

Connecticut Comprehensive HIV Prevention Plan 2005-2008

2007 Updates



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Appendices are available by request to AIDS & Chronic Diseases Section, Connecticut Department of Public Health gina.dangelo@ct.gov

CHAPTER ONE: CONNECTICUT'S HIV PREVENTION COMMUNITY PLANNING GROUP (CPG)

Welcome to the Connecticut CPG

HIV prevention community planning is a collaborative process by which the Connecticut Department of Public Health (DPH) works in partnership with the Connecticut HIV Prevention Community Planning Group (CPG) to develop a comprehensive HIV prevention plan that best represents the needs of populations at risk for, or infected with, HIV.

OVERVIEW: HIV PREVENTION COMMUNITY PLANNING

The CDC provides HIV prevention funding to 65 health departments in the form of cooperative agreements. These recipients include all 50 state health departments, the District of Columbia; the health departments of Chicago, Houston, Los Angeles, New York City, Philadelphia, and San Francisco; Puerto Rico, the U.S. Virgin Islands and six U.S. - affiliated Pacific Islands.

Beginning in 1994, the CDC changed the way in which federally funded state and local level HIV prevention programs were planned and implemented. State, territorial, and local health departments receiving federal prevention funds through the CDC were asked to share the responsibility for developing a comprehensive HIV prevention plan with representatives of affected communities and other technical experts. This led to the development of a process called **HIV Prevention Community Planning**.

The basic intent of the HIV Prevention Community Planning process is to:

- **increase meaningful community involvement in prevention planning,**
- **improve the scientific basis of program decisions, and,**
- **target resources to those communities at highest risk for HIV transmission/acquisition.**

CONNECTICUT HIV COMMUNITY PLANNING

The purpose of Connecticut's community planning process is for the populations most at-risk for HIV infection, and those affected by HIV/AIDS, to provide input to DPH about HIV prevention needs and effective prevention interventions. These populations also provide guidance regarding the distribution of HIV prevention dollars among prioritized at-risk populations throughout the state. This is accomplished through the **Connecticut HIV Prevention Community Planning Group (CPG)**.

The Connecticut CPG began its work in April 1994. By September 1994, the first HIV Prevention Plan for the State of Connecticut was written. In October of 1994, the Connecticut Department of Public Health (DPH) sent its 1995 HIV Prevention Application for funding along with the CPG's 1995 Comprehensive Prevention Plan to the CDC with a request for \$4.1 million of federal HIV prevention funding. Since 1994, DPH has submitted 13 applications, along with the corresponding CPG HIV Prevention Plan, to the CDC for funding. Current federal HIV prevention dollars for Connecticut total \$6.26 million.

The CDC supports this process by providing funding and making technical assistance available to develop the capacity of the Community Planning Group. The CDC expects community planning groups to improve HIV prevention programs by strengthening the: (1) scientific basis, (2) community relevance, and (3) population-or-risk-based focus of HIV prevention interventions in each project area.

CDC GUIDANCE

The CDC *Guidance for HIV Prevention Community Planning* functions as a blueprint for HIV prevention planning. It also provides direction to CDC grantees receiving federal HIV prevention funds to design and implement a participatory HIV prevention community planning process. The CDC has set three major goals for Community Planning:

- 1 Community planning supports broad-based community participation in HIV prevention planning.
- 2 Community planning identifies priority HIV prevention needs (a set of priority targeted populations and interventions for each identified target population) in each jurisdiction.
- 3 Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

The Guidance further outlines the following eight objectives, which align with the three goals, as a framework for monitoring and measuring progress in achieving a reduction of new HIV infections and reduced HIV-related morbidity:

- Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.
- Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.
- Foster a community planning process that encourages inclusion and parity among community planning members.
- Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.
- Ensure that prioritized target populations are based on an epidemiological profile and a community services assessment.
- Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.
- Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.
- Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

HIV Prevention Community Planning is one of nine required components of a comprehensive HIV prevention program. The primary task of the CPG is to develop a Comprehensive Prevention Plan that includes prioritized target populations and a mix of proven effective prevention activities or interventions for each target population. Once the Comprehensive Plan is developed, DPH uses it as a basis for its application for funding under the Cooperative Agreement between the State of Connecticut and the CDC. The CPG then reviews the application and sends one of three letters to the CDC. The first option is a letter supporting the health department's application (called a "Letter of Concurrence"); the second is a letter of dissatisfaction with the health department's application ("Letter of Non-concurrence"); the third is a letter of concern with the health department's application ("Letter of Concurrence with Reservations").

HIV Prevention Community Planning is a flexible, but accountable process based on shared decision making between the Connecticut Department of Public Health and the Connecticut CPG. It involves participation, collaboration, cooperation, inclusion, parity and representation. Connecticut's planning process plays a key role in stemming the tide of HIV/AIDS throughout the state.

Core Objectives

This chapter describes the Connecticut CPG's efforts in fulfilling five of the ten *Guiding Principles of HIV Prevention Community Planning*:

Goal 2: *The community planning process must reflect an open, candid and participatory process, in which differences in cultural and ethnic background, perspective, and experience are essential and valued;*

Goal 3: *The community planning process must involve representatives of populations at greatest risk for HIV infections and people living with HIV and AIDS (PLWHA);*

Goal 4: *The fundamental tenets of community planning are parity, inclusion and representation (PIR);*

Goal 5: *An inclusive community planning process includes representatives of varying races and ethnicities, genders, sexual orientations, ages and other characteristics such as varying educational backgrounds, and expertise; and,*

Goal 6: *The community planning process must actively encourage and seek out community participation.*

OPENNESS AND PARTICIPATORY NATURE – CPG MEMBER PARTICIPATION

Currently, the CPG is comprised of 18 members who are representative of the cultural and geographic diversity of the HIV/AIDS epidemic in Connecticut. Members are expected to actively participate in all CPG-related meetings, events and activities. All CPG members serve on at least one of the three standing committees. To encourage participation in the community planning process by all CPG members and members of the public, the CPG holds its monthly meetings at different locations throughout the state. The CPG's Executive Committee began meeting immediately after CPG meetings beginning in December 2006. During the 2006-2007 planning year (July 2006-June 2007) the CPG met 12 times throughout the state, including three joint meetings with the Statewide HIV Care Consortium. **(See Figure 1-1 and Figure 1-2).** In 2007, CPG monthly meetings continue to be conducted at various locations throughout the state.

The CPG also supports its membership by working to eliminate potential barriers to participation. Members who are unemployed or who lose wages by attending meetings are eligible to receive a stipend. All members who are eligible receive mileage and transportation reimbursements. For members who do not have reliable or available transportation to meetings, the CPG contractor provides alternate arrangements.

Members are also encouraged to carpool and provide rides for each other. The CPG works constantly to improve communications by maintaining a national toll-free telephone number (866-972-2050 ext. 25) that enables members to contact the CPG staff at no cost.

For CPG members who are deaf and hard of hearing, American Sign Language interpreters are provided at CPG meetings. The CPG also purchased a portable sound system to make meetings more audible for CPG members and public participants. Spanish translators and translation systems, as requested, are made available at CPG meetings to assist CPG members for whom English is a second language.

Figure 1-1
 CPG meeting sites: July 2006 through December 2006.

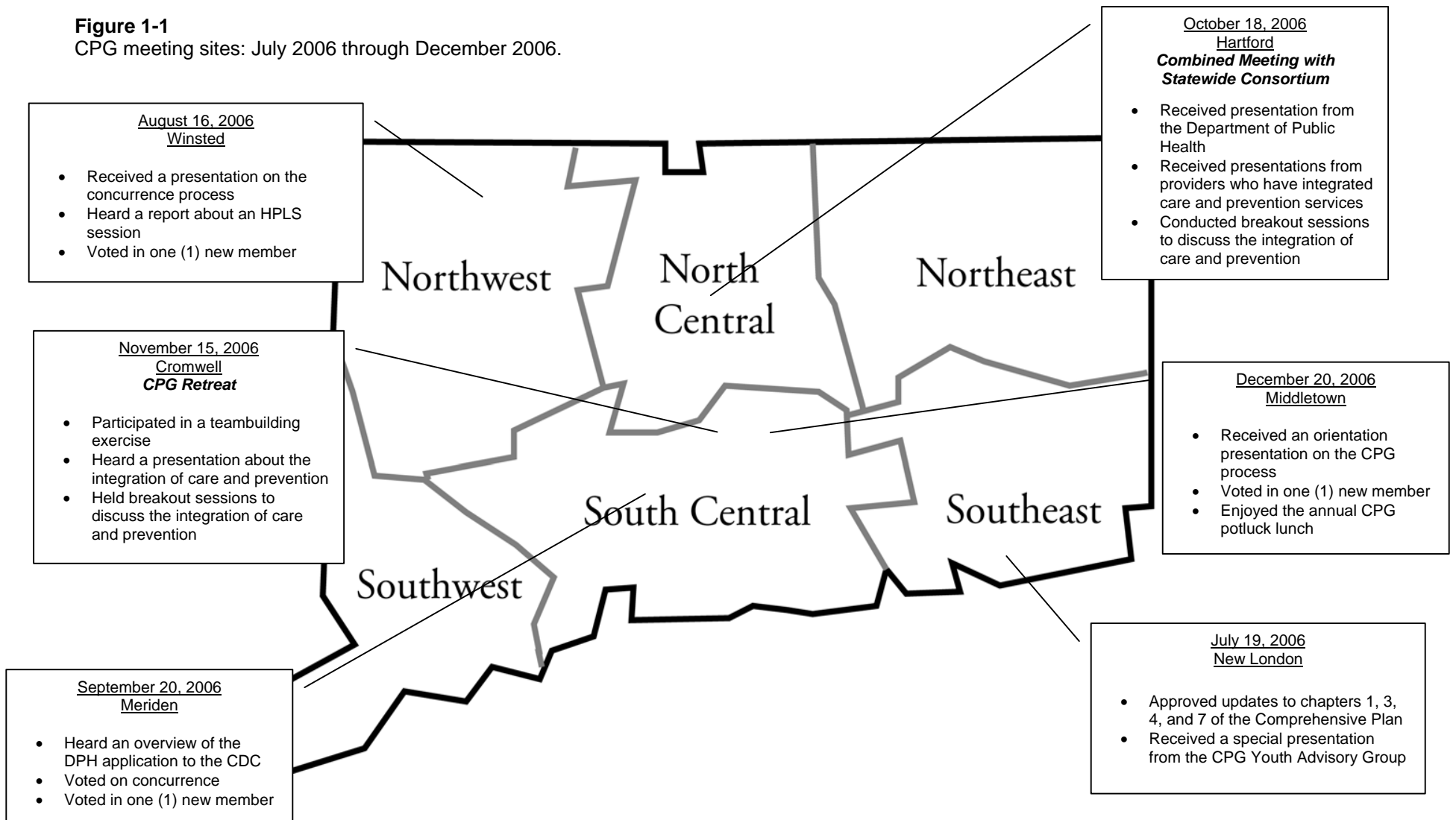
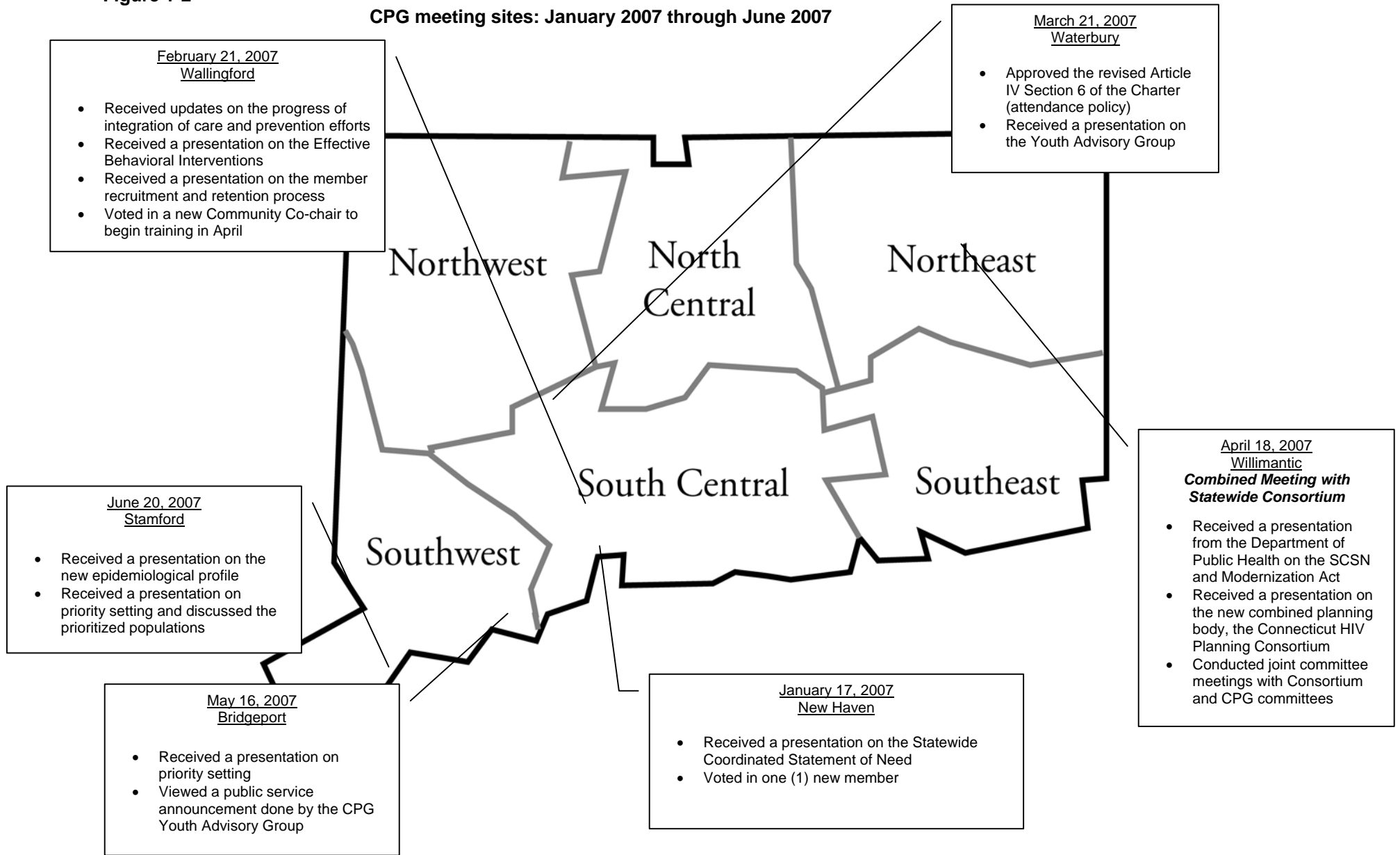


Figure 1-2

CPG meeting sites: January 2007 through June 2007



PUBLIC PARTICIPATION

Since its inception, the Connecticut CPG has incorporated public input in several ways - public hearings, public comment periods during regular monthly meetings, focus groups, key informant interviews, and Community Days. Community Days, initiated in 1996, are a type of community hearing that involves a series of community meetings in a variety of settings on a given day in a given city. Community Days provide CPG members with the opportunity to travel to community sites and dialog with community members on their own "turf" (e.g. homeless shelters, youth centers, churches, syringe exchange programs, schools, and correctional institutions). Community Days also allow CPG members the chance to gather information about HIV risk behaviors, suggestions about unmet needs, and discuss "what will work to prevent HIV" in the respective community.

On June 27, 2007 the CPG hosted a Community Day Event in New Haven, Connecticut. Working in collaboration with the New Haven Mayor's Task Force on AIDS and New Haven HIV prevention providers, the CPG's Membership, Parity, Inclusion, and Representation (MPIR) Committee organized presentations at Immanuel Missionary Baptist Church and site visits to several New Haven HIV/AIDS service providers to allow CPG members and public participants to see the services available in New Haven.

To further encourage public participation, the CPG also incorporates a public comment period in its monthly meeting agenda. This designated period not only gives members of the public an opportunity to bring concerns to the CPG, but also provides a forum for information sharing. While members of the public are not permitted to vote during CPG decision-making, they are always encouraged to take part in discussions and CPG committee meetings and activities.

The CPG, in collaboration with the Statewide Care Consortium and the Department of Public Health, publishes a quarterly newsletter designed to keep interested members of the public, agencies and community-based organizations up-to-date on HIV/AIDS planning activities - including CPG activities. *HIV/AIDS Planning News and Notes* highlights important CPG events and initiatives as well as general HIV/AIDS related announcements and activities. Each quarter, the CPG contractor distributes the newsletter electronically, in English and Spanish, to a distribution list of over 300 individuals and agencies. Over 400 newsletter hard copies are also distributed by mail to HIV prevention and care contractors throughout the state, and are made available at HIV/AIDS planning meetings. The newsletter includes a calendar of monthly planning meetings and events.

To promote integration of prevention and care as well as encourage cross membership and participation, announcements regarding the CPG meetings and activities are also sent to Ryan White Title I Planning Councils in the Hartford and New Haven/Fairfield County Eligible Metropolitan Areas (EMA) and to the Ryan White Title II Statewide Consortium.

An HIV/AIDS Prevention & Care Guide was launched in October 2006 on the United Way of Connecticut's 2-1-1 website. The Guide was created to provide information about HIV/AIDS services in Connecticut by leveraging 2-1-1's position as the state's premier source of information about community resources. The Guide is a product of collaboration among 2-1-1, the State Department of Public Health, the Statewide Care Consortium, and the CPG. The Guide is accessible online and by dialing 211, and provides up-to-date HIV/AIDS care and prevention information. It also provides information about resources beyond the scope of HIV/AIDS. The Guide can be accessed by going to the 2-1-1 homepage at www.211infoline.org, clicking on "Find Help," and then on "HIV/AIDS Prevention and Care Guide." The community resources contained in the Guide can also be accessed by calling 2-1-1 within Connecticut.

CPG LEADERSHIP

Effective and participatory leadership is key to Connecticut's community planning process. Equal and shared responsibilities, mutual respect, collaboration and cooperation are trademarks of Connecticut's CPG leadership structure. Connecticut's CPG is led by two elected community co-chairs and a DPH designated co-chair.

Bill Behan was the DPH Co-Chair from April 2004 until June 2007. Bill was the Assistant Administrator of the AIDS & Chronic Diseases Section at the Connecticut Department of Public Health. In addition to his

responsibilities as CPG DPH Co-Chair, Bill served as the DPH Co-Chair of the Statewide Care Consortium. Bill had been with the AIDS Section for four and a half years and had worked in the HIV/AIDS field for over twenty years.

Barbara Mase took over as the DPH Co-Chair in July 2007. Barbara is a Health Program Associate in the AIDS & Chronic Diseases Section at the Connecticut Department of Public Health.

The two Community Co-Chairs elected by the CPG are Mark Bond-Webster and Joseph Simard. Mark has been a CPG member since April 2003 and will complete his second term in October 2007. He also serves as a member of the Membership, Parity, Inclusion, and Representation (MPIR) Committee. Mark works as Director of AIDS Services at Perception Programs in Willimantic.

Joseph Simard is the Director of Clinical Services at the Hartford Gay and Lesbian Health Collective. A CPG member since October 2004, he also serves as Co-Chair of the Finance, Policy, and Procedures Committee (FPP). He was elected Community Co-Chair in January 2006 to replace a former Community Co-Chair who resigned.

Robert Houser has been a CPG Community Co-Chair In-Training since February 2007 and will begin his term as Co-Chair in November 2007. Robert is an HIV Counselor/Educator at Southwest Community Health Center in Bridgeport.

COMMITTEE STRUCTURE

The CPG has a clearly defined organizational structure, which currently includes three standing committees [Community Services Assessment (CSA), Finance, Policy and Procedures (FPP), Membership, Parity, Inclusion, Representation and (MPIR)], an Executive Committee, and specifically designated ad hoc committees (e.g. Priority Setting).

