i>Venue:</i>	
<i>Mode:</i>	Counseling – structured or semi-structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	

School-based Clinics for HIV Testing and Prevention (CT)

Encompassed under Community Level Interventions – These are interventions that try to change HIV risk behavior by changing community norms (and sometimes even the laws) of a community to support HIV prevention.

School based clinics are usually general health clinics located on school grounds that treat all kinds of problems, and provide other types of birth control in addition to condoms. They may provide condoms and HIV testing to students.

Does The Intervention Change Behavior?

- There are very few, if any, school-based clinics that have been evaluated in terms of HIV risk behavior change.
- In general, school-based clinics don't seem to increase sexual activity among students, but they may not increase contraception use or condom use either.

With What Populations Is It Successful In Changing Behavior?

- May be most successful in areas such as inner cities where students may not have access to health care from other sources.

Duration/Dosage:

Venue: Health care facility/clinic

Mode: Biomedical – minimally structured

Material Distribution – minimally structured

Provider:

Outcome: Biomedical

Level: Community

Target Population: Students

Other:

Counseling, Testing, Reporting and Partner Notification (HO)

This intervention is part of standard procedures that accompany the HIV test and it blends a client-centered counseling approach with risk-reduction education and testing procedures (Bor, Miller and Goldman, 1992; Green and McCreaner, 1989). According to CDC guidelines, pretest client-centered counseling is conducted to establish the reasons for testing (including an individual's prior history of risky behaviors), provide basic information about testing procedures and HIV/AIDS and explain the implications of getting the HIV test. Post-test counseling focuses on communicating test results, assess the individual's response to the results, discuss its consequences and provide risk-reduction counseling tailored to the needs of the client (CDC, 1994).

Also included in Comprehensive Plan.

Duration/Dosage:

Venue:

Mode: Counseling – structured
Biomedical – structured

Provider:

Outcome: Biomedical

Level: Individual

Target Population:

Other:

Counseling, Testing, Referral (CTR) (IA)

Includes description from the Taxonomy of HIV/AIDS Prevention Interventions from the Academy of Educational Development and the CDC's 2000 Evaluation Guidance (CDC, 1999) for the purpose of "making meaningful distinctions and choices among possible interventions".

Counseling and Testing provides a personalized, client-centered encounter in which an individual can learn her/his serostatus as well as obtain tools to assess her/his own risk. Counseling can help clients develop personal methods for behavior change that decrease risk for HIV and help in maintaining a low risk status. Clients can also receive referrals and information relevant to their needs as well as assistance in notifying partners.

Prevention providers report that counseling and testing services can motivate individuals to recognize their risk, ask questions about safer sex in safe environment, and formulate personal risk reduction plans. Counseling and testing programs allow prevention providers to identify new target populations.

Risk Assessment:

Risk assessment counseling consists of a meeting between a client and a trained HIV prevention counselor. It includes the assessment of a person's risk for referral purposes, and to determine appropriateness of testing. Information is provided to the client based on individual needs. Counseling and Testing services are confidential, where the client is guaranteed that identity and locating information will not be accessible to anyone outside of the immediate clinic of testing site.

Post-test Result Disclosure

Post-test disclosure sessions focus on giving clients their HIV test result, and also include provision of risk reduction counseling and referrals, and assistance with obtaining medical or other care. The primary purposes of post-test counseling are reinforcing a realistic perception of risk, helping those with a negative result initiate and sustain behavior change; arranging access to necessary medical, prevention, and case management services for people with

positive test results; and supporting HIV positive clients in referring sexual or needle sharing partners for testing.

Referrals:

Referrals provide individuals with resources appropriate to their particular needs at that time.

Serostatus Approach to Fighting the HIV Epidemic:

The primary goal of CTR is to increase the number of HIV-infected persons who know their status as soon after infection as possible. To reach that goal CTR prevention providers must encourage persons to seek testing. This can be accomplished by educating persons at risk about benefits of testing and by developing a campaign to decrease the stigma associated with HIV testing.

Providers also need to assure HIV testing is readily available to at-risk populations. Strategies include utilizing rapid HIV tests and offering outreach testing by community based organizations, offering routine voluntary testing in high prevalence medical settings, such as emergency rooms and offering testing in correctional facilities (Gayle, 2000).

Demonstrated effectiveness...

Suggested uses...

- a. advantages and strengths
- b. considerations

Includes a diagram illustrating a continuum through which high-risk HIV-negative individuals and those living with HIV infection receive optimal prevention and treatment services.

Duration/Dosage:

Venue: Safe environment

Mode: Counseling – structured
Biomedical – structured

Provider: Professional

Outcome: Behavioral

Level: Individual

Target Population: High-risk individuals

Other:

Counseling and Testing (C/T) (IL)

Counseling and testing (C/T) is a client-centered service delivered by trained personnel to all persons who request or are offered HIV testing. Anonymous and confidential services utilize HIV testing technology appropriate for the site, population, and staff qualifications.

Includes:

Goals of HIV C/T are to:

- help clients identify their risk(s) of acquiring or transmitting HIV
- negotiate a realistic and incremental HIV/STD risk reduction plan
- prepare the client to receive, understand, and manage the test result
- allow the client the opportunity to learn his or her HIV serostatus
- make referrals for additional medical and social services as needed
- offer STD screening and treatment services to persons at risk
- offer Partner Counseling and Referral Services (PCRS) to sex and needle sharing partners of HIV positive persons

HIV prevention counseling and testing is offered in three types of sites.

Fixed sites are traditional health department or clinical settings. Fixed sites provide regularly scheduled services by appointment or on a walk-in basis. Clients must travel to fixed sites to access services. Fixed sites typically serve a broad range of populations, although agencies may do targeted marketing to increase clients from priority populations.

Examples of fixed sites include health department anonymous HIV counseling and testing sites, STD clinics, and family planning clinics.

Satellite sites establish regularly scheduled services in nontraditional or nonclinical settings to make services more accessible to many high risk clients. Like fixed sites, satellite sites require clients to take initiative to seek services. However, well chosen satellite locations can reduce barriers such as those related to transportation, travel time, culture, "turf," and the clinical environment. Successful satellite sites are selected and marketed in partnership with the communities to be served. Examples of satellite sites include social services agencies, cultural centers, and local offices.

Outreach sites are located in settings that are easily and regularly frequented by members of a specific target population. Because certain at risk populations will not come to traditional health department settings to receive services, "outreach testing" staff go where high risk clients are and offer them immediately accessible services. Members of the target population have input in outreach site location, times, and culturally appropriate promotion. Some outreach sites are regularly scheduled, while others are offered one time only. Examples of outreach sites include gay bars, correctional facilities, housing projects, homeless shelters, and areas near shooting galleries.

Duration/Dosage:

Venue: Fixed, Satellite, and Outreach Sites

Mode: Counseling – structured

Biomedical – structured

Provider: Professional

Outcome: Biomedical

Level: Individual

Target Population: High-risk and HIV positive individuals

Other:

HIV Counseling, Testing, Referral, and Partner Notification (CTRPN) (KS)

A. Provide opportunities for individuals to:

1. learn whether they are HIV positive or HIV negative and
2. receive prevention counseling and referral to other health, medical, and psycho-social services.

- Provide confidential and anonymous client-centered HIV prevention counseling and testing within a 100 mile radius of where every Kansan lives.
- Provide services in private and public areas known to have:
 1. high rate of HIV infection; and/or
 2. a high number of individuals who engage in behaviors that put them at risk for HIV infection.
- Contact individuals, especially those who are HIV positive or at high risk of becoming infected, who have not returned to receive HIV test result, and post-test counseling to help them learn their serostatus.
- Offer partner counseling and referral services to ensure that sex and needle-sharing partners of HIV infected persons are notified about their risk and offered HIV prevention counseling, testing, and referrals.
- Ensure individuals who are at increased risk for HIV infection and those who are HIV receive further counseling, evaluation of immune system function, early positive medical intervention, STD screening and treatment, substance abuse counseling and treatment, tuberculosis testing and treatment, and family planning, by providing these services at the testing site or through linkages to other agencies.

B. Provide counseling and testing services that are tailored to the behaviors and unique needs of the individual being served and will help high-risk persons address their most pressing medical and psycho social needs.

- Conduct counseling which is
 1. focused on the client;
 2. interactive;
 3. sensitive to individual needs and sexual identity;

4. culturally competent;
 5. linguistically and age appropriate.
- Provide post-test counseling which includes the distribution of materials that
 1. describe why individuals should use recommended referral resources and obtain early treatment and care, and
 2. encourage HIV+ persons to take charge of their own health care and enhance the quality of their lives.

Duration/Dosage:

Venue: Private and public areas known to have high rates of HIV infection and a high number of HIV high-risk individuals

Mode: Counseling – structured
Biomedical – structured

Provider:

Outcome: Biomedical
Behavioral

Level: Individual

Target Population: High-risk and HIV positive individuals

Other:

Perinatal Transmission Prevention Activities (KS)

- A. Provide voluntary HIV testing available to pregnant women at high risk for HIV-infection.
- B. Ensure that HIV-infected women and HIV-exposed infants have access to appropriate prevention interventions to reduce perinatal HIV transmission, and that HIV-infected women have access to appropriate treatment services.

Duration/Dosage:

Venue:

Mode: Biomedical – minimally structured

Provider:

Outcome: Biomedical

Level: Individual

Target Population: HIV high-risk pregnant women

Other: Ensure that HIV-infected women and HIV-exposed infants have access to appropriate prevention interventions to reduce perinatal HIV transmission, and that HIV-infected women have access to appropriate treatment services.

HIV Counseling, Testing and Referral Services (LA)

Description: One-on-one client-centered counseling (both pre-and post test) with persons at high risk for HIV infection to decrease sexual and needle-sharing risk behaviors; offering of HIV test for individuals interested in knowing their HIV serostatus; and providing HIV counseling and testing to pregnant women. Provide appropriate referrals.

CDC Intervention level: Individual Level Intervention.

Theoretical Basis: Theory of Reasoned Action

Sites: DHH clinics; CBOs; drug treatment centers; community health centers; correctional facilities; and mobile testing by these agencies.

Key Elements:

- Compliance with Louisiana ACT 1054 regarding confidentiality, consent and disclosure of HIV testing.
- Assess clients risk.
- Develop realistic and incremental plan to reduce risk.
- Reinforce and support changes already attempted.
- Provide HIV testing, when applicable.
- Provide condoms, female condoms, bleach kits, etc. when appropriate.
- Refer pre-test and post-test negative for appropriate services.
- Must provide HIV-positive client with referral for further care and notification of partners of HIV-positive persons.
- Compliance with Louisiana ACT 1065 enabling minors (13 and older) to obtain screening treatment for venereal disease without parental consent.
- Utilize appropriate small media (information and risk-reduction guidance disseminated through print materials such as pamphlets, posters, and other literature; audio and video taped messages; etc.) to reinforce the counselors message.
- Practice harm reduction counseling with substance.

- Use of incentives and outreach during mobile testing events to enhance effectiveness should be considered.

Recommended Training: HIV/AIDS 101 Training, HIV Prevention Counseling Training, Annual HIV Update, Harm Reduction Training, STD Training, Substance Abuse and Mental Health cross-training.

Evaluation Methods...

Expected Outcomes: Behavior change/risk and harm reduction (e.g.. Decrease number of unprotected sex partners; decrease needle sharing, etc.); decreased STD rates; reduced perinatal transmission; increased life expectancy of HIV seropositive individuals due to increase access to services.

Implemented By: Trained Disease Intervention Specialists; substance abuse clinic staff; CBO staff; DHH staff; trained health care professionals and trained volunteers.

Includes:

1. Addresses High Priority Needs
2. Addresses Community/Cultural Norms and Values
3. Outcome Effectiveness
4. Accessible to the Target Populations
5. Intervention Feasibility and Cost-Effectiveness
6. Sources

Duration/Dosage:

Venue: DHH clinics, drug treatment ctrs, prisons, mobile units, CBOs, health ctrs

Mode: Counseling – structured
Biomedical – minimally structured

Provider: Professionals and trained volunteers

Outcome: Behavioral
Biomedical

Level: Individual

Target Population: MSM, Females, Youth, Substance users, Ethnic minorities

Other: Compliance with LA Act 1054 and 1065

HIV Antibody Counseling and Testing (MA)

In addition to its historic role of providing individuals at self-identified risk of HIV infection to learn their HIV status and, if needed, be referred to follow up HIV Care, the MPPG (Massachusetts Planning and Prevention Group) -sponsored Counseling and Testing Evaluation directed the Bureau to consider an expansion of counseling and testing into two new roles. The first is the translation of counseling into a more thoroughgoing risk assessment mechanism. The second is the articulation of counseling and testing as a triage tool for directing both HIV infected and uninfected individuals at continued high risk of infection into more sustained and intensive prevention interventions.

Duration/Dosage:

Venue:

Mode: Counseling – minimally structured
Biomedical – minimally structured

Provider:

Outcome: Behavioral
Biomedical

Level: Individual

Target Population:

Other:

Counseling, Testing and Referral (CTR) (MI)

CTR refers to HIV antibody testing and prevention counseling and referral services provided in the context of HIV antibody testing.

Duration/Dosage:

Venue:

Mode: Counseling – minimally structured
Biomedical – minimally structured

Provider:

Outcome: Biomedical
Behavioral

Level:

Target Population:

Other:

Non-Clinic Based HIV CTRPN (NH)

2 Sessions:

1. A trained counselor helps clients identify their risky behaviors and make a plan to reduce risks.
2. The client returns for test results and the counselor works with the client to strengthen his/her plan to reduce risky behavior.
3. Risk reduction supplies (condoms, lubricants, bleach kits, etc.) are provided.
4. Referrals are made to more extensive programs to help clients with risk reduction.
5. HIV+ individuals are referred to treatment and support services.
6. HIV+ individuals are assisted in notifying sex and needle sharing partners.
7. Testing services may include new test methods such as oral fluid tests, rapid tests
8. Counseling and testing as described above, but offered in locations where clients are likely to be in their day-to-day lives (e.g. neighborhood locations with mobile medical vans, community centers, bars, street outreach sites, etc.) Oral fluids tests and rapid tests may become useful in these settings.

Overall Premises to be Considered in All Interventions

1. All interventions need to explicitly define a population to be served and the steps to reach that population.
2. All interventions must have explicitly defined HIV prevention goals (e.g. reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required data collection will be more limited than for individual and group level interventions due to the nature of the work.)
6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.
7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

<i>Duration/Dosage:</i>	2 Sessions
<i>Venue:</i>	Locations where clients are likely to be in their day-to-day lives.
<i>Mode:</i>	Biomedical – structured Counseling – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Biomedical Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	

Clinic Based HIV CTRPN (Counseling, Testing, Referral and Partner Notification (NH)

2 Sessions:

- A trained counselor helps clients identify their risky behaviors and make a plan to reduce risks.
- The client returns for test results and the counselor works with the client to strengthen his/her plan to reduce risky behavior.
- Risk reduction supplies (condoms, lubricants, bleach kits, etc.) are provided.
- Referrals are made to more extensive programs to help clients with risk reduction.
- HIV+ individuals are referred to treatment and support services.
- HIV+ individuals are assisted in notifying sex and needle sharing partners.
- Testing services may include new test methods such as oral fluid tests, rapid tests.

Overall Premises to be Considered in All Interventions

1. All interventions need to explicitly define a population to be served and the steps to reach that population.
2. All interventions must have explicitly defined HIV prevention goals (e.g. reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required data collection will be more limited than for individual and group level interventions due to the nature of the work.)
6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.

7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

<i>Duration/Dosage:</i>	2 sessions
<i>Venue:</i>	Clinic
<i>Mode:</i>	Biomedical – structured Counseling – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Biomedical Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	HIV positive individuals
<i>Other:</i>	

Counseling, Testing, Referral and Partner Notification (NV)

Counseling is the most individualized form of AIDS prevention. It is a one-on-one prevention method in which a trained counselor provides the client with information, support, referrals, and skills to reduce the risk of HIV/AIDS. Counseling in AIDS prevention programs has most often been associated with HIV testing, as most HIV testing programs require clients to receive counseling prior to being tested. Additional counseling and support is available to those who test positive for HIV, and many programs offer a partner notification component.

Partner notification programs help locate, counsel, and test the partner of HIV-infected individuals. They depend on the voluntary cooperation of the index patient to provide the names of partners, and are a means of identifying HIV-infected individuals who might otherwise be missed by screening program. Partner notification can be accomplished in two ways. In the patient referral method, HIV positive people notify their partners themselves and refer them to the health department for testing and counseling. In the provider method, the AIDS prevention counselors notify the partners based on the names given to them by the index patient. The name of the index patient is not disclosed to the partner (Patina et al., 1995). ...

Also includes advantages and disadvantages of intervention, and demonstrated effectiveness and implications.

Duration/Dosage:

Venue:

Mode: Counseling – semi-structured or minimally structured

Provider: Professional

Outcome: Behavioral

Level: Individual

Target Population: HIV + individuals and their partners

Other:

Voluntary HIV Counseling and Testing (OK)

Encompassed under Counseling, Testing, Referral, and Partner Counseling and Referral.

Voluntary HIV Counseling & Testing refers to the voluntary process of HIV testing accompanied by client-centered, interactive information-sharing in which an individual is made aware of the basic information about HIV/AIDS, testing procedures, and how to prevent the transmission and acquisition of HIV infection. In the best of situations, the individual also receives tailored information, skills and support in order to effectively incorporate HIV prevention into their daily life. Voluntary HIV counseling and testing is recommended because it fosters a trusting relationship between the prevention provider and client which facilitates better understanding of what the test means for the clients, their partners, and their families and helps ensure that they become linked to needed services and care.

Counseling provides a critical opportunity to assist the client in accurately identifying and assessing his or her risk of acquiring or transmitting HIV. Counseling also provides an opportunity to negotiate and reinforce a personalized action plan to eliminate the risk. Counseling prior to HIV testing should prepare the client to receive and manage his or her test result. Prevention counseling should also:

- Facilitate an accurate perception of HIV risk for those who are unaware, uninformed, misinformed, or in denial;
- Translate the client's risk perception into a risk reduction plan that may be enhanced by knowledge of HIV infection status;
- Help clients initiate and sustain behavior changes that reduce their risk of acquiring or transmitting HIV.

Anonymous testing opportunities, as well as confidential ones should be available to increase options for individuals seeking to learn their serostatus. The availability of anonymous services may encourage some persons at risk to seek services who would otherwise be reluctant to do so. (HIV Counseling, Testing and Referral: Standards and Guidelines, May 1994, CDC; N. Corby

and M. Jamner, (1996) "HIV Prevention Interventions: What Works and What Doesn't ?" Center for Behavioral Research and Services, California State University)

Also includes – Evidence of Effectiveness.

Duration/Dosage:

Venue:

Mode: Counseling – semi-structured

Biomedical – semi-structured

Provider: Prevention provider

Outcome: Biomedical

Behavioral

Level: Individual

Target Population:

Other:

Client-Centered Counseling (OK)

Encompassed under Counseling, Testing, Referral, and Partner Counseling and Referral.

(Information in this Section taken from Voluntary HIV Counseling and Testing Efficacy Study-Counselor Training Manual Prepared by The Center for AIDS Prevention Studies (CAPS) University of California, San Francisco, CA, USA, February 1995, unless otherwise cited.)

One way of attempting to change HIV risk behavior is to provide information about HIV, how it is transmitted and how transmission can be prevented. It is unclear if this is the most effective method of helping of clients to change their risk behavior. The client-centered approach to HIV counseling was designed to decrease the emphasis on education, persuasion and test results in favor of personalized risk assessment and the development of a personalized risk reduction plan for each client. The emphasis in client-centered counseling is on developing a risk reduction plan for each client that takes into account the client's emotional reactions, interpersonal situation, social/cultural context, specific risk behaviors and readiness to change.

The content of the counseling sessions and the amount of counseling that each client receives is determined by their level of knowledge and their specific, persona concerns about HIV/AIDS. Rather than providing standardized information about HIV/AIDS, the counselor solicits information about what the client already knows or has heard and then corrects misperceptions and provides additional information through discussion. The counselor also assists the client to cope with emotional reactions and to cope with the consequences of their HIV risk behavior. In the client-centered approach to HIV counseling, the client and counselor weigh whether taking the HIV antibody test at the time is consistent with the client's personal risk reduction goals.

