

*Delaware Comprehensive
HIV Prevention Plan
2005-2009*



**Delaware Department of Health and Social Services
Division of Public Health**



Delaware HIV Prevention Planning Group

June 30, 2004

Centers for Disease Control and Prevention (CDC)
Procurement and Grants Office
Sandra R. Manning, Director
2920 Brandywine Road, Room 3000, Mail Stop E-15
Atlanta, GA 30341-4146

**RE: Program Announcement 04012
Delaware Comprehensive HIV Prevention Plan 2005-2009**

Dear Ms. Manning:

The Delaware Prevention Planning Group authors this letter of support for the Comprehensive HIV Prevention Plan 2005-2009. Delaware's single community planning group, the HIV Prevention Planning Group (PPG), created the plan as one step in the overall planning process required by the Centers for Disease Control and Prevention guidance on community planning and health department application for HIV prevention funding. The Delaware Division of Public Health works with the Delaware HIV Consortium to facilitate community planning processes for both prevention and treatment services statewide.

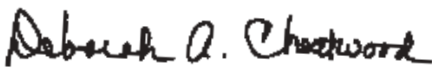
The Delaware HIV Consortium, a non-profit organization, has an open membership policy and recruits community members; religious, civic and business leaders; public health and medical professionals; and individuals affected by and infected with HIV to work together in forming policy documents to shape Delaware's response to the epidemic. Consortium staff is committed to providing an atmosphere where all members feel welcome and are encouraged to participate in committees where their voices can be heard. Whether through the Community HIV/AIDS Advisory Teams (C.H.A.T.) or membership on the Prevention Planning Group