The governing body of the CPG is the Executive Committee. It meets on a monthly basis to discuss CPG business and strategize for the future. The Executive Committee is made up of nine members: the DPH Co-chair, two Community Co-chairs, and six standing committee chairpersons (2 co-chairs per each of the three committees). Committee co-chairs each have a vote on the Executive Committee. In March 2006, the CPG established a Priority Setting Ad Hoc Committee which continued to work throughout the 2006 and 2007 planning cycles. The Chair of the Priority Setting Ad Hoc Committee also attended and participated at Executive Committee meetings during 2006-2007.

The CPG committee structure consists of the following three committees: **(See Committee Responsibilities in Appendix A).**

❑ **Community Services Assessment Committee (CSA):**

Responsibilities: To collaborate with and provide input to DPH in the development, collection, analysis, production, update and dissemination of a community services assessment (e.g. needs assessment, resource inventory and gap analysis) as part of the development of a comprehensive statewide HIV prevention plan.

❑ **Membership, Parity, Inclusion, Representation and (MPIR):**

Responsibilities: To collaborate with DPH to develop and apply criteria for the selection, interviewing and retention of CPG members to ensure parity, inclusion and representation among the membership, and to sponsor Community Days.

❑ **Finance, Policy & Procedures (FPP):**

Responsibilities: To consult with the contractor and DPH to review the annual budget and quarterly CPG expenditures, advise the CPG on cost-effectiveness of federal funds for HIV prevention, develop, review and make changes to the CPG Charter, bylaws, and Policy and Procedure Manual, to oversee the evaluation of the community planning process, and recommend appropriate actions and positions for the CPG on various local and national HIV prevention related issues.

Each committee consists of two chairs who equally share roles and responsibilities.

Committees consist of 4-11 members. The CPG Co-Chairs each serve on one committee, with the DPH chair designated to the Community Services Assessment Committee. In addition, Holt, Wexler & Farnam (HWF), as contractor, provides staffing for each committee.

CPG Executive Committee members and their related experiences

Member	Experience
Bill Behan	Former CPG DPH Co-Chair – Bill Behan was the DPH Co-Chair from April 2004 through June 2007. In addition to his responsibilities as CPG DPH Co-Chair, Bill served as the DPH Co-Chair of the Statewide Care Consortium. Bill was the Assistant Administrator of the AIDS & Chronic Diseases Section at the Connecticut Department of Public Health. Bill was with the AIDS Division for four and a half years and has worked in the HIV/AIDS field for over twenty years.
Barbara Mase	New CPG DPH Co-Chair – Barb Mase succeeded Bill Behan as the DPH Co-Chair in July 2007. Barb is a Health Program Associate in the DPH AIDS and Chronic Diseases Section.
Mark Bond-Webster	CPG Community Co-Chair – Mark Bond-Webster has been a CPG member since April 2003. He will complete his second term in October 2007. He also serves as a member of the MPIR Committee. Mark works as Director of AIDS Services at Perception Programs in Willimantic.
Joseph Simard	CPG Community Co-Chair – Joseph Simard is the Director of Clinical Services at the Hartford Gay and Lesbian Health Collective and has been a CPG member since October 2004. He was elected Community Co-Chair in January 2006. Joseph is also Chair of the Priority Setting Ad Hoc Committee.
Robert Houser	CPG Community Co-Chair In-Training – Robert Houser is an HIV Counselor/Educator at Southwest Community Health Center in Bridgeport. Robert was elected as a CPG Community Co-Chair in February 2007 and will begin his term as Co-Chair in November 2007. Robert is also a member of the MPIR Committee.
Brian Datcher	Finance, Policy and Procedures (FPP) Committee Co-Chair – Brian Datcher is a Community Advisory Board Leader in New Haven and Fairfield Counties through the Children, Youth, & Family AIDS Network; a member of the New Haven/Fairfield Counties Ryan White Part A Planning Council and co-chair of the Planning Council Membership Committee; and is an AIDS Alliance National Trainer of Trainees. Brian has been a CPG member since April 2005 and became Co-Chair of the FPP in February 2006.
Jeanne Nodine	Membership, Parity, Inclusion, Representation and Committee (MPIR) Co-Chair – Jeanne Nodine became a CPG member in April 2005 and was elected Co-Chair of MPIR in January 2006.
Willy Quesada	Community Services Assessment (CSA) Committee Co-Chair – Willy Quesada works as an HIV Prevention Counselor at Bridgeport Community Health Center. Willy became a CPG member in January 2006 and began serving as a Co-Chair of the CSA Committee in September 2006.
Barbara Rogers	Finance, Policy and Procedures (FPP) Committee Co-Chair – Barbara Rogers is a Statewide Consumer Consultant for Ryan White Part D; serves on the Government Affairs Committee of the AIDS Alliance in Washington D.C; is a founder of Computer 4 Kids; is an Outreach Worker for women in crisis at Neon House, and a Prevention Worker for professional street workers. Barbara is also a trained Harm Reduction Training Institute outreach worker for women of color and transgendered individuals, and for religion, spirituality, and HIV prevention, and is a HRSA-certified Trainer of Trainers, and also conducts harm reduction programs serving African Americans. Barbara also teaches college students how to do their own HIV prevention work and does youth training on prevention and basic understanding of the human body in connection to HIV and AIDS. Barbara became a CPG member in March 2006 and began serving as a Co-Chair of the FPP Committee in November 2006.
Tyrone Waterman	Membership, Parity, Inclusion, Representation and Committee (MPIR) Co-Chair – Tyrone Waterman is an Adolescent Case Manager at the University of Connecticut/Connecticut Children's Medical Center in Hartford. Tyrone is also the facilitator of the Teens Against Negligence (TAN) Program, a peer education program. Tyrone became a CPG member in January 2006 and was elected Co-Chair of the MPIR Committee in August 2006.

MEMBER RECRUITMENT

During the 2006-2007 planning cycle, the Membership, Parity, Inclusion, and Representation (MPIR) Committee took on the task of recruiting new members for the CPG. The recruitment of Latino/as, males, HIV-positive persons, people with a history of intravenous drug use, and individuals from Southeastern and South Central Connecticut continues to be of particular interest to the MPIR Committee. Each month, the Committee reviews the CPG's Diversity Chart, prepared by the CPG contractor, to help guide recruitment efforts (**TABLE 1-1**).

During the final months of 2006, MPIR (at the direction of the CPG Co-Chairs) revised the Diversity Chart. The two fundamental goals accomplished by these changes are: 1) Categories listed on the Diversity Chart (used to consider CPG nominees) are now based strictly on the CDC guidance regarding membership criteria; and 2) The membership goals (target numbers) listed on the front page of the Diversity Chart are now based strictly on the Connecticut Epidemiologic Profile. The MPIR Committee's process for reviewing new nomination forms and interviewed nominees was also updated to ensure that the review process is consistent and clear.

Information about current membership included on the Diversity Chart is collected from the original CPG member nomination forms and the annual CDC membership grid survey. Using the Diversity Chart, the committee identifies populations needed by the CPG in order to reflect the epidemic in Connecticut. To ensure that the group's membership goals reflect the current statewide HIV/AIDS epidemic, MPIR also reviews the best available HIV/AIDS data, prioritized populations from the Comprehensive HIV Plan, and the considered expertise needed by the CPG to complete the community planning process.

During the 2006-2007 planning cycle, the MPIR Committee continued its recruitment of CPG members to better reflect the diversity of the epidemic in Connecticut. The Connecticut CPG's overall membership goal is to recruit and retain 30 members. Nominees are selected on the basis of how well their demographic profile fits the CPG's current membership needs and the MPIR Committee's judgment about their potential to contribute to the CPG as a member (based on personal characteristics including personal experience and community involvement, skills, knowledge of HIV prevention and care issues, commitment to HIV prevention and community planning, and ability to work in diverse teams). (**See current list of CPG members in Appendix A**).

Currently, members are recruited through word of mouth, announcements at Ryan White I Eligible Metropolitan Area (EMA) Planning Council and Statewide Care Consortium meetings, direct mail via the *HIV/AIDS Planning News and Notes* and, and at regular CPG monthly meetings. In 2007, the presiding CPG Co-Chair began referring CPG members and meeting participants to a copy of the Diversity Chart during each CPG meeting, and pointed out the most pressing demographic needs for the CPG.

CPG MEMBERSHIP

To be considered for CPG membership, interested individuals must complete a nomination form that is reviewed by the MPIR Committee. If invited, nominees must participate in an interview conducted by members of MPIR. Once potential members have completed the nomination and interview process, the MPIR Committee recommends candidates for approval first to the CPG Executive Committee and then to the entire CPG. Seven nominees were approved by the CPG for membership positions from July 2006 to June 2007.

Members have a term of office of two years beginning as soon as they are approved for membership by the CPG. No member may sit on the CPG for more than two consecutive terms (4 years), and after serving their second term, former members must wait one year before re-applying for member status.

In March 2007, the CPG approved a change to its attendance policy. The revised policy states that "CPG members will be administratively discharged after four absences incurred during the most recent 12 months of membership. CPG members will be notified of their membership status after their third absence in a continuous 12 month period. A CPG Member who is dismissed for administrative reasons can make an appeal by completing a short, confidential appeal form, attending the next CPG meeting, and meeting confidentially with the Executive Committee. The Executive Committee will make a decision

and notify the discharged member.” This policy differs from the previous attendance policy because it does not excuse absences for medical illness.

ORIENTATION, MENTORING AND MEMBER TRAINING

As new members join the CPG, orientations are held to inform them about the work of the CPG and their responsibilities as CPG members. An orientation specifically for new members was last held in May 2006, but an orientation/review of HIV/AIDS community planning for both new and veteran CPG members was also held during the December 2006 CPG meeting. In addition, the CPG’s joint meeting with the Statewide Care Consortium in April 2007 included an overview of each planning body’s mission, tasks, structure, and responsibilities. No further new member orientations are planned at this time because the CPG will soon merge with the Statewide Consortium to become the Connecticut HIV Planning Consortium – at which time all members of the merged planning body will need an orientation. New CPG members receive the CPG Policy and Procedure Manual¹ and the CPG Charter.

The CPG does not currently have a formal mentoring program for new members. Instead, veteran CPG members, including members of the Executive Committee, attempt to make themselves available for questions and conversation to newer CPG members during breakfast and lunch on the day of each CPG meeting. When the CPG merges with the Statewide Care Consortium to form the Connecticut HIV Planning Consortium (CHPC) in October 2006, the possibility of creating a more formal mentoring program will be examined.

The Connecticut CPG also values ongoing community planning training for all of its members. To ensure continued training opportunities, the CPG voted to allocate funding in 2006-2007 for conferences related to community planning and HIV prevention.

From July 2006 to June 2007, the CPG sponsored selected CPG members to attend the 2007 HIV Prevention Leadership Summit (HPLS) from May 20-23, 2007 in New Orleans, Louisiana. (5 CPG members, 1 DPH staff person, and 1 contractor staff member attended).

The CPG will continue its policy of offering members the opportunity to attend community planning-related conferences during 2007-2008. The CPG will also send representatives to the Pro Visions Conference, Connecticut’s Regional Conference on HIV and AIDS.

THE CPG YOUTH ADVISORY GROUP

It is critically important that young people understand the facts about HIV/AIDS and act in ways that prevent HIV infection. AIDS is not just a virus – it is a life-long, life threatening illness. HIV/AIDS is preventable; young people can protect themselves from contracting HIV.

As the contractor for the CPG, Holt, Wexler & Farnam (HWF) is working with the Department of Public Health to ensure that the voices of young people are heard in planning HIV prevention efforts in Connecticut through the formation of the CPG Youth Advisory Group. This group addresses critical issues such as common myths and misperceptions about HIV/AIDS; credible sources of information about HIV/AIDS and sexually transmitted diseases; barriers and challenges young people face in accessing HIV/AIDS prevention information; effective strategies for reaching young people at risk of contracting HIV/AIDS, and compelling prevention messages.

Over the past year, 28 young people participated on the CPG Youth Advisory Group. From April 2006 to June 2007, the Group met as a full body seven times. The Youth Advisory Group also made a presentation to the CPG in July 2006, and 15 Group members participated in a video shoot for the creation of an HIV prevention public service announcement (PSA) in February 2007. The PSA was made with DCTV, the United Way of Connecticut, and Comcast, and is now airing across the state. Finally, the Youth Advisory Group produced the first-ever Youth Chapter of The Connecticut Comprehensive Statewide HIV Prevention Plan. The Youth Chapter includes an introduction, data, and resources for youth, information about HIV prevention programs that are proven to work with youth, and recommended youth prevention efforts going forward.

¹ The CPG’s Policy and Procedure Manual is currently being revised.

MEETING STRUCTURE

The CPG convenes one meeting per month in various sites throughout the state. Holt, Wexler, & Farnam, a New Haven-based consulting firm and contractor for the CPG, coordinates all meeting logistics. Each meeting follows an agenda, approved by the Executive Committee, the governing body of the CPG (*see Sample Agenda in Appendix A*). Either the DPH Chair or one of the Community Co-Chairs alternates the facilitation of the meetings. Meetings are conducted using the CPG bylaws and a relaxed version of Robert's Rules of Order.

Each monthly CPG meeting is evaluated for its process and content. CPG members and public participants are given the opportunity to evaluate the CPG meetings. The contractor prepares the monthly evaluation surveys and final reports for review by the co-chairs and Executive Committee. (*For more on the Evaluation Process, see Chapter 7.*) From July 2006 to June 2007, the CPG conducted 11 regular meetings (including two joint meetings with the Statewide Care Consortium) as well as the CPG retreat in November 2006.

During a typical CPG meeting, the entire CPG meets for two hours in the morning, followed immediately by 90-minute committee meetings. Members of the public are encouraged to participate in these committee meetings. At the end of the session, each committee chair reports to the full CPG on the activities of his or her committee. Currently, the full CPG meets on the third Wednesday of each month. Monthly CPG meetings are designed to include mini HIV prevention presentations, technical assistance and trainings, as well as important community planning information and business. Each meeting's agenda includes time for members of the public to address the CPG on topics or concerns related to HIV prevention. In March 2006, the CPG's Priority Setting Ad Hoc Committee began meeting to plan and implement the priority setting process for the next planning cycle, which will begin in 2009.

Sexual Orientation	# of Members
Heterosexual	12
Gay Man	3
Lesbian	0
Bisexual	2
Occupation	# of Members
State Health Dept. HIV Prevention/STD Treatment Staff	2
Local Health Dept. HIV Prevention/STD Treatment Staff	3
State Education Agency	1
Local Education Agency	4
Substance Abuse Governmental Agency	1
Mental Health Governmental Agency	0
Department of Corrections Representative	0
Non-governmental STD agency	3
Non-governmental TB agency	0
Non-governmental substance abuse prevention & treatment	2
Non-governmental mental health services	1
Non-governmental homeless shelters	1
Non-governmental prisons/corrections	0
Non-governmental HIV care and social services	7
Non-governmental education agencies	1
Business community	1
Labor community	0
Faith community	3
Field of Expertise	# of Members
Health Planning	6
Epidemiology	1
Behavioral Science	3
Social Science	4
Program Evaluation	2

Table 1-1: CPG DIVERSITY CHART² as of June 2007

Data-Driven Portion Based on CDC Guidance and Epidemiologic Profile

CATEGORIES	MEMBERSHIP	GOAL	NEEDED	% SHORT OF GOAL
Total	18	30	12	40%
PRIORITY POPULATIONS³				
HIV+	8	15	7	47%
MSM	3	6	3	50%
IDU	4	14	10	71%
Heterosexual	12	10	0	--
GENDER				
Female	9	10	1	10%
Male	9	20	11	55%
RACE/ETHNICITY⁴				
Black ⁵	9	9	0	--
Hispanic or Latino	3	10	7	70%
White	7	11	4	36%
AGE				
<29 ⁶	2	3	1	33%
30-39	2	5	3	60%
40-49	5	12	7	58%
50+	9	10	1	10%
REGION (COUNTY)^{7 8}				
Southwest (Fairfield)	6	7	1	14%
North Central (Hartford)	8	8	0	--
Northwest (Litchfield)	1	1	0	--
South Central (Middlesex/New Haven)	2	8	6	75%
Southeast (New London)	0	1	1	100%
Northeast (Windham/Tolland)	1	1	0	--
Department of Corrections ⁹	6	4	0	--

² Categories separated by bold lines are not mutually exclusive.

³ Categories are not mutually exclusive, so total may be larger than # of members.

⁴ Categories are not mutually exclusive, so total may be larger than # of members.

⁵ Black includes African-American, African, Caribbean-American, West Indian, Haitian, etc.

⁶ The CPG Youth Advisory Group, which represents people age 24 and younger, is in addition to the goal for individuals 29 and younger.

⁷ Categories are not mutually exclusive, so total may be larger than # of members.

⁸ Members who work in one region and live in another region are categorized according to their work region

⁹ The Department of Corrections is represented by former inmates.

Table 1-2: CPG MEMBERSHIP COMPARED TO CURRENT EPIDEMIC

Connecticut CPG membership vs. the current Connecticut AIDS epidemic

CPG Membership as of June 2007		People Living with HIV/AIDS in Connecticut as of December 31, 2006	
Priority Populations			
HIV positive	44%	HIV positive	100%
MSM	17%	MSM	20%
IDU history	22%	IDU	43%
Heterosexual	67%	Heterosexual	22%
Gender			
Male	50%	Male	66%
Female	50%	Female	34%
Race/Ethnicity			
Black	50%	Black	31%
Hispanic/Latino	17%	Hispanic	32%
White	39%	White	35%
Age			
<29	11%	<29	6%
30-39	11%	30-39	18%
40-49	28%	40-49	43%
50+	50%	50+	34%
Region*			
Northwest	6%	Northwest	2%
North Central	44%	North Central	27%
Northeast	6%	Northeast	3%
Southwest	33%	Southwest	24%
South Central	11%	South Central	29%
Southeast	0%	Southeast	4%
Dept. of Corrections	33%	Dept. of Corrections	12%

* At time of diagnosis

CHAPTER THREE: COMMUNITY SERVICES ASSESSMENT

OVERVIEW

The Community Planning Group is on a three year planning and priority setting cycle. Each year, the CPG updates components of its plan as new data becomes available and resources change. Key information necessary to develop and/or update the comprehensive HIV prevention plan is found in the epidemiologic profile and the community services assessment. **The Community Services Assessment** describes the prevention needs of populations at risk for HIV infection, the prevention activities/interventions implemented to address these needs, and service gaps.

The Community Services Assessment (CSA) committee gathers and makes available to the Community Planning Group and the interested general public up-to-date information about 1) the populations at risk for HIV infection; 2) the prevention resources available to those populations; and 3) their unmet needs.

Specific steps involved in completing the Community Services Assessment include:

1. Conducting a Needs Assessment which gathers information on the prevention needs of identified populations at risk for HIV Infection
 - a. Identifying and describing new trends in HIV infection and newly emerging populations at risk for HIV infection
 - b. Focus groups and key informant interviews
2. Conducting a Gap Analysis that describes gaps in services that are not being addressed by existing prevention programs
3. Creating a Resource Inventory that describes the existing prevention services available to address the needs of those populations

1. NEEDS ASSESSMENT - Statewide Combined Needs Assessment

The Connecticut HIV Community Planning Group participated in the first combined needs assessment process for care and prevention. The Data Work Group of the Statewide HIV/AIDS Care Consortium convened a meeting of Titles I and II (now Part A and B), and CPG to discuss unifying efforts among the needs assessment efforts. At this meeting, the discussion focused on the different data needs of Title I (Part A) and Title II (Part B) planning bodies, the six core service categories identified by the Health Resources and Services Administration (HRSA), the needs of CPG planning body, the focus of Centers for Disease Control and Prevention (CDC), the different timelines of assessments for planning bodies, the inclusion of secondary prevention questions, the feasibility of conducting a combined survey, the development and agreement over instrument, and aligning questions with the State's Uniform Reporting System (URS) data fields.