The goal of client-centered HIV counseling is to develop an individualized risk reduction plan, to facilitate the participant to enact this plan, to help the participant cope with the emotional reactions to HIV counseling and testing, and to help the participant cope with interpersonal and familial consequences of HIV counseling and testing. Following the counseling intervention, participants are expected to have increased their accurate knowledge about HIV/AIDS to have accurately assessed their risk for HIV and to have an individualized risk reduction plan.

<i>Duration/Dosage:</i>	Content and amount determined by client's level of knowledge
<i>Venue:</i>	
<i>Mode:</i>	Counseling – structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	

Mobile Field Based Counseling and Testing (OK)

Encompassed under Counseling, Testing, Referral, and Partner Counseling and Referral.

(Information in this section taken from 'Connecting with Hard-to-Reach Clients' Barbara Adler, MFCCI in Focus Supplement Volume 13, Number 1, December 1997, unless otherwise cited.)

Mobile field-based counseling and testing, which has grown in popularity in recent years, makes HIV counseling and testing services particularly visible and accessible by bringing them directly into the communities hardest hit by the epidemic. Mobile testing is particularly effective if it is implemented consistently at annual events, offering time savings and other efficiencies for testing counselors and a sense of reliability and trust for clients. Some clients report that they test each year at street fairs and at no other site.

A variation on this theme is mobile testing on the street in mobile vans. Mobile vans provide space for HIV counseling and testing at night in high-risk communities, for example, at dance clubs or in public parks, or on streets, for instance, where sex workers commonly congregate. Mobile vans can also be set-up outside health fairs, near streets, and at community college events, rodeos, and county fairs.

Other mobile testing approaches include counseling and testing within the offices of agencies that provide other health care services, including HIV-related services. An outside HIV counseling and testing program can offer the clients of the host agency risk assessment, counseling and testing program' stationary sites. (In this scenario, the host agency would not have access to a client's test result unless the client chose to disclose the result and the agency requested this in writing.) This model of mobile testing is particularly valuable because it offers

host programs high quality counseling and testing and offers clients direct linkage to services such as HIV treatment, family planning, employment training, or substance abuse treatment.

Duration/Dosage:

Venue: Mobile vans

Mode: Counseling – semi-structured
Biomedical -structured

Provider:

Outcome: Biomedical
Behavioral

Level: Individual

Target Population:

Other:

Voluntary HIV Counseling and Testing (SD)

Encompassed under Counseling, Testing, Referral, and Partner Counseling and Referral.

Counseling and testing refers to voluntary process of HIV testing accompanied by client-centered, interactive information-sharing in which an individual is made aware of basic information about HIV/AIDS, testing procedures, and how to prevent the transmission and acquisition of HIV infection. In the best of situations, the individual also receives tailored information, skills and support in order to effectively incorporate HIV prevention into their daily life.

Counseling provides a critical opportunity to assist the client in accurately identifying and assessing his or her risk of acquiring or transmitting HIV. Counseling also provides an opportunity to negotiate and reinforce a personalized action plan to reduce or eliminate the risk. Counseling prior to HIV testing should prepare the client to receive and manage his or her test result. Prevention counseling should also:

- Facilitate an accurate perception of HIV risk for those who are unaware, uninformed, misinformed, or in denial;
- Translate the client's risk perception into a risk reduction plan that may be enhanced by knowledge of HIV infection status;
- Help clients initiate and sustain behavior changes that reduce their risk of acquiring or transmitting HIV.

Anonymous testing opportunities, as well as confidential ones should be available. The availability of anonymous services may encourage some persons at risk to seek services who would otherwise be reluctant to do so. (HIV Counseling, Testing and Referral: Standard and Guidelines, May 1994, CDC; N. Corby and M. Jamner, (1996) "HIV Prevention Interventions:

What Works and What Doesn't? Center for Behavioral Research and Services, California State University)

Includes:

- *Evidence of Effectiveness*
- *Risk Assessment*
- *Client-Centered Counseling*

Duration/Dosage:

Venue:

Mode: Counseling – semi-structured
Biomedical – semi-structured

Provider:

Outcome: Behavioral
Biomedical

Level: Individual

Target Population:

Other:

Mobile Field- Based Counseling and Testing (SD)

Encompassed under Counseling, Testing, Referral, and Partner Counseling and Referral.

(Information in this section is taken from Connecting with Hard to Reach Clients Barbara Adler, MFCCI in Focus Supplement Volume 13, Number 1, December 1997, unless otherwise cited)

Mobile field-based counseling and testing, which has grown in popularity in recent years, makes HIV counseling and testing services particularly visible and accessible by bringing them directly into the communities hardest hit by the epidemic. Mobile testing is particularly effective if it is implemented consistently at annual events, offering time savings and other efficiencies for testing counselors and a sense of reliability and trust for clients. Some clients report that they test each year at street fairs and at no other site.

A variation on this theme is mobile testing on the street in mobile vans. Mobile vans provide space for HIV counseling and testing at night in high-risk communities, for example, at dance clubs or in public parks, or on streets, for instance, where sex workers commonly congregate. Mobile vans can also be set-up outside health fairs, near streets, and at community college events, rodeos, and county fairs.

Other mobile testing approaches include counseling and testing within the offices of agencies that provide other health care services, including HIV-related services. An outside HIV counseling and testing program can offer the clients of the host agency risk assessment,

counseling and testing program' stationary sites. (In this scenario, the host agency would not have access to a client's test result unless the client chose to disclose the result and the agency recessed this in writing.) This model of mobile testing is particularly valuable because it offers host programs high quality counseling and testing and offers clients direct linkage to services such as HIV treatment, family planning, employment training, or substance abuse treatment.

Includes:

- *Mobile Testing Challenges*

Duration/Dosage:

Venue: Mobile van

Mode: Counseling – semi-structured
Biomedical – semi- structured

Provider: Professional

Outcome: Behavioral
Biomedical

Level:

Target Population:

Other:

Counseling, Testing, Referral and Partner Notification (TN)

Taken from section: Description of interventions.

Category I. CTRPN refers to voluntary HIV/AIDS counseling, testing, referral and partner notification. The basic assumption is that individuals are able to learn their serostatus, i.e., whether or not they are HIV positive or negative. This is called serostatus.

- a. 'Counseling' refers to the voluntary process of client-centered, interactive information sharing. In counseling, clients are given basic information about HIV/AIDS and testing procedures. They are made aware of how the disease is spread and how to prevent infection. Clients are also given information on how to tailor HIV prevention methods to their current lifestyle.
- b. 'Testing' refers to the actual blood drawn for the purpose of conducting the ELISA test or Western Blot to determine HIV status.
- c. 'Referral' is the process by which individuals with high risk behaviors and those infected with HIV are made aware of, and referred to preventive, psychosocial, and medical resources needed to meet their primary and secondary HIV prevention needs.

- d. 'Voluntary partner notification' is the process where sexual partners and needle-sharing partners are located and informed of their possible risk. They are encouraged to seek counseling and testing.
- e. 'Other' programs can be identified under this category. Specifically noted is the effort of continuing staff training in health care, employment, and school settings.

Duration/Dosage:

Venue:

Mode: Biomedical – semi-structured
Counseling – semi-structured

Provider:

Outcome: Biomedical
Behavioral

Level: Individual

Target Population: High-risk behavior individuals

Other:

HIV Counseling, Testing, Referral and Partner Notification (CTPRN) (VT)

The overall functions of Vermont's CTRPN Program should be the following:

- provide a convenient opportunity for persons to learn their current HIV status,
- allow such persons to receive prevention counseling to help initiate behavior changes to avoid infection, or, if they already infected, to prevent transmission to others,
- help persons obtain referrals to receive additional information, medical care, and other needed services, and
- provide prevention services and referrals for sex and needle-sharing partners of people with HIV.

Although it is unlikely that a single episode of HIV counseling will result in the immediate and permanent adoption of safer behaviors, client-centered HIV counseling and attendant prevention services (CTPRN) do contribute to the initiation and maintenance of safer behaviors.

Duration/Dosage:

Venue:

Mode: Biomedical – minimally structured
Counseling – minimally structured

Provider:

Outcome: Biomedical
Behavioral

Level: Individual

Target Population:

Other:

Counseling and Testing Services (CTS) (WI)

HIV counseling, in the context of testing, focuses on the reduction of individual risk behaviors, providing information regarding the HIV antibody test, and assisting the individual in making a decision regarding HIV testing. In publicly- funded sites, counselors offer two counseling sessions: one during the initial visit when an HIV antibody test is typically done, and a follow-up session when test results are provided. During the initial session, the emphasis is on a risk assessment for HIV infection and development of an individualized risk reduction plan. If the person decides to take the test, the counselor explains the test and possible results and obtains informed consent. During the test results session, the emphasis is on interpretation of the test result, continued support for the individual's risk reduction plan, and referrals to appropriate service providers as needed (HIV care and treatment providers, mental health providers, support groups, etc.) During either of the sessions, the person being tested may have the opportunity to learn about and obtain risk reduction materials such as male and female condoms.

The purpose of counseling and testing is two-fold:

1. to promote primary and secondary prevention through risk reduction counseling to change behaviors and
2. to identify cases of infection for referral to early intervention and treatment. HIV-infected persons are referred for medical follow-up, case management, and partner counseling and referral services (PCRS).

Includes:

- *Scientific Basis*
- *Resources*

<i>Duration/Dosage:</i>	Two sessions
<i>Venue:</i>	Clinics, CBOs, Community health clinics, HDs, etc.
<i>Mode:</i>	Counseling – structured Biomedical – minimally structured Material distribution- semi- structured
<i>Provider:</i>	Professional
<i>Outcome:</i>	Behavioral Biomedical
<i>Level:</i>	Individual
<i>Target Population:</i>	
<i>Other:</i>	

Counseling, Testing, Referral and Partner Notification (CTRPN) (WY)

Counseling, Testing, Referral and Partner Notification (CTRPN) refers here to all forms of voluntary HIV/AIDS counseling (anonymous and confidential) and partner notification when accompanied by HIV testing. It is further defined by three major tasks:

- a. Counseling and Testing refers to the voluntary process of client-centered, interactive information sharing in which the individual is made aware of the basic information about HIV/AIDS, assessing the individual's risk of acquisition and transmission, and affecting the individual's behavior in ways to reduce the risk of acquiring and transmitting HIV infection;
- b. Referral is more than just providing information to the client. It is the process by which HIV infected and high risk individuals are guided toward appropriate primary and secondary prevention services such as CD4 testing, TB testing and STD examination;
- c. Provider assisted Partner Notification is the voluntary process by which sex and needle-sharing partners are located and notified of their possible exposure to HIV and provide counseling and testing service.

Duration/Dosage:

Venue:

Mode: Biomedical – minimally structured
Counseling – minimally structured

Provider:

Outcome:

Level: Individual

Target Population: MSM

Other:

Needle/Syringe Exchange

The Number of Intervention Characteristics by Each Needle/Syringe Exchange Intervention

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Needle Exchange Programs	CA		✓	✓		✓	✓	✓		5
Needle Exchange Programs	CH		✓	✓		✓	✓	✓	✓	6
Needle Exchange Programs	CT			✓		✓	✓	✓		4
Needle Exchange	IL			✓				✓	✓	3
Needle Availability and Collection	LA		✓	✓	✓	✓	✓	✓	✓	7
Needle Exchange	LA		✓	✓	✓	✓	✓	✓	✓	7
Needle Exchange	MA			✓	✓	✓		✓	✓	5
Needle Exchange	NC			✓				✓	✓	3
Needle Exchange	NH			✓				✓	✓	3
Needle/Syringe Exchange Programs	NV			✓		✓		✓		3
Needle Exchange Programs	WI	✓	✓	✓	✓	✓	✓	✓	✓	8
TOTAL (N = 11)		1	5	11	4	8	6	11	8	38

✓ - Indicates that evidence of the intervention characteristic was found in reviewing the FY 2001 Cooperative Agreement Applications and Comprehensive Plans and Web sites. Definitions or guidelines addressing these elements may exist in other documentation not reviewed for this study.

Needle/Syringe Exchange – Listing of Evidence by Intervention Characteristic

Duration/Dosage:

	Intervention Name:	Evidence of Intervention Characteristic:
WI	Needle Exchange Programs	Consistent and continuous; Intensity not as high as for ILI

Venue:

	Intervention Name:	Evidence of Intervention Characteristic:
CA	Needle Exchange Programs	Areas where high risk people congregate
CH	Needle Exchange Programs	Health care facility/clinic
LA	Needle Exchange	Mobile or fixed sites in areas identified as high risk for IDU
LA	Needle Availability and Collection	Appropriate community sites
WI	Needle Exchange Programs	Location convenient to members of the target populations – based upon input of active users

Mode:

	Intervention Name:	Evidence of Intervention Characteristic:
CA	Needle Exchange Programs	Needle/syringe exchange Health education – minimally structured
CH	Needle Exchange Programs	Needle/syringe exchange Health Education – minimally structured
CT	Needle Exchange Programs	Needle/syringe exchange
IL	Needle Exchange	Needle/syringe exchange Health Education – minimally structured Counseling – minimally structured
LA	Needle Exchange	Needle/syringe exchange Health Education – minimally structured Counseling – minimally structured
LA	Needle Availability and Collection	Needle/syringe exchange

MA	Needle Exchange	Needle/syringe exchange
NC	Needle Exchange	Needle/syringe exchange
NH	Needle Exchange	Needle/syringe exchange
NV	Needle/Syringe Exchange Programs	Needle/syringe exchange
WI	Needle Exchange Programs	Outreach – semi-structured Health Education – minimally structured Counseling – minimally structured Needle/syringe exchange

Provider:

	Intervention Name:	Evidence of Intervention Characteristic:
LA	Needle Exchange	Trained CBO staff and volunteers
LA	Needle Availability and Collection	Professional
MA	Needle Exchange	State of Massachusetts
WI	Needle Exchange Programs	Paraprofessional (near peer), Peer

Outcome:

All 8 needle/syringe exchange programs referenced behavioral outcomes in the definition.

Level:

Four of the six needle/syringe exchange programs were described as individual level; the other two were referred to as being community level.

	Intervention Name:	Evidence:
CA	Needle Exchange Programs	Individual
CH	Needle Exchange Programs	Individual
CT	Needle Exchange Programs	Community
LA	Needle Exchange	Individual
LA	Needle Availability and Collection	Community
WI	Needle Exchange Programs	Individual

Target Population:

Ten interventions specifically targeted injection drug users (IDUs). The eleventh intervention, needle availability and collection (LA) described the target population as substance abusers.

Other:

	Intervention Name:	Evidence of Intervention Characteristic:
CH	Needle Exchange Programs	Needle Exchange cannot be funded as a stand-alone intervention (i.e., as the only intervention in a program) but must be coupled with 1 or more of the other HPPG approved interventions.
IL	Needle Exchange	NEPs offer a variety of related services, including harm reduction counseling, health education, condom distribution, referrals to treatment centers, health services, HIV prevention counseling and testing, and prevention case management.
LA	Needle Exchange	One-for-one exchange of used syringes for new. Practice harm reduction. Can be enhanced by advocating for supportive changes in existing laws and increasing availability of treatment for injection drug users.
LA	Needle Availability and Collection	Change attitudes of pharmacists about needle sales to IDUs from one of viewing needle sales as detrimental to viewing needle sales as a community service through educational sessions for pharmacists. Partner with treatment facilities. Establish systems for referral of high risk individuals by outreach workers to pharmacies
MA	Needle Exchange	Refers to the provision of free sterile needles and syringes to injection drug users in exchange for used injection equipment, and the delivery other risk and harm reduction services, including referrals to C/T, health care, drug treatment/detox, etc.
NC	Needle Exchange	Distribution of clean syringes, and other sterile injection drug equipment.
NH	Needle Exchange	Referrals offered into drug treatment centers and other services.

WI Needle Exchange Programs

Outreach workers should be trained in the following areas: the principles of outreach, the harm reduction model, referral sources, confidentiality issues, and safety issues.

Focuses on information dissemination, not on skills building and behavior change as with ILI. Includes needle exchange program.

Jurisdictions' Definitions of Needle/Syringe Exchange Programs

Needle Exchange Programs (CA)

Program Category 1: Individual-Level Interventions

Individual level interventions provide information, risk assessment, and risk reduction counseling to assist individuals to learn about transmission and risk behaviors, make plans for individual behavior change and ongoing appraisal of their own behaviors, and to facilitate linkages to resources to support behavior changes. The common denominator of these strategies is their focus on one-on-one interactions between provider and individual.

Definition based upon a review of the literature:

1. HIV Antibody Counseling, Testing, and Partner Referral
2. Education, Information, and Referral Hotlines
3. Street and Community Outreach
4. Individual Peer Education
5. On-site Risk Reduction Education and Counseling
6. Prevention Case Management
7. Needle Exchange Programs – Needle exchange programs (NEP) offer distribution of clean needles in exchange for used needles and related supplies and provision of referrals in areas where high-risk people congregate. Limited one-on-one health education or risk reduction may be offered.
8. Condoms, Other Barriers, and Bleach Demonstration and Distribution

Outcome effectiveness and/or cost effectiveness provided for each intervention.

Duration/Dosage:

Venue: Areas where high risk people congregate

Mode: Needle/syringe exchange

Health education – minimally structured

Provider:

Outcome: Behavioral

Level: Individual

Target Population: IDUs

Other:

Needle Exchange Programs (CH)

Describes:

- I. Minimum Criteria
 - A. Designed to reduce the transmission of HIV by providing sterile syringes in exchange for used, potentially contaminated ones
 - B. Offers appropriate referrals (e.g., HIV counseling and testing, substance abuse counseling/treatment, etc.)
 - C. NEP programs must be linked to a research project and possess an exemption from the Illinois Hypodermic Syringes and Needles Act
 - D. Needle Exchange cannot be funded as a stand-alone intervention (i.e., as the only intervention in a program) but must be coupled with 1 or more of the other HPPG approved interventions.
- II. Quality Assurance Measures
 - A. Agency must have a written safety protocol
 - B. Agency must have a formal written intake policy for needle exchange participants
 - C. A formal written referral mechanism must exist between the NEP provider and substance abuse providers/treatment facilities
- III. Data Requirements
 - A. In an effort to better document service delivery citywide, all CDPH prevention funded agencies will be required to collect and submit the following data for each intervention used in their program. Data will be submitted to CDPH scan forms (provided by CDPH). This information will be used to improve the quality and effect of HIV prevention projects in Chicago.
 - 1.Type of agency
 - 2.Risk population
 - 3.Client demographics
 - 4.Setting
 - 5.Number of interventions
 - 6.Staffing
 - 7.Expenditures
 - 8.Amount of prevention materials (i.e., condoms, lit., Needles) distributed

What Works in Prevention?