The participants agreed that a collaborative effort through a statewide needs assessment would be in the best interest of each planning body and consumers throughout Connecticut and would maximize limited resources as well as help to relieve the burden of numerous surveys on consumers. The CPG developed a set of questions that provided specific information about the HIV positive population, risk behaviors and perceived or actual need for services. The survey asked demographic information as well as prevention and care service needs. This effort is one of several collaborative activities supporting the integration of care and prevention efforts.

The Needs Assessment Results

A total of 1,135 in-care consumers completed the Needs Assessment Survey¹⁰.

- 8 counties participated
- The target was 860 valid surveys. 967 (112%) valid surveys were collected.
- 325 surveys collected through CADAP
- 64 provider agencies directly administered 810 surveys

¹⁰ See Appendix A for Statewide Needs Assessment Survey summary tables.

Demographics: Of the Survey respondents, 35% were white, 35% were Black and 28% were Latino/a. 60% were male and 39% female (of people in CT living with HIV/AIDS, 67% male and 33% female). 4% were 20-29 years old. 19% were 30-39 years old. 40-49 year olds accounted for 49% of respondents and 28% of respondents were 50 years old or older.

Risk/Mode of transmission: 41% of respondents reported that their mode of transmission were heterosexual risk, 25% reported that they men having sex with men, and 24% reported injection drug use. This differs from the general population of people in CT living with HIV/AIDS in that 55% of PLWHA in CT are IDU, 21% are heterosexual risk.

Service Utilization

Individuals were asked to respond to questions related to prevention services, whether or not they needed them, get them, or do not need them. Overall, the prevention service most used in the state is Information and Support groups (55%). Prevention for partners (39%) and risk reduction (25%) appear to be used less.

The following table 1. shows the utilization of prevention services as reported by respondents.

Self Reported Utilization of Prevention Services by People Living with HIV/AIDS By Risk and Race/Ethnicity - 2005 Combined Needs Assessment Data							
Table 1.	% reporting recent unprotected sex*	% not using any prevention services	% using prevention groups	% using risk reduction	% using prevention Information	% using prevention for partners	% average utilization of prevention services
IDU -Black	15	14	69	35	72	55	58
IDU-Hispanic	16	15	70	48	63	51	58
IDU-White	18	25	58	25	47	37	41
MSM-Black	18	22	54	36	58	36	46
MSM-Hispanic	22	24	51	37	55	41	46
MSM-White	31	44	40	14	42	26	31
Hetero-Black	23	16	58	24	60	42	46
Hetero-Hispanic	18	22	53	24	59	44	45
Hetero-White	24	22	62	17	56	42	44

Gaps

Gaps in prevention services for in-care PLWH/A across the state were not significant, which means that overall the state appears to be meeting the prevention needs. The greatest percentage of individuals who reported they wanted but did not get a prevention service was for **support groups or services (12%)** and the other 4 listed services were under 10%. However, the large percentage of HIV+ individuals who report that they do not need prevention services signifies a possible prevention problem:

- 65% of surveyed individuals answered "I do not need" risk reduction services
- One half (49%) indicated that they thought they did not need prevention for partners
- One third did not want prevention information, support groups or services, or case management.

Disproportionate populations

Analysis of available data indicates the following as disproportionate populations:

- Latinos, MSM, males and younger individuals encounter service gaps at disproportionate rates.
- The unemployed, individuals engaging in unprotected sex, have been in prison, are IDU or are fewer years HIV+ are also disproportionately reporting gaps in services.

Personal Risk Factors

Individuals were also asked if after testing positive for HIV they engaged in behaviors such as having unprotected sex, sex with an anonymous partner, sex with HIV negative partners, sex for drugs or money, sharing needles or injection equipment and if they notified their partner(s) of HIV status. The chart to the right indicates the percentages as reported by respondents.

For the first time, the state has a comprehensive statewide assessment of need for HIV+ individuals living in Connecticut. The CSA Committee and Ad Hoc Priority Setting Committee have been focusing on this statistically significant data for its planning processes during the 2005 – 2006 and through 2007- 2008 planning cycles. Four major federally funded planning bodies are using this data for their federal applications and to apply priorities to their planning processes. This effort was also featured at the June 2006 HPLS Conference in Dallas, Texas.

Large numbers of HIV+ individuals are not using prevention:

- 65% reported not needing risk reduction services
- 49% reported they did not need prevention for partners
- One third did not want prevention information, support groups or services, or case management.
- 23% of those surveyed say they need at least 1 service
- 55% of those surveyed are engaging in two or more risk behaviors since being HIV+

Emerging Need for Prevention / Intervention

- MSM, being in prison, having had recent unprotected sex, IDU, being Female and / or Younger, Latino, or Older.

Specific Barriers to Prevention

The Connecticut Comprehensive HIV Prevention plan cited identified barriers to prevention and services. Whereas, populations are mostly aware of the need for risk behavior change and for the need to use condoms/dental dams, actually making and sustaining behavior changes is the challenge (e.g. difficulty in sustaining safer-sex behaviors) In addition to the barriers identified above, prevention barriers include:

- Internalized or external racism, homophobia and heterosexism
- Risky behavior, including multiple sex partners and infrequent condom use; sharing needles (e.g. need to expand needle exchange programs) or no perceived risk/misconceptions about HIV
- AIDS-fatigue
- Cultural, family, religious and economic and language barriers, including for undocumented immigrants, and reading comprehension
- Lack of safe “gathering spaces” and effective support groups
- Gaps in services (e.g. transportation, housing and health and mental health); few late night services

Barriers and Challenges to Prevention for Youth

Specific barriers and challenges identified with youth include:

- Abstinence only policy keeps students from learning all the facts about preventing HIV and because of this, students will be less likely to practice safe sex once they become sexually active (in high school, college, etc.).
- Peer pressure to have sex especially among boys, to have sex (or at least pretend they have had sex). Many girls feel pressure to have sex to keep their boyfriends.
- Young people not using prevention information.
- Stigma attached to HIV/AIDS, which may keep HIV+ youth from being open about their status.
- Myths about HIV/AIDS, including: 1) It only affects certain populations; 2) Tattoos and piercing are not seen as high risk, 3) myths about how the virus is transmitted.

Statewide Coordinated Statement of Need Recommendations for Prevention and Care

The needs assessment data serve as the basis for the Statewide Coordinated Statement of Need (SCSN) – a truly coordinated effort among Ryan White Parts A, B, C, D, F and Prevention. Seven overall recommendations came out of the 2007 updates to the SCSN. The recommendations represent broad goals based on SCSN findings and development discussions. The goals directly respond to data collected and reflect thematic service delivery needs identified through studies of disproportionately represented and underserved populations, crosscutting themes, critical gaps and emerging needs. The following recommendations, which integrate care and prevention, were developed to inform the allocation and use of resources for service delivery in the State of Connecticut for PLWHA:

Service Utilization

Recommendation 1: Engage PLWHA (out-of-care and in-care) into primary care by fully integrating comprehensive risk counseling services (CRCS) with medical case management through, for example, coordinated services, co-location, cross training, outreach, and referral. Note: attention should be given to specific issues arising in areas such as rural areas that may not have significant representative data.

Recommendation 2: HIV Care providers should offer or refer prevention interventions including combination of individual interventions, group level interventions, peer and non-peer outreach, prevention case management, partner counseling and referral services, community level interventions and structural interventions.¹¹

Service Needs

Recommendation 3: Continue focusing on the six core HRSA services as prioritized in anticipation of the 2008 needs assessment, gather further information on the additional core services resulting from the 2006 Ryan White Modernization Act and additional information on rural and non-urban areas, and obtain data resource information by partnering with Department of Correction (DOC), Department of Social Services (DSS), Department of Mental Health and Substance Abuse (DMHAS) and the State Department of Education (SDE)

Recommendation 4: Fund supportive services to ensure that people have access to and remain in primary care. For example: services such as transportation, housing related services, emergency financial assistance (EFA) and food.

Recommendation 5: Provide training and education for primary care providers on secondary prevention methods.

Recommendation 6: Communicate the need for transportation services for PLWHA to the State of Connecticut Department of Transportation (DOT) and work with them to provide services through a Locally-Coordinated Public Transit Human Services Transportation Plan, particularly in rural areas where transportation services do not exist

Emerging Needs

Recommendation 7: To identify emerging needs in order to better anticipate the at-risk populations and identify ongoing trends in the HIV+ population, and to reinforce the need for supportive services. Use methods such as Statistical modeling processes, ADA Database, Local input, Out of Care Survey, Provider Survey, and other data sources, e.g. literature search, organization reports and others.

¹¹ Structural interventions refer to public health interventions that promote health by altering the structural context within which health is produced. Most prevention interventions focus on individuals, encouraging them to make healthy choices. Structural interventions focus “outside” of the individual, trying to expand the healthy choices available to the individuals, create norms that make healthy choices acceptable, and ensure that individuals have the power and resources to access healthy choices. Leif Mitchell, Assistant Director, Community Research Core, Center for Interdisciplinary Research on AIDS (CIRA), Yale University School of Medicine, http://cira.med.yale.edu/about_us/bios.asp?PID=4#publications

Population Focus Groups and Key Informant Interviews

The CSA committee looks at different sets of information to inform the Community Planning process. CSA committee conducts focus groups and key informant interviews to gather information on communities at risk that may be underserved by existing HIV prevention efforts, and to identify the specific risks and needs of those communities. This information is assessed by the CPG and considered in the planning process.

Deaf and Hard of Hearing Key Informant Interview and Youth Planning Meeting

During May 2006 the CSA committee conducted an additional key informant interview of a member of the deaf population, and received information from the Youth Advisory Group planning meeting held in May 2006 at the American School for the Deaf.

Factors that put deaf people at greater risk for HIV/AIDS

1. Lack of confidence may lead to submission to (sexual) abuse to gain attention or care
2. Medical providers may not ask individuals who are deaf or disabled about their sexual activity
3. Lack of broader connection with the hearing world translates into less incidental learning, i.e., about social issues, behavior, etc., captioned television is limiting
4. Many AIDS programs are not very receptive to the deaf and hard of hearing populations
5. Interpreters have not been available at agencies
6. Peer pressure and curiosity leading to unprotected sex
7. Drinking / drug use

Barriers

1. Lack of appropriate, trained HIV savvy interpreters and culturally sensitive staff at hospitals, HIV clinics, AIDS service organizations
2. Lack of visually, linguistically appropriate materials
3. Frequent inability to access any supports.
4. Discomfort with and lack of understanding of deaf persons on the part of the hearing population
5. Built in biases – perception that the deaf population is not sexually active or uses drugs
6. Lack of concern on the part of youth about contracting HIV

Prevention Needs

1. Provision of ASL interpreters without hesitation and presenters who can sign in ASL
2. Make offices culturally deaf friendly (display of printed information or wall posters) where is it made clear that an individual should ask for an ASL interpreter within reasonable timelines
3. Culturally appropriate outreach and multi-cultural hearing loss workshops on prevention
4. Culturally appropriate materials and information that are accessible / deaf friendly brochures are basic designed to stimulate discussion
 - a. Current, culturally appropriate, and accessible training materials (printed, visuals, videos and DVD) on HIV prevention directed at all ages and given by trained staff
 - b. Education of kids in mainstream programs with lack of appropriate supports (It may be easier for youth to talk about HIV prevention if the groups are separated by gender)
 - c. Information about confidential HIV testing for youth and where they can go to get tested

Effective Programs or Strategies for adults and youth

Currently, there are few effective programs directed to the deaf population. Of the CDC models, the one DEBI that would be more likely to reach the deaf population is the popular opinion leader, i.e., someone

who is deaf and HIV+ that could step up and speak on behalf of the community. However the model would have to be modified and training would be needed on both the intervention and the method to reach this population.

Students noted that most of their peers know the basic facts about HIV/AIDS, and that their friends mainly shared information they heard from teachers. Specific activities that youth identified as most effective include:

1. Motivational teachers who can inspire their students are more effective, as well as teachers who can create a safe, trusting environment, and ask for feedback. e.g., HIV-positive speakers who can talk about what it is like to live with HIV/AIDS, and make it more real for students.
2. Start earlier. Students should begin learning about HIV/AIDS in elementary school.

2. RESOURCE INVENTORY

The CDC's *Guidance on HIV Prevention Community Planning* defines a resource inventory as one of the three components of a Community Services Assessment. A resource inventory assesses existing community resources for HIV prevention and care to determine the community's capability and capacity for responding to the HIV epidemic.

The CPG's resource inventory is designed to define current HIV prevention/care and related resources and activities. In previous years, all known prevention resources were listed regardless of the funding source (federal, state, and private). Surveys of providers were conducted by CPG to determine what services exist in Connecticut. However, after the results of the last survey were compiled, it became apparent that some of the information was not completely reflective of services being offered.

For the 2006 Chapter update, the CSA committee decided to only include DPH funded service providers since the information is accurate readily available and will not change for another two years. This information has been updated for 2007, and reflects the most currently funded DPH service providers (care and prevention). Realizing a more comprehensive resource inventory has value, the committee decided to partner with Infoline in order to get accurate information that is updated regularly about prevention services that exist but are not funded by DPH. In October 2006, the ***HIV/AIDS Prevention and Care Guide*** was launched on the United Way of Connecticut's 2-1-1 website. The Guide is a product of collaboration among 2-1-1, the Connecticut Department of Public Health (DPH), the Statewide Care Consortium (SWC), and the Connecticut HIV Prevention Community Planning Group (CPG). To obtain further information about HIV/AIDS services in Connecticut not listed here contact Infoline at 2-1-1 or www.infoline.org. The DPH funded resources are listed by region immediately following section 3 Gap Analysis update.

3. GAP ANALYSIS UPDATE

The CSA Committee has used the information provided by the 2005 Statewide Needs Assessment to reassess the identified gaps established in August 2005. The committee reviewed the gaps identified in August and agreed that prioritized gaps need to be based on quantifiable data and decided to take a two step approach: 1) determine gaps from hard data and 2) then include more subjective information. With the Statewide Needs Assessment, the data supports using a statewide approach to identify prevention services gaps. The group reviewed information on utilization of prevention services and on available services.

The committee reviewed the data carefully to determine its meaning. The committee found that large numbers of HIV+ individuals are not using prevention (65%). However, more than half of the survey respondents (55%) indicated that they are engaging in two or more risk behaviors since being HIV+, and one third did not want prevention information, support groups or services, or case management.

Based upon this discussion and subjective information which supports the need for prevention education of deaf and hard of hearing populations (adult and youth), the Committee agreed upon the major gap as: **"Prevention Education for HIV+, HIV-, high risk and the broader population"**.

RESOURCES BY REGION
Northcentral Region – consists of Hartford County

NC: PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)
AIDS Project Hartford 110 Bartholomew Ave. Hartford, CT 06106 P: 860-951-4833 F: 860-951-4779 TDD: 860-951-4791	Care and Prevention	Healthy Relationships	HIV Positive, MSM, Women Heterosexual Men
		Street Smart	Heterosexual - African American, Latino, and White (Youth)
		Project TLC (Statewide) – Transitional Medical Case Management, Emergency Financial Assistance (EFA). Medication Adherence	HIV Positive
Central CT AHEC 30 Arbor St. North Hartford, CT 06106 P: 860-233-7561	Care	Outpatient/ambulatory, Medical Case Management, EFA, Transportation	HIV Positive
Charter Oak Health Center 21 Grand St. Hartford, CT 06106 P: 860-550-7500 F: 860-550-7501	Prevention	Counseling and Testing	High Risk Individuals
		HIGHT (Counseling and Testing)	IDU - Latino/a, African American, White
		CRCS	HIV Positive
City of Hartford, Dept. of Health & Human Services 131 Coventry St. Hartford, CT 06112 P: 860-543-8822 F: 860-722-6713	Prevention	Counseling and Testing	High Risk Individuals
Community Renewal Team, Inc. 555 Windsor St. Hartford, CT 06120 P: 860-560-5600 F: 860-527-3305	Prevention	Community Promise	African American and Latino/a IDU, Latino/a and White Heterosexual
		Healthy Relationships	HIV Positive
		SISTA	Latina Heterosexual
ConnectiCOSH 683 North Mountain Rd. Newington, CT 06111 860-953-2674 860-953-1038	Prevention	Safety Counts	HIV+, Latino/a IDU, Latino/a Heterosexual
		Voices/ Voces	HIV+, Latino/a Heterosexual
CT AIDS Resource Coalition 20-28 Sargent St. Hartford, CT 06105 P: 860-761-6699	Care	Housing Assistance	HIV Positive
East Hartford Health Department 740 Main St. East Hartford, CT 06108 P: 860-291-7295 F: 860 291-7304	Prevention	Counseling and Testing	High Risk Individuals
Hartford Dispensary 345 Main Street Hartford, CT 06120 P: 860-527-5100	Care and Prevention	Community Promise	High Risk Individuals
		Medication Adherence	HIV Positive

NC: PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)
Hartford Gay & Lesbian Health Collective P.O. Box 2094 Hartford, CT 06145-2094 P/TDD: 860-278-4163 F: 860-278-5995	Care and Prevention	Counseling and Testing	High Risk Individuals
		Oral Health Services	HIV Positive
Hispanic Health Council 175 Main St. Hartford, CT 06106 P: 860-527-0856 F: 860-724-0437	Prevention	Mpowerment	Latino MSM
		SISTA	Latina Heterosexual
Human Resources Agency of New Britain, Inc. 336 Arch St. New Britain, CT 06051 P: 860-826-4482 F: 860-832-4663	Prevention	RAPP	Latino/a Hetero
Human Resources Agency of New Britain, Inc. 180 Clinton St. New Britain, CT 06053 P: 860-225-8601 F: 860-225-4843	Care	Medical case management, EFA, Food Bank Medication adherence	HIV Positive
Latino Community Services 184 Wethersfield Ave. Hartford, CT 06114 P: 860-296-6400 F: 860-728-3782	Care and Prevention	RAPP	Heterosexual - African American, Latino/a
		Safety Counts	HIV Positive IDU - Latino/a, African American
		Voices/Voces	HIV Positive Heterosexual - African American, Latino/a
		Counseling and Testing	High Risk Individuals
		Medical Case Management, EFA, Linguistic Services Medication Adherence	HIV Positive
New Britain Health Department 56 Hawkins St. New Britain, CT 06051 P: 860-612-2772 F: 860-826-3475	Prevention	Counseling and Testing	High Risk Individuals
University of Connecticut Health Center 286 Farmington Ave. Farmington, CT 06030 P: 860-679-4745 TDD: 860-679-2242	Care	Medical Case Management, Medical Adherence	HIV Positive
University of Connecticut Health Center/ CCMC (Pediatrics) 282 Washington St. Hartford, CT 06106 P: 860-547-7477	Care	Medical Case Management, EFA, Home and community-based health services	HIV Positive Children

NC: PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)
Village for Families and Children 1680 Albany Ave. Hartford, CT 06105 P: 860-236-4511	Care	Mental Health Services Individual, Group, and Family Therapies	HIV/AIDS Affected Youth

Southcentral Region – consists of New Haven and Middlesex Counties

SC: PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)
AIDS Interfaith Network 1303 Chapel St. New Haven, CT 06511 P: 203-624-4350	Care and Prevention	CRCS	HIV Positive
		SISTA	African American Heterosexual
		Medical Case Management, Food Bank/Home Meals, EFA	HIV Positive
AIDS Project New Haven 1302 Chapel St. New Haven, CT 06511 P: 203-624-0947 F: 203-401-4457	Care and Prevention	SISTA	Heterosexual - African American, Latino/a HIV Positive
		Community Promise	Latino/a IDU, Latino MSM, HIV Positive
		Medical case management, EFA (Health), EFA (Utilities), Mental Health, Food Vouchers, Housing, Transportation	HIV Positive
Clifford W. Beers Guidance Clinic 93 Edwards St. New Haven, CT 06511 P: 203-772-1270	Care	Mental Health Services Individual, Group and Family Therapies	HIV/AIDS Affected Youth
Community Health Center 635 Main St. Middletown, CT 06457 P: 860-347-6971 F: 860-347-2043	Care and Prevention	Counseling and Testing	High Risk Individuals
		Safety Counts	IDU - Latino/a, African American, White HIV Positive
		Medical case management	HIV Positive
Hill Health Center HIV/AIDS Division 428 Columbus Ave. New Haven, CT 06519 P: 203-503-3000	Prevention	CRCS	All Populations
		Counseling & Testing	High Risk Populations
Hispanos Unidos, Inc. 116 Sherman Ave. New Haven, CT 06511 P: 203-781-0226 F: 203-781-0229	Care and Prevention	Voices/Voces	Latino/a Heterosexual, Latino MSM, Latino/a IDU, HIV Positive
		Healthy Relationships	Latino/a IDU, Latino/a Heterosexual, Latino MSM, HIV Positive
		Medical case management, EFA, Medical services, Mental Health, Medication adherence	HIV Positive

Northeast Region – consists of Tolland and Windham Counties

NE: PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)
Perception Programs 54 North St. Willimantic, CT 06226 P: 860-450-7248 F: 860-450-7160	Prevention	Community Promise (yr 1) Mpowerment (yr2-3)	White MSM
		Safety Counts	IDU – Latino/a, African American, White Latino/a Heterosexual
Visiting Nurse & Health Services of Connecticut 8 Keynote Dr. Vernon, CT 06066 P: 860-872-9163 F: 860-872-2419	Care	Medical Case management Medication adherence	HIV Positive
Windham Regional Community Council 872 Main St. Willimantic, CT 06226 P: 860-423-4534 F: 860-423-2601	Care and Prevention	Counseling and Testing	High Risk Individuals
		Healthy Relationships	HIV Positive
		Street Smart	(Youth), Heterosexual - African American, Latino/a
		Medical case management, EFA, Food bank, Psychosocial support services, Transportation, Ambulatory/Outpatient, Oral Health Services, Mental Health, Medication Adherence	HIV Positive

Northwest Region – consists of Litchfield County

Northwestern Connecticut AIDS Project 100 Migeon Ave. Torrington, CT 06790 P: 860-482-1596 F: 860-482-3606	Care and Prevention	Community Promise	White IDU, White Hetero
		Community Promise	White MSM
		Counseling and Testing	High Risk Individuals
		Healthy Relationships	HIV Positive
		Be Proud/Be Responsible	Heterosexual - White, Latino/a and African American (High Risk Youth)
		Medication Adherence, Ambulatory/Outpatient, Oral Health, Mental Health, Medical case management, Psychosocial Support, EFA, Transportation, Housing, Food Ban/Meals	HIV Positive

Southwest Region – consists of Fairfield County

SW: PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)
AIDS Project Greater Danbury 30 West St. Danbury, CT 06810 P: 203-778-2437 F: 203-743-1439	Care and Prevention	DTA	HIV Positive
		CRCS	All Populations
		Counseling and Testing	High Risk Individuals
		Medical case management, Transportation, Medical services, EFA, Housing assistance	HIV Positive
Bridgeport Community Health Center (Optimus Health Care) 471 Barnum Ave. Bridgeport, CT 06608 P: 203-333-6864 F: 203-332-0376	Prevention	Integrated Prevention Services in Routine Medical Care	All Populations

SW: PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)
Bridgeport Health Dept 752 East Main St. Bridgeport, CT 06610 P: 203-576-7679	Prevention	Community Demonstration Project	MSM - White, African American, Latino
		Safety Counts	HIV Positive, Latino/a IDU, African American IDU, White IDU, Drug users and non-drug users at high risk
		Counseling and Testing	High Risk Individuals
		CRCS	HIV Positive, White MSM, IDU - Latino/a, African American
		DTA	HIV Positive, IDU - Latino/a, African American
Child Guidance Center of Greater Bridgeport 180 Fairfield Ave. Bridgeport, CT 06604 P: 203-394-6529 F: 203-394-6534	Care	Mental Health Services Individual, Group and Family Therapies	HIV/AIDS Affected Youth
Family Services Woodfield 475 Clinton Ave. Bridgeport, CT 06605 P/TDD: 203-368-4291 F: 203-368-1239	Care and Prevention	SISTA	HIV Positive
		Holistic, Harm Reduction	IDU – Latino/a, African American, White
		Healthy Relationships	IDU – Latino/a, African American, White MSM – Latino/a, African American, White HIV Positive
		CRCS	HIV Positive
		Medical case management, EFA, Food bank/home meals/nutrition, Transportation, Psychosocial support services, Health insurance, Housing services, Mental Health	HIV Positive
Greater Bridgeport Adolescent Pregnancy Program 200 Mill Hill Ave. Bridgeport, CT 06610 P: 203-384-3629 F: 203-384-4034	Prevention	Counseling and Testing	High Risk Individuals
		RAPP	Heterosexual - African American, Latino/a, White
Health Care Connections, Inc. 888 Washington St. Stamford, CT 06901 P: 203-977-5096 F: 203-977-4946	Care	Medical case management, EFA, Medical services, Mental Health Medication adherence	HIV Positive
Interfaith AIDS Ministry of Greater Danbury 39 Rose St. Danbury, CT 06810 P: 203-748-4077 F: 203-748-2841	Prevention	Mpowerment	HIV Positive MSM - White, African American, Latino Young Adult Males 18-36
Mid-Fairfield AIDS Project 16 River St. Norwalk, CT 06850 P: 203-855-9535 F: 203-855-1531	Care and Prevention	CRCS	HIV Positive
		DTA	All persons with addiction behavior with substances and/or alcohol
		Medical case management, Medical services, Oral health care, EFA	HIV Positive
Norwalk Health Dept. 137 East Ave. Norwalk, CT 0685 P: 203-854-7979 F: 203-854-7926	Prevention	Counseling and Testing	High Risk Individuals
		Voices/Voces	Heterosexual - African American, Latino/a, White
		Safety Counts	HIV Positive & Non IDU IDU - Latino/a, African American, White

SW: PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)
Shelter for the Homeless 597 Pacific St. Stamford, CT 06901 P: 203-348-2792 F: 203-348-5813	Prevention	DTA	IDU - Latino/a, African American, Whites Heterosexual - Latino/a, White Other – Street Outreach
Southwest Community Health Center 351 Bird St. Bridgeport, CT 06605 P: 203-330-6000 F: 203-576-8444	Prevention	Prevention Intervention with persons living with HIV	HIV Positive
		Counseling and Testing	High Risk Individuals
Stamford Health Dept. 888 Washington Blvd. 8 th Floor Stamford, CT 06901 P: 203-977-4387 F: 203-9775460	Prevention	CRCS	All populations
		Healthy Relationships	HIV Positive
		Intensive AIDS Education in Jail (RAPP)	Heterosexual - African American, Latino/a, Whites; High Risk Youth
		Counseling and Testing	High Risk Individuals
		Information and Enhanced AIDS Education	IDU - Latino/a, African American, and White Heterosexual - African American, White
Southeast Region - consists of New London County			
Alliance for Living 154 Broad St. New London, CT 06320 P: 860-447-0884 F: 860-447-3226	Care	Medical Case Management, Medical Services, EFA, Transportation, Oral Health Services	HIV Positive
Lawrence and Memorial Hospital 365 Montauk Ave. New London, CT 06320 P: 860-442-0711 X2056	Prevention	Counseling and Testing	High Risk Individuals
		RAPP	Heterosexuals - African American, Latino/a, White
		CRCS	HIV Positive
United Community and Family Services 47 Town St. Norwich, CT 06360 P: 860-892-7242	Care	Mental Health Services	HIV/AIDS Affected Youth
William W. Backus Hospital 326 Washington St. Norwich, CT 06360 P: 860-889-8331 F: 860-823-6329	Prevention	Counseling and Testing	High Risk Individuals
DEPARTMENT OF CORRECTION			
Community Partners in Action Beyond Fear Program 110 Bartholomew Ave. Suite 4020 Hartford, CT 06106 P: 860-293-3985 F: 860-293-3952	Prevention	RHAP (Rikers Health Advocacy Program)	Incarcerated Individuals
UCHC/Correctional Managed Health Care 263 Farmington Ave. Farmington, CT 06030 P: 860-699-8410 F: 860-699-8416	Prevention	Counseling and Testing Individual Level Interventions Group Level Interventions Specific Interventions for HIV+	Incarcerated Individuals

CHAPTER FOUR: SCIENCE BASED PREVENTION ACTIVITIES/INTERVENTIONS

Advancing HIV Prevention - What Works in HIV Prevention?

As part of its overall public health mission, the Centers for Disease Control and Prevention (CDC), provides leadership in helping control the HIV/AIDS epidemic by working with community, state, national and international partners in surveillance, research, prevention, and evaluation activities. These activities are critical because CDC estimates that over one million people may be living with HIV, and approximately one quarter of them are unaware of their status.

CDC makes every effort to ensure that HIV prevention interventions meet local needs. Specifically, CDC asks that interventions used be science-based and culturally competent to meet the needs of the populations served. Community planning helps ensure that priorities for HIV prevention are determined locally with input from the affected communities. However, it is also expected that the interventions used to reach them be consistent with scientific findings about what programs are most effective at decreasing risk within the identified populations.

CDC's HIV/AIDS Prevention Strategy: Advancing HIV Prevention (AHP): New strategies for a Changing Epidemic

Over the past two decades, CDC's HIV prevention activities have focused on keeping uninfected persons from acquiring HIV. However, because the number of new infections has remained relatively level and because every new HIV infection involves an HIV positive individual, CDC is supporting prevention programs that address the needs of those living with HIV as well. In 2003, CDC began an initiative aimed at reducing barriers to early diagnosis of HIV infection and increasing access to quality medical care, treatment, and ongoing prevention services for HIV positive persons and their partners.

The overall goal of the AHP initiative is to use proven public health approaches to reduce the incidence and spread of HIV and capitalize on new rapid test technologies, interventions that encourage awareness of status through HIV counseling and testing, and effective behavioral interventions that bring HIV prevention skills to people living with HIV.

Through the initiative, three primary areas of prevention are emphasized:

- Early detection and care through HIV counseling, testing and referral
- Prevention interventions with persons living with HIV
- Prevention interventions with persons who are at high risk for HIV

CDC's new initiative has three strategies to accomplish this:

- Make voluntary testing for HIV a routine part of medical care
- Implement new models for diagnosing infections outside of medical settings
- Prevent new infections by working with people diagnosed with HIV

Advancing HIV Prevention in Connecticut

Integration of Prevention and Care

- Joint planning meetings between prevention and care planning bodies
- Joint prevention and care newsletter created and distributed quarterly
- Joint web based HIV/AIDS care and prevention resource guide
- Cross training of prevention and care providers
- First combined effort for a Statewide Needs Assessment that captures care and prevention data
- Integration of prevention and care planning bodies by January 2008
- First Comprehensive Public Health Plan for HIV/AIDS expected to be complete by 2009
- Goal of providing a better continuum of prevention and care services to those infected, affected or at risk for infection

Early Detection and Care through HIV Counseling, Testing and Referral

- Majority of DPH funded counseling and testing programs now using rapid testing
- Rapid testing allows for testing in non-traditional settings
- Rapid testing ensures more people learn their status
- Official training and protocols have been set around using the rapid testing method
- Referrals can be made immediately

Prevention Interventions with Persons Living With HIV

- Per CDC, CPG made HIV positive individuals the number one priority population
- DPH gave funding priority to all of the priority populations, including HIV positives
- DPH funded 9 contractors to conduct Healthy Relationships, an effective intervention for people living with HIV, from the DEBI Project
- DPH funded 2 contractors to integrate prevention services for people living with HIV

Prevention Interventions with Persons at High Risk For HIV

- In the state of Connecticut there are over 40 contractors funded by DPH to provide interventions geared for those at high risk for HIV.
- Interventions for high risk individuals include: individual, group and community level interventions, counseling and testing, comprehensive risk counseling services, drug treatment advocacy and syringe exchange.
- Several Effective Behavioral Interventions from the Compendium of Effective Interventions and the DEBI Project are being implemented statewide targeting high-risk individuals.

HIV Prevention Works

The United States' HIV prevention investments have paid off. Prevention has helped slow the rate of new HIV infections from over 150,000 per year in the mid 1980s to around 40,000 a year now. However, new HIV infections are still unacceptably high and AIDS is still a crisis. In fact, new infections have leveled off at an estimated 40,000 new cases annually.

Prevention's effectiveness has been proven scientifically. The CDC's Compendium provides state of the science information about interventions with evidence of reducing sex- and/or drug- related risks and the rate of HIV/STD infections. The interventions in the Compendium have been proven effective with a variety of populations, e.g., clinic patients, heterosexual men and women, high risk youth, incarcerated populations, injection drug users (IDU), and men who have sex with men (MSM). They have been delivered to individuals, groups and communities in a variety of settings such as storefronts, gay bars, health centers, housing communities, and schools.

According to the CDC, in order for prevention efforts to be effective they must be comprehensive and science-based. The following elements are required for HIV prevention to work:

- An effective community planning process
- Epidemiological and behavioral surveillance: compilation of other health and demographic data relevant to HIV risks, incidence and prevalence
- HIV counseling, testing and referral and partner counseling and referral, with strong linkages to medical care, treatment and needed prevention services
- Health education and risk reduction activities, including individual, group and community level interventions
- Accessible diagnosis and treatment of other STDs
- Public information and education programs
- Training and quality assurance
- HIV prevention capacity building activities
- HIV prevention and technical assistance assessment and plan
- Evaluation of major program activities, interventions and services

They must also have the following Ten Characteristics of Effective Programs:

- Narrow focus
- Based on solid theory
- Appropriate goals, methods, and materials
- Interactive methods
- Strengthen individual values and group norms
- Address social pressure
- Target functional knowledge
- Stress modeling and practice
- Spend time on tasks
- Provide training for teachers and peers to facilitate

Effective Behavioral Interventions

Effective Behavioral Interventions (EBIs) are evidence-based program models that were proven effective with a given population in a given venue through rigorous research studies. In order to be proven effective they had to produce positive behavior change among participants such as increased condom use, or produce positive health outcomes such as a reduction in the number of new infections. The Behavioral Interventions that met the criteria were put into a Compendium of Effective Interventions.

The CDC developed the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* in response to prevention service providers, planners, and others who requested science-based interventions that work to prevent HIV transmission. All of the interventions selected for the Compendium came from behavioral or social studies that had both intervention and control/comparison groups and positive results for behavioral or health outcomes.

The Compendium is a listing of evidence-based interventions that CDC considers effective because they went through rigorous studies. The document is organized into the following four sections:

Section 1 includes summaries of the prevention interventions. These are one-pagers that include the target population, content of the intervention, and methods used to deliver the content.

Section 2 includes two tables. Table One highlights population and intervention characteristics. Table Two indicates the interventions that are part of CDC's Replicating Effective Programs (REP+), Prevention Counseling Course Series, and Research to Classroom: Programs That Work (now being called Programs that have Proven to be Effective). These ongoing projects support the development of intervention materials, training and technical assistance.

Section 3 is an Intervention Checklist. The checklist is a tool CDC created for prevention program planners who decide to use their own interventions over the ready-to-access interventions with known effectiveness. The tool lists elements of successful programs so that prevention program planners can assess if their locally developed prevention programs will work or help them see where they can be strengthened.

Section 4 contains the appendices or extra documents. Appendix A is about CDC's Prevention Research Synthesis Project (PRS), the project that searched for and collected the interventions included in the Compendium. All of the criteria used to determine effectiveness are listed. It also lists the three goals in doing so. The first was to conduct reviews that address the population, intervention, study design, setting and outcome factors associated with intervention effectiveness. The second was to identify rigorous studies of interventions that have statistically significant/positive results. The third was to identify gaps in the existing research and directions for future study. Appendix B is a bibliography or list of sources for the intervention studies described in the Compendium.

In summary, the Compendium is a list of interventions which includes the Diffusion of Effective Behavioral Interventions (DEBIs) targeting several populations, Replicating Effective Programs Plus (REP+), also targeting several populations, and Research to Classroom that target youth.

Diffusion of Effective Behavioral Interventions (DEBIs)

Under the guidance of the CDC/DHAP, the Academy for Educational Development's Center on AIDS and Community Health (AED), coordinates the Diffusion of Effective Behavioral Interventions Project (DEBI), a national level strategy to provide training and ongoing technical assistance on selected evidence-based HIV/STD interventions to state and community HIV/STD program staff. In addition, staff of CDC/DHAP Capacity Building Branch, HIV/STD Prevention Training Centers, state-level health departments, and Capacity Building Assistance providers all offer training and technical assistance for the Interventions.

There are thirteen interventions from the Compendium that are included in DEBI Project. The DEBIs can target multiple populations/risk groups and are listed based on their primary or original population/risk group. The interventions are packaged into user-friendly kits. Once an intervention from the Compendium or DEBI Project is adopted, its actual impact depends on how it is implemented. In order for an intervention to be considered effective it must be replicated with fidelity. This means that the core elements of the intervention must be adhered to, as they are believed to be what makes the intervention work.

Comprehensive training on the DEBIs funded in Connecticut was conducted in 2005. Additional training and technical assistance is available for all DPH funded contractors on an ongoing basis. All DPH funded educators are required to be trained in the intervention they will be implementing.

Effective Behavioral Interventions from the DEBI Project:

- ***Community PROMISE*** is a community-level intervention based on several behavior change theories. A community assessment process is conducted, peer advocates are recruited and trained from the target population, role model stories are written from interviews with the target population, and these stories are distributed to the target audience to help people move toward safer sex or risk reduction practices. The intervention can be adapted for various population groups.
- ***Healthy Relationships*** is a group-level intervention based on Social Cognitive Theory. It consists of 5 group sessions for people living with HIV/AIDS to build risk reduction and disclosure skills.
- ***Holistic Health Recovery Program (HHRP)*** is a 12 session, manual guided, group-level intervention based on the Information, Motivation and Behavior Model of Behavior Change. It targets HIV positive and HIV negative intravenous drug users.
- ***Many Men, Many Voices (3MV)*** is a seven-session, group-level STD/HIV prevention intervention for gay men of color. The intervention addresses behavior influencing factors specific to gay men of color, including cultural/social norms, sexual relationship dynamics, and the social influences of racism and homophobia.
- ***Mpowerment*** is a community-level intervention for young men who have sex with men that uses a combination of formal and informal outreach, discussion groups, creation of safe spaces, social opportunities, and social marketing to reach a broad range of young gay men with HIV prevention, safer sex, and risk reduction messages.
- ***Popular Opinion Leader (POL)*** is a community-level intervention that involves identifying, enlisting, and training key opinion leaders to encourage safer sexual norms and behaviors in their social networks through risk-reduction conversations.
- ***Real AIDS Prevention Project (RAPP)*** is a community mobilization program, designed to reduce risk for HIV and unintended pregnancy among women in communities at high risk by increasing condom use. This intervention relies on peer-led activities including: outreach/one-on-one brief conversations with brochures, referrals and condom distribution and small group safer sex discussions and presentations. There is also peer interaction with community businesses that participate in media campaigns with distribution of role model stories and prevention and health information newsletters and brochures. RAPP is based on the trans-theoretical model of behavior change.
- ***RESPECT*** is an individual-level intervention that utilizes a client-focused and interactive HIV risk-counseling model. It is designed to support risk reduction by increasing perception of risk and

emphasizing incremental risk reduction strategies. RESPECT can be implemented with any population at risk but was originally tested with heterosexuals ages 14 and older accessing STD services.