Key factors of Successful Interventions and Programs

- I. Services are:
 - A. delivered in a culturally appropriate and culturally sensitive manner
 - B. easily accessed
 - C. voluntary
- II. Target Population is:
 - A. clearly defined and with a proven need of HIV prevention services
- III. Goals and Objectives of the Program are:
 - A. clearly defined, time-phased, and measurable
- IV. Interventions are:
 - A. based on sound behavioral research

- B. well planned, implemented, monitored and evaluated
 - C. created (whenever possible) with input from target population
 - D. focused on reducing specific behaviors and address skill levels, attitudes, and behaviors that influence high risk activities (i.e., how to use condoms appropriately, how to clean injection equipment, and reinforcing positive attitudes about condom use)
 - E. vehicles for demonstrating, reinforcing, and promoting positive behaviors
- V. Agencies have:
- A. the ability to maintain multiple contacts with participants
 - B. the ability to document service delivery (i.e., develop and maintain survey questionnaires, client assessment forms, etc.)
 - C. a strong referral and follow-up system exists (formal, established, and written with signed memorandums of agreement)
 - D. the ability and desire to collaborate with other organizations
 - E. policies that conform with prevailing local, state and federal laws regarding client confidentiality
 - F. staff with necessary academic background or experience in a human-services-related field (i.e., social work, psychology, nursing, counseling, or health education); and case management and assessment techniques
 - G. staff that are knowledgeable about HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change.
- VI. How Do We Assure Quality?
- A. Minimum Quality Assurance Standards
- VII. Services are:
- A. offered in a safe environment. The agency should be clean, neat, well ventilated, and clutter free
- VIII. Interventions are:
- A. whenever possible, implemented/delivered by individuals representative of the target population
- IX. Agencies have:
- A. Policies and Procedure Manual. This manual must contain all intervention protocols, policies, and procedures of the services being delivered
 - B. current collaborative linkages within community and, when possible, should participate in one or more Community Planning Groups
 - C. staff that are familiar with available community resources
 - D. staff that are trained in the implementation of program intervention(s). All trainings must be documented in staff folders. The agency should promote and encourage continuing educational trainings.
 - E. grievance procedures in place and a method for informing clients of this process. Proof of client receipt should be documented in client charts
 - F. policies on staff safety (on site and off site)
 - G. a relationship with local authorities (police) such that the program is well known in the community
 - H. regular assessments of clients satisfaction through periodic client satisfaction surveys
 - I. regular management/supervisors meetings with program staff to discuss project and status progress towards stated outcomes

Duration/Dosage:

Venue: Health care facility/clinic

Mode: Needle/syringe exchange

Provider:

Outcome: Behavioral

Level: Individual

Target Population: IDUs

Other: Needle Exchange cannot be funded as a stand-alone intervention (i.e., as the only intervention in a program) but must be coupled with 1 or more of the other HPPG approved interventions.

Needle Exchange Programs (CT)

Encompassed under Community Level Interventions – These are interventions that try to change HIV risk behavior by changing community norms (and sometimes even the laws) of a community to support HIV prevention.

Needle exchange programs provide new needles in exchange for used needles to injection drug users. These programs are usually run by community-based organizations, but in some states they are run by public health departments.

Does The Intervention Change Behavior?

- Needle exchange programs have been shown to decrease HIV transmission by decreasing rates of needle sharing and using dirty needles for injecting drug.
- In communities that have needle exchange programs, the number of people injecting drugs and the rate of injection drug use do not increase.

With What Populations Is It Successful In Changing Behavior?

- Needle exchange programs help people who use injection drugs and are not ready to stop this practice to inject safely.

Duration/Dosage:

Venue:

Mode: Needle/syringe exchange

Provider:

Outcome: Behavioral

Level: Community

Target Population: IDUs

Other:

Needle Exchange (IL)

Needle exchange programs help prevent the transmission of HIV and other blood borne infectious diseases by providing new, sterile syringes and other sterile injection supplies to needle users in exchange for used syringes. Needle exchange programs (NEPs) often offer a variety of related services, including harm reduction counseling, health education, condom distribution, referrals to treatment centers, health services, HIV prevention counseling and testing, and prevention case management.

Includes:

- *NEPs reduce HIV Risks among injection drug users through:*
- *Effectiveness*
- *Policy Issues*

Duration/Dosage:

Venue:

Mode: Needle/syringe exchange
Health education – minimally structured
Counseling – minimally structured

Provider:

Outcome:

Level:

Target Population: Injejection Drug Users

Other: NEPs offer a variety of related services, including harm reduction counseling, health education, condom distribution, referrals to treatment centers, health services, HIV prevention counseling and testing, and prevention case management.

Needle Availability and Collection (LA)

Facilitate needle sales to IDUs at pharmacies and/or collection of used needles.

Listed as CDC Street and Community Intervention.

Key Elements:

- Change attitudes of pharmacists about needle sales to IDUs from one viewing needle sales as detrimental to viewing needle sales as a community service through educational sessions for pharmacists.
- Establish systems for referral of high risk individuals by outreach workers to pharmacies (by prior agreement) for needle sales and collection sites.

- Practice harm reduction counseling with substance users.
- Partner with treatment facilities.
- This intervention can be enhanced by advocating for supportive changes in existing laws.
- Consideration must be given to proper disposal of used syringes (Ex: provide sharps containers in key locations (restrooms, shooting galleries, community centers) or allow outreach workers to carry the containers).

Includes:

1. Addresses High Priority Needs
2. Addresses Community/Cultural Norms and Values
3. Outcome Effectiveness
4. Accessible to Target Population
5. Intervention Feasibility and Cost-Effectiveness
6. Sources

Duration/Dosage:

Venue: Appropriate community sites

Mode: Needle/syringe exchange

Provider: Professional

Outcome: Behavioral

Level: Community

Target Population: Substance Users, Pharmacists

Other: Change attitudes of pharmacists about needle sales to IDUs from one of viewing needle sales as detrimental to viewing needle sales as a community service through educational sessions for pharmacists.

Partner with treatment facilities.

Establish systems for referral of high risk individuals by outreach workers to pharmacies

Needle Exchange (LA)

The term "needle exchange program" refers to any establishment at which injecting drug users can exchange an old needle or syringe for a new one. These programs seek to reduce the harm associated with injection drug use practices, a philosophy sometimes referred to as harm reduction or harm minimization."

Listed as CDC Individual Level Intervention.

Key Elements:

- One-for-one exchange of used syringes for new syringes.

- Provide a variety of services ranging from condom and bleach distribution to drug treatment referrals.
- Practice harm reduction counseling with substance users.
- This intervention can be enhanced by advocating for supportive changes in existing laws and increasing availability of treatment for injection drug users.

Includes:

1. Addresses High Priority Needs
2. Addresses Community/Cultural Norms and Values
3. Outcome Effectiveness
4. Accessible to Target Population
5. Intervention Feasibility and Cost-Effectiveness
6. Sources

Duration/Dosage:

Venue: Mobile or fixed sites in areas identified as high risk for IDU

Mode: Needle/syringe Exchange
 Helath education – minimally structured
 Counseling – minimally structured

Provider: Trained CBO staff and volunteers

Outcome: Behavioral

Level: Individual

Target Population: IDUs

Other: Can be enhanced by advocating for supportive changes in existing laws and increasing availability of treatment for injection drug users.

Needle Exchange (MA)

Needle exchange refers to the provision of free sterile needles and syringes to injection drug users in exchange for used injection equipment, and the delivery other risk and harm reduction services, including referrals to counseling and testing, health care, drug treatment/detox, and other services. Needle exchange programs have been shown to reduce needle sharing and serve as a source for referral to drug treatment in numerous studies of its efficacy. Recognizing the prohibition on the use of federal funds for supporting needle exchange the state of Massachusetts utilizes state fund solely to support these programs.

Duration/Dosage:

Venue:

Mode: Needle/syringe exchange

Provider: State of Massachusetts

Outcome: Behavioral

Level:

Target Population: IDUs

Other: Refers to the provision of free sterile needles and syringes to injection drug users in exchange for used injection equipment, and the delivery other risk and harm reduction services, including referrals to counseling and testing, health care, drug treatment/detox, etc.

Needle Exchange (NC)

The exchange or distribution of clean syringes, and other sterile injection drug equipment, for injection drug users.

Duration/Dosage:

Venue:

Mode: Needle/syringe exchange

Provider:

Outcome:

Level:

Target Population: IDU

Other: Distribution of clean syringes, and other sterile injection drug equipment.

Needle Exchange (NH)

- Clean syringes, needles and other sterile injection drug equipment are given to injection drug users in exchange for used needles.
- Workers offer referrals into drug treatment centers and other services which help users top and reduce their drug intake."

Overall Premises to be Considered in All Interventions

1. All interventions need to explicitly define a population to be served and the steps to reach that population.

2. All interventions must have explicitly defined HIV prevention goals (e.g. reduction of use of unclean injection equipment, increased condom use with main partners, etc. Note behavioral objectives as outlined in the compendium.)
3. All interventions must show evidence that they are based on sound behavioral science theory.
4. All interventions need to either be based on proven models or must show evidence to support the expectation that they will be effective.
5. All interventions must demonstrate the ability to collect basic demographic and risk data on clients served. (For community level interventions such as street outreach the required data collection will be more limited than for individual and group level interventions due to the nature of the work.)
6. All interventions must be able to demonstrate outcome monitoring that focuses on at least one behavior change objective which was identified by the program. Monitoring should demonstrate the degree to which change has occurred.
7. All HIV positive clients should be referred for medical intervention (if not already in place) and for partner services.
8. All programs must either directly or by referral provide clients with access to risk reduction supplies including, at minimum, condoms and lubricants.

Duration/Dosage:

Venue:

Mode: Needle/syringe exchange

Provider:

Outcome:

Level:

Target Population: IDU

Other: Referrals offered into drug treatment centers and other services.

Needle/Syringe Exchange Programs (NV)

The goal of needle or syringe exchange programs (NEPs) is to reduce transmission of HIV and other bloodborne diseases associated with drug injection by providing sterile needles and syringes in exchange for used, potentially contaminated ones. In addition to the provision of sterile needles and syringes, many NEPs also provide information about safer injection equipment. Other services may also include referral of clients to substance-abuse treatment programs, and instruction on how to use condoms most effectively (CDC, 1997).

Also includes advantages and disadvantages of intervention, and demonstrated effectiveness and implications.

Duration/Dosage:

Venue:

Mode: Needle/syringe exchange

Provider:

Outcome: Behavioral

Level:

Target Population: IDUs

Other:

Needle Exchange Programs (WI)

Level of Intensity: Contact

This includes ... Educational interventions conducted face-to-face in places where clients congregate, includes needle exchange

This does not include ... Lectures or group educational presentations; Outreach solely for the purposes of counseling and testing (CTS)

Outreach is most effective when it is continuous, consistent, and performed by someone indigenous to the community targeted. The success of outreach is critically dependent on the skills of the outreach workers, who should not only be peers or near peers of the community, but also viewed as credible, open, dedicated, non-threatening, and non-judgmental. Additionally, outreach workers should be trained in the following areas: the principles of outreach, the harm reduction model, referral sources, confidentiality issues, and safety issues. Finally, outreach work collaboratively with gatekeepers to minimize interference. Gatekeepers are those individuals that manage the operations in the setting, such as bartenders or bar owners, park police, housing site managers, methadone maintenance providers, and correctional facility managers.

Outreach is set apart from many other interventions by virtue of location and intensity of the intervention. This intervention is delivered at a location of convenience to members of the target population, rather than asking them to come to a clinic for services. Examples of outreach locations are streets, drug using settings ("shooting galleries" and "crack houses"), gay bars, public sex environments such as parks and waysides (for men engaging in anonymous sexual encounters with other men), homeless shelters, public housing single room occupancies, methadone maintenance programs, and correctional settings. This level of intensity of Outreach is not as high as that of an Individual Level Intervention (ILI). Outreach focuses on information dissemination, not on skills building and behavior change as with ILI.

Needle exchange programs (NEPs) are one type of outreach. NEPs supply syringes and other supplies to individuals who inject substances in exchange for used syringes, which enables users to avoid sharing equipment. This contact creates an opportunities for one-on-one health education and/or risk reduction counseling and referral to other services, such as drug treatment and HIV counseling and testing. Sites for needle exchange should be based upon input of active users.

Needle exchange is legal, and several programs operate in Wisconsin. ...

Includes:

- *Scientific Basis*
- *Resources*

<i>Duration/Dosage:</i>	Consistent and continuous; Intensity not as high as for ILI
<i>Venue:</i>	Location convenient to members of the target populations – based upon input of active users
<i>Mode:</i>	Outreach – semi-structured Health education – minimally structured Counseling – minimally structured Needle/syringe exchange
<i>Provider:</i>	Paraprofessional (near peer), Peer
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	IDUs
<i>Other:</i>	Outreach workers should be trained in the following areas: the principles of outreach, the harm reduction model, referral sources, confidentiality issues, and safety issues. Focuses on information dissemination, not on skills building and behavior change as with ILI. Includes needle exchange program.

“Other” Interventions

The Number of Intervention Characteristics by “Other” Interventions

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Capacity Building – Training	AK			✓		✓	✓			3
Capacity Building	AK		✓	✓		✓	✓			4
Policy Changes	CT					✓	✓			2
Religious Support	CT		✓			✓	✓	✓		4
Capacity Building	CT			✓	✓	✓	✓	✓		5
Out of School Based Programs	IA		✓	✓		✓		✓		4
Capacity Building	IL			✓		✓	✓	✓	✓	5
Collaboration, Coordination, and Linkage with Other Related Programs	KS		✓							1
Evaluation of HIV Prevention Activities	KS			✓		✓				2
HIV Prevention Technical Assistance Plan and Capacity Building	KS		✓	✓		✓		✓		4
Changing High Risk Environments	LA		✓		✓	✓	✓	✓		5
Limited Drop-in Services	MA	✓	✓	✓		✓	✓	✓		6
Systemic Change	ME					✓				1
Capacity Building	MN			✓						1
Distributing Condoms Without Face-to-Face Education	NC		✓	✓					✓	3

Intervention Type Name	Code	Duration/ Dosage	Venue	Mode	Provider	Outcome	Level	Target Population	Other	TOTAL
Distributing Educational and Awareness Raising Materials without Face-to-Face Education	NC		✓	✓					✓	3
Peer Education	NV			✓	✓	✓	✓	✓	✓	6
Health Education/Risk Reduction	NY					✓	✓			2
Capacity Building	OK			✓				✓	✓	3
Evaluation	SC			✓						1
Health Education/Risk Reduction	SC		✓	✓					✓	3
Capacity Building	SC			✓				✓	✓	3
Capacity Building	SD			✓				✓		2
Out-of-School Based Programs	SD		✓	✓	✓	✓	✓	✓		6
Evaluation	TN			✓						1
Capacity Building	TN			✓						1
Institution Based Programs	TN		✓		✓					2
Peer Education Model	VI			✓	✓				✓	3
Capacity Building	WI			✓				✓	✓	3
School- Based Diversity Programs	WI		✓	✓		✓		✓		4
Alcohol And Other Substance Treatment And Methadone Maintenance Programs	WI		✓	✓		✓	✓	✓	✓	6
TOTAL (N = 31)		1	13	24	6	17	13	14	10	98

✓ Indicates that evidence of the intervention characteristic was found in reviewing the FY 2001 Cooperative Agreement Applications and Comprehensive Plans and Web sites. Definitions or guidelines addressing these elements may exist in other documentation not reviewed for this study.

“Other” – Listing of Evidence by Intervention Characteristic

Duration/Dosage:

	Intervention Name:	Evidence of Intervention Characteristic:
MA	Limited Drop-in Services	Several visits

Venue:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Capacity Building	Community and institutions
CT	Religious Support	Churches
IA	Out of School Based Programs	Out of school setting
KS	Collaboration, Coordination, and Linkage with Other Related Programs	Community
KS	HIV Prevention Technical Assistance Plan and Capacity Building	Community
LA	Changing High Risk Environments	Shooting galleries, crack houses, bars, public sex environments, etc.
MA	Limited Drop-in Services	Where clients are – Convenient place to rest, get warm, and make conversation.
NC	Distributing Educational and Awareness Raising Materials without Face-to-Face Education	Clinics, nightclubs, bars, stores
NC	Distributing Condoms Without Face-to-Face Education	Places such as clinics, nightclubs, bars, stores
SC	Health Education/Risk Reduction	Street & Community
SD	Out-of-School Based Programs	Organized treatment centers & alternative educational settings
TN	Institution Based Programs	In an organization or establishment dedicated to a specific cause or program.
WI	School- Based Diversity Programs	School
WI	Alcohol And Other Substance Treatment And Methadone Maintenance Programs	Treatment centers

Mode:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Capacity Building	Capacity Building – Minimally Structured
AK	Capacity Building – Training	Capacity Building – Minimally Structured
CT	Capacity Building	Capacity Building – Semi-structured
IA	Out of School Based Programs	Health Education
IL	Capacity Building	Capacity Building
KS	Evaluation of HIV Prevention Activities	Evaluation
KS	HIV Prevention Technical Assistance Plan and Capacity Building	Technical Assistance Capacity Building
MA	Limited Drop-in Services	Counseling – Minimally Structured Biomedical – Minimally Structured
MN	Capacity Building	Capacity Building – Minimally Structured
NC	Distributing Educational and Awareness Raising Materials without Face-to-Face Education	Material/supply distribution
NC	Distributing Condoms Without Face-to- Face Education	Material distribution
NV	Peer Education	Health education – Structured or Semi- Structured
NY	Health Education/Risk Reduction	Health education Counseling
OK	Capacity Building	Capacity Building – Structured
SC	Health Education/Risk Reduction	Health Education
SC	Evaluation	Evaluation – Structured
SC	Capacity Building	Capacity Building – Structured
SD	Out-of-School Based Programs	Health Education – Minimally Structured
SD	Capacity Building	Capacity Building – Structured
TN	Evaluation	Evaluation – Minimally Structured
TN	Capacity Building	Capacity Building – Minimally Structured
VI	Peer Education Model	Health Education
WI	Capacity Building	Capacity Building – Semi- Structured

WI	Alcohol And Other Substance Treatment And Methadone Maintenance Programs	Health Education
WI	School- Based Diversity Programs	Capacity Building

Provider:

	Intervention Name:	Evidence of Intervention Characteristic:
CT	Capacity Building	Professional
LA	Changing High Risk Environments	Peers and advocates
NV	Peer Education	Peer
SD	Out-of-School Based Programs	Peers
TN	Institution Based Programs	Peer and non-peer
VI	Peer Education Model	Trained peers

Outcome:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Capacity Building	Structural
AK	Capacity Building – Training	Structural
CT	Religious Support	Behavioral
CT	Capacity Building	Structural
CT	Policy Changes	Structural
HI	Substance Abuse Treatment	Behavioral
IA	Out of School Based Programs	Behavioral
IL	Capacity Building	Structural
KS	Evaluation of HIV Prevention Activities	Structural
KS	HIV Prevention Technical Assistance Plan and Capacity Building	Structural
LA	Changing High Risk Environments	Structural
MA	Limited Drop-in Services	Behavioral
ME	Systemic Change	Policy Legal
NV	Peer Education	Behavioral
NY	Health Education/Risk Reduction	Behavioral

SD	Out-of-School Based Programs	Behavioral
WI	Alcohol And Other Substance Treatment And Methadone Maintenance Programs	Behavioral
WI	School- Based Diversity Programs	Structural

Level:

	Intervention Name:	Evidence of Intervention Characteristic:
AK	Capacity Building	Community
AK	Capacity Building – Training	Community
CT	Policy Changes	Community
CT	Capacity Building	Community
CT	Religious Support	Community
IL	Capacity Building	Group
LA	Changing High Risk Environments	Community
MA	Limited Drop-in Services	Individual
NV	Peer Education	Individual and group
NY	Health Education/Risk Reduction	Individual, Group, Community
SD	Out-of-School Based Programs	Group
WI	Alcohol And Other Substance Treatment And Methadone Maintenance Programs	Individual

Target Population:

	Intervention Name:	Evidence of Intervention Characteristic:
CT	Religious Support	Hispanic and African Americans
CT	Capacity Building	CBOs and ASOs
IA	Out of School Based Programs	Youth in non-traditional settings
IL	Capacity Building	IDUs, MSM, gay youth, homeless
KS	HIV Prevention Technical Assistance Plan and Capacity Building	Service providers & CPG members
LA	Changing High Risk Environments	MSM, females, youth, Substance users, ethnic minorities

MA	Limited Drop-in Services	Sex workers, IDUs, MSMs, and transgenders.
NV	Peer Education	MSM
OK	Capacity Building	Grassroots agencies
SC	Capacity Building	Youth, Women, Men at-risk
SD	Out-of-School Based Programs	Youth
SD	Capacity Building	Individuals, organizations and groups
WI	Capacity Building	Educators, Medical personnel, service providers
WI	Alcohol And Other Substance Treatment And Methadone Maintenance Programs	Substance abusers
WI	School- Based Diversity Programs	teachers and Youth serving professionals

Other:

	Intervention Name:	Evidence of Intervention Characteristic:
HI	Substance Abuse Treatment	Provide a continuum of drug treatment services based on a harm reduction model.
IL	Capacity Building	Activities are planned efforts to increase the availability or effectiveness of area HIV prevention and CTRPN services for specific target populations...guided by measurable objectives that ID specific outcomes at the provider level.
NC	Distributing Educational and Awareness Raising Materials without Face-to-Face Education	Distributing materials without face-to-face education.
NC	Distributing Condoms Without Face-to-Face Education	Distributing materials without substantive face-to-face education.
NV	Peer Education	Provide their peers with information, referrals, emotional support and other skills designed to reduce the risk of HIV/AIDS.
OK	Capacity Building	Development of organizational infrastructure and staff expertise which will lead to agency becoming self-sustaining and fully capable of providing services.

SC	Capacity Building	<p>Strengthening the governmental and nongovernmental public health infrastructure in support of HIV prevention, implementing systems to ensure the quality and integration of services(particularly HIV, STD, TB, and drug treatment).</p> <p>Training and technical assistance are provided to staff of CBOs, collaborations, and local health departments to improve skills and the quality of services provided.</p>
SC	Health Education/Risk Reduction	Includes Case Management
VI	Peer Education Model	Provides an opportunity for individuals to develop leadership skills and to perceive themselves as empowered through assisting others in their communities.
WI	Alcohol And Other Substance Treatment And Methadone Maintenance Programs	<p>Abstinence-based model.</p> <p>Harm reduction model focused on reduced substance use and a shift from injection to other practices.</p> <p>Considered a contact or interaction</p>
WI	Capacity Building	<p>Includes: conferences, institutes, mini-grants, resource centers, training , and related activities.</p> <p>Cultural competence training for service providers.</p> <p>AIDS/HIV information resource center with lending library books, videotapes, referrals, quantities of printed materials, and internet access.</p> <p>Conferences for educators to better reach and serve gay, lesbian, & bisexual youth with HIV prevention info.</p>

Jurisdictions' Definitions of "Other" Interventions

Capacity Building – Training (AK)

HIV prevention training for providers of health care, social services, counseling, and health education to enhance their ability to provide HIV prevention activities for their clients.

Duration/Dosage:

Venue:

Mode: Capacity Building – Minimally Structured

Provider:

Outcome: Structural

Level: Community

Target Population:

Other:

Capacity Building (AK)

Information sessions to further HIV prevention efforts in communities and institutions.

Duration/Dosage:

Venue: Community and institutions

Mode: Capacity Building – Minimally Structured

Provider:

Outcome: Structural

Level: Community

Target Population:

Other:

Religious Support (CT)

Encompassed under Community Level Interventions – These are interventions that try to change HIV risk behavior by changing community norms (and sometimes even the laws) of a community to support HIV prevention.

Religious support usually consists of religious leader and congregations getting involve in HIV prevention. There are national organizations like the AIDS Interfaith Network where many

religions join together to help people who are affected by HIV and AIDS. For some communities, churches are used as places to hold HIV prevention interventions.

Does The Intervention Change Behavior?...

With What Populations Is It Successful In Changing Behavior?

- Religious organizations are often used to target minority populations, specifically Hispanic Americans and African Americans. No research has yet evaluated the efficacy of these interventions"

Duration/Dosage:

Venue: Churches

Mode:

Provider:

Outcome: Behavioral

Level: Community

Target Population: Hispanic and African Americans

Other:

Capacity Building (CT)

Encompassed under Community Level Interventions – These are interventions that try to change HIV risk behavior by changing community norms (and sometimes even the laws) of a community to support HIV prevention.

Capacity building is, in part, linking community based organizations and AIDS service organizations together through a network. When these organizations work together, they can determine what needs exist in the community, and who might be able to best fill those needs. Capacity building can also involve organizations bringing in outside experts like medical personnel, epidemiologists, behavioral scientists, and statisticians to help them analyze the problems in their community and learn how to solve those problems. Ultimately, CBOs and ASOs can learn from these "experts" and develop some of their capabilities on their own.

Does The Intervention Change behavior?...

With What Populations is it Successful In Changing Behavior?

- Capacity building might be very useful for new community based organizations, or those just beginning to deal with HIV and AIDS issues. Organizations without much money or many resources could benefit by partnering with organizations who have more experience, are better funded, or have more resources.

Duration/Dosage:

Venue:

Mode: Capacity Building – Semi-Structured

Provider: Professional

Outcome: Structural

Level: Community

Target Population: CBOs and ASOs

Other:

Policy Changes (CT)

Encompassed under Community Level Interventions – These are interventions that try to change HIV risk behavior by changing community norms (and sometimes even the laws) of a community to support HIV prevention.

Policy changes are changes in the laws allowing certain types of HIV prevention. So far example, if needle exchange programs or over the counter needles sales were against the law in a certain state, a good policy change to make would be to change the law. Another useful policy change might be to choose an effective HIV prevention program and mandate that it be taught in schools in a state.

Does The Intervention Change Behavior?...

With What Populations Is It Successful In Changing Behavior?

- Many different populations can be affected by policy changes, depending upon the policy that is being changed."

Duration/Dosage:

Venue:

Mode:

Provider:

Outcome: Structural

Level: Community

Target Population:

Other:

Substance Abuse Treatment (HI)

1. Provide a continuum of drug treatment services based on harm reduction model.
2. Provide extensive community outreach to reduce the harms associated with injection drug use, and to assist IDU in accessing treatment or in modifying their substance use.
3. Provide funding for methadone detox and maintenance for syringe exchange participants.
4. Ensure that MED-QUEST insurance provides methadone detox and maintenance treatment services.
5. Develop interventions targeting heroin smokers to prevent initiation of injection drug use.
6. Increase coordination and collaboration of service providers of primary care, substance abuse treatment, mental health, and programs for the homeless to further develop effective service delivery.

Duration/Dosage:

Venue:

Mode:

Provider:

Outcome: Behavioral

Level:

Target Population:

Other: Provide a continuum of drug treatment services based on a harm reduction model.

Out of School Based Programs (IA)

The term "out-of-school" refers to adolescents not participating in a traditional secondary school educational setting, but regularly participating in an organized treatment or alternative educational setting, but regularly participating in an organized treatment or alternative educational setting. This includes incarcerated youth, youth in mental health facilities, and youth in alternative high school programs.

Duration/Dosage:

Venue: Out of school setting

Mode: Health Education

Provider:

Outcome: Behavioral

Level:

Target Population: Youth in non-traditional settings

Other:

Capacity Building (II)

Capacity building activities are planned efforts to increase the availability or effectiveness of areas HIV prevention and CTRPN services for specific target populations. Capacity building activities are guided by measurable objectives that identify specific outcomes at the provider level.

Examples of Capacity Building Activities:

- a. Creating new structures or programs that will be able to reach target populations in the future, such as:
 - establishing an organization that will provide harm reduction outreach to injection drug users
 - assisting in the development of a non-profit MSM or gay youth organization that includes HIV prevention in its mission
 - organizing a volunteer peer hotline for non-gay identified MSM
 - forming a discussion group for gay and bisexual men in recovery
- b. Increasing specific prevention interventions offered by existing agencies, such as:
 - the number of substance abuse treatment programs that provide skill-building, group HIV prevention programs to clients
 - the number of local schools and youth serving organizations that include at least one example of young MSM in HIV prevention role plays and other skill-building activities
 - the number of mental health agencies that have policies assuring the availability of condoms and/or CTRPN referrals to clients
- c. Gaining support and cooperation for planned programs, such as:
 - securing the partnership of a CBO for a new outreach testing site
 - meeting with park officials and police to gain support for prevention outreach in public sex environments
- d. Improving the ability of professionals and volunteers to provide specific HIV prevention interventions, such as:
 - training health care workers to sensitively provide HIV risk reduction counseling to MSM
 - training homeless shelter staff to provide harm reduction messages and bleach kits to injection drug users
 - training and technical assistance to help youth agencies implement effective HIV/STD prevention curricula

Capacity Building Does Not Include:

- general attendance at area coalition or meetings, unless working toward a specific capacity building outcome
- basic HIV in-services or updates
- routine meetings or phone calls related to program implementation

Duration/Dosage:

Venue:

Mode: Capacity Building

Provider:

Outcome: Structural

Level: Group

Target Population: IDUs, MSM, gay youth, homeless

Other: Activities are planned efforts to increase the availability or effectiveness of area HIV prevention and CTRPN services for specific target populations...guided by measurable objectives that ID specific outcomes at the provider level.

Evaluation of HIV Prevention Activities (KS)

A. Evaluate HIV prevention program activities, interventions, and services.

- Assess the quality of proposed interventions to make sure they are scientifically sound, well organize and that the goals are clear and reasonable.
- Conduct process evaluation of HIV prevention interventions for the purpose of prioritizing prevention efforts and improving the contractors ability to measure accomplishments in conducting prevention activities.
- Conduct outcome monitoring of HE/RR individual and group level interventions for the purpose of measuring on-going behavior change in at-risk populations.
- Gather and monitor information from contractors to ensure that targeted populations receive necessary services and/or are referred to other providers that will address the psycho social issues associated with high priority populations in Kansas.

B. Assess the implementation of HIV prevention community planning in Kansas.

- Document the recruitment of community planning group members and representation of affected communities and areas of expertise on the CPG.
- Verify the application of the needs assessment and an epidemiologic profile to prioritize target populations and strategies for HIV prevention activities and the application of scientific knowledge in the selection of prevention strategies.
- Develop and monitor goals and measurable objectives for the community planning process and calculate the cost of the process.
- Determine the extent to which the health department distributes resources to match the epidemiologic profile and conducts prevention activities which match the community planning group's recommendations.

Duration/Dosage:

Venue:

Mode: Evaluation

Provider:

Outcome: Structural

Level:

Target Population:

Other:

HIV Prevention Technical Assistance Plan and Capacity Building (KS)

- A. Assess the current and projected needs of service providers and the members of the CPG. Provide the necessary technical assistance and training that they have identified in order to build on their skills and knowledge.
- Provide technical assistance to service providers and CPG members in the areas of grant writing, coalition building, behavioral science and theory based prevention activities, HIV prevention program planning, implementation, and evaluation.
- B. Solicit and contract with agencies, workers, and volunteers who are representative of populations at high risk for HIV infection to conduct prevention activities.
- C. Ensure that all HE/RR contractors
1. successfully complete the American Red Cross "Basic HIV/AIDS Program" including Fundamentals and Prevention Skills training; and
 2. attend sensitivity training which includes issues of communities who are denied access to privileges and benefits based on skin color, gender, sexual orientation, economic circumstance, disability, language and/or spiritual belief.
- D. Strengthen the communication network between HIV prevention service providers and coordinate HIV prevention services and programs.
- Develop and continue to make available an on-going statewide HIV prevention and care service directory.
 - In each region of the state, designate a contractor to serve as a regional HIV/AIDS resource coordinator for the purpose of strengthening communication, assistance, programming and delivery of services.
 - Designate one contractor serving each CPG designated high priority target population to serve as a resource consultant for other service providers targeting that population.

Duration/Dosage:

Venue: Community

Mode: Technical Assistance
Capacity Building

Provider:

Outcome: Structural

Level:

Target Population: Service providers and CPG members

Other:

Collaboration, Coordination, and Linkage with Other Related Programs (KS)

Linkages between Primary and Secondary HIV Prevention Activities

The term 'primary prevention' refers to preventing the transmission of HIV from one person to another. The term 'secondary prevention' refers to preventing progression of HIV infection to severe immunosuppression, and preventing morbidity and mortality from opportunistic infections in persons already infected with HIV. 'Linkage between primary and secondary prevention refers to linkage between services for primary prevention and secondary prevention.

CPG recommendations for linking primary and secondary prevention services in counseling and testing sites includes:

1. develop case management models that target HIV+ individuals and their sex partners for the purpose of teaching behavior modification techniques that decrease the risk of HIV transmission;
2. establish appropriate sources (used in the counseling process), to medical, care, social, and psychological services;
3. provide services to HIV infected individuals and their sex partners that encompass on-going health education and skills training for risk reduction ; facilitate the development of peer-to-peer networking structures; provide and/or refer HIV+ individuals and their sex partners to counseling services as appropriate, assist consumers in making long term risk reduction behavior changes; and provide support and education regarding secondary infection. Services must be empowering, culturally linguistically, age and gender appropriate. The CPG recommended the development of an electronic and group network within HIV positive communities to provide information, enhance the sharing of knowledge, increase the visibility and decrease the alienation of individuals infected with the virus.

Linkages with HIV Prevention Related Activities

Set up networks and/or focus groups with communities to identify and assess continuing HIV prevention needs, and to disseminate the results of targeted prevention and community planning activities.

KDHE should promote the community planning process and make survey information, needs assessment results, recommendations, and the epidemiologic profile available to HIV prevention service providers and the public. An evaluation tools should be provided to KDHE contractors to assist them in developing, assessing, and disseminating result of behavior change surveys for at-risk populations. HIV prevention activities should be integrated and linked with other disciplines such as drug treatment programs, STD treatment, and university-based research.

Coordination of HIV Prevention Services and Programs

To coordinate HIV prevention services and programs, contractors should set up networks and/or focus on groups with community members, prevention counselors, educators, and care providers for the purpose of identifying and assessing continuing HIV prevention needs, information sharing and other related issues. KDHE should designate a funded contractor to serve as a regional HIV/AIDS Resource Coordinator for the purpose of strengthening the communication network between service providers in each HIV Case Management region. Additionally, a funded contractor for each high priority target population should serve as a resource consultant, provide skills training, educational materials development, and establish a statewide network for HIV prevention contractors and other organizations serving each targeted population. HIV prevention counselor and educator training session should be coordinated with other co-sponsors.

Duration/Dosage:

Venue: Community

Mode:

Provider:

Outcome:

Level:

Target Population:

Other:

Changing High Risk Environments (LA)

Description: Change environments where people engage in high risk activities (unprotected sex, substance use and needle sharing) in such a way as to discourage unprotected sex and the sharing of needles and/or encourage safer behaviors."

CDC Intervention Level: Community Level Intervention

Theoretical Basis: Social Marketing Theory

Target Persons: Racial/Ethnic Minorities, Sexually Active Females, Males who have Sex with Males, Youth Substance Users

Sites: Shooting galleries; crack houses; bars; nightclubs; alcohol outlets; community settings; rest areas; public sex environments; and gathering places in neighborhood like parks.

Key Elements:

- Physical environment is changed to discourage high-risk behavior. For example "manager" of crack house provides condoms to customers, clean needles are available in shooting galleries, posters encourage safe drug-use and sexual behavior.
- Advocate for changes in the physical environment which provide barriers to unsafe behaviors. Examples include better lighting, improved property maintenance, destruction of crack houses, removing graffiti, restoration of blighted houses, neighborhood improvement projects, etc.

Recommended Training: HIV/AIDS 101, Field Safety, Advocacy Training/Workshop

Evaluation Methods...

Expected Outcomes: Safer environments which do not encourage risky behavior.

Implemented by: Volunteers, advocates. Advocates can include volunteers, church groups local civic organizations, etc. May be implemented through a peer education program.

Includes:

1. Addresses High Priority Needs
2. Addresses Community/Cultural Norms and Values
3. Outcome Effectiveness
4. Accessible to Target Population
5. Intervention Feasibility and Cost-Effectiveness
6. Sources

Duration/Dosage:

Venue: Shooting galleries, crack houses, bars, public sex environments, etc.

Mode:

Provider: Peers and advocates

Outcome: Structural

Level: Community

Target Population: MSM, Females, Youth, Sub. users, Ethnic minorities

Other:

Limited Drop-in Services (MA)

Augmenting street and community outreach, drop-ins create informal spaces where clients may self-select the point in time that they choose to engage HIV prevention services. Just as likely, persons who must be on the street (as function of their living situations, work, or substance use patterns) find drop-ins a convenient place to rest, get warm, and make conversation. Once there, and usually after several visit, clients may begin to engage workers in conversations about their health concerns, including HIV. In the spirit of meeting clients where they are, drop-ins maximize clients' sense of freedom and control in the intervention, and help develop trust in the provider. In their more successful implementation, local community residents develop a sense of ownership of and personal responsibility for their center. Drop-ins also create locations for education, HIV counseling and testing, risk assessment, and referral to additional services. Currently drop-in services are integrated into prevention services targeting women sex workers, IDUs, MSMs (including young MSMs) and transgenders.

<i>Duration/Dosage:</i>	Several visits
<i>Venue:</i>	Where clients are – Convenient place to rest, get warm, and make conversation.
<i>Mode:</i>	Counseling – Minimally Structured Biomedical – Minimally Structured
<i>Provider:</i>	
<i>Outcome:</i>	Behavioral
<i>Level:</i>	Individual
<i>Target Population:</i>	Sex workers, IDUs, MSMs, and transgenders.
<i>Other:</i>	

Capacity Building (MN)

In addition to these interventions designed to influence risk behavior directly, many states are investing in capacity building efforts designed to influence risk behavior directly, many states are investing in capacity building efforts designed to assess and improve the quality of these interventions classified above.

Duration/Dosage:

Venue:

Mode: Capacity Building – Minimally Structured

Provider:

Outcome:

Level:

Target Population:

Other:

Distributing Educational and Awareness Raising Materials without Face-to-Face Education (NC)

The distribution of educational and awareness raising materials without providing any substantive face-to-face education as part of the effort, such as placing brochure resource tables in clinics, nightclubs, bars, and stores.

Duration/Dosage:

Venue: Clinics, nightclubs, bars, stores

Mode: Material/supply distribution

Provider:

Outcome:

Level:

Target Population:

Other: Distributing materials without face-to-face education

Distributing Condoms Without Face-to-Face Education (NC)

The distribution of condoms without providing any substantive face-to-face education as part of the effort, such as placing condoms bowls in clinics, nightclubs, bars, and stores.

Duration/Dosage:

Venue: Places such as clinics, nightclubs, bars, stores

Mode: Material distribution

Provider:

Outcome:

Level:

Target Population:

Other: Distributing materials without substantive face-to-face education

Peer Education (NV)

Peer education is an AIDS prevention strategy in which members of the target population are recruited to receive training to help them provide their peers with information, referrals, emotional support and other skills designed to reduce the risk of HIV/AIDS. Unlike outreach workers, who are usually paid staff, peer educators generally volunteer their time to AIDS prevention activities. These activities include imparting information about the transmission and prevention of HIV to individuals and groups, providing counseling, support, and referral information and serving as role-models to at-risk populations.

Also includes advantages and disadvantages of intervention, and demonstrated effectiveness and implications.

Duration/Dosage:

Venue:

Mode: Health Education – Structured or Semi-Structured

Provider: Peer

Outcome: Behavioral

Level: Individual and group

Target Population: MSM

Other: Provide their peers with information, referrals, emotional support and other skills designed to reduce the risk of HIV/AIDS.

Health Education/Risk Reduction (NY)

In Health Education/Risk Reduction Proposed 2001 Objectives

During 2001, the AIDS Institute will continue to provide a range of high quality health educational and risk reduction activities to:

- assist uninfected individuals in maintaining their seronegative status;
- provide high risk uninfected person timely and effective access to HIV prevention and other services that will assist them in maintaining their serostatus; and
- modify behaviors of infected persons so as to further risks to themselves and risks to others.

...

Three core elements of HE/RR programs:

- individual level science-based interventions that provide ongoing health communications, health education, and risk reduction counseling to assist clients in making plans for behavior change and ongoing appraisals of behavior;
- group level science-based interventions which provide peer education and support, as well as promote and reinforce safer behaviors and provide interpersonal skills training in negotiating and sustaining appropriate behavior change; and
- community level science-based interventions for populations at risk which seek to change attitudes, norms, and practices that increase the chances of transmission (Modified from CDC's "Guidelines for HE/RR Activities").

Description of HE/RR objectives and program activities in various settings (e.g., women's services, community-based peer programs, etc.) and for special populations (e.g., lesbian, gay, bisexual, and transgender).

Duration/Dosage:

Venue:

Mode: Health Education
Counseling

Provider:

Outcome: Behavioral

Level: Individual, Group, Community

Target Population:

Other:

Capacity Building (OK)

The Oklahoma Community Planning Group defines capacity building as the development of organizational infrastructure and staff expertise within grassroots agencies which will ultimately lead to agency becoming self-sustaining and fully capable of providing effective HIV prevention programming.