- **Safety Counts** is an intervention that targets active injection and non-injection drug users to reduce risk for HIV and Viral Hepatitis. It is a seven-session intervention conducted over a four-month period that includes group and individual sessions. It uses the Stages of Change Theory to help participants identify risk reduction goals and steps. This intervention strongly encourages HIV testing as a precursor to program enrollment, clients can be recruited from testing programs, and sessions include a discussion of the importance of testing to the client. The intervention addresses the needs of both HIV negative and HIV positive clients.
- **SISTA** is a group-level, gender- and culturally-specific intervention, designed to increase condom use with African-American women. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk reduction behaviors and decision making. The intervention is based on Social Learning theory as well as the theory of Gender and Power.
- **Street Smart** is a multi-session, skill-building program designed to help runaway and homeless youth practice safer sexual behaviors and reduce substance use. Sessions address improving youths' social skills, assertiveness and coping through exercises on problem solving, identifying triggers, and reducing harmful behaviors. The intervention includes individual counseling and trips to community health providers.
- **Together Learning Choices (TLC)**: is a group-level intervention based on cognitive-behavioral strategies to change the behavior of young people living with HIV. This program helps young people identify ways to improve the quality of their lives by setting new habits and daily social routines. They set goals regarding their health, sexual relationships, drug use, and daily peace. TLC is based on Social Action theory.
- **Voices/Voces**: is a single-session video-based intervention designed to increase condom use among heterosexual African-American and Latino/a men and women who visit STD clinics. Participants, grouped by gender and ethnicity, view an English or Spanish video on HIV risk behaviors and condom use and take part in a facilitated discussion.

Most of the Replicating Effective Programs (REP +) are already in the DEBI Project; however, the following are not yet. These include: Partnership for Good Health (HIV+), and Project Light (Sexually Active Adults). Like the DEBIs they contain core elements that must be followed in order to be effective.

There are also Other Effective Behavioral Interventions (EBIs) that are a part of the compendium. These interventions do not contain as much detail as the DEBI and REP+ interventions and are broken into 4 target populations: Drug Users, Heterosexual Adults, Men who have Sex with Men, and Youth. (Only one of the following is also a DEBI, Street Smart)

Drug Users: AIDS Community Demonstration Project, AIDS/Drug Injection Prevention, Skills Building, Intensive AIDS Education in Jail (RHAP), Informational and Enhanced AIDS Education.

Heterosexual Adults: AIDS Community Demonstration Projects, Condom Skills Education, Group Discussion Condom Practice, Social Skills Training, Reducing AIDS Risk Activities, Cognitive Behavioral Skills Training Group, Women and Infants Demonstration Project, HIV Education, Counseling and Testing.

Men who have Sex with Men: Behavioral Self-Management and Assertion Skills, Small Group Lecture Plus Training.

Youth: AIDS Community Demonstration Projects, Be Proud! Be Responsible! Reducing the Risk, Intensive AIDS Education in Jail (RHAP), Get Real About AIDS, StreetSmart, Focus on Kids, Becoming a Responsible Teen.

CPG and DPH recognize that some HIV prevention partners have expressed that some Effective Behavioral Interventions including those in the DEBI Project do not fit community needs and that there are homegrown or locally developed interventions in existence. However, health departments are able to

decide which interventions to support or fund in their jurisdiction. It is important for health departments and CPG's to consider what type of evidence is available for each intervention and whether or not they are worthy of funding. To access the compendium on the web:

http://www.cdc.gov/hiv/resources/reports/hiv_compendium/index.htm

For more information on the DEBIs: <http://www.effectiveinterventions.org>

Effective Behavioral Interventions for People Living With HIV: What Works?

Although some stakeholders have discussed the need to develop and expand interventions that focus on the HIV positive population, to date scientifically and programmatically sound data and guidance on effective interventions with this population has been limited. However, several publications provide useful guidance for implementing prevention with positives, including the CDC's Revised Comprehensive Risk Counseling Services Guidance (CRCS, 2006) and the CDC's Procedural Guidance for Selected Strategies and Interventions for Community Based Organizations. Comprehensive Risk Counseling Services (CRCS) have proven effective with this population. The CDC's CRCS Guidance defines CRCS as a client-centered intervention that supports HIV positive and HIV negative individuals through initiating and maintaining risk reduction behaviors.

Healthy Relationships is a group-level intervention (GLI) that is a skills-based, behavior change intervention model grounded in social cognitive theory. The sessions focus on defining stress in three life areas; disclosing to friends and family, disclosing to partners and having healthy sexual relationships. Together Learning Choices (TLC) is an intervention for positive teens that is based on social action theory. Three of the modules focus on the different outcomes of staying healthy, acting safe and improving quality of care. Holistic Health Recovery Program is based on the Information, Motivation and Behavior (IMB) model of behavior change that aims to reduce harm, promote health, and improve quality of life for HIV positive intravenous drug users (IDUs). All three of these GLIs are DEBIs.

In 2004, the CDC mandated that community planning groups' in all jurisdictions make HIV positives the highest priority population when resetting priorities for the next planning cycle. Accordingly, HIV positives were given funding priority through the Department of Public Health. CDC's new emphasis on prevention with positives in the battle against HIV/AIDS is critical to the future of the epidemic. Prevention with positives has the potential to reduce the transmission of HIV significantly.

In 2004, the Academy for Educational Development (AED) developed a document entitled, "Best Practices in Prevention Services for Persons Living with HIV". The document was developed for the CDC Division of HIV/AIDS Prevention-Intervention Research and Support Capacity Building Branch.

The Best Practices document is designed to provide staff and decision makers in health departments and community based organizations with general guidance on developing and implementing prevention programs for positives. The document is a compilation of information from the best available research, programmatic experience, and expert sources. The strategies and approaches described are based on best practices recommended by consumers, stakeholders, researchers, and experts who have extensive experience in working with individuals living with HIV and a comprehensive understanding of their prevention needs.

The seven chapters in the Best Practices document provide readers with key information about client recruitment and outreach strategies, information on the scientific basis to support prevention with positives, intervention information and legal and ethical issues.

For more information on the Best Practices document: <http://www.effectiveinterventions.org/index.cfm?Search=Best+Practices> and click on Best Practices 80% to get PDF

Effective Interventions in Connecticut

CDC is requiring grantees that receive federal funding to use more evidence-based interventions, like the EBIs and DEBIs described in this chapter, which have been rigorously evaluated and proven effective. In

fact, they have constructed an elaborate structure for the selection and use of Program Models or interventions that they have approved for use in developing HIV Prevention Programs.

During the last RFP process, bidders were informed that funding priority through the DPH for the prevention funding cycle 2005-2008 would be given to proposals that incorporated the use of evidence-based interventions targeting the CPG priority populations. Priority was also given to proposals that incorporated the CDC's new initiative, Advancing HIV Prevention (AHP), and to interventions that have Procedural Guidance including Counseling, Testing, and Referral (CTR), Comprehensive Risk Counseling Services (CRCS), and Drug Treatment Advocacy. Syringe Exchange Programs are funded through a separate process with state funds. For the CPG's Position Statement on the effectiveness of Syringe Exchange Programs, please see appendix.

Training was provided to all DPH staff, potential bidders, RFP review committee members, and CPG members on these concepts.

The DPH funded 9 out of the 13 EBIs in the DEBI Project and 6 Other Effective Interventions from the Compendium. DPH also funded 24 CTR, 9 CRCS, and 5 DTA programs for a total of 53 funded prevention activities. DPH also funds five Syringe Exchange Programs with state funds. For a complete list of DPH funded interventions, refer to the Service Matrix in Chapter 3. For prevention services funded through other sources, contact Infoline online at www.infoline.org or by calling 2-1-1.

Monitoring of Effective Interventions in Connecticut

The DPH recognized that contracted agencies needed start up time in order to be able to implement the effective interventions for which they received funding. Therefore, the first year (2005-2006), contractors were afforded time for capacity building and training. Training was brought into the state on most of the Effective Interventions from the DEBI Project. Other contractors were sent out of state for training when it was not possible to offer training here.

DPH is committed to working with contractors to provide technical assistance and capacity building as needed. Additional trainings have been conducted on topics of group facilitation and recruitment and retention. DPH has also held meetings for contractors to network with other agencies across the state funded to do the same intervention. DPH will continue to help contractors identify challenges in implementation of effective behavioral interventions and solutions for dealing with them.

Funded contractors were expected to fully implement interventions during the contract year 2006-2007. Staff from the HIV Prevention Unit was assigned to be Intervention Specialists for each funded Intervention from the DEBI Project. All funded interventions are in the process of being monitored using tools developed by the Evaluation Bank. This monitoring will continue through the final year of funding, 2007-2008.

It was requested that information on how many people were reached through funded Effective Interventions be included in this chapter. There are some things to keep in mind when looking at the numbers.

- The data below is not a full year's worth of data. Therefore, it is premature to use this information as a baseline. Also for various reasons such as staff turnover, etc. several agencies implemented late.
- The numbers are much lower than what has been reported in the past prior to the use of Effective Behavioral Interventions. In the past, HIV prevention education focused on reaching the masses with information. Effective Behavioral Interventions target specific populations and most of them require small group work. Therefore it is the quality of the information not the quantity of people reached that matters.
- KEEP in mind – this is not a complete picture – and the numbers may appear odd because it was not a complete year, some agencies just got their programs up and running, and there may be duplications in the reporting of individuals

- This is just an early report on the information – no conclusions should be drawn from this early information.
- Remember these are effective because of how they are focused and are targeted specific areas and issues and populations

Effective Behavioral Interventions 7/1/06-3/31/07

		Individuals
Category	Intervention	Report Total
GLI	Be Proud Be Responsible	51
Outreach	Community Promise	4699
GLI	Healthy Relationships	165
GLI	Holistic Harm Reduction	0
Outreach	Mpowerment	5475
GLI	Mpowerment	49
ILI	Prevention Intervention for Persons Living with HIV	140
CLI	RAPP- Community Network (any person in the network who was interviewed for community mapping)	1841
HCPI	RAPP- Role Model Stories (also denotes total stories created)	85
GLI	RAPP/ Small Group Activities	121
Outreach	RAPP/Peer Network	1073
GLI	Rikers Health Advocacy	924
GLI	Safety Counts	68
GLI	SISTA	160
GLI	Street Smart	121
GLI	VOICES/VOCES	799
	Total	15,771

CHAPTER FIVE: AN UPDATE - CONNECTICUT'S PRIORITIES FOR 2007

Priority Setting in Connecticut: Priority Populations and Interventions for 2005-2008

Priority Setting Background

The Academy for Educational Development (AED) in its priority setting tool, *Setting HIV Prevention Priorities: A Guide for Community Planning Groups*, defines priority setting as a process, which produces a list of ranked priority target populations and interventions proven appropriate and effective. In the CDC's 2003 Guidance for *HIV Prevention Community Planning* a number of goals, guiding principles and objectives are established for the priority setting process. This process ultimately assists the Department of Public Health in appropriating CDC designated and statewide prevention funds to those CPG identified populations most at risk for HIV.

The primary task of the CPG is to develop a comprehensive HIV prevention plan that includes prioritized target populations and a set of prevention activities/interventions for each target population. Priority setting in community planning is based on a review of all relevant factors both new and existing prior to decision-making (e.g. epidemiologic profile, community services assessment, previously prioritized target populations, selected set of prevention activities/interventions, and the 2007 Update to Connecticut's Comprehensive HIV Prevention Plan for 2005-2008). The outcome of the CPG priority setting process is that the DPH will have a list of prevention priorities determined through a data-driven process, which can be used in allocating prevention funds to those populations most at risk for HIV.

In April 2003, the CDC announced a new initiative aimed at reducing the number of new HIV infections each year in the United States. This initiative consists of four parts and includes:

- (a) making HIV testing a routine part of medical care,
- (b) creating new models for diagnosing HIV infections outside medical settings,
- (c) preventing new infections by working with people diagnosed with HIV and their partners, and,
- (d) further decreasing mother-to-child HIV transmission by incorporating HIV testing in the routine battery of prenatal tests.

This new focus, *Advancing HIV Prevention Initiative*, set the foundation for Connecticut's HIV Prevention Community Planning Priority Setting Process. According to the Community Planning Guidance, CPGs must now consider the following:

- (1) to target populations for which HIV prevention activities will have the greatest impact, and,
- (2) to reduce HIV transmission in populations with highest incidence.

The CDC Guidance clearly states that because of the new initiatives potential to substantially reduce HIV incidence, CPG's will be required to prioritize HIV- positive persons as the highest priority population for appropriate prevention services. In addition, uninfected, high-risk populations such as sex or needle-sharing partners of people living with HIV/AIDS (PLWHA) will need to be prioritized based on local epidemiology and community needs.

The Guidance clearly states that CPG's are no longer required to prioritize interventions for specific populations. As a result, for its 2005-2008 Plan, the Connecticut CPG developed a set or mix of interventions for prioritized target populations (Injection Drug Users, Men who Have Sex with Men, Heterosexual Sex, and HIV-Positives) that will have the potential to prevent the greatest number of new infections. This mix of interventions utilized the prioritized interventions developed for the 2002-2004 Plan, with additional activities included for HIV positive individuals. All interventions are based on behavioral and scientific theory, outcome effectiveness, and/or have been adequately tested with the targeted populations for cultural appropriateness, relevance and acceptability. (*Additional information related to effective interventions is included in Chapter 4: "What Works in HIV Prevention?"*)

2007 CPG Priority Setting Process: Setting the Stage

CPG's Goal: To implement a Priority Setting Process that:

1. Is understandable
2. Has a clear purpose
3. Is data-driven
4. Supports allocations that will have the greatest impact
5. Is not based on politics or emotions

The CPG had decided in 2004 to develop a new approach to priority setting based on new guidance from CDC. Prior to establishing a process for Connecticut, a review of various approaches and processes used in other states was conducted. Connecticut adapted a process similar to that used in Washington State, where they have interpreted the CDC HIV Prevention Planning Guidance to give the HIV Epidemiologist the authority to analyze the epidemiologic data and establish one to ten populations most at risk of HIV infection and include these populations in the Epidemiologic Profile for presentation to the planning group. Washington CPG received confirmation from their Project Officer, and other CDC staff, that this is an appropriate approach. This was identified as one of the fundamental changes inherent in the "new" planning guidance and intended to take the responsibility for interpreting "raw data" off of the planning group members. The planning groups retain the responsibility to prioritize from among the populations most at risk as established by the epidemiologist.

Between the years of 2005 and 2006, the CPG experienced a change in leadership and a significant number of members, making it necessary to begin with educating the CPG members and leaders on priority setting and their role in reviewing data, selecting a process, and identifying gaps. This included a full explanation of the role of the DPH as a partner to provide epidemiology, data, a service matrix, and surveillance to inform the priority setting process.

In January 2006, the Community Services Assessment Committee (CSA) began an in depth review of new information that emanated from the Statewide Needs Assessment conducted as a collaborative effort among CARE Act grantees, the Community Planning Group, PLWH/A, and providers. The CSA committee recommended that in preparation for 2008, an Ad Hoc Priority Setting Committee be convened. In advance of the first meeting, the CPG leadership, state epidemiologists, and members of the provider and non-provider community discussed the approach.

Connecticut's 2007 Priority Setting Process

The current priority populations were set in 2004 for the 2005-2008 Comprehensive Plan to be in effect through June 2008. Therefore the 2007 priority setting process set the priorities that will take effect on July 1, 2008.

The process development for 2007 priority setting was based on the fact that there is now better and cleaner data; the state is now at approximately 10,000 reported cases of HIV disease since 2002, and there is more data, which means there is a better picture now than in the past. The overall approach was to:

- gain consensus on the need for quantitative gaps based on supportable data
- work with the DPH/Epidemiologist to articulate gaps in quantifiable terms and provide supportive data
- show relationship between priority setting and presentations at monthly meetings
- assign an Ad Hoc Committee as the appropriate vehicle for priority setting.

Priority Setting Ad Hoc Committee: Process Timeline

In March 2006, the CPG formally resumed its priority setting process for the 2008 Connecticut HIV Prevention Comprehensive Plan with the establishment of an Ad Hoc Priority Setting Committee. The Committee was charged with the following:

- To review and refine the priority setting process
- Decide on an approach for priority setting
- Create a timeline for priority setting
- Identify data needs and relevant factors to be considered
- Work with the Epidemiologist/DPH to assist with gathering and analyzing data
- Recommend a list of priority populations for CPG approval

In March 2006, the CPG Executive Committee agreed that Mr. Joe Simard would be the co-chair for the Ad Hoc Priority Setting committee. The first meeting of the Ad Hoc Priority Setting Committee was March 15 immediately after the CPG meeting. On March 15th the CSA committee agreed to look at hard data before moving forward to include more subjective information in the gap analysis process. During the March Ad Hoc Meeting, the committee agreed upon the data sets to be used for priority setting – (those identified in August 2005); asked that Dr. Kenneth Carley, Epidemiologist/DPH present options for an approach to look at and review the data sets; and recommended that the next meeting be held after the CSA committee finalized its conversation on gaps after a second review of needs assessment data. On May 17, 2006 the CSA Committee agreed upon the major gap as “Prevention Education for HIV+, HIV-, high risk and the broader population”. At the April 19, 2006 CPG / SWC combined meeting members and participants received a brief priority setting primer and the CSA/DWG – heard information about each group’s role and received data updates.

During the second meeting of the Ad Hoc Priority Setting Committee on June 14, 2006 the committee reviewed information coming from the CSA Committee, revisited the agreed upon data sets and then selected the approach to look at data. The options were to rank the priority populations 1-9 or by the three major risk categories. After considering the following two approaches, the first approach was chosen. (See below)

1. IDU Black	6. MSM White	1. IDU Black, Hispanic, White
2. IDU Hispanic	7. Hetero Black	2. MSM Black, Hispanic, White
3. IDU White	8. Hetero Hispanic	3. Hetero Black, Hispanic, White
4. MSM Black	9. Hetero White	
5. MSM Hispanic		

The model that was employed involved working with the epidemiologist to identify HIV/AIDS prevalence by risk groups and race. Numbers were assigned for all datasets and ranked from 1-10 with HIV+ being number 1. The group then set a timeline to complete their process and to identify data sets. The group also reviewed the CPG’s former approach that included a system of weighting data. They determined that there was no need for weighting with better data (HIV information). Because the DPH was in the process of creating a new Epidemiological report, the Ad Hoc committee decided to meet again after the new data was available. Data would be compiled through December 2006.

On January 10, 2007 the committee reconvened for a process meeting and discussed the rationale for using other data sets and decided upon the approach that would consider two major factors: HIV/AIDS prevalence and newly diagnosed cases. Then they looked at contributing factors which included: Syphilis and Chlamydia by race; Hepatitis C; Counseling and testing data # of tests conducted and the Needs Assessment.

During the month of February 2007, the committee reviewed information on the EPI profile, needs assessment and agreed to keep the rank order, and re-examine it when the data from contributing factors was complete. The committee determined that the CPG would receive presentations on the data sets and the EPI profile itself before voting on the ranked priorities.

On June 6, 2007 the Ad Hoc committee reviewed all the requested data sets and agreed to a rank order of priority populations to be presented to the CPG at the June 20, 2007 meeting. (See priority setting primers and presentations in Appendix). The Ad Hoc committee looked at the proposed target populations

and asked that the DPH Epidemiologists provide them with factors that would help them make a decision regarding rank order. They reviewed HIV/AIDS prevalence through 12/31/06 as presented in the SCSN and the EPI profile and also considered the newly diagnosed cases through May 31, 2007.

Then they looked at the contributing factors, which included STDs, Hepatitis C, Counseling & testing data and the needs assessment. In comparing those data sets, they found that there was a tie in ranking for White IDU and Black Heterosexual, so they first looked at the total numbers of HIV/AIDS prevalence and saw that the White IDU are much higher than Black Heterosexual. The second factor discussed was that IDU represents a higher risk than heterosexual contact and that IDU has driven Connecticut's epidemic.

The Ad Hoc committee discussed the fact that Hepatitis C and Syphilis data were the two most influential when looking at HIV/AIDS. The data – in numbers – aligned with the ranked priorities. They discussed the needs assessment regarding gaps in services, and confirmed there was no significant bearing on the ranking since - no major gaps were identified. The committee then agreed by consensus on the ranked list of targeted populations.

Below are the factors considered in determining the priority populations:

Data Sets used in Priority Setting	CT CPG's Approved Priority Populations
<ul style="list-style-type: none"> • HIV AIDS prevalence • Newly diagnosed cases • STDs: <ul style="list-style-type: none"> ○ Syphilis by race ○ Chlamydia by race • Hepatitis C • Counseling and testing data # of tests conducted • Needs Assessment 	<ol style="list-style-type: none"> 1. HIV+ 2. Hispanic IDU 3. White MSM 4. Black IDU 5. White IDU 6. Black Hetero 7. Hispanic Hetero 8. Hispanic MSM 9. White Hetero 10. Black MSM

The committee felt it important to stress that the priority list is meant to serve as a guide for service providers and does not mean that one must adhere to this if it doesn't match the community priorities. The purpose is to begin at the top with HIV+ as the population of most concern and then each follows by ranking since that is how the numbers of cases fall. The committee stressed that they recognize that every community is different, and that the list is meant to serve as a starting point to help providers connect their target populations in their community to this list. For example, it is understood that Willimantic's populations, risk groups and needs will be significantly different from those in New Haven, and, Litchfield's will be different from those in Hartford and so on.

Every community will apply this ranking according to their populations, and then apply the Effective Behavioral Intervention that best suits their needs. Funding is not determined by the rank order. Interventions are funded based on whether or not the proposed target population is on the list and whether or not the agency demonstrates a need and the expertise to reach the target population.

Ongoing updates of the process were provided in mini-presentations to the CPG, which included getting data from the State Epidemiologist, looking at effective interventions funded by DPH, reviewing all data sets as presented by State Epidemiologist, assessing factors and gaps identified in the statewide HIV/AIDS needs assessment, and finally determining if there was a need for additional or supportive data. The Ad Hoc Committee then presented the final recommendations to the CPG for approval in June / July of 2007. When the recommended populations were presented to the CPG in June, the CPG had a tie vote. Members who voted against the proposed populations were asked to submit their reasons in writing so that the Executive Committee could decide how to move forward. It was decided to hold an Executive Session in July for members only to address their written concerns while reviewing the information and the priority setting process again more clearly. Following the Executive Session, the members voted to accept the new priority populations.

Interventions

The new CDC Guidance for Community Planning indicates that rather than prioritizing interventions for priority target populations as in previous priority setting processes, that CPGs should instead “conceptualize interventions/activities as a set or mix of interventions/activities versus one specific intervention/activity for each target population. Regardless of the mix or set of interventions selected, all interventions, however, must be science-based, proven effective and culturally/ethnically appropriate.

Chapter 4 - What Works in HIV Prevention is dedicated to the interventions that have evidence of effectiveness. These include interventions from the CDC’s *Compendium of HIV Prevention Interventions* (2001) and *Replicating Effective Programs Plus* (REP+) and interventions that have procedural guidance (e.g. Counseling and Testing, Comprehensive Risk Counseling Services.) Other interventions, also included in the mix, although not necessarily on the CDC’s list, are research-based and have a positive and significant behavior/health component (e.g. Needle Exchange Program, Drug Treatment Advocacy and Methadone Maintenance.). The CPG also recognizes that there are homegrown or locally developed interventions that may be effective however, if not CDC sanctioned the interventions may not receive funding priority. The CPG has identified injection drug users (IDUs) as a priority population, and has found that, based on extensive research, syringe exchange programs (SEPs) are an effective, cost-efficient HIV prevention intervention for IDUs, but they are only funded through state dollars. In addition, research also shows that syringe exchange programs have not been associated with increased drug use or initiation of injection drug use. Therefore, the CPG has identified SEPs as an effective HIV prevention intervention for IDUs (**See the CPG Position Statement on Syringe Exchange Programs in Appendix D**)

Based on the CDC’s *Advancing HIV Prevention: New Strategies for a Changing Epidemic*, HIV service and health care providers are also strongly encouraged to include the following concepts/programs within the mix of selected population specific interventions/activities:

- **Incorporation of HIV testing as a routine part of care in traditional medical settings** (e.g. encouraging all health care providers to include HIV testing, when indicated, as part of routine medical care),
- **Implementation of new models for diagnosing HIV infections outside medical settings** (e.g. use of the rapid HIV test),
- **Prevention of new infections by working with people diagnosed with HIV and their partners** (e.g. get HIV positive individuals into care and treatment, provide prevention case management and counseling for people with HIV, promote and institute prevention education and risk reduction activities for people living with HIV, and promote and implement partner counseling and notification),
- **Further decrease mother-to-child HIV transmission** (e.g. promote screening of every pregnant woman for HIV, using the “opt-out” approach, make prenatal screening a routine part of medical care, and promote screening of newborns whose mother’s HIV status is not known).

Given the complexity involved in developing evidence-based interventions as well as trying to understand the social, economic, cultural and individual variables associated with human behavior across Connecticut, designing and assigning interventions which promote positive behavior change can be an enormous challenge. The interventions chosen for the priority populations were selected with a statewide view, thus giving HIV prevention service providers the flexibility to adopt the interventions to the specific population and regional needs of their service area.

Prevention for Positives

The CDC has identified prevention for HIV-positive individuals as the highest priority for CPGs. According to the CDC, although numerous effective prevention interventions have concentrated on HIV-negative populations, only a small number have focused on HIV-positive persons. (e.g. support group/ structured risk-reduction, skills building group, couples or individual-level intervention).

It is crucial in “Prevention for Positives” that individuals both newly and currently diagnosed with HIV be enrolled or referred to medical care. This emphasizes the role of linking prevention and care services into a continuum of care (*See Integration of Prevention and Care in Chapter 6: Linkages*).

In the 2001 Institute of Medicine's (IOM) report *No Time to Lose: Getting More from HIV Prevention*,¹² the authors emphasize the need for enhanced HIV prevention efforts in the clinical setting as part of the standard of care for HIV-infected persons. Care services have traditionally focused on treatment and support services related to primary care. But according to IOM, health care providers should incorporate effective prevention counseling within their care services. A better connect between the two worlds of prevention and care needs to be addressed and measures put into place in order to meet the care and prevention needs of HIV-positive individuals. As part of the CDC's strategic plan, it has developed the SAFE project (Serostatus Approach to Fighting the HIV Epidemic), which calls for efforts to:¹³

1. Increase the availability of prevention services for people with HIV,
2. Teach health care practitioners to perform HIV and sexually transmitted disease (STD) risk assessments in HIV-infected patients, and,
3. Increase delivery of prevention messages to HIV-infected patients by health care workers.

Prevention providers face new challenges in providing prevention interventions for HIV-positive individuals. Not only must consideration be given to getting people into care and maintaining their "in-care status", but providers must also take into account the stigma, barriers, psychological, social, cultural and economic factors that impact PLWHAs and ultimately affect sexual and risk-reduction behaviors.

Prevention for Positives represents a new and challenging opportunity for prevention providers to make an impact on the epidemic. Additional information regarding effective interventions for HIV-positive persons can also be accessed through the CDC's Replicating Effective Programs (REP) and the Diffusion of Effective Behavioral Interventions (DEBI) projects. See Chapter four for intervention descriptions.

The following charts list the prevention interventions/activities recommended for Connecticut's 2005-2008 priority populations, based on research, literature reviews, the CDC's Compendium and REP, and the CPG's 2001 Priority Setting Process for Interventions.

☑HIV positives

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, methadone maintenance, couples counseling, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups

Peer and Non-Peer Outreach

Comprehensive Risk Counseling Services (CRCS)

Partner Counseling and Referral Services (PCRS)

Community Level Interventions (CLI) -- social marketing campaigns, community wide events, policy interventions, structural interventions

☑ African American Injection Drug Users

Individual Level Interventions (ILI) – counseling and testing, individual drug/alcohol counseling, peer counseling, methadone maintenance, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups

Peer and Non-Peer Outreach

Comprehensive Risk Counseling Services (CRCS)

Health Communications (HC/PI) -- one shot presentations

Community Level Interventions (CLI) -- community wide events, policy interventions, structural interventions

¹² MS Ruiz, AR Gable and EH Kaplan, et al. *No Time to Lose: Getting More from HIV Prevention*, Washington, D.C.: Institute of Medicine, 2001.

¹³ Carlos del Rio, MD. *New Challenges in HIV Care: Prevention Among HIV-Infected Patients*. *Topics in HIV Medicine*, International AIDS Society-USA, Volume 11, Issue 4, July/August 2003.

☑ White Injection Drug Users

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, methadone maintenance, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups

Peer and Non-Peer Outreach

Comprehensive Risk Counseling Services (CRCS)

Health Communications (HC/PI) -- one shot presentations

Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ Latino/as Injection Drug Users

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, methadone maintenance, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups

Peer and Non-Peer Outreach

Comprehensive Risk Counseling Services (CRCS)

Health Communications (HC/PI) -- one shot presentations

Community Level Interventions (CLI) -- social marketing campaigns, community wide events, structural interventions

☑ African American Men who have Sex with Men

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups, single session workshops

Peer and Non-Peer Outreach

Health Communications (HC/PI) -- one shot presentations

Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ Latino Men who have Sex with Men

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups, single session workshops

Peer and Non-Peer Outreach

Health Communications (HC/PI) -- one shot presentations

Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ White Men who have Sex with Men

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, couples counseling, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups

Peer and Non-Peer Outreach

Prevention Case Management (PCM)

Health Communications (HC/PI) – broadcast media, hotlines, one-shot presentations, print and other media

Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ African American Heterosexuals

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups, single session workshops

Peer and Non-Peer Outreach

Health Communications (HC/PI) -- one shot presentations

Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ Latino/a Heterosexuals

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, methadone maintenance, peer counseling and couples counseling

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups

Peer and Non-Peer Outreach

Health Communications (HC/PI) – one-shot presentations

Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ White Heterosexuals

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, methadone maintenance, peer counseling, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups

Peer and Non-Peer Outreach

Partner Counseling and Referral Services

Health Communications (HC/PI) -- one-shot presentations

Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

Intervention Descriptions as taken from CDC Evaluation Guidance and the Connecticut DPH 2005 Request for Proposal	Key Elements of Intervention	Examples of Possible Programs under this Intervention
Individual Level Interventions (ILI) – health education and risk-reduction counseling provided to one individual at a time. Individual Level Interventions help clients to make ongoing appraisals of their own behavior, motivate clients to make changes in their behavior, and assist clients in making plans for individual behavior change. 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 help clients make plans to obtain these services.	<ul style="list-style-type: none"> • Provided to one individual at a time • Assists clients in making individual behavior change • Facilitates linkages to services in clinic and community settings 	<ul style="list-style-type: none"> • One-to-one peer counseling • Motivational interviewing • Couples Counseling
Group Level Interventions (GLI) – health education and risk reduction counseling (see above) 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. GLIs do not include one-shot education presentations or lectures that do not contain a skills component.	<ul style="list-style-type: none"> • Delivery of service to groups of varying sizes • Use peer and non-peer models 	<ul style="list-style-type: none"> • Multiple session workshops • Single session workshop with skills building component • Self Help/Support Groups
Outreach (peer or non-peer) – HIV/AIDS educational interventions conducted by peer or paraprofessional educators (paid person with training on educational interventions) face-to-face with high risk individuals in the clients’ neighborhoods or other areas where clients typically congregate. Outreach includes distribution of condoms, bleach, sexual responsibility kits and educational materials.	<ul style="list-style-type: none"> • Face-to-face contact with individuals in the neighborhoods or other areas 	
Comprehensive Risk Counseling Services (CRCS) 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 combination of HIV risk-reduction counseling and traditional case management that provide intensive ongoing, and individualized prevention counseling, support and service brokerage.	<ul style="list-style-type: none"> • Adoption of HIV risk-reduction behaviors by clients • Combination of HIV risk-reduction counseling and traditional case management 	
Health Communication/ Public Information - (HC/PI) – delivery of prevention messages through one or more channels (broadcast, print, or other media) to target audiences. Messages are intended to build support for safer behaviors, support personal risk reduction efforts, and to tell at-risk individuals how to obtain services.	<ul style="list-style-type: none"> • Delivers prevention messages through media 	<ul style="list-style-type: none"> • Radio, television announcements and broadcasts; Newspapers, magazines, pamphlets and billboards; Hotlines; Clearinghouse • Presentation and lectures (one shot education)
Counseling and Testing – the voluntary process of client-centered, interactive information sharing in which an individual is made aware of the basic information about HIV/AIDS, testing procedures, how to prevent the transmission and acquisition of HIV infection and given tailored support on how to adapt this information to his/her life. Clients who request testing must be provided with pre-test counseling that enables them to make informed decisions that meet the requirement of the Connecticut HIV Confidentiality Law through Partner Counseling and Referral Services (PCRS) .	<ul style="list-style-type: none"> • Voluntary • Client-centered • Interactive information sharing • Clients who ask for testing must receive pre-test counseling 	
Partner Counseling and Referral Services (PCRS) . - Clients should be assisted with notification of sex and needle-sharing partners of their risk and of the availability of HIV counseling and testing services	<ul style="list-style-type: none"> • Partner notification is an option 	
Other Interventions including Community Level Interventions (CLI) —other interventions are interventions that cannot be described by the other types listed above. CLIs seek to improve risk conditions and behaviors in a community by focusing on the community as a whole rather than on individuals or small groups. CLI often attempts to alter social norms, policies, or characteristics of the environment.	<ul style="list-style-type: none"> • CLIs improve risk conditions and behaviors by focusing on the community 	<ul style="list-style-type: none"> • Community mobilization • Social marketing campaigns • Community-wide events • Policy interventions • Structural interventions

CHAPTER SIX: PUTTING THE PLAN INTO PRACTICE – LINKAGES, SURVEILLANCE AND RESEARCH, TECHNICAL ASSISTANCE, AND CAPACITY BUILDING; INTEGRATION OF CARE AND PREVENTION

Putting the Plan into Practice: *Linkages, surveillance and research, technical assistance, and capacity building*

The CDC recommends that HIV Prevention Plans include information about how the Comprehensive Plan is put into practice within the jurisdiction. The following chapter discusses how Connecticut utilizes its Comprehensive HIV Plan by addressing three distinct areas that include: **(1)** the link between community planning and primary and secondary prevention efforts; **(2)** the participation of governmental and non-governmental agencies in the development and implementation of the Plan; and **(3)** a description of ongoing surveillance and research activities directly related to community planning. The CDC encourages and promotes community planning groups “*to foster strong, logical linkages between the community planning process, the Comprehensive HIV Prevention Plan, the application for funding, and the allocation of resources.*”

Primary and Secondary Prevention Efforts

To ensure that the Comprehensive Plan is relevant to both prevention and care services providers, the Connecticut CPG has worked to enhance the links between primary and secondary prevention efforts in Connecticut. The continued recruitment and participation of providers offering both care and prevention services in the HIV prevention community planning process is one method the CPG employs to ensure this linkage is achieved

Integration of Care and Prevention

The Ryan White Care Act Part B Manual¹⁴ clearly states that coordination of care and prevention planning can help bridge gaps across care and prevention and thus help individuals learn their HIV status and enter care if infected. The Care Act further expects Part B to coordinate with prevention planning bodies and programs in the areas of planning body membership, conducting planning activities (e.g. needs assessments), and service delivery coordination (e.g. early intervention services, outreach, etc.). CDC expects CPGs not only to be aware of Part B activities, but to also identify opportunities for collaboration. While the CDC does not require merger of the two planning bodies, it highly recommends consideration of merging prevention planning activities with those of other local planning bodies that already exist.

In August 2003, an Ad Hoc Integration Committee comprised of Ryan White Part B Planning Consortia and CPG leadership met to discuss the development of an integrated Comprehensive HIV/AIDS Plan for Care and Prevention 2009. Members of the Ad Hoc Integration Committee discussed areas of collaboration, differences in processes between the Ryan White Part B Statewide Consortia and the CPG, and potentials for linkage and integration. During this meeting, the Integration Committee identified the following areas for cross collaboration and potential integration of activities: Needs Assessment, Epi Profile, Resource Inventory and Gap Analysis, and Comprehensive Planning and Evaluation. The Committee agreed that care providers should be more involved with primary prevention and that the prevention of secondary infection for HIV-positive individuals is of primary importance. In addition, the committee members also identified counseling and testing, prevention outreach and health education/risk

¹⁴ HIV/AIDS Bureau: Ryan White Care Act Title II Manual: Section VII, Chapter 3: Care/Prevention Collaborative Planning.

reduction (HERR) as the primary areas where prevention and care efforts overlap and noted that these areas require a more concerted collaborative effort. The intent of the future integration of care and prevention is to move beyond information sharing across planning bodies to the establishment of better protocols for making referrals and serving clients in a well coordinated continuum of care.

Multi-Year Strategies: The Comprehensive Plan – An Ideal System of Care and Prevention

Funders, systems and providers throughout the state recognize the importance of collaboration to creatively and effectively respond to the needs of target populations. That shared vision creates an ideal care and prevention system in which the rate of new HIV infections is significantly reduced, and those who are living with and affected by HIV/AIDS are connected to appropriate care and support services. The Ad Hoc Integration Committee, in an effort to guide the development of the 2009 integrated Comprehensive Plan for Care and Prevention, put forward the following recommendations in the Statewide Care Consortium's Statewide Coordinated Statement of Need (SCSN) contained in the 2004-2007 Ryan White Part B Comprehensive Plan:

- Services will be culturally sensitive, geographically accessible and offer flexible hours of operation.
- Providers will reflect the HIV/AIDS population they serve.
- Individuals will receive culturally appropriate information on HIV/AIDS, Mental Health and Substance Abuse Treatment services at each and every portal of entry into the continuum of care.
- System of care linkages will be strengthened through co-location, cross-training and referral strategies among substance abuse treatment, mental health treatment, and case management, outreach and medical providers.
- Relapse prevention will be an ongoing consideration for providers.
- Efforts to engage and bring into care the Hispanic population will be increased.
- Providers will strategize and make best efforts to bring under- and uninsured individuals, especially people of color, into care and become increasingly aware of the needs of an aging AIDS population.

Recognizing that both HRSA and CDC have expectations that care and prevention will be integrated in their planning processes, the goals outlined by the Ad Hoc Integration Committee acknowledge that to address prevention effectively, care communities need to be engaged. The following are the goals of that future integration process:

- To create an ideal system of care and prevention that creatively responds to the needs of the target population.
- To respond to the new directives (CDC and HRSA).
- To decrease the number of new infections.
- To create appropriate links for a comprehensive continuum of care that increases efficiency and avoids duplication of efforts.
- To strengthen care and prevention efforts.
- To better identify and address unmet needs statewide.
- To maximize resources.

Essential to the development of this integrated 2009 Comprehensive Plan for Care and Prevention will be not only the implementation of the common goals (indicated above), but also the adoption of a totally integrated care and prevention system – an ideal continuum of care. Efforts are already underway toward accomplishing the 2009 Care and Prevention Plan Integration. Part B's Comprehensive Care Plan for 2004-2007 included CPG Needs Assessment information, identified prevention needs and gaps, listed prioritized populations, and featured HIV/AIDS surveillance data. The CPG's 2005-2008 Comprehensive Plan has included prevention/care integration strategies, as well as Care identified gaps, emerging needs and recommendations. The 2004 CPG Resource Inventory and its updates were designed as a joint

effort to assess both prevention and care services. For the future, the Ad Hoc Integration Committee, Statewide Care Consortium committees and the CPG will continually review and reassess the integration process for ongoing planning, revision and implementation of the goals, strategies and vision to ensure a seamless and coordinated effort in the production of a fully integrated care and prevention plan for 2009. **(See Executive Summary, Comprehensive Part B Plan, 2004-2007 in Appendix E).**

The Process to Integrate Care and Prevention

The idea to integrate Care and prevention was conceived with the development of a Comprehensive Care Plan to collaborate with Prevention in 2003. The Ad Hoc Integration of Care and Prevention committee was formed in 2004 to work on the Care Plan. Several Collaborations began in 2004 including a Statewide Needs Assessment Survey, cross training of care and prevention providers, joint resource inventory, joint gap analysis or unmet need, out of care survey, universal Ryan White Client Intake forms, etc.

The successful collaborations were a catalyst for the discussion on integrating prevention plans and planning bodies. Community co-chairs and stakeholders began to acknowledge the similarities in the tasks of both planning bodies and plans and began to envision an integrated planning system. Presentations were given on the benefits of collaboration and integration to educate the community on the concept and get buy-in.

Joint meetings of both planning bodies were held for members of the groups to give input into the integration process. The Ad Hoc Integration of Care and Prevention Committee was made a formal committee and charged with working out the details of merging efforts. In December of 2006, the Integration of Care and Prevention (ICP) committee made sure they had the appropriate representation in membership and then committed to do the work of combining the planning bodies. The ICP committee developed a vision, structure and timeline to accomplish the work.

To date the ICP committee has established a basic structure for the new combined group. The name of the body will be, The Connecticut HIV Planning Consortium (CHPC). The idea is to have one public health planning body for HIV/AIDS Care and Prevention. There will be three co-chairs (two from the community and one from the Department of Public Health). In addition to the co-chairs, there will be an Executive Committee that will oversee the planning process and the work of the committees. There will be three working committees, the Data and Assessment Committee (DAC), the Membership and Awareness Committee (MAC) and the Operations and Procedures Committee (OPC).

The new planning group will meet monthly beginning in December 2007. Membership parameters are still being determined but will be reflective of the current epidemic. The ultimate goal is to have one Planning Body that will create one Comprehensive Care and Prevention Plan submitted twice annually once to CDC and once to HRSA. The rationale is to create a holistic approach to HIV and AIDS planning that will better respond to the epidemic of today.

CPG/DPH Collaboration

The DPH received funds from the CDC to establish a Health Program Associate position to work directly with the CPG. The Health Program Associate works with the CPG contractor to support the HIV prevention planning process and the development of the comprehensive plan. A major responsibility of this DPH staff person is to work with the CPG to develop the Community Services Assessment. The presence and participation of additional DPH staff in the community planning process has helped to keep communication open and to foster the collaborative spirit of community planning in Connecticut.

For the second time in Connecticut's community planning history, a DPH staff person is a voting member on the CPG. In prior years the DPH co-chair was the only voting CPG member on the group.

Agency and Organization Participation

Participation of governmental and non-governmental organizations in the development and implementation of the plan exists on two levels. First, 80% of the CPG members who developed the 2005-2008 Comprehensive Plan come to the table on behalf of their agencies throughout the state. Second, between 60%-100% of the public who regularly participate in the community planning process at each meeting are agency representatives and serve as the link between the CPG and their respective organizations. Table 6-1 displays the current CPG members and advisors, their respective organization and category (governmental or non-governmental).

Agencies funded through DPH to provide prevention services are contractually obligated to have a member of their staff attend CPG meetings. Educators must attend two meetings a year, and supervisors must attend one meeting per year in order to establish a link between the plan and agencies. To further foster the plan-agency relationship, the CPG continues its practice of issuing media advisories (see sample Appendix A) as well as community alerts regarding the upcoming meeting to all HIV-related service organizations in the respective geographic area. Increasing attendance at CPG meetings by members of public and area agencies will not only continue to foster stronger linkages between the community planning process, agencies and the public, but also serve to expand the base of prevention knowledge in the wider community.

Connecticut's linkage between the Comprehensive Plan and governmental and non-governmental agencies continues to grow stronger as the CPG increases its community planning knowledge and puts the new information into action. Moreover, seeing the results of the planning work reflected in the DPH 2004 funding cycle brought to the forefront the importance of the coordination between government and non-governmental agencies and the Comprehensive Plan.

Ongoing Surveillance and Research

In the coming year, the CPG will continue its involvement on the Ryan White Collaborative Planning Committee, the Statewide Care Consortium, and the Evaluation Advisory Committee, and, thus, continue to offer input and support to these ongoing evaluation, planning and coordination efforts. In addition, the DPH has agreed to keep the CPG informed of these efforts with presentations to the full CPG as warranted.

Examples of this collaboration include:

- ❑ The CPG and the Statewide Care Consortia (SWC) held three joint meetings (April 2006, October 2007, and April 2007) to address the issue of integrations of care and prevention. Information was presented in the morning sessions and the afternoon sessions were reserved for members to meet in groups to discuss how to collaborate and integrate.
- ❑ Members from the CPG joined the Integration of Care and Prevention Committee in December 2006 and committed to the process of integrating care and prevention planning bodies and comprehensive plans.
- ❑ The AIDS Surveillance Unit has an epidemiologist through federal surveillance funds to work closely with the CPG and other statewide planning bodies on data issues relevant to their work.
- ❑ The AIDS Surveillance Unit of the DPH presented the new 2007 Epidemiological Profile of HIV and AIDS in Connecticut at the June 2007 CPG meeting.
- ❑ The 2005-2008 Plan is posted on the DPH website.
- ❑ The CPG collaborated with the United Way of Connecticut's 2-1-1 Infoline, the DPH, and the Statewide HIV Care Consortium to produce the HIV/AIDS Prevention & Care Guide, an online resource guide about HIV/AIDS services in the state.

CHAPTER SEVEN: EVALUATION

Evaluation of the Connecticut Community Planning Process: 2007

The CPG monitors and evaluates the HIV prevention planning process to comply with the CDC guidance and to improve how well the group works. The **Finance, Policy & Procedure (FPP) Committee** gains the perspective, insights, and feedback of CPG members and CPG guests. **CPG members** provide feedback through: a) CDC CPG Member survey; b) an annual CPG Member survey; and c) monthly CPG meeting feedback forms. **CPG guests** (*referred to in meeting summaries as members of the public*) provide feedback through: a) completion of the (monthly) CPG meeting feedback form and b) through other channels such as “public comment” sessions and unsolicited comments to CPG leaders, CPG members, CPG staff, and/or Department of Public Health staff.

The **meeting feedback form** captures information about the meeting environment and atmosphere, flow and organization, group interaction, presentations/group work, and committee meeting process.¹⁵ The form includes open-ended questions (e.g., what I liked best about the meeting). The **customized CPG Member feedback** form uses an open ended question format to probe more deeply into current issues/concerns raised through the monthly meeting feedback results or as areas for additional considerations by the Executive Committee. The CPG administers the **CDC Membership survey** in its required form (with the option of receiving assistance from CPG staff to read aloud the questions). Additionally, the CPG piloted a **committee-level feedback** form to gain more specific insight about committee-level leadership, environment, and productivity.¹⁶

The CPG Executive Committee reviews the results of the monthly CPG meeting feedback forms at Executive Committee meetings.¹⁷ The other “special” CPG member survey results are discussed first by the FPP Committee. The FPP Committee forwards the results and any recommendations to the Executive Committee for further discussion and action. The information from survey results as well as other operational practices forms the basis for this Chapter. Information is organized around the CDC goals and objectives of the HIV prevention community planning.

In general, results from all methods of feedback confirm that the CPG creates and maintains a productive planning environment that honors parity, inclusion, and representation. Routinely, monthly meeting feedback surveys yield agreement (or satisfaction) across 90% of participants. Any areas falling below the 90% threshold are discussed by the Executive Committee. The As warranted, the Executive Committee adjusts meeting process or requests that the Finance Policy and Procedure Committee study the issue and develop recommendations.¹⁸

Addressing CDC Goals and Objectives of HIV Prevention Community Planning

Goal 1 – Supporting broad-based community participation in HIV prevention planning

Objective A: Implement an open recruitment process (outreach, nominations, and selection) for CPG membership

¹⁵ The completion rate for meeting feedback forms typically exceeds 50% of the total meeting attendees. Monthly meeting participation ranges from approximately 45 to 90 participants – the majority of whom are public participants. Feedback responses are analyzed in terms of total responses as well as responses by subgroups (members v. public participants).

¹⁶ The Committee-level feedback form will be used periodically. The results of the initial effort confirmed that the committees functioned well and the feedback reflected the comments shared orally at the end of Committee meetings. However, the committee-level feedback appeared to cause a sharp decrease in the response rate of the overall meeting feedback forms collected at the end of the meeting day.

¹⁷ The Executive Committee meeting occurs immediately after the CPG monthly meeting. Therefore, the FPP Committee defers to the Executive Committee to process and discuss the feedback results while the meeting remains fresh in the memories of CPG leaders.

¹⁸ Please contact the CPG for copies of meeting feedback forms as well as copies of the feedback results.

- The CPG monthly meetings rotate across eight counties in Connecticut. Rotation of CPG meeting locations: a) creates broader exposure for the HIV Planning Body; b) increases the CPG's capacity to gain input directly from local communities; and c) aligns with the CPG efforts to reach out to all (diverse) populations, educate the public about the CPG, and to recruit new CPG members.
- The Membership, Parity, Inclusion, and Representation (MPIR) Committee manages an ongoing nomination process.¹⁹ The MPIR Committee screens nominees based on their nomination forms and then conducts an in-person interview prior to determining whether (or not) the nominee should be recommended for CPG Membership. MPIR forwards membership nominations to the full CPG for formal approval (in an Executive Session vote).
- DPH issues quarterly a statewide newsletter titled, "HIV/AIDS Planning News & Notes". The newsletter (along with other information posted on the DPH web site) creates a regular flow of information about prevention and care planning efforts and activities as well as updates about other information (e.g., Community Day, DPH Corner, Agency Profile, contact information for web sites).
- 88% of CPG members (via the CDC member survey) agree or strongly agree that "The CPG makes adequate efforts to recruit members who are representative of all communities affected by HIV".
- 82% of CPG members (via the CDC member survey) agree or strongly agree that the "CPG makes it easy for members to participate in community planning".
- The current CPG Membership holds steady at 17, short of the ideal range of 25 to 30 members.²⁰

Objective B: Ensure that the CPG membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies

- 88% of CPG members (via the CDC member survey) agree or strongly agree that CPG holds "an adequate mix of people infected with and affected by HIV/AIDS". The CPG will continue to increase the voices of community representatives, particularly those who are not affiliated with prevention funding.
- 82% of CPG members (via the CDC member survey) agree or strongly agree that "members of the CPG adequately reflect the populations most affected by the HIV/AIDS epidemic in the jurisdiction".
- The Membership Parity Inclusion and Representation (MPIR) Committee provides monthly membership composition updates to the CPG members. CPG members learn about membership openings and assist in recruiting and grooming individuals using a peer-to-peer model (e.g., geographically, diversity characteristics).
- Most CPG members a) are age 40 or above; b) live in urban geographies; and c) under-represent in the Hispanic or Latino community. The representation appears consistent with the AIDS epidemic. However, the representation does not match new HIV surveillance demographics. The CPG has and will continue targeting representatives that are from rural areas, younger in age²¹, and from Hispanic or Latino communities.
- More than half of the CPG members bring valuable and diverse professional expertise to the planning table. The members include: Department of Public Health Officials, local public health officials, and a diverse cross-section of representatives from community-based organizations involved in HIV prevention work (e.g., nurses, Comprehensive Risk Counselors)

¹⁹ During 2006, the CPG changed its nomination process to a continuous recruitment and nominations review process. Prior to this time, the process occurred only every six (6) months.

²⁰ Due to the current activity to merge the care and prevention planning bodies, CPG purposefully ramped down recruitment efforts.

²¹ The CPG sponsored a Youth Advisory Group that represented the perspectives of the younger age cohort and developed the Youth Chapter for this plan.

- Other “public participants” attend regularly and play specific roles in the planning process (e.g., epidemiologists, trainers that help explain DEBIs).

Objective C: Foster a community planning process that encourages inclusion and parity among community planning members

- 100% of CPG members (via the CDC member survey) agree or strongly agree that “members of the CPG feel comfortable discussing issues openly, even when there are disagreements.”
- 88% of CPG members (via the CDC member survey) agree or strongly agree that “the CPG responds adequately to concerns about community planning from people not on the CPG”.
- 87% of CPG members (via the CDC member survey) agree or strongly agree that “the amount of time available for conducting all community planning activities is adequate”.
- CPG rotates meeting locations and therefore receives public comment from all regions and jurisdictions throughout the state.
- The Department of Public Health intensified its efforts to contact (via e-mail) a broader array of interested parties and stakeholders – particularly those associated with the integration of care and prevention.
- The CPG leadership structure endorses the position that a diverse set of CPG members should lead the CPG as well as its standing Committees. CPG leaders receive the benefit of training and development prior to assuming leadership responsibilities.

Goal 2 – Identifying priority HIV prevention needs in each jurisdiction

Objective D: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction

- Refer to Chapter 5 of the Comprehensive Plan for a description of the data-driven priority-setting methodology.
- CPG convened an Ad Hoc priority setting committee (open to the public) to lead the priority setting process. At the request of CPG members, a targeted educational session to review the priority setting process and results was conducted prior to the priority setting vote. (CPG members overwhelmingly approved the priorities set forth by the Ad Hoc priority setting committee. See Chapter 5, page for additional details on the priority setting process for 2007.)

Objective E: Ensure that prioritized target populations are based on an epidemiologic profile and community services assessment

- The Ad Hoc priority setting committee convened (open) meetings over a seven month time period and incorporated a wide range of data sets including updated epidemiological profiles as well as information from an updated Statewide Coordinated Statement of Need.
- 100% of CPG members (via the CDC member survey) agreed or strongly agreed that the “epidemiologic profile is useful for decision-making purposes”.
- 94% of CPG members (via the CDC member survey) agreed or strongly agreed that “needs assessment is useful for decision-making purposes”.
- 81% of CPG members (via the CDC member survey) agreed or strongly agreed that “the plan adequately incorporates data from the needs assessment”.

Objective F: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability

- Descriptions of the evidence-based interventions recommended by the CPG can be found in Chapter 4 of the Comprehensive Plan.
- The CPG members receive presentations about new programs such as DEBI – EBIs remaining current with CDC required technical assistance and guidance.
- The majority of CPG members (via the CDC member survey) reported that interventions are prioritized based on explicit consideration of “known effectiveness of interventions” (82%) and “needs of target populations” (76%).
- The majority of CPG members (via the CDC member survey) answered “no” or “I don’t know” with respect to how interventions are prioritized based on explicit consideration of “social and behavioral theories” and “community norms and values”.
- The CPG’s Finance Policy and Procedure Committee recommend that additional presentations occur to show “real life, front-line” examples of how the CDC approved DEBIs and EBIs work in Connecticut. These presentations have begun as part of the movement to integrate care and prevention planning.

Goal 3 –Ensuring that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan

Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding

- In 2006, the CPG voted to concur with the Connecticut Department of Public Health’s Application for federal HIV prevention funding. Any written reservations were forwarded to DPH and CDC using the required process.
- CPG members via committee work and general review provided input into the revisions to the Comprehensive Plan to ensure the direct correlation between priorities and implementation.
- 79%²² of CPG members (via the CDC survey) reported that “there was adequate time to comment on the health department’s applications for funding before it was submitted to CDC”.
- 67%²³ of CPG members (via the CDC survey) reported that “the application for funding adequately incorporates decisions made by CPG”.

Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions

- Four CPG members participated in the DPH RFP review process for prevention funding in the fall of 2004.²⁴ Reviews are based upon priorities and recommendations set forth in the Comprehensive Plan.
- The Department of Public Health provides a presentation about how the funding decisions relate to funding allocations and funded interventions (to meet local priorities and needs and remain consistent with the Plan). DPH officials explain how these investments relate to other prevention resources (and gaps) across the State.
- 60% of CPG members (via the CDC survey) reported that “the health department’s HIV funds have been distributed fairly”.²⁵

²² Three members answered “I don’t know” because they had not been involved in the process. “I don’t know” responses were included in the calculation of the total percentage.

²³ Four members answered “I don’t know” because they had not been involved in the process. “I don’t know” responses were included in the calculation of the total percentage.

²⁴ DPH awarded multi-year contracts and will use a similar review process during its subsequent funding cycle.

²⁵ Two members answered “I don’t know” because they had not been involved in the process. “I don’t know” responses were included in the calculation of the total percentage.

Chapter 8: HIV Prevention Youth Chapter

Produced by the Connecticut HIV Prevention Youth Advisory Group

“Adults can’t change the sexual or social drives of youth. Promoting abstinence-only and shunning teens that don’t agree only perpetuates the very cycle they are trying to stop. Youth need positive, understanding role models to listen and educate them, rather than trying to keep them in the dark.”

Youth Advisory Group member

1. INTRODUCTION

The HIV prevention community planning process seeks input from a wide range of stakeholders, including populations at greatest risk for HIV infection; people living with HIV/AIDS; and representatives of varying races and ethnicities, genders, sexual orientations, ages, educational backgrounds, profession, and expertise. One of the key stakeholders is young people. What young people are learning about HIV prevention – and how they are acting on this information today and as they enter adulthood – will determine the course of the epidemic in future years. In developing HIV prevention plans, it is important to hear what young people are saying about how best to prevent the spread of HIV/AIDS.

Staff engaged young people across the state through the following strategies:

1. **Youth Planning Meetings.** Meetings were held with young people to seek their feedback on HIV prevention efforts, working in collaboration with youth organizations that deliver HIV prevention programs and organizations that serve youth at higher risk for contracting HIV/AIDS.
2. **Statewide Youth Advisory Group.** Twenty-five (25) young people volunteered to serve on a statewide Youth Advisory Group, mainly youth who participated in planning meetings. The Youth Advisory Group began meeting in April 2006.
3. **HIV Prevention Youth Updates.** Updates inform interested youth and adults about the role of young people in the statewide HIV prevention planning process. Six updates were distributed from December 2005 through January 2007 to more than 130 youth and adults.

2. ABOUT CONNECTICUT’S HIV PREVENTION YOUTH ADVISORY GROUP

The Youth Advisory Group was formed in Spring 2006 as a sub-committee of the CPG to give youth a voice in the HIV prevention planning process. The Advisory Group: (1) develops the Youth Chapter for the state’s HIV Prevention Plan; (2) presents and shares ideas about HIV prevention with the CPG; and (3) provides feedback to DPH on HIV prevention products and programs. ***This Youth Chapter is the culmination of the Advisory Group’s work over the past 15 months***, and includes the voices of youth in sidebars throughout the Chapter.

“HIV is one of the biggest problems facing my generation because even though it’s 100% preventable, it infects millions of people every day. We as a generation have to take on the challenge of ending this epidemic.”

Alexandra Clement

Twenty-five (25) youth initially volunteered to serve on the Youth Advisory Group: 23 have attended at least one meeting and another 7 young people joined as guests of Advisory Group members. On average, 14 youth attended statewide meetings, with 16 youth attending at least three statewide meetings.

The young people participating on the Advisory Group are a diverse group:

- **Gender.** The Advisory Group has 15 female and 15 male participants.
- **Racial/ethnic.** More than half are African-American and/or Latino youth.
- **Geographic.** Youth are from urban (15), suburban (10) and rural (5) areas of Connecticut.
- **Age / School.** The Advisory Group includes a mix of high school students (20), college students (2) and older, out-of-school youth (8).
- **GLBT and Allies.** Four (4) youth are members of gay-straight alliance (GSA) groups.

While diverse in many ways, **all Advisory Group participants share a common commitment to preventing the spread of HIV/AIDS among youth in Connecticut.** Twenty-three (23) youth are HIV prevention peer educators and a number have personal experiences with HIV/AIDS (e.g., family members or friends living with HIV/AIDS).

The full Youth Advisory Group met seven times from April 2006 through May 2007, and presented at the July 19, 2006 CPG meeting. In addition, Advisory Group committees and ad hoc groups have met 13 times since March 2006 – to help plan statewide Youth Advisory Group meetings, prepare for the CPG presentation, and plan specific projects like an HIV prevention public service announcement (discussed below). Meetings included a mix of “work” and fun activities – including team building ice breaker activities, interactive HIV prevention exercises, outings like a trip to Ocean Beach State Park in New London, presentations by guests speakers on HIV prevention topics, and whole-group and small-group discussions. To create this Youth Chapter, **members engaged in animated, intense debates** on the issues – and over the year developed and refined the key recommendations. As one member stated, “This is serious business, and we’re passionate about it.”