Quality assurance review, services utilization, programmatic and administrative evaluations, standards, and client record systems, cash flow, and staff who have the necessary credentials and/or experience to compete successfully for available funds are typically needed within small organizations. The need for staff who can manage administrative and evaluative functions as well as write grants, present particularly difficult problem for grassroots organizations. The Oklahoma Community Planning Group recommends the formation of an individualized capacity building plan. Specific technical assistance needs should be identified with specific plans to meet those needs, including but not limited to the following list:

- Program Planning;
- Program implementation;
- Program evaluation;
- Board development;
- Recruitment of staff and/or volunteers;
- Obtaining funds to cover administrative services;
- Grant and contract proposal writing;
- Meeting various regulatory requirements;
- Assessing different funding sources and methods of fund raising;
- Identifying and accessing third-party payment for services (where applicable);
- Implementing and managing an automated service delivery/utilization system.

In order to accomplish true capacity building, the Oklahoma Community Planning Group, recommends the following course of action:

1. Identify existing organization and social networks that are currently providing services on a volunteer basis and/or are interested in providing services.
2. Identify community-based organizations or other local public health institutions that have a strong financial base and the capacity to provide technical assistance for grassroots service provider.
3. Develop an individualized technical assistance plan, based on the idea of empowerment, to promote the accurate assessing and addressing of the grassroots agencies' infrastructure, administrative, financial, programmatic and fund raising needs.
4. Identify the providers within the larger organization and/or within the community or Oklahoma State Department of Health who will ensure that the technical assistance needs of the grassroots organizations are being met.
5. Reassess the grassroots program and redevelop subcontracting plans on an annual basis.
6. Continue the capacity-building relationship for the period necessary in order to produce a viable self-sustaining HIV prevention service provider. The Oklahoma Community ...

Duration/Dosage:

Venue:

Mode: Capacity Building – Structured

Provider:

Outcome:

Level:

Target Population: Grassroots agencies

Other: Development of organizational infrastructure and staff expertise which will lead to agency becoming self-sustaining and fully capable of providing services.

Health Education/Risk Reduction (SC)

HE/RR programs and services are efforts to reach persons at increased risk of becoming HIV-infected or, if already infected, of transmitting the virus to others. The goal of HE/RR programs is to reduce the risk of these events occurring. These programs should be directed to persons whose behaviors or personal circumstances place them at high risk. HE/RR programs and services should be culturally competent, sensitive to issues of sexual identity, developmentally appropriate, and linguistically specific. HE/RR are not programs to educate the general public or low risk populations. Please see a later section on Public Information for programs addressing low-risk populations. HE/RR programs are provided by local health departments staff as well as other governmental community-based organizations that have access to and credibility with persons at risk. HE/RR includes street and community outreach, risk reduction, community-level interventions, and HIV prevention case management.

Duration/Dosage:

Venue: Street and Community

Mode: Health Education

Provider:

Outcome:

Level:

Target Population:

Other: Includes Case Management

Evaluation (SC)

Evaluation and Research activities are necessary to conduct formative, process, and outcome evaluations of HIV prevention programs and to assess the cost-effectiveness and cost benefits of strategies and interventions.

To date we have formative and process evaluation efforts in place to assess counseling and testing and to assess health education/risk reduction and public information efforts by local health department staff. Community-based organizations under contract with DHEC have been using EPI-Info to provide information for process evaluation.

Results of the 1997 Survey of S.C. HIV Prevention Services show that 87 percent perform some type of evaluation of their prevention programs. Fifty-one percent evaluate their programs by the number of people reached, 42 percent by participants' satisfaction 42 percent by change in participants' knowledge, 28 percent by change in participants' self-reported behavior, and 10 percent by cost effectiveness.

Duration/Dosage:

Venue:

Mode: Evaluation – Structured

Provider:

Outcome:

Level:

Target Population:

Other:

Capacity Building (SC)

Capacity building includes strengthening the governmental and nongovernmental public health infrastructure in support of HIV prevention, implementing systems to ensure the quality and integration of services (particularly HIV, STD, TB, and drug treatment), strengthening laboratory capacity, and improving the ability to assess community needs and provide technical assistance in all aspects of program planning and operations.

Training and technical assistance are provided to staff of CBOs, collaborations, and local health department to improve skills and the quality of services provided.

The 1997 Survey of S.C. HIV prevention Services shows that 43 percent of respondents engage in efforts to foster collaboration among agencies, 30 percent conduct training of HIV prevention educators, and 26 percent develop and/or distribute HIV prevention curricula...

Duration/Dosage:

Venue:

Mode: Capacity Building – Structured

Provider:

Outcome:

Level:

Target Population: Youth, Women, Men at-risk

Other: Strengthening the governmental and nongovernmental public health infrastructure in support of HIV prevention, implementing systems to ensure the quality and integration of services (particularly HIV, STD, TB, and drug treatment).
Training and technical assistance are provided to staff of CBOs, collaborations, and local health departments to improve skills and the quality of services provided.

Out-of-School Based Programs (SD)

The term "out-of-school" refers to adolescents not participating in a traditional secondary school educational setting, but regularly participating in an organized treatment or alternative educational setting. This includes incarcerated youth, youth in mental health facilities, and youth in alternative high school programs.

Effective curricula points based on philosophy of Buckingham, Doyen, and Main 1995.

Duration/Dosage:

Venue: Organized treatment centers and alternative educational settings

Mode: Health Education – Minimally Structured

Provider: Peers

Outcome: Behavioral

Level: Institution

Target Population: Youth

Other:

Capacity Building (SD)

Capacity building, as an HIV prevention strategy, is a mechanism

1. to assist individuals, organizations and groups in motivating and developing community support around HIV related issues and HIV prevention- community mobilization;
2. to help organizations strengthen their infrastructure- organizational infrastructure; and
3. to help individuals and organizations increase their skills and knowledge about HIV interventions and service delivery- prevention intervention capacity.

Capacity building is a planned, structured sequence of events that may include training, consulting, technical assistance, facilitation and mentoring activities. Capacity building increases skill-levels most effectively when services are tailored to meet the specific needs of each customer, and when customers are provided with continuous support and are committed to the process of building their capacity.

Duration/Dosage:

Venue:

Mode: Capacity Building – Structured

Provider:

Outcome:

Level:

Target Population: Individuals, organizations and groups

Other:

Institution Based Programs (TN)

Taken from section: Description of interventions.

Encompassed under Category II HE/RR.

Institution Based Programs are defined according to the scope of intervention which lies in an organization or establishment dedicated to a specific cause or program. These interventions can offer both peer and non-peer models. For example, researchers have shown that incarcerated populations are a viable group for such a program (Polonsky, Kerr, Harris, Gaiter, Fitchner, and Kennedy, 1994).

Duration/Dosage:

Venue: In an organization or establishment dedicated to a specific cause or program.

Mode:

Provider: Peer and non-peer

Outcome:

Level:

Target Population:

Other:

Evaluation (TN)

Taken from section: Description of interventions.

Category IV. Evaluation. ... refers to efforts designed to assess and improve the quality of interventions. Although not specifically listed with each target population, this category is appropriate for all populations as the last priority except where otherwise ranked.

Duration/Dosage:

Venue:

Mode: Evaluation – Minimally Structured

Provider:

Outcome:

Level:

Target Population:

Other:

Capacity Building (TN)

Taken from section: Description of interventions.

Category V. Capacity Building. ... refers to efforts to strengthen the infrastructure and the ability of community agencies to provide effective HIV prevention education.

Duration/Dosage:

Venue:

Mode: Capacity Building – Minimally Structured

Provider:

Outcome:

Level:

Target Population:

Other:

Peer Education Model (VI)

Peer education model implies a role-model method of educating in which members of the target population provide HIV/AIDS education to their peers. This model provides an opportunity for individuals to develop leadership skills and to perceive themselves as empowered through assisting others in their communities.

Duration/Dosage:

Venue:

Mode: Health Education

Provider: Trained peers

Outcome:

Level:

Target Population:

Other: Provides an opportunity for individuals to develop leadership skills and to perceive themselves as empowered through assisting others in their communities.

Capacity Building (WI)

Capacity building is designed to increase service providers' effectiveness in reaching and serving members of the target populations. Capacity-building encompasses a range of activities including conferences and institutes, mini-grants, resource centers, training and related activities. These activities are distinguished from other strategies by the fact that these are primarily aimed at the agencies that provide services, rather than at members of the target population.

Some examples of capacity-building activities are:

- AIDS/HIV information resource center with lending library of books, videotapes, referrals, quantities of printed materials, and Internet access;
- conferences for educators to better reach and serve gay, lesbian, and bisexual youth with HIV prevention information;
- training of medical personnel to encourage voluntary, universal counseling and testing of pregnant women;
- cultural competence training for service providers;
- technical assistance to help agencies that provide AODA, pregnancy-related, and other services that bear upon HIV integrate HIV prevention skill-building into their existing services;
- technical assistance to assist agencies in developing infrastructure with regard to evaluation, behavioral science, program and fiscal management, staff and board development, and other areas;
- mini-grants to build capacity in churches, civic organizations, and GLBT organizations that reach communities of color to recognize and better serve men of color who have sex with men (MCSM)."

Includes:

- *Scientific Basis*
- *Resources*
- *Centers for Disease Control and Prevention (CDC) – Business responds to AIDS and Labor Response to AIDS Programs.*

Duration/Dosage:

Venue:

Mode: Capacity Building – Semi-Structured

Provider:

Outcome:

Level:

Target Population: Educators, Medical personnel, service providers

Other: Includes: conferences, institutes, mini-grants, resource centers, training , and related activities.

Cultural competence training for service providers

Alcohol And Other Substance Treatment And Methadone Maintenance Programs (WI)

Treatment facilities assist users in eliminating or reducing alcohol and other substance use. Accessible substance abuse treatment enables individuals to seek out treatment when ready. Outpatient drug treatment is an important option for clients waiting for residential treatment.

Alcohol and drug treatment programs provide an opportunity to incorporate HIV risk reduction education. Abstinence-based models, focused on the user ceasing all substance use may not be a realistic or even desirable goal for many users. A harm reduction treatment model focused on reduced substance use and a shift from injection to other practices is effective to reduce some users' risk for HIV. Because the relapse rate for treatment is relatively high, users who have gone through treatment may be in risk situations again following treatment.

Methadone maintenance programs offer those addicted to heroin a substitute substance that addresses some of the effects of the addiction. Methadone taken orally avoids the risk of needle sharing. Providers must, however, remember that methadone maintenance clients may still be using other substances.

Includes:

- *Scientific Basis*
- *Resources*

Duration/Dosage:

Venue: Treatment centers

Mode: Health Education

Provider:

Outcome: Behavioral

Level: Individual

Target Population: Substance abusers

Other: Abstinence-based model.

Harm reduction model focused on reduced substance use and a shift from injection to other practices.

Considered a contact or interaction

School- Based Diversity Programs (WI)

Schools have an obligation to support and foster the growth and development of all students regardless of their national origin or ancestry, gender, age, religion, disability, or sexual orientation. Students have the right to attend schools free of verbal and physical harassment, where education, not survival, is the priority. As students struggle with academic or other difficulties, they also have a right to seek assistance from knowledgeable educators, administrators, and guidance counselors who are free of negative judgment.

School-based diversity programs are a capacity building approach that enable diversity awareness to be implemented at the student level. Teachers and other youth-serving professionals are trained to serve as adults that students can seek out to address questions or concerns. Students' issues may be related to relationships, discrimination based upon sexual or ethnic minority status, or other concerns. In a school-based diversity program, teachers' or counselors' offices are designated as places where an adult is available for individual counseling and where intolerance is not accepted against any individual or group. If a critical mass of teachers are trained and support diversity in their classrooms, the program can significantly affect the larger school climate. The following are some key steps involved in implementing a school-based diversity program:

- Communication with school boards and administrations to encourage adoption of program is key to a successful school-based diversity program.
- Program developers should recruit and train teachers and other youth-serving professionals
- Program developers should plan the project in collaboration with school districts, schools, or other organizations to encourage widespread implementation of the program.

Includes:

- *Scientific Basis*
- *Resources*

Duration/Dosage:

Venue: School

Mode: Capacity Building

Provider:

Outcome: Structural

Level:

Target Population: Teachers and Youth serving professionals

Other:

Development of a National HIV/AIDS Prevention Intervention Taxonomy

Summary of the Expert Panel Discussion

July 23-24, 2001

Swissôtel - Atlanta, GA

Prepared by:

Centers for Disease Control and Prevention and ORC Macro

Table of Contents

I.	Introduction	1
II.	Objectives of the Meeting	2
III.	Overview of Preliminary Activities	2
	A. Literature Review	2
	B. Data Abstraction	3
	C. CDC Past and Present Initiatives.....	3
IV.	Panelist Presentations.....	4
V.	Developing a Standard HIV Prevention Intervention Taxonomy	5
	A. Identifying the Purpose of the Taxonomy	6
	B. Stakeholders.....	6
	C. Potential Uses for an HIV Prevention Intervention Taxonomy	7
	D. Key Characteristics of Developing a National Taxonomic System	7
	E. Other issues to consider.....	10
VI.	Where to Begin?.....	10
	A. Who Should Be Involved?.....	11
	B. Mission Statement	12
VII.	Next Steps	12
VIII.	Conclusion.....	13

Appendices

Appendix A: Development of a National HIV Intervention Prevention Taxonomy

Appendix B: Panelist Presentations

Development of a National HIV/AIDS Prevention Intervention Taxonomy

Summary of the Expert Panel Discussion

I. Introduction

The Program Evaluation Research Branch of the Division of HIV/AIDS Prevention - Intervention Research and Support (DHAP-IRS) at the Centers for Disease Control and Prevention (CDC) convened this expert panel to address concerns, gain advice on, and input into the development of a national HIV/AIDS prevention intervention taxonomy. The taxonomy would be for the National Center for HIV, STD, and TB Prevention (NCHSTP) generally and evaluation purposes specifically. Panelists with diverse expertise in HIV prevention, taxonomy and standards development, and informatics were gathered to provide their unique perspectives on the development and use of a national HIV/AIDS prevention intervention taxonomy.

The meeting was co-facilitated and organized by **Dr. Timothy Akers**, CDC, and **Dr. David Cotton**, ORC Macro. It was held early in the process to discuss the value of and need for a national, standardized HIV/AIDS prevention intervention taxonomy. After reviewing the CDC's efforts in developing classification categories for HIV prevention interventions, the debates that still continue within and between health departments and community based organizations regarding the distinctions, definitions, and characteristics of various types of HIV prevention interventions were summarized. Drs. Akers and Cotton discussed the anticipated difficulties of developing a taxonomic system, identifying the needs of potential users of such a system, and determining what course of action in the development of the taxonomy would best meet those requirements. The meeting proved to be a valuable forum for this type of discussion.

II. Objectives of the Meeting

- To discuss the value of and needs for an intervention taxonomy system, its benefits and uses, and potential resistance to a common system
- To describe possible ways of describing the parameters for categorizing interventions that will be useful for stakeholders
- To determine the level of specificity needed for making taxonomic categories mutually exclusive, including minimal criteria or standards for interventions or their component activities, and
- To identify appropriate stakeholders, participants, and steps for proceeding with taxonomy development

III. Overview of Preliminary Activities

To aid in meeting the expert panel objectives, a brief overview of findings from preliminary research was given (See Appendix A). Various definitions of terms and key principles of taxonomy development were presented to the group. The distinction among intervention, a multi-component intervention, and a multiple intervention program were noted in the CDC's and the Academy for Educational Development's (AED) definitions of *intervention*. The definitions for *taxonomy* indicated that it is both a process and product of a classification system.

The key goals and principles of developing a taxonomic system included making sure that the system is scientifically based, practical and applicable in a variety of settings, broadly acceptable, comprehensive, and assures mutual exclusivity across type of characteristics unique within and between categories.

A. Literature Review

Brief descriptions of the existing literature, including other efforts to categorize HIV prevention interventions and the data abstraction summary were also presented. As stated in the literature review, several efforts have been made to categorize interventions. Senior CDC staff, for the purpose of an economic evaluation, developed *A Suggested Taxonomy for HIV-Related Prevention and Treatment Services*. Since then, that classification system has been used by

many health department grantees. The Suggested Taxonomy was also the foundation for the development of the *Evaluating CDC-Funded Health Department HIV Prevention Programs, Volume 1: Guidance* (Evaluation Guidance) intervention definitions. Seven types of interventions were identified for which jurisdictions are to report aggregate data:

- Individual-Level Intervention
- Group-Level Intervention
- Outreach
- Prevention Case Management
- Partner Counseling and Referral Service
- Health Communication/Public Information
- Other (e.g., Community-Level Intervention)

The Evaluation Guidance categories were developed to capture a minimum data set from CDC-funded health departments. Major limitations of the Evaluation Guidance were noted, including the lack of distinguishing characteristics of specific interventions, and the need for inclusiveness, consistency and clarity of ambiguous definitions and categories that are not mutually exclusive. Improvements in these areas need to be carried out with greater input from stakeholders and end-users, both internal and external to the CDC.

B. Data Abstraction

The review of the FY 2001 Cooperative Agreement Applications and Comprehensive Plans revealed that some jurisdictions used the *Suggested Taxonomy* or Evaluation Guidance taxonomy to classify their HIV prevention interventions. For any particular intervention type, it was noted that no more than 15 jurisdictions had standard, operational definitions for that intervention. Some jurisdictions had developed their own independent organizational structure for categorizing their interventions. It is important to note that these reviews also illustrated a wide variation in definitions and standards of interventions by the jurisdictions that are not necessarily consistent with CDC's previous classification initiatives.

C. CDC Past and Present Initiatives

In addition to the Evaluation Guidance and the *Suggested Taxonomy* by Holtgrave, Valdiserri and West (1994), the Behavioral Intervention Research Branch (BIRB) of the CDC has been in the process of developing a categorization scheme for the components of prevention interventions. **Dr. Mary Neumann** of BIRB presented their work on the classification of

behavioral and structural interventions currently underway with the Synthesis Project at the CDC. Descriptions of HIV prevention interventions found in articles published since 1988 were reviewed for this project. The interventions were deconstructed into their major characteristics, such as type, setting, content and method, grouping, length, facilitator and theoretical basis.

IV. Panelist Presentations

Four panelists were asked to speak about their previous experiences in developing definitions, standards, or taxonomies (See Appendix B). The presenters included taxonomy experts and potential end-users such as the CDC and health departments. A summary of each presentation follows below.

Dr. Stuart Nelson of the National Library of Medicine presented on the development and maintenance of the Medical Subject Headings. He spoke of the need for a common nomenclature and advocated for an indexing system over a classification or taxonomy system, stating a taxonomy suggests a hierarchy among interventions. An indexing system is poly-hierarchical and interventions can be organized by any given characteristic or element.

Dr. Patricia Fleming, Branch Chief of Surveillance at the CDC, spoke about the lack of behavioral surveillance data for HIV/AIDS and the need for a system that could integrate with other CDC branches and at the state and local levels. Dr. Fleming stated such a system would aid in understanding which interventions are linked to which outcomes. She also said that a common vocabulary would be useful in communicating with Congress and other federal organizations, like Office of Management and Budget.

Georgia Sales of the INFOLINE of Los Angeles spoke on the development and maintenance of the *Taxonomy of Human Services*. This classification system was “designed to index and access information about a subject in a systematic, unambiguous way.” She went on to describe the *Taxonomy of Human Services* as having categories that take into account a broad range of services within the public and private sectors.

Robert Bongiovanni, from the Colorado Department of Public Health and Environment,

presented the *HIV Prevention Interventions and Standards of Practice in Colorado*. This document was created by a workgroups of stakeholders, and is revised and updated annually. Key components for all interventions are listed, followed by specific definitions and standards for each intervention. Colorado is beginning to look at the content areas of the interventions to identify gaps in where and how services are being provided. A matrix of the intervention types as listed in the Evaluation Guidance by six content areas was presented: biomedical, restrictive measures, deficits, harm reduction, environment and system.

V. Developing a Standard HIV Prevention Intervention Taxonomy

After considering previous classifications (e.g., *A Suggested Taxonomy for HIV Prevention Treatment and Services* and the *Behavioral and Structural Interventions*), along with discussions that listed potential uses, it was noted that the question should not be “*is a taxonomy needed?*” but rather “*should we develop it?*” The panel agreed upon the need for a systematic way of defining and classifying HIV prevention interventions. There was also consensus that either the workgroup or CDC/NCHSTP staff should begin to work toward the development of the taxonomy, with input from stakeholders and end-users.