Youth Advisory Group

- Hope Angell
- Erin Baier
- Rondell Batson
- William Braswell
- Reynaldo Caraballo
- Janeé Chapman
- Alexandra Clement
- Blaise Gilchrist
- Danny Huang
- Tempestt Latham
- Amanda Leslie
- Brian X. Lester
- Javon Meekins
- Dana Rogers
- Anna Russi
- Jonathan Simmons
- And 14 more youth from across the state

Advisory Group members take an active role in planning meetings, and bring their skills as peer educators to the Group. Peer educators led HIV prevention exercises, youth facilitated and presented the key points from group discussions, and several youth co-facilitated youth planning meetings in the community. Many Advisory Group members belong to other youth groups (peer education, GSAs), and shared information and prevention activities with these groups to raise HIV/AIDS awareness in their communities. Over the past 15 months, the Advisory Group created and shared the following products and activities:

- **A Poem about HIV/AIDS.** At the April 2006 meeting, an Advisory Group member shared a poem she wrote: *I Didn't Mean It.*
- **HIV Prevention Poster and Skits.** Advisory Group members created a poster and three skits with the theme: It Could Be You. The skits focused on three different scenarios: a skit featuring men on the “down low”, a tattoo artist operating out of his house using unclean needles, and a straight couple where the man is forced to disclose his HIV status.

“You can see at events like AIDS Walk NY that millions rally in support of AIDS awareness and prevention. We have to face challenges head-on. In the end, when lives are saved, we will be happy that we took a risk and promoted the kind of programs that we know will work, even if it means being controversial.”
Youth Advisory Group member

- **HIV Prevention Activities.** Youth facilitated a range of activities, drawing on their work as peer educators. These included exercises about 'going on a date' to explore the positive aspects and risks of dating, a Jeopardy-style game with questions on HIV/AIDS and related topics, and discussions of 'what you did on Saturday night.'
- **HIV Prevention Public Service Announcement (PSA).** Youth worked with staff and Downtown Community Television (DCTV) to develop a successful grant application to the Cable Positive Tony Cox Community Fund, create a storyboard for the PSA, assemble the art and props needed for the PSA, and serve as actors and crew for the video shoot. Two youth traveled to DCTV in summer 2006 to plan the application, 10-12 youth were involved in developing the final script and storyboard this past fall, and 15 youth helped produce the PSA at a February 11, 2007 video shoot in Hamden. DCTV has produced the 30-second PSA, which Comcast will air throughout Connecticut in June 2007. Youth Advisory Group members will help disseminate the PSA through DVDs and the Internet in the coming months.
- **Presentations to CPG.** Fifteen (15) members of the Youth Advisory Group presented at the July 2006 CPG meeting, including a PowerPoint presentation and two skits (noted above). An Advisory Group member and staff person co-presented an update on the Youth Chapter at the March 2007 CPG meeting.

Please see the attached Appendix for documents produced by and with the Youth Advisory Group.

3. DATA ON HIV/AIDS AND HIV PREVENTION AMONG YOUTH IN CONNECTICUT

At the November 2006 Youth Advisory Group meeting, Kenneth Carley, an epidemiologist with the Connecticut Department of Public Health (DPH), led a presentation and discussion on the use of data in HIV prevention planning. Below are key findings from the data and research, and youth perspectives on the data.

Few reported HIV/AIDS cases among teens. Connecticut data shows very few reported HIV cases among teens (see chart). The Advisory Group discussed the implications and limitations of this data.

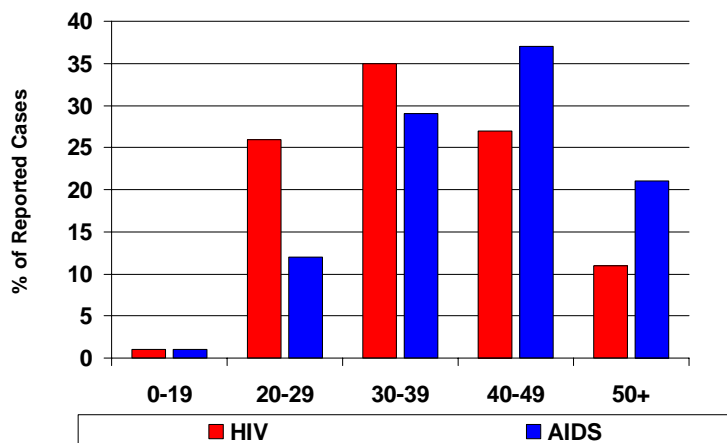
First, data on HIV cases by age does not tell you when people were infected with HIV.

Young people may be getting infected but not learn their status until they are in their 20's. Second, the number of HIV cases increases dramatically in the 20-29 age group, suggesting the need to keep young people safe as they reach their late teens and early 20's. Finally, the data does not show the prevalence of risky behaviors among youth (see below).

Many Connecticut youth are engaging in risky behaviors. The 2005 Connecticut School Health Survey was completed by 2,256 high school students (grades 9-12) in 45 public schools. Nearly half (46%) of students reported that they have had sexual intercourse. Among sexually active teens, more than 1 in 4 (26%) reported drinking alcohol or using drugs before they had sexual intercourse the last time, a major risk factor for unprotected sex. Approximately 1 in 3 sexually active teens reported not using a condom the last time they had sex. 2004 Connecticut DPH data shows that **33% of all STDs (Chlamydia or gonorrhea) are among teens**, and 67% of all cases are among those under age 25.

Most schools are not teaching "all the facts." The 2004 CDC School Health Profile surveyed approximately 500 principals and teachers in Connecticut. While 99% of CT schools report teaching HIV

Cases Reported in 2006 by Age Group
(Connecticut Data of 12/31/06)



prevention, only 55% taught how to effectively use a condom, and only 44% taught all 10 HIV prevention topics listed in the CDC survey. A 2003 national survey found that 30% of schools taught abstinence-only, 47% taught “abstinence plus” (abstinence is best but also teach about condoms and contraception), and 20% taught that making responsible decisions about sex was more important than abstinence (NPR/Kaiser/Kennedy School Poll).

Youth Advisory Group members shared some negative experiences with HIV education. Many districts teach abstinence-only, or only teach HIV prevention once in high school, or teach directly from a textbook without any discussion and/or interactions. Youth comments from this discussion included the following:

- We didn’t get to practice role plays or practice putting on condoms. All we did was read a book.
- We began taking classes freshmen year. We had peer buddies who talked to us about how to practice safe sex, but it didn’t work because they were not serious.
- I had six weeks of nothing.
- I had mis-education. We never talked about STDs.
- I just had a basic health class – we just focused on the human body and there was only one chapter on pregnancy.
- There weren’t any classes before the prom, ring dances, or carnation balls. These are the events where there is a lot of buzz about having sex. We should be having classes around these events to remind us about abstinence, safe sex and pregnancy prevention.
- I noticed that sex education classes never get repeated as I went further on in high school. I think that we should be taking classes every year and they should progress in levels of knowledge that we learn.
- In my class, the teacher was the only one who demonstrated how to put on a condom properly. All of us were interested in practicing but she wouldn’t let us because there were not resources for all of the students to practice with.

“Teens are going to have sex. Instead of discouraging young adults, we need you to embrace us, make yourself accessible to help if asked, and accepts our views and opinions.”
Tempestt Latham

It is important to note that the Connecticut State Department of Education’s new Healthy and Balanced Living Curriculum Framework supports **students learning “all the facts.”** The Framework includes expectations for what students will know at Kindergarten, Grade 4, Grade 8 and Grade 12. For example, Grade 8 expectations are that students will “describe puberty and human reproduction as it relates to medically accurate comprehensive sexuality education” (page 13).

“Adults need to know how to help young adults by understanding the mindset of young adults, and take everything we say seriously.”
Javon Meekins

Most parents do NOT want abstinence-only education for their teens. The 2003 national survey found that only 15% of parents reported that they wanted schools to teach abstinence-only – 46% of parents believe that the most appropriate approach is abstinence-plus and 36% believe that schools should teach teens how to make responsible decision about sex.

4. HIV PREVENTION RESOURCES AND PROGRAMS FOR YOUTH

As part of the HIV prevention planning process, staff assembled a database of community-based organizations offering HIV prevention programs and/or services for youth. Of the 50 organizations identified, 30 are in the major cities: 12 in Hartford, 12 in New Haven and 6 in Bridgeport. Danbury, Meriden, New Britain, New London and Stamford also have two or more programs. At least 12 organizations offer multiple programs and services (e.g., counseling and testing, street outreach,

“As a society, we place the burden and responsibility of choice on our youth. At an age when they are not allowed to buy cigarettes, drive or buy alcohol, we expect youth to just IGNORE the highest-risk activity, sex. Only with the best possible education can we expect young people to develop independence, but still keep themselves safe.”
Danny Huang

education programs, case management). At least 9 organizations run peer education programs, and many offer HIV prevention education programs. Finally, a number of programs (9) work directly with HIV-positive or HIV-affected children and youth.

Youth Advisory Group members noted the following challenges related to HIV prevention resources:

- **Traveling to programs.** While there are resources available, many youth from suburban areas will not travel to the cities to access resources like HIV testing and counseling. For example, teenagers from Fairfield may not go to Bridgeport, even if most of the services and programs are located there.
- **Limited reach of peer education programs.** Many peer education programs meet once a week, so it can take a long time to train and prepare peer educators, and to develop the materials and outreach programs. As a result, these programs may not reach large numbers of youth beyond those directly involved in the program. For example, the Collaborative Arts Project (CAP) will develop 1 or 2 plays each year, and give a total of 3-6 performances in Bridgeport and Fairfield.
- **School restrictions.** Many high schools restrict access to information and access to condoms. Peer educators can get in trouble for giving out condoms at school.
- **Bring education to youth on a regular basis.** It is important to bring programs and HIV prevention directly to youth, and for programs to keep coming back to schools, rather than just having one-time events. For example, Greater Bridgeport Adolescent Pregnancy Program (GBAPP) has weekly programs in schools that address issues that lead to risky behaviors (e.g., low self-esteem), and weekly programs for teen parents.

“All I can say is be safe.”
Youth Advisory Group member

5. WHAT WORKS IN HIV PREVENTION FOR YOUTH?

This section highlights what young people in Connecticut say works in HIV prevention. A diverse group of young people contributed their thoughts, including youth living with HIV/AIDS.

It is important to note that youth perspectives in many ways agree with and build on what the research says about effective HIV prevention. For example, at the September 2006 Youth Advisory Group meeting, youth learned about Effective Behavior Interventions (EBIs), HIV prevention programs that have been studied carefully over time and proven to work. In examining the CDC list of 10 common characteristics of effective prevention programs, youth noted many similarities with their own recommendations. Also, the CPG liaison to the Advisory Group suggests that networks and collaborations like the Youth Advisory Group itself are effective HIV prevention programs.

DPH funds three EBIs for youth: (1) AIDS Project Hartford and Windham Regional Community Council are implementing *Street Smart* – an HIV prevention program for runaway and homeless youth; (2) Northwestern Connecticut AIDS Project is implementing *Making Proud Choices* – an 8-module curriculum that provides young adolescents with the knowledge, confidence and skills necessary to reduce their risk of STIs, HIV and pregnancy; and (3) the Stamford Health Department is implementing *Intensive AIDS Education in Jail*. Approximately 448 young people have participated in these programs from July 2005 through March 2007. These programs were funded to reach youth exclusively; however there are other DPH-funded EBIs reaching youth while targeting heterosexuals of any age (e.g., SISTA, RAPP and Community PROMISE).

“I’d rather save a life to save a soul than lose a soul because I lost a life. Know the facts, get tested.”
Javon Meekins

Youth Participating in Planning Meetings

From December 2005 through February 2007, a total of 26 “youth planning meetings” were held with 266 young people. Meetings were held all across Connecticut, including seven meetings in New Haven, five in Hartford and three in Bridgeport. Youth Advisory Group members co-facilitated two meetings. Meetings were held with a wide variety of groups – with emphasis on reaching peer educators and those populations at higher risk

of infection (MSM, youth involved with juvenile justice, homeless youth and youth living in communities with high infection rates).

Young people noted a key challenge to HIV prevention efforts – that many young people do not worry about HIV/AIDS or cannot imagine becoming infected. In other words, HIV affects other people; ***“it can’t happen to me.”*** Staff at HIV prevention agencies cited lack of funding as a critical challenge – for salaries, staff training, and incentives for youth to participate in prevention programs (e.g., food, stipends).

At these meetings, youth suggested ways to make HIV/AIDS real and to get the attention of young people. Strategies included:

- Interactive and engaging education, including games, activities, performances, discussions, role plays, etc. Programs should use a range of strategies, rather than just reading about HIV/AIDS in a textbook.
- Using the media, celebrities, and rap stars to get the message out.
- HIV-positive guest speakers, especially speakers who “looked like” the youth. Many youth noted the importance of making HIV/AIDS real, and showing the consequences of risky behaviors.
- Encouraging youth to get tested, by noting that testing is free and confidential and through incentives like gift certificates.
- Easier access to condoms (e.g., free, available at school).
- Peer education and one-on-one conversations with young people.
- Starting education in middle school.
- Providing comprehensive sex education in schools.
- Educating parents as well as young people.

“Some things are forever. Know the facts, get tested.”
William Braswell

Youth Advisory Group Members

Advisory Group members discussed what works at many meetings. The main themes are presented below:

- **100% real information without any sugar coating.** Young people need to know all the facts about HIV/AIDS, and learn all the ways to protect themselves. Abstinence-only programs will not be effective, because many young people are already sexually active.
- **Use a range of strategies to reach youth.** There is no one approach that will work for everyone. Programs should include interactive exercises, role plays, games, peer education, multimedia (visuals, videos, music), group discussions, guest speakers, written materials, etc. There should be opportunities to practice skills in a realistic environment – whether it’s role playing how to talk to a partner or practicing how to use a condom.
- **Ongoing education starting in middle school.** One-time events or presentations are not enough. Young people need more consistent education in HIV/STI prevention. Students need to start learning at a young age, before they become sexually active.
- **Make it real.** One of the challenges is that many young people do not worry or think about HIV/AIDS. Programs need to make HIV/AIDS real – through guest speakers, discussions about what it is like to be infected or have a family member infected, activities that show what it is like to be HIV-positive, or education that shocks youth out of their complacency.
- **Speakers/teachers should have real experience of HIV/AIDS and come from the same background as students.** The best messengers are those who have personal experience with HIV/AIDS (affected or HIV-positive)

“What works for me is knowing that my life is going to be lived and that I am having a positive influence. That’s why I participate on the Youth Advisory Group: to help those who need it and have no place to find that help.”
Brian X. Lester

and who “look like” the audience. Peer educators can be very effective if they are serious and know the material. Having youth and young adults telling their stories about STIs and HIV/AIDS can be powerful. This can make HIV/AIDS real for young people – and convey the message of what it is really like to live with HIV/AIDS (the medications, the hope that there is life after infection).

- **Educate parents on how to talk to their children about HIV prevention.** Parents often do not want to think about their children engaging in risky behaviors, and may avoid conversations about HIV and safe sex. Parents need to know the facts about HIV/AIDS so they can talk about it with their children. The importance of parent-child communication is supported by research. The Connecticut School Health Survey found that students who report good communication with their parents are much less likely to engage in risky behaviors. These students report less sexual intercourse (40% vs. 64%), less alcohol use (39% vs. 62%) and less marijuana use (18% vs. 38%) than their peers.
- **Written materials should show people who “look like us” and give all the facts.** Pamphlets and brochures should be 100% real and supply information on who to call if a person thinks they may be infected with HIV/AIDS or other STIs. Materials need to include eye-catching photos (using the latest fashions) and graphics – including pictures that really show the different stages of STIs. Youth noted that written materials should be used in combination with the other strategies discussed above.

The What Works sub-committee of the Advisory Group also developed two slogans for youth prevention: (1) Practice what you preach. (2) No slippies in the '07 [no slip-ups in being safe].

6. RECOMMENDATIONS

At the May 2007 meeting, Youth Advisory Group members finalized the key recommendations for improving HIV prevention for youth, building on discussion of “what works.” The five most important recommendations are:

1. **Give Youth All the Facts.** Young people need to know how to protect themselves. Abstinence-only education is not enough. We need to work against the taboo of talking about sex – there should be no sugar-coating of the facts. Information needs to be presented in a real way, not just using medical/clinical terms and statistics. As one member noted, “I don’t think of myself as a statistic.” With all education, the focus should be on quality – not just one-time events that reach lots of young people but do not change behavior.
2. **Teach Adults how to Engage Youth.** This is a critical issue for parents, teachers and adults who work with young people.
 - a) Learn how to engage young people. Teachers and youth workers should know the facts about HIV/AIDS and be trained in how to engage young people (e.g., facilitate effective group discussions, cultural competency).
 - b) Be positive. Parents, teachers and adults should serve as positive role models and be positive in their approach. Encourage young people to learn the information and have the resources, not just for themselves but to help their friends and peers as well. As one Advisory Group member tells her peers, “Don’t be scared to know too much – the knowledge you learn can help others.”
 - c) Encourage questions. Adults should not judge youth or make youth feel bad about their decisions. Adults should encourage young people to ask questions, which after all are perfectly natural. (There are no “stupid” questions, and young people should not feel stupid for asking about sex and about how to protect themselves.)
 - d) Learn with young people. If you do not know the facts or answer to a question, acknowledge this and find out the answer together with the youth.

- e) Continue the conversations. There need to be many conversations about these topics, not just one parent-child talk about “the birds and the bees.”
3. **Bring Education to Young People.** Most young people will not go out of their way to learn about HIV and STIs. Programs need to bring education to young people, whether at school, in the community or through conversations with their families at home.
 4. **Start Younger.** Young people need to learn about HIV prevention before they become sexually active, which for some can be as young as middle school. At the elementary school level, students can learn about what STIs and HIV are, how to be healthy, and how to make healthy decisions. (Advisory Group members noted that there may be differences by gender, with many girls developing physically at a younger age than boys.)
 5. **Bring Youth and Policymakers Together.** There need to be more opportunities for young people to speak with policymakers, legislators, and groups like the Connecticut Board of Education. One member suggested, “There should be a Connecticut law that schools teach all the facts (no abstinence-only) and an HIV prevention training requirement for all school principals.” We need to have these discussions with policymakers, so our voices are heard.

“Listen to us. We may know more than you think.”
Amanda Leslie

To be effective, we need both laws and culture change. Schools should be required to teach all the facts, but individuals also need to change how they engage young people in discussions of HIV and healthy behaviors, and more young people need to take the lead in educating their peers.

7. EVALUATION

At the May 2007 meeting, members provided feedback on the Youth Advisory Group itself. Why do you participate? Did the Advisory Group accomplish its goals? Were the meetings well-organized? What did you like best? How can the Advisory Group be improved?

Overall, members enjoyed participating on the Advisory Group, meeting other young people, creating the Youth Chapter and producing the HIV prevention public service announcement. Major themes include:

- **Young people can be leaders.** Many members emphasized that young people can make a difference in ending HIV/AIDS, and that youth can be leaders in HIV prevention. “I strongly believe HIV/AIDS can be eliminated.”
- **The Advisory Group is accomplishing its goals.** All agreed that the Advisory Group accomplished its goals this past year, that meetings were well-organized, diverse cultures and opinions of members were respected, and that they enjoyed participating. Members enjoyed meeting young people from across the state who shared their dedication to HIV prevention, and the “friendly and goal-oriented atmosphere.”
- **Reach out to other youth and communities next year.** Several youth suggested publicizing the Advisory Group and holding meetings in different parts of the state to engage more young people in discussions of HIV prevention and in the Advisory Group.

“Youth are the ones to make a change and can definitely help make a difference. We have accomplished a lot and next year will bring even more success.”
Blaise Gilchrist