As extracted from the health departments’ Cooperative Agreement Applications, some jurisdictions have already begun to define and classify interventions. While the taxonomic structures vary by jurisdiction, many community-based organizations and local health departments gravitate to what the state is doing. Participants pointed out that if there is a need for a nationally standardized taxonomy, it should be developed soon before fifty different systems are developed and implemented. There will be a great deal of frustration if the CDC then tells them that they need to change.

The taxonomy experts recommended that the panel not become involved with specifics until the purpose and key stakeholders of the taxonomy are decided upon. The panelists were asked to consider who is going to be using the taxonomy and how the taxonomy will be used?

A. Identifying the Purpose of the Taxonomy

The group proposed four purposes of the taxonomy:

- To communicate in a clear and concise way about funds.
- To account for where the money goes.
- To organize activities, program support, funding, etc.
- To provide an expandable foundation for program grantees to do continuous program improvement.

B. Stakeholders

To address the question of “*Who would use a standardized national taxonomy for HIV prevention interventions?*”, the participants identified the following stakeholders of such a system:

- Researchers
- Evaluators
- Community Planners
- Communities for whom there is little literature
- Funders (e.g., Foundations, other Federal agencies, etc)
- Office of Management & Budget (OMB)
- Other CDC units
- Data collectors/surveyors (e.g., NEDSS)

By the second day, it was necessary for the group to begin thinking in a “*DHAP-centric*” manner about how the taxonomy should be developed to focus the discussions. The division encompasses the prevention, behavioral intervention, technical assistance, evaluation and surveillance branches. Coordination and buy-in from these branches is imperative. It was determined that at a minimum, DHAP needs a common and consistent language to talk amongst themselves about the interventions they ultimately fund.

In order to be broadly acceptable and applicable in a variety of settings, there needs to be further consideration of who is not “at the table”, such as Substance Abuse Mental Health Services Administration (SAMHSA). STD prevention interventions should also be integrated into the system. In addition, the taxonomy needs to be flexible and adaptable to individual state and local laws. Acceptability by the states is important. One means of achieving this would be to involve

them in the development of the taxonomy. It was recommended that if the taxonomy is broad and general enough, it could be adaptable to the other CIOs (Centers, Institutes and Offices) of the CDC and other federal, state, philanthropic, and other non-governmental agencies.

For a taxonomy to be useful to the broad range of potential stakeholders, it must be both general and specific enough in its descriptions of interventions. However, one panelist expressed concern about involving too many stakeholders. HIV is a small part of the biomedical world, and trying to get buy-in from so many different stakeholders may stall the process. There needs to be a hierarchy of need in considering stakeholders, otherwise the benefit to HIV may be minimal.

C. Potential Uses for an HIV Prevention Intervention Taxonomy

Panelists then listed potential uses of the taxonomy by the identified stakeholders:

- Evaluation – comparability among interventions to understand what works
- Coordination and prioritization of interventions
- Funding decisions
- Program planning and delivery
- Technical assistance and capacity building
- Research
- Surveillance – identification of the setting and type of service received

D. Key Characteristics of Developing a National Taxonomic System

Two significant considerations in the development of an HIV prevention intervention taxonomy were identified. The first is the development of definitions for the major interventions funded by the CDC (by building on the Evaluation Guidance) that are mutually exclusive. The second step is the identification of characteristics and elements that reflect the minimum criteria of activities that go into a particular type of intervention.

Determining Definitions of Interventions. The definitions of interventions need to be meaningful to researchers, evaluators and the end-users, while, at the same time, being mindful

of those jurisdictions that have already begun to “define” or “taxonomize” their interventions. There is also a need to communicate the purpose of the taxonomy so that it is not used inappropriately. The purpose of the taxonomy should be clear and support planning at the local level. Consideration must be given to categorizing multi-component interventions and multiple intervention programs.

During the meeting, it was further noted that there are at least two different ways to define *program*. One is as a collection of interventions and the other includes all of the activities that are required to support one or more interventions to include elements like planning, collection of data for planning, monitoring, making changes, etc. Ultimately, a *program*, *project* and *intervention* all have to be defined within the taxonomy. To address these issues, the development of the taxonomy system must be a dynamic, interactive and an ongoing process that allows for input from the stakeholders and end-users on a periodic basis.

Characteristics/Elements of Interventions. There was some confusion as to whether the taxonomy would consist of specific mutually exclusive interventions or if it would be much more specific with a *multi-axial* approach in ways to describe mutual or diverse categories. The purpose of multiple axes is to choose and describe how you want to look at the interventions. The taxonomy can then be accessed in various ways, such as by level (e.g., individual or group) or by target population. The panel expressed that in order for this type of model to work, it is very important to have unambiguous definitions. Panelists felt that the multi-axial model might be the best to work with.

The panel identified a long list of characteristics or elements of interventions that could be used as axes:

- Duration/dosage
- Target
- Venue
- Deliverer/provider
- Level
- Cost
- Resources needed
- Resource intensity
- Desired outcome
- Whether you go to them or they come to you
- Underlying philosophy, theory, or models
- Intervention type
- Cultural relevance
- Acceptability

Each of the elements identified has a series of attributes that enable an intervention to maintain its mutual exclusivity (e.g., deliverer/provider includes peers, professionals, and paraprofessional; intervention type includes biomedical, behavioral, social, and structural). It was further noted that there were, however, some characteristics that were functions of other characteristics (e.g., culturally appropriate interventions are a function of characteristics such as target population, level and provider). These types of characteristics were deemed standards and should be differentiated from characteristics.

The taxonomic experts recommended that there be approximately five or six critical elements by which interventions can be catalogued or classified as it takes a considerable amount of money to construct and maintain such a complicated taxonomy. This comment elicited critical questions about the CDC's commitment to the project. *Does the CDC support such a project? Are there funds available to begin, and even more importantly, maintain the taxonomy?* While there is verbal support, panelists strongly recommended that these issues be considered before moving forward with the development of the taxonomy. CDC representatives communicated that the outcome of this expert panel meeting would better enable and guide CDC/NCHSTP/DHAP directors to determine the future direction of this project or other similar projects.

Discussion about the list of intervention characteristics continued. Cost-benefit analysis, underlying theory, and cultural relevance sparked another discussion about definitions versus standards. These features were described as common standards for all interventions; all good interventions should be theory-based, culturally relevant and cost effective. The degree to which this occurs may be an axis; however the distinctions of cultural relevance and cost effectiveness would be determined by looking at other features (e.g., culturally appropriate interventions may be a function of characteristics such as target population, level, and provider).

Several panelists felt that cost, or resource intensity, is a necessary feature to consider in selecting an intervention. Others commented that the monetary costs for implementing an intervention would vary by jurisdiction and over time (e.g., the cost of an intervention in 1991 would differ from the cost of implementing that intervention in 2001).

Panelists recommended six critical elements of interventions for the taxonomy:

- Duration/dosage
- Target
- Venue (i.e., where the intervention takes place)
- Deliverer/provider (e.g., peers, paraprofessionals, professionals)
- Desired outcome
- Level (e.g., individual, group, etc.)

E. Other Issues to Consider

Throughout the discussion, panelists raised several other concerns and issues that should be considered in the development of the taxonomy. Many of those issues were consistent with the goals and principles of taxonomic development.

The taxonomy must be comprehensive and inclusive, yet flexible and open to innovation and change. In creating a “data dictionary” interventions not included in the taxonomy are less likely to be implemented. Also data is not likely to be collected on those interventions not included. It should also include those interventions that have yet to be evaluated. This is important because there has been limited research on effective models of HIV prevention in communities of color. However, this discussion addressed “taxonomy” as a catalogue of interventions, rather than a multi-axial, descriptive system. If the later approach is pursued, these considerations become less of a concern.

VI. Where to Begin?

There were several suggestions for how to begin the development process for an HIV prevention intervention taxonomy. One recommendation was for the panelists to draft definitions of the interventions and then circulate it among intended stakeholders for input. It was noted that vocabulary development, and classification for that matter, is not a democratic process. While there may be input from stakeholders, the decisions of categorization of a particular intervention received should be done internally by those managing or housing the database. If each individual or jurisdiction is able to interpret the definitions and self-classify, there will be no consistency.

Another suggestion was for the group to decide upon a model and then determine definitions. Since some jurisdictions have begun using a system derived from the seven interventions listed in the Evaluation Guidance, this may be a logical model to begin with, thereby minimizing the burden on jurisdictions to readapt to a totally new system. On the other hand, it was noted that as the model grows, the Guidance's broadly defined seven intervention categories might become a barrier because it is no longer what users are looking to manage. For example, over time, people may become more interested in the content area of the intervention rather than the level or general category.

A. Who Should Be Involved?

Before beginning, some expressed the necessity of inviting all the stakeholders to the table. This will allow for the taxonomy to be useful to not only DHAP, but also other divisions within CDC, HRSA and other federal funding agencies, as well as those from the local health departments and community-based organizations operating with multiple funding streams. Additionally, there needs to be more representation from minority groups and rural areas. It was further expressed that if future meetings such as this are to occur, that they need to follow the model of this type of meeting by not only inviting HIV experts but also including taxonomic, informatics, modeling, standards, and evaluation experts to provide their shared input as well, given that it will be inevitable that such a taxonomic system will eventually have to be computerized and may be adopted by other agencies or organizations.

In discussion of how to proceed, it became apparent that there were two different issues trying to be addressed at once. The first was the recognition for definitions and a common language of what activities are necessary in particular interventions (e.g., *who delivers it? where it is delivered? how many events comprise it?*). The second relates to standards for those interventions. Once again, panelists stressed the importance of being flexible and allowing for variation and innovation as needed. It was clarified that regulatory standards should not be included in the definitions, but there needs to be certain criteria to differentiate between interventions. For example, group interventions must have a minimum of *X* people. It was agreed that the lack of a common nomenclature was making the discussion difficult. This highlighted the need for a standard taxonomy to allow discussion about the actions and functions

of an intervention and avoid “semantic” debates about the same functional issues.

B. Mission Statement

A mission statement to guide the development of the taxonomy was proposed by the panelists. Comments and suggestions were made for the following mission statement:

To develop a common [controlled] vocabulary, through a dynamic, integrated process with periodic review, to describe and index HIV/AIDS prevention interventions for the purpose of: defining; comparing; supporting and improving; and establishing standards for [regulating], evaluating, replicating, and communicating about and reporting on those interventions.

The term *regulating* concerned many of the panelists. There was consensus that the taxonomy should not carry the burden of enforcement of regulations. The word *controlled* is part of the lexicon for computer-based systems.

While proceeding with the development of the taxonomy, or mission, the features of a good classification system need to be kept in mind. The taxonomy must be specific so that “*gophers don’t turn into land tortoises,*” as one panelist described the risk of non-specificity. It must also be expandable for new ideas to be added while allowing room to tailor interventions for different communities. The taxonomy should be exhaustive of all HIV/AIDS prevention interventions. Lastly, the taxonomy needs to be theoretically neutral.

VII. Next Steps

Panelists discussed the use of subcommittees or working groups to develop the taxonomy. Some felt it necessary to have working groups for each intervention, while others felt that continuity and consistency would be lost with the different groups. It was determined that a core group of individuals (fewer than those on the expert panel) should make the decisions with input from stakeholders. This process should take place yearly or every other year to ensure that the taxonomy is up-to-date and relevant. The leader of this workgroup should be someone

committed to the system. He or she must be familiar with the range of users and their needs from federal funders to the end users of interventions. This individual must be able to provide leadership and push toward the completion, and possible institutionalization of the taxonomy.

Before adjourning, the group was asked, “What message should the CDC take from this meeting?” A written commitment from the CDC is necessary for this project to move forward; budgets (one for development and the other for maintenance) and timelines need to be defined. From there, the CDC needs to:

- Inform Project Officers (and AIDS Directors) of project.
- Determine the resources available to develop a taxonomy.
- Determine the resources available to maintain/manage the taxonomy products.
- Communicate the expert panel meeting report and recommendations to the stakeholders.
- Develop a written plan of next phase (whose is involved, what will be involved, intended outcomes).
- Document the benefits for end-users.

Once developed, the CDC will need to require and participate in the rigorous, yet practical update of the taxonomy on a regular basis. They should also let stakeholders know when changes or updates will go into effect.

VIII. Conclusion

The group concluded that there is a definite need for a common language and taxonomy. The purpose of the taxonomy needs to be more clearly defined and priorities must be set in terms of primary and secondary stakeholders. Once these have been decided upon, a working group will need to be established. This group, with input from the various stakeholders, will identify key elements of interventions to be used as axes and define the terms and the interventions in the taxonomy. The taxonomy will need to be updated on a regular basis. However, before proceeding on to the next phase, it will be essential for CDC to communicate their commitment to the development, sustainability, and institutionalization of a national, standardized HIV/AIDS prevention intervention taxonomy if such an undertaking is to be successful.

Appendix A

Development of a National HIV Intervention Prevention Taxonomy

**Development of a National
HIV Intervention
Prevention Taxonomy**

*Expert Panel Meeting
July 23 - 24, 2001*

ORC MACRO[®] CDC

**“Problems cannot be
solved at the same
level of awareness
that created them”**

~ Albert Einstein

Objectives

- To discuss the value of and needs for an intervention taxonomy system, its benefits and uses, and potential resistance to a common system
- To discuss ways of describing the parameters for categorizing interventions standard ways that will be useful for stakeholders

Objectives

- To discuss the level of specificity needed for making taxonomic categories mutually exclusive, including minimal criteria or standards for interventions or their component activities
- To determine appropriate stakeholders, participants, and steps for proceeding with taxonomy development

**HIV Prevention
Interventions**

Definitions

- Intervention
 - A specific activity (or set of related activities) intended to bring about HIV risk reduction in a particular target population using a common strategy for delivering the prevention messages.
- An intervention has:
 - distinct process and outcome objectives AND
 - a protocol outlining the steps for implementation

Source: Evaluating CDC-Funded Health Department HIV Prevention Programs, Volume 1: Guidance (CDC, 2001)

Definitions

- Intervention
 - Any organized activity designed to influence knowledge, attitudes, beliefs or behavior related to the prevention of HIV/AIDS. Interventions can vary widely in scope from a single educational material, such as a national mailing on AIDS information, to multifaceted comprehensive programs, such as client-centered counseling and testing activities.

Source: Academy for Educational Development. *What Intervention Studies Say About Effectiveness: A Resource for HIV Prevention Community Planning Groups*. 1995

Definitions

- Taxonomy
 - The study of systematic classification including their bases, principles, procedures, and rules. The science of how to classify and identify.

Source: Fleishman, E.A. and Quaintance, M.K. *Taxonomies of Human Performance: The Description of Human Tasks*. Orlando: Academic Press, Inc., 1984.

Definitions

- Taxonomy
 - A classification system which organized entities, objects, programs, etc. into categories for the purpose of description, study, analysis and communication.

Source: Academy for Educational Development. *What Intervention Studies Say About Effectiveness: A Resource for HIV Prevention Community Planning Groups*. 1995

Definitions

- Classification
 - The ordering or arrangement of entities into groups or sets on the basis of their relationships based on observable or inferred properties.

Source: Fleishman, E.A. and Quaintance, M.K. *Taxonomies of Human Performance: The Description of Human Tasks*. Orlando: Academic Press, Inc., 1984.

A Suggested Taxonomy ...

...for HIV-Related Prevention and Treatment Services

- Developed by senior CDC staff
- Used in CDC announcements
- Widely used by many health department grantees
- Primary source for Evaluation Guidance taxonomy

Source: Holtgrave, D.R., Valdiserri, R.O., & West, G.A. (1994). Quantitative Economic Evaluation of HIV-Related Prevention and Treatment Services: A Review. *Risk: Health, Safety & Environment*, 5(1), 29-47

CDC Evaluation Guidance

- Developed by the Division of HIV/AIDS Prevention (DHAP) for the purposes of evaluating HIV prevention activities
- Seven (7) types of interventions were identified for which jurisdictions are to report aggregate data.

Source: Evaluating CDC-Funded Health Department HIV Prevention Programs, Volume 1: Guidance (CDC, 2001)

CDC Evaluation Guidance

- Individual Level Interventions (ILI)
- Group Level Interventions (GLI)
- Outreach
- Prevention Case Management (PCM)
- Partner Counseling & Referral Services (PC/RS)
- Health Information/Public Information (HC/PI)
- Other

Source: Evaluating CDC-Funded Health Department HIV Prevention Programs, Volume 1: Guidance (CDC, 2001)

Limitations of CDC Guidance

- Not comprehensive
- Not mutually exclusive
- Limited number of stakeholders were involved in the development process

Intervention Documents

- CDC Guidelines
 - Guidelines for Health Education and Risk Reduction Activities
 - Counseling, Testing, Referral, & Partner Notification (CTRPN)
 - Revised Guidelines for HIV Counseling, Testing and Referral - Draft
 - HIV Partner Counseling and Referral Services - Guidance
 - HIV Prevention Case Management - Guidance

Other documents/projects ...

- that have identified key characteristics/features of HIV prevention interventions:
- Compendium of HIV Prevention Interventions with Evidence for Effectiveness (*CDC's HIV/AIDS Prevention Research Synthesis Project*)
 - Evaluating CDC-Funded Health Department HIV Prevention Programs, Volume 2: Supplemental Handbook, Chapter 3
 - HIV Prevention Case Management - Guidance
 - HIV Prevention Among Drug Users (*NIDA*)

Health Department HIV Prevention Interventions: Data Abstraction

- 65 CDC-funded jurisdictions
- Data abstracted from:
 - Applications for FY2001 HIV Prevention Cooperative Agreements
 - FY2001 HIV Prevention Comprehensive Plans
 - Health Department or Community Planning Group Web pages

Health Department HIV Prevention Interventions: Data Abstraction

- Intervention definition categorized:
 - Goals and Objectives
 - Definition/Description
 - Standards or Guidelines
- Noted if information provided on:
 - Specific activities
 - Frequency/duration
 - Staff qualifications

Health Department HIV Prevention Interventions: Data Abstraction

- Wide variation among jurisdictions in:
 - Intervention names
 - Levels of specificity within a definition type
 - Classification structures
- No more than 15 jurisdictions had standards or guidelines for any one intervention type.

Behavioral and Structural Interventions

Mary Neumann
*Centers for Disease Control & Prevention
Atlanta, GA*

An HIV Prevention Intervention Taxonomy

- Is there a need for a national standardized taxonomy system?
- If yes,
 - **WHY** is it needed?
 - **WHAT** will it be used for?
 - **WHO** would use it?
- **HOW** do we create it?

Stakeholders

- Who are the stakeholders of an HIV prevention intervention taxonomy?
- How would they use a taxonomy?
- What other benefits or values might a taxonomy have?

Medical Subject Headings/ICD

Stuart Nelson
*U.S. National Library of Medicine
Washington, D.C.*

Taxonomy of Human Services

Georgia Sales
INFO LINE of Los Angeles

HIV Prevention Interventions and Standards of Practice in Colorado

Robert Bongiovanni
*Colorado Department of Public
Health and Environment*

HIV/AIDS Surveillance Purposes

Patricia Fleming
*Centers for Disease Control & Prevention
Atlanta, GA*

Goals and Principles ...

...for developing an HIV prevention
intervention taxonomy:

- Broadly acceptable
- Scientifically-based
- Practical
- Applicable in a variety of settings
- Inclusive (i.e., comprehensive)
- Mutually exclusive

What organizations have
systems that this
taxonomy would need
to be integrated with?

Development of a Taxonomy

What factors need to be considered
in the development of a taxonomy?

- Structure
- Classes
- Definitions
- Classification

Where do we go from here?

- What are the next steps?
- What other information is needed
to proceed?

Appendix B

Panelist Presentations

Dr. Stuart Nelson of the National Library of Medicine presented on the development and maintenance of the Medical Subject Headings.

TAXONOMY, NO! ORGANIZATION, SI!

- The Disavowal
- Why Organize?
 - Questions and viewpoints
 - Need to establish value of efforts
- Why Not a Taxonomy?
 - Not Adam, after Noah
 - Classification doesn't work
- What Else is There?

Organization of Knowledge

- How to Make a Good Vocabulary
 - Thesaurus
 - Reference Terminology
- Polyhierarchy
- Evaluation Criteria
- The Nature of the Task

The Nature of the Task

- Classification versus Indexing
 - What is Classifying?
 - What is Indexing?
- Identifying the Important Variables
- Aristotle versus Escher

Criteria - You are You and I am Me

- Useful
- Reproducible
- Understandable
- Meaningful distinctions
- Expressive Names

Polyhierarchy

- Supports Multiple Views
- Potentiates Use of is_a Hierarchies
- Enables Use of Axes in Indexing
 - Optional
 - Required
- Facilitates Retrieval

Important Practices

- Use Meaningless Identifiers
- Use Separate Tree Numbers
- Use Expressive Names
- Plan for Updates
 - Use makes better
 - Science marches on

Things to Avoid

- "Not Elsewhere Classified"
- "Not Otherwise Specified"
- Reuse of Codes and Identifiers
- Becoming Trapped
 - Interfaces
 - Database Systems

Observations

- Engineering, not Science
- Trade-offs Inevitable
- Need a Decision Maker

Suggestions for Next Steps

- Coordinate with Efforts of Others (e.g., NIH)
- Establish Responsible Parties
- Inclusive Process

Georgia Sales of the INFOLINE of Los Angeles spoke on the development and maintenance of the *Taxonomy of Human Services*.

A BRIEF INTRODUCTION TO

A TAXONOMY OF HUMAN SERVICES

A Conceptual Framework With Standardized Terminology and
Definitions for the Field

Georgia Sales

INFO LINE of Los Angeles

Presentation for
the Centers for Disease Control and Prevention
July, 2001

WHAT IS A TAXONOMY?

A classification system that is designed to index and access information about a subject in a systematic, unambiguous way.

Example: the Dewey Decimal System.

In a human services context, a classification system that is designed to index and access community resources based on the services they provide and the targets they serve, if any.

TYPES OF CLASSIFICATION SYSTEMS

Subject Headings/Subject Classification Systems

Examples: *Library of Congress Subject Headings*
HIV/AIDS Treatment Thesaurus
ACT HIV/AIDS Thesaurus

Purpose: To classify journal articles, books and other bibliographic materials by the topic e.g., side effects, mast cells, perinatal transmission.

Organizational Classification Systems

Examples: *North American Industry Classification System (NAICS)*
National Taxonomy of Exempt Entities (NTEE)

Purpose: To classify organizations by type of organization e.g., hospitals, outpatient clinics, hospice facilities.

Program Classification Systems

Example: *Nonprofit Program Classification System*

Purpose: To classify classes of programs offered by organizations, but not individual activities, e.g., AIDS/HIV programs; patient care.

Service Classification Systems

Examples: *AIRS/INFO LINE Taxonomy of Human Services*
UWASIS (United Way of America Services Identification System)

Purpose: To classify discrete service offered by organizations, e.g., HIV testing, AIDS treatment, AIDS prevention, long-term case/care management.

TYPES OF TAXONOMY TERMS

Service Terms

- Home Delivered Meals
- Money Management
- HIV Testing
- Case/Care Management

Organization Type

- Adult Schools
- Hospitals
- Hospice Facilities
- Public Libraries

Modality (way the service provided)

- Group Counseling versus Individual Counseling
- Legal Representation versus Legal Counseling
- Training versus Consultation

Orientation/Philosophy

- Gestalt Therapy
- Pro-Choice Counseling

Major Program

- WIC
- Social Security Disability
- Medicare

Target Population

- Older Adults
- Pediatric AIDS
- Victims/Survivors
- Topical Identifiers/Issues

TAXONOMY ELEMENTS

Term Identification Numbers (Codes)

- Alpha-numeric structure
- Mark place and level of terms within the hierarchy
- Mechanism for grouping related terms, showing broader and narrower relationships
- Space for expansion

Terms

- Preferred wording for service concepts
- Wording for the term in the hierarchy display
- Wording for the term in searches/database products

Definitions

- Touchstone to assure consistent use
- Descriptive rather than prescriptive
- Not a substitute for individual narratives

See Also References

- Identify related terms in other parts of the hierarchy
- Help to assure selection of most appropriate term

Use References

- Synonyms for preferred terms
- Accommodate regional differences in the language
- Facilitate “common language” word/phrase searches

HIERARCHY OUTLINE LEVELS I & II

B Basic Needs

- BD Food
- BH Housing
- BM Material Resources
- BR Temporary Financial Aid
- BT Transportation

D Consumer Services

- DD Consumer Assistance/Protection
- DF Consumer Regulation

F Criminal Justice & Legal Services

- FC Courts
- FF Criminal Correctional System
- FJ Judicial Services
- FL Law Enforcement Agencies
- FN Law Enforcement Services
- FP Legal Assistance Modalities
- FR Legal Education/Information
- FS Legal Insurance
- FT Legal Services

H Education

- HD Educational Delivery System
- HH Educational Programs
- HL Educational Support Services

J Environmental Quality

- JB Domestic Animal Services
- JD Environmental Improvement and Protection
- JF Environmental Maintenance
- JH Environmental Management
- JP Public Health

- JR Public Safety

L Health Care

- LD Emergency Medical Care
- LE General Medical Care
- LF Health Screening/Diagnostic Svc
- LH Health Supportive Services
- LJ Human Reproduction
- LL Inpatient Health Facilities
- LM Medical Laboratories
- LN Outpatient Health Facilities
- LR Rehabilitation/Habilitative Services
- LT Specialized Treatment
- LV Specialty Medicine
- LX Substance Abuse Services

N Income Security

- ND Employment
- NL Income Maintenance Programs
- NS Social Insurance Programs

P Individual and Family Life

- PB Death Certification/Burial Arrangements
- PF Family Surrogate/Alternative Living Services
- PH Individual and Family Support Services
- PL Leisure Activities
- PS Social Development/Enrichment
- PV Spiritual Enrichment

R Mental Health Care and Counseling

- RB Adjunctive Therapies
- RD Counseling Approaches
- RF Counseling Modalities
- RM Mental Health Facilities

RP Outpatient Mental Health Care
RR Psychiatric Support Services
RT Special Psychiatric Programs

T Organizational/Community Services

TB Community Economic Development
TD Community Groups
TF Community Services
TH Disaster Services
TJ Information Services
TN Occupational/Professional Assns
TP Organizational Development

Y Target Populations

YB Age Groups
YC Aided Persons
YD Caregivers
YE Citizenship
YF Disabilities
YG Educational Status
YH Ethnic Group/National Origin
YI Experiencers of
Paranormal/Extraterrestrial
Events
YJ Families Needing Support
YK Family Relationships
YL Income Groups
YN Military Personnel
YO Occupations
YP Offenders
YQ Organizational Perspective
YR Religious Groups
YS Sex/Gender
YT Sexual Orientation/Gender
Identity
YV Transients
YW Urban/Rural Location
YX Victims/Survivors
YY Volunteers
YZ Topical Identifiers/Issues

FIVE LEVELS OF DETAIL

B Basic Needs
D Consumer Services
F Criminal Justice and Legal Services
H Education
J Environmental Quality
L Health Care
N Income Security
P Individual and Family Life
R Mental Health Care and Counseling
T Organizational/Community Services
Y Target Populations

L Health Care
LD Emergency Medical Care
LF Health Screening/Diagnostic Services
LH Health Supportive Services
LJ Human Reproduction
LL Inpatient Health Facilities
LN Outpatient Health Facilities
LR Rehabilitation/Habilitative Services...

L Health Care
LF Health Screening/Diagnostic Services
LF-010 Activities of Daily Living Assessment
LF-480 Diagnostic Imaging/Radiology
LF-490 Disease Specific Screening
LF-527 Eye Screening
LF-535 Genetic Testing and Screening
LF-700 Pediatric Evaluation
LF-730 Prenatal Evaluation...

L	Health Care
LF	Health Screening/Diagnostic Services
LF-490	Disease Specific Screening
LF-490.045	Allergy Testing
LF-490.055	Asbestosis Screening
LF-490.150	Cancer Detection
LF-490.155	Cholesterol/Triglycerides Tests
LF-490.165	Dementia Evaluation
LF-490.210	H Pylori Tests
LF-490.240	HIV Testing
LF-490.450	Lead Poisoning Screening...

L	Health Care
LF	Health Screening/Diagnostic Services
LF-490	Disease Specific Screening
LF-490.240	HIV Testing
LF-490.240-05	Anonymous HIV Testing
LF-490.240-15	Confidential HIV Testing
LF-490.240-30	Home HIV Test Collection Kits
LF-490.240-60	Oral Fluid HIV Tests
LF-490.240-70	Rapid HIV Tests
LF-490.240-90	Urine HIV Tests

Basic Subsistence Outline

B	BASIC SUBSISTENCE	BH-180	Emergency Shelter
BD	Food	BH-180.150	Crisis Shelter
BD-150	Communal Food Storage Facilities	BH-180.150-10	Battered Women's Shelter
BD-180	Emergency Food	BH-180.150-15	Crisis Nurseries
BD-180.100	Brown Bag Programs	BH-180.150-20	Family Crisis Shelter
BD-180.200	Food Pantries	BH-180.150-70	Runaway Shelter
BD-180.200-20	Food Lines	BH-180.150-75	Safe Houses
BD-180.200-62	Occasional Emergency Food Assistance	BH-180.150-80	Sexual Assault Shelter
BD-180.200-64	Ongoing Emergency Food Assistance	BH-180.350	Homeless Drop-In Centers
BD-180.225	Food Vouchers	BH-180.850	Homeless Shelter
BD-180.250	Government Surplus Food Distribution Sites	BH-180.850-10	Bad Weather Shelter
BD-180.800	Sack Lunches/Dinners	BH-180.850-15	Community Shelters
BD-180.820	Specialty Food Providers	BH-180.850-18	Environmental Hazards Shelter
BD-180.820-18	Drinking Water	BH-180.850-50	Missions
BD-180.820-20	Food Supplements	BH-180.850-53	Motel Vouchers
BD-180.820-25	Formula/Baby Food	BH-180.850-90	Urban Campsites
BD-200	Food Banks	BH-180.855	Homeless Shelter Pick-Up Sites
BD-220	Food Gleaning Programs	BH-180.900	Postshelter Housing
BD-240	Food Outlets	BH-180.950	Transitional Shelter
BD-240.200	Farm Trails	BH-300	Home Improvement
BD-240.225	Farmers Markets	BH-300.180	Energy Conservation Improvements
BD-240.250	Food Co-Ops	BH-300.180-18	Energy Conservation Rebates
BD-240.500	Mini Markets	BH-300.180-95	Weatherization
BD-240.900	U-Pick Programs	BH-300.350	Home Barrier Evaluation/Removal
BD-260	Food Production	BH-300.350-10	Bathroom Modifications
BD-260.050	Agricultural Assistance	BH-300.350-35	Kitchen Modifications
BD-260.050-33	Irrigation Services	BH-300.350-70	Ramp Construction
BD-260.050-35	Home Gardening Assistance	BH-300.353	Home Maintenance Services
BD-260.150	Community Gardening	BH-300.353-15	Carpet Cleaning
BD-260.450	Livestock Breeding/Development/Management	BH-300.353-18	Chimney Sweeping
BD-260.700	Rent-A-Tree	BH-300.353-30	House Painting
BD-500	Meals	BH-300.353-95	Window Washing
BD-500.145	Child Care Food Programs	BH-300.355	Home Rehabilitation/Repair Services
BD-500.150	Congregate Meals	BH-300.355-35	Home Rehabilitation/Repair Grants
BD-500.350	Home Delivered Meals	BH-300.450	Landscaping Services
BD-500.450	Low-Cost Meals	BH-300.650	Plant Banks
BD-500.500	Meal Vouchers	BH-300.975	Yard Work
BD-500.510	Milk Programs	BH-300.975-45	Lawn Mowing
BD-500.520	Mobile Canteens	BH-300.975-70	Residential Brush Clearance
BD-500.800	School Breakfasts	BH-300.975-80	Snow Shoveling
BD-500.820	School Lunches	BH-300.975-85	Tree Maintenance
BD-500.830	Soup Kitchens	BH-300.975-87	Tree Removal
BD-500.850	Summer Food Service Programs	BH-330	Home Insurance
BH	Housing	BH-350	Home Loans
		BH-350.300	Home Barrier Removal Loans
		BH-350.320	Home Construction Loans
		BH-350.330	Home Improvement Loans
		BH-350.340	Home Purchase Loans
		BH-350.340-20	FHA Loans
		BH-350.340-45	Low-Income Home Loans

Alphabetical Display

A

AA

use *Twelve-Step Mutual Support Groups (PH-500.850)*

Abandoned Building Inspection (JH-100.100-05)

Programs that inspect buildings that are unoccupied and make a recommendation regarding their disposition.

Abandoned Children

use *Street Youth (YV-300.800)*

Abandoned Property Claims Assistance

use *Unclaimed Property Assistance (FT-915)*

Abandoned Vehicle Reports/Removal (FN-170.025)

Programs that accept reports regarding abandoned motor vehicles on public roads, in parking lots or on other public property and/or arrange for their removal. Also included are programs that accept and/or act upon reports of violations of local ordinances regarding vehicles stored on private property.

ABE

use *Adult Basic Education (HH-050.050)*

Abortion Counseling

use *Pregnancy Counseling (LJ-200.650)*

Abortion Rights Groups (TD-160.310-05)

Organizations whose members have joined together on a voluntary basis to support the passage and enforcement of laws and other social measures which preserve a woman's right to terminate her pregnancy.
used for *Reproductive Rights Groups*

Abortions (LJ-200.100-05)

Programs that provide pregnancy termination services for women who have decided not to follow through with their pregnancies.
used for *Pregnancy Termination*

Absentee Ballots (TF-650.180-05)

Programs that arrange for the participation (usually by mail) in elections by qualified voters who, because of serious illness, military service or absence from home for business or other reasons, are unable to appear at the polls in person on election day.

Abused Adults (YX-030)

Individuals age eighteen and older who have been subjected to a persistent pattern of physical, sexual or emotional maltreatment by their caretakers, spouses, partners, or other family members or who have been sexually assaulted by a family member, acquaintance or stranger either as adults or as children.

Abused Children (YX-050)

Individuals younger than age eighteen who have been subjected to a persistent pattern of violence and/or neglect which may include emotional abuse, emotional deprivation, physical abuse and corporal punishment that results in a traumatic condition, physical neglect and/or inadequate supervision and/or sexual abuse or exploitation any of which is perpetrated by the adults responsible for their care, siblings or other family members.

Abusing Parents

use *Child Abusers (YP-140)*

Abusive Parents

use *Child Abusers (YP-140)*

Academic Counseling (HL-250.050)

Programs that assist students to select a program of studies that is suited to their abilities, interests, future plans and general circumstances.

used for *Advisement*

Educational Counseling

Academic Libraries (TJ-440.050)

Libraries that are units of or affiliated with public or private postsecondary educational institutions such as polytechnics, colleges and universities which are organized and administered to meet the teaching, research and professional information needs of students, faculty and affiliated staff of the institution.
used for *Research Libraries*

Acanthamoeba Keratitis (YF-300.002)

A rare corneal infection which is often caused by the use of homemade saline solutions for rinsing, storing or cleaning contact lenses and which may lead to blindness. See also *Corneal Disease (YF-300.218)*.

ACAs

use *Adult Children of Alcoholics (YJ-230.050)*

Accessibility Information (TJ-050)

Programs that provide information about the accessibility of parks, airports, public buildings and other facilities for use by people who have restricted mobility. See also *Home Barrier Evaluation/Removal (BH-300.350)*, *Barrier-Free Home Rental Listings (BH-390.305-10)*, *School Accessibility (HL-250.790-80)*, *Architectural Accessibility Compliance (JD-050)*, *Workplace Evaluation/Modification (ND-950)*.

Accessible Clothing

use *Adapted Clothing (BM-650.150-05)*

Accessible Housing

use *Barrier-Free Home Rental Listings (BH-390.305-10)*

Accident Prevention

use *Safety Education Programs (JR-820)*

Basic Subsistence

- B Basic Subsistence:** Programs that furnish survival level resources including food, housing, material goods, transportation and temporary financial assistance for low and fixed-income, indigent, elderly or disabled people who are otherwise unable to adequately provide for themselves and their families. Also included are related services that are available to the community at large.
- BD Food:** Programs that seek to meet the basic nutritional needs of the community by providing improved access to free or low-cost food products. See also Nutrition Maintenance (NL-600), Hunger/Poverty Action Groups (TD-160.320), Donor Services (TF-180).
- BD-150 Communal Food Storage Facilities:** Programs that provide access to community freezers, meat lockers or other storage facilities for individuals who do not have access to refrigerators, freezers or other private means of storage or who do not have enough space at home to store food purchased in bulk.
- BD-180 Emergency Food:** Programs that provide a limited amount of food for individuals or families during times of personal crisis, or for people who have no food or cannot afford to purchase food at retail costs. See also Mobile Canteens (BD-500.520), Soup Kitchens (BD-500.830), Christmas Baskets (TF-300.150-12), Thanksgiving Baskets (TF-300.850-85).
- BD-180.100 Brown Bag Programs:** Programs offered by senior centers or other community organizations outside the food pantry network that pack shopping bags with a supply of nutritional donated and surplus food for distribution to low-income individuals or families or elderly people to supplement their meals at home.
- BD-180.200 Food Pantries:** Programs that acquire food products through donations, canned food drives, food bank programs or direct purchase and distribute the food to people who are in emergency situations.
- BD-180.200-20 Food Lines:** Emergency food pantries that provide a limited number of boxes or bags of food on a first come, first served basis for eligible people who line up on a designated date and time to receive service.
- BD-180.200-62 Occasional Emergency Food Assistance:** Emergency food pantries that provide a box or bag of groceries on a one-time-only or other limited basis for people who are unable to provide food for themselves or their families. Included are programs that provide enough food for an entire balanced meal or series of meals and those that provide a supplemental supply of groceries.
- BD-180.200-64 Ongoing Emergency Food Assistance:** Emergency food pantries that provide an ongoing supply of groceries, usually once a month, for people whose income from SSI, AFDC or other forms of public assistance is not sufficient to meet their needs. Included are programs that provide enough food for an entire balanced meal or series of meals and those that provide a supplemental supply of groceries.
- BD-180.225 Food Vouchers:** Programs that supply people who are in emergency situations with food coupons which can be exchanged in designated grocery stores and supermarkets for food products that have been approved by the issuing agency as nutritious. See also Temporary Financial Aid (BR).
- BD-180.250 Government Surplus Food Distribution Sites:** Organizations with established food distribution programs that are authorized, on a periodic basis, to acquire and distribute targeted surplus commodities stockpiled by the federal government to people who qualify for this service on the basis of income.
- BD-180.800 Sack Lunches/Dinners:** Programs that provide lunch or dinner in a small bag for people who would not otherwise have a meal. The program may target homeless, indigent or low-income people or other specific groups.
- BD-180.820 Specialty Food Providers:** Programs that provide necessary food items that are not regularly or even typically available through most food pantries for people who are in emergency situations and unable to purchase the items at retail prices or are unable to locate those items in their local stores due to shortages precipitated by a fire, flood, hurricane, earthquake, tornado or other disaster.
- BD-180.820-18 Drinking Water:** Programs that provide bottled water or other sources of potable water for people who have no access to drinking water due to ruptured water mains, problems with water purification plants or other disruptions in the community water supply. See also Water Connection/Repair (BH-900.950), Waterworks (JF-900), Water Pollution Control (JJ-950), Domestic Disaster Relief (JR-150.150), Water Purification Bulletins (JR-800.940).

Permuted Display

- Community Dial-A-Rides
 - Rent-A-Tree
 - Subject A Test Preparation
 - Abandoned Building Inspection
 - Abandoned Vehicle Reports/Removal
 - Lead Paint Abatement
 - Noise Abatement
 - Weed Abatement/Brush Control
 - Australian Aborigines
 - Abortion Rights Groups
 - Abortions
 - American Schools Abroad
 - Employment Abroad
 - Study Abroad
 - Absentee Ballots
 - Adult Child Abuse Survivors
 - Central Intake/Assessment for Alcohol Abuse
 - Central Intake/Assessment for Drug Abuse
 - Central Intake/Assessment for Substance Abuse
 - Child Abuse Counseling
 - Child Abuse Hotlines
 - Child Abuse Medical Evaluations
 - Child Abuse Prevention
 - Child Abuse Reporting/Emergency Response
 - Comprehensive Outpatient Drug Abuse Treatment Programs
 - Comprehensive Outpatient Substance Abuse Treatment Programs
 - Drug Abuse Counseling
 - Drug Abuse Education/Prevention
 - Drug Abuse Hotlines
 - Elder Abuse Counseling
 - Elder Abuse Prevention
 - Elder Abuse Victims
 - Inpatient Drug Abuse Treatment Programs
 - Inpatient Substance Abuse Treatment Programs
 - Outpatient Substance Abuse Treatment Programs
 - Parent Abuse Counseling
 - Primary Drug Abuse Recovery Homes
 - Residential Drug Abuse Treatment Programs
 - Residential Substance Abuse Treatment Programs
 - Spousal Abuse Counseling
 - Spousal Abuse Prevention
 - Substance Abuse Counseling
 - Substance Abuse Crisis Intervention
 - Substance Abuse Day Treatment
 - Substance Abuse Drop-In Services
 - Substance Abuse Education/Prevention
 - Substance Abuse Hotlines
 - Substance Abuse Intervention Programs
 - Substance Abuse Services
 - Supportive Drug Abuse Recovery Homes
 - Transitional Substance Abuse Services
 - Abused Adults
 - Abused Children
 - Emotionally Abused Children
 - Sexually Abused Adults
 - Sexually Abused Children
 - Alcohol Abusers
 - Amphetamine Abusers
 - Amyl Nitrite Abusers
 - Analgesic Abusers
 - Antidepressant Drug Abusers
 - Barbiturate/Sedative Abusers
 - Child Abusers
- Children of Drug Abusers
 - Cocaine Abusers
 - Designer Drug Abusers
 - Drug Abusers
 - Elder Abusers
 - Families of Drug Abusers
 - Hallucinogenic Drug Abusers
 - Inhalant Abusers
 - Injected Drug Abusers
 - Marijuana/Hashish Abusers
 - Opiate Abusers
 - Parent Abusers
 - PCP Abusers
 - Poly Drug Abusers
 - Pregnant Drug Abusers
 - Recovering Drug Abusers
 - Self-Abusers
 - Siblings of Drug Abusers
 - Sober Living Centers for Recovering Drug Abusers
 - Spouse/Partner Abusers
 - Substance Abusers
 - Teenage Drug Abusers
 - Tranquilizer Abusers
 - Academic Counseling
 - Academic Libraries
 - Acanthamoeba Keratitis
 - Referral to Physicians Accepting Medi-Cal/Medicaid
 - Computer Display Access Aids
 - Computer Input Access Aids
 - Accessibility Information
 - Architectural Accessibility Compliance
 - School Accessibility
 - Accident Victims
 - Driving/Accident Records
 - Families of Accident Victims
 - Traffic Accident Rescue
 - Families of Victims of Accidents Caused by Impaired Drivers
 - Industrial Accidents
 - Victims of Accidents Caused by Impaired Drivers
 - Leisure Accommodations
 - Accompaniment Services
 - Accountant Complaints
 - Licensing/Certification/Accreditation
 - School Accreditation
 - Achievement Testing
 - Achondroplasia
 - Acidosis
 - Acne
 - Acoustic Neuroma
 - Acquired Brain Injuries
 - Building Acquisition/Construction/Renovation Funds
 - Employment Acquisition
 - Land Acquisition Funds
 - Acrocephaly
 - Acromegaly
 - Acrophobia
 - Acting Instruction
 - Class Action Litigation
 - Community Action Groups
 - Consumer Action Groups
 - Ecumenical Action Groups
 - Hunger/Poverty Action Groups
 - Political Action/Lobbying Groups

PERMUTED

“HUMAN SERVICES” DEFINED

The activities of human services professionals which help people to become more self-sufficient, prevent dependency, strengthen family relationships, support personal and social development and ensure the well-being of individuals, families, groups and communities. Specific human services include ensuring that people have access to adequate food, shelter, clothing and transportation; financial resources to meet their needs; consumer advice and education; criminal justice or legal services; education and employment; health and mental health care including substance abuse services; and environmental protection; both routinely and in times of disaster or other emergencies. Human services also facilitate the capabilities of people to care for children or other dependents; ensure that protective services are available to those who are vulnerable; provide for the support of older adults and people with disabilities; offer social, religious, and leisure time activities; provide for the cultural enrichment of the community; and ensure that people have the information they need to fully participate in community life.

TAXONOMY TERMS RELATING TO AIDS/HIV

AIDS/HIV-Specific Terms

AIDS Control	JP-150.170-05
AIDS Prevention Supplies	JP-150.170-10
AIDS Treatment	LT-175.050
HIV Testing	LF-490.240
Anonymous HIV Testing	LF-490.240-05
Confidential HIV Testing	LF-490.240-15
Home HIV Test Collection Kits	LF-490.240-30
Oral Fluid HIV Tests	LF-490.240-60
Rapid HIV Tests	LF-490.240-70
Urine HIV Tests	LF-490.240-90
HIV Waivers	FT-360.025-30
AIDS	YF-300.028
Pediatric AIDS	YF-300.028-65
AIDS Issues	YZ-035
Families of HIV Positives	YJ-460
Families of People with AIDS	YJ-670
HIV Infections	YF-300.367
Maternal HIV Infections	YF-300.367-50

Support Services (use with a Target Term)

Accelerated Death Benefits	LH-400.050
Burial Expense Assistance	BR-090
Case/Care Management	PH-100
Clinical Trials	LT-153
Community Shelters	BH-180.850-15
Crisis Intervention	RP-150
Death and Dying	PH-620.180
Dental Care	LV-160
Disabled Rights Groups	TD-160.310-18
Disease/Disability Information	LH-270.170
Do Not Resuscitate Orders	FT-270.050-15
Durable Power of Attorney for Health Care	FT-270.050-20
Food Pantries	BD-180.200
Friendly Visiting	PH-140.210
Health Facilities Complaints	DD-150.428
Health Insurance	LH-300
Health Insurance Counseling	LH-350
Health Insurance Premium Assistance	BR-500.300
Health Problems Counseling	RP-450.300
Health Related Support Groups	PH-500.300

Home Delivered Meals	BD-500.350
Home Health Care	LT-280
Homemaker Assistance	PH-330.300
Hospice Facilities	LT-300.300
In Home Hospice Care	LT-300.330
Insurance Complaints	DD-150.480
IV Pain Management	LT-350.340
Living Will Preparation Assistance	FT-270.050-45
Medicaid/Medi-Cal	NL-500.500
Medicaid/Medi-Cal Planning	LH-400.500
Medical Bill Assistance	BR-500.500
Medical Equipment/Supplies	LH-500
Medical Information Lines	TJ-320.500
Medical Libraries	TJ-440.810-50
Medical Social Work	LH-550
Medical Transportation	BT-450.650-50
Medically Indigent Adult Programs	NL-500.250-50
Medically Indigent Child Programs	NL-500.250-55
Mercy Flights	LH-560
Nursing Facilities	LL-660
Outreach Programs	TJ-650.630
Pain Management	LT-660
Pastoral Counseling	RD-620
Patient Education	LH-270.950-65
Patient Rights Assistance	FT-620
Patient/Family Housing	LH-655
Personal Financial Management Counseling	DD-500.650
Pet Visitation Programs	RB-640
Pharmacies	LH-660
Physician Referral Services	LH-260.650-50
Physician/Surgeon Complaints	DD-150.723-66
Prescription Drug Discount Programs	LH-670.640-65
Prescription Expense Assistance	BR-500.650
Research	TJ-700
Respite Care	PH-700
Safer Sex Education	LJ-800.800
Second Opinion Services	LT-750
Specialized Information and Referral	TJ-300.800
Subject Specific Public Awareness/Education	TJ-650.850
Terminal Illness Counseling	RP-450.850
Terminal Illness Support Groups	PH-500.100-85
Therapeutic Camps	PL-640.150-85
Utility Bill Payment Assistance	BR-900.910
Viatical Settlements	LH-400.900
Voluntary Health Organizations	TD-120.660-90
Wish Foundation	PH-950

Robert Bongiovanni, from the Colorado Department of Public Health and Environment, presented the *HIV Prevention Interventions and Standards of Practice in Colorado*.

HIV Prevention Interventions and Standards of Practice in Colorado

Bob Bongiovanni
Colorado Dept of
Public Health & Environment

Development of the Colorado Definitions and Standards

- Convened “Stakeholder Work Groups” composed of intervention experts and community members in conjunction with our community planning process
- Began with “Guidelines for Health Education and Risk Reduction Activities” (HHS, April 1995)
- Also informed by Colorado regulations and statutes

Development of the Colorado Definitions and Standards

- Submitted to the CPG for approval, and has been reviewed, revised, and approved by them each year since 1996.
- Supplemented in 1997 by an “Intervention Effectiveness Report” which is also used for priority setting.

Key Components of all Interventions

- General characteristics of effective programs (to which was recently added brief descriptions of key theories)
- Cultural competence
- Code of ethics
- Public health orders
- Client feedback systems
- Confidentiality guidelines

Specific definitions and standards

- Counseling, testing and referral
- Group level
- Individual level
- Populations (community) level
- Partner counseling and referral
- Prevention case management
- Public Information

Items covered for each intervention

- Definition
- Goals for the intervention
- Target populations
- Cultural competence
- Where delivered
- When delivered
- Duration of the intervention
- Qualifications of providers
- Content and methods employed
- Continuing education requirement
- Consent/confidentiality considerations
- Quality assurance
- Evaluation
- Penalties for violating the standards

Purposes of the definitions and standards

- Common vocabulary for community planning and providers
- Applicants for funding must address how their interventions comply with standards
- Contracts are monitored for their compliance with the standards
- Health department staff must adhere to the standards when delivering direct services
- Used for evaluation purposes

How the standards are distributed

- Available on the Internet
- Mailed to all providers
- Used in many of our trainings, including those conducted by our Prevention Training Center
- Distributed with the requests for proposal

What's next?

	CTR	GLI	ILI	PLI	PCRS	PCM	PI
Biomedical							
Restrictive measures							
Deficits							
Harm reduction							
Environment							
Systems							

Development of an HIV/AIDS Prevention Intervention Taxonomy

Expert Panel Meeting Agenda

Swissôtel, Atlanta, Georgia

July 23 and 24, 2001

MONDAY, JULY 23, 2001

- 8:00-8:30 Morning Refreshments
- 8:30-8:45 Welcome & Introductions
- 8:45-9:00 Purpose & Objectives of this Meeting
- 9:00-9:20 Methods Used in Identifying “State-of-the State” Intervention Taxonomies
- 9:20-9:30 CDC Classification Systems: The Value of Standardizing & Integrating Systems
- 9:30-10:15 Open Discussion
- Developing a Broadly Adopted Scientific- and Practical-Based “*Standard*” HIV Prevention Intervention Taxonomy Classification System
- 10:15-10:30 **BREAK** (Refreshment Available)
- 10:30-11:00 Experts’ Input on Needs for Consensus Taxonomy

DEVELOPERS:

- Medical Subject Headings/ICD
- Taxonomy of Human Services

Stuart Nelson

Head, Medical Subject Headings Section

U.S. National Library of Medicine, Wash., DC

Georgia Sales

Developer

INFO LINE of Los Angeles, Sierra Madre, CA

END-USERS:

- HIV Prevention Interventions and Standards of Practice in Colorado
- HIV/AIDS Surveillance Purposes

Robert Bongiovanni

Colorado Dept. Public Health & Environment

Patricia Fleming

Chief, Surveillance Branch

CDC

- 11:00-12:00 Open Discussion
- Goals and Principles for Developing a Taxonomy
- 12:00-1:00 **LUNCH**
- 1:00-2:15 Integration with Existing Systems and Organizations
- 2:15-2:30 **BREAK**
- 2:30-3:30 Development of an HIV Prevention Intervention Taxonomy
- 3:30-4:00 Summary of Discussion

Development of an HIV/AIDS Prevention Intervention Taxonomy

Expert Panel Meeting Agenda

Swissôtel, Atlanta, Georgia

July 23 and 24, 2001

TUESDAY JULY 24, 2001

- | | |
|-------------|---|
| 8:00-8:30 | Morning Refreshments |
| 8:30-9:00 | Summarize Previous Discussion |
| 9:00-10:30 | Next Steps in the Development of a National Standardized HIV Prevention Intervention Taxonomy |
| 10:30-10:45 | BREAK |
| 10:45-11:15 | Further Information Needs |
| 11:15-11:30 | Summary of Discussion |
| 11:30-11:45 | Closing Remarks |

Development of an HIV/AIDS Prevention Intervention Taxonomy

Expert Panel Meeting Participants *July 23-24, 2001*

Dr. Stephen Banspach

Centers for Disease Control & Prevention
Koger Center
Evaluation Research Section
NCCDPH/DASH, Mailstop K-33
Columbia Building, Room 40
Atlanta, GA 30333
770-488-6183
sbanspach@cdc.gov

Mr. Robert Bongiovanni

Colorado Department of Public Health &
Environment
4300 Cherry Creek Drive South
Denver, CO 80246
303-692-2703
bob.bongiovanni@state.co.us

Dr. Charles Collins

Centers for Disease Control & Prevention
1600 Clifton Road, N.E.
NCHSTP/DHAP-IR, Mailstop E-40
Atlanta, GA 30333
404-639-2918
cwc4@cdc.gov

Mr. Sam Costa

Centers for Disease Control & Prevention
8 Corporate Square
DHAP/Surveillance, Mail Stop E-47
Atlanta, GA 30333
404-639-5381
scc8@cdc.gov

Dr. Laurie Feinberg

Centers for Medicare & Medicaid Services
CMS/CHPP
7500 Security Boulevard
Room C-50223
Baltimore, MD 21244
410-786-7069
lfeinberg@hcfa.com

Dr. Patricia Fleming

Centers for Disease Control & Prevention
8 Corporate Square
DHAP/Surveillance, Mail Stop E-47
Atlanta, GA 30333
404-639-2050
pfleming@cdc.gov

Ms. Debra Hickman

Sisters Together and Reaching
1505 Eutaw Street
Baltimore, MD 21217
410-383-1903
debbie7rev@aol.com

Dr. David Holtgrave

Emory University
1525 Clifton Road, 5th Floor
Atlanta, GA 30322
404-727-5401
dholtgr@sph.emory.edu

Mr. Michael Hughes

Centers for Disease Control & Prevention
8 Corporate Square
NCHSTP/DHAP, Mail Stop D-21
Atlanta, GA 30333
404-639-0922
mhughes1@cdc.gov

Dr. Robert Janssen

Centers for Disease Control & Prevention
8 Corporate Square
NCHSTP/DHAP, Mailstop D-21
Atlanta, GA 30333
404-639-0900
rjanssen@cdc.gov

Ms. Nancy Jewell

Indiana Minority Health Coalition
3737 North Meridian Street, Suite 303
Indianapolis, IN 46208
317-926-4011
sdekemper@imhc.org

Development of an HIV/AIDS Prevention Intervention Taxonomy

Expert Panel Meeting Participants *July 23-24, 2001*

Dr. Steven Jones

Centers for Disease Control & Prevention
8 Corporate Square
DHAP, Mail Stop E-35
Atlanta, GA 30333
404-639-5209
tjones@cdc.gov

Dr. Faisal Khan

West Virginia Department of Health & Human
Resources
350 Capitol Street, Room 125
Charleston, WV 25301
304-558-2195
faisalkhan@wv.dhhr.org

Mr. Robert Kohmescher

Centers for Disease Control & Prevention
8 Corporate Square
NCHSTP/DHAP-IR, Mailstop E-58
Atlanta, GA 30333
404-639-1914
rnk1@cdc.gov

Ms. Linda Lampkin

The Urban Institute - National Center for
Charitable Statistics
2100 M Street, N.W.
Washington, DC 20037
202-261-5806
llampkin@ui.urban.org

Mr. James Mackison

General Services Administration
Office of Intergovernmental Solutions
1800 and F Street, N.W., Room 5228
Washington, DC 20405
202-501-1135
james.mackison@gsa.gov

Dr. Faye Malitz

Health Resources and Services Administration
Epidemiology and Data Analysis Branch
HIV/AIDS Bureau
5600 Fishers Lane, Parklawn Building 7-90
Rockville, MD 20857
301-443-3259
fmalitz@hrsa.gov

Ms. Tonya Martin

Centers for Disease Control & Prevention
8 Corporate Square
Mail Stop E-08
Atlanta, GA 30333
404-639-8050
tmartin@cdc.gov

Ms. Victoria Moody

Tennessee Department of Health
425 5th Avenue, North
Cordell Hull Building, 4th Floor
Nashville, TN 37203
615-532-8485
vmood@email.state.tn.us

Dr. Stuart Nelson

National Institute of Health
NLM/MESH
Bldg 38A, Room B2E17
8600 Rockville Pike
Bethesda, MD 20894
301-496-1495
nelson@nlm.nih.gov

Dr. Mary Neumann

Centers for Disease Control & Prevention
8 Corporate Square
NCHSTP/DHAP-IR, Mailstop E-37
Atlanta, GA 30333
404-639-1928
msn1@cdc.gov

Mr. Randy Pope

National Alliance of State and Territorial AIDS
Directors (NASTAD)
13049 Apple Tree Lane
DeWitt, MI 48820
517-669-8330
papers@mindspring.com

Mr. Tim Quinn

Centers for Disease Control & Prevention
1600 Clifton Road, N.E.
NCHSTP/DHAP-IR, Mailstop E-58
Atlanta, GA 30333
404-639-5239
tiql@cdc.gov

Development of an HIV/AIDS Prevention Intervention Taxonomy

Expert Panel Meeting Participants *July 23-24, 2001*

Mr. Harold Rasmussen

California Office on AIDS
Department of Health Services
611 N 7th Street
Sacramento, CA 94234-7320
916-323-4314
hrasmuss@dhs.ca.gov

Dr. Cornelis (Kees) Rietmeijer

Centers for Disease Control & Prevention
Denver STD/HIV Behavioral Interventions
NCHSTP/OD
605 Bannock MC 2600
Denver, CO 80204
303-436-7363
cdr2@cdc.gov

Ms. Georgia Sales

INFO LINE of Los Angeles
499 West Sierra Madre Blvd., Unit A
Sierra Madre, CA 91024
626-350-4215
gsales4215@aol.com

Dr. Ron Stall

Centers for Disease Control & Prevention
1600 Clifton Road, N.E.
NCHSTP/DHAP-IR, Mailstop E-37
Atlanta, GA 30333
404-639-1900
rys3@cdc.gov

Dr. Timothy A. Akers

Centers for Disease Control & Prevention
NCHSTP
1600 Clifton Rd., NE
Mailstop E-59
Atlanta, GA 30333
404-639-0926
tca1@cdc.gov

Dr. David Stevenson

George Mason University
Enterprise Hall, 4th Floor, MSN 5D3
4400 University Drive
Fairfax, VA 22030
703-993-4589
dsteven2@gmu.edu

Dr. Esther Sumartojo

Centers for Disease Control & Prevention
1600 Clifton Road, N.E.
NCHSTP/DHAP-IR, Mailstop E-37
Atlanta, GA 30333
404-639-1938
ems2@cdc.gov

Dr. Ron Valdiserri

Centers for Disease Control & Prevention
8 Corporate Square
NCHSTP/OD, Mailstop E-07
Atlanta, GA 30333
404-639-8002
rov1@cdc.gov

Mr. Dan Wohlfeiler

California Dept. of Health
Division of STD
1947 Center Street, Suite 201
Berkeley, CA 94704
510-540-2315
dwohlfei@dhs.ca.gov

Dr. David Cotton

ORC Macro
3 Corporate Square
Suite 370
Atlanta, GA 30329
404-321-3211
cotton@macroint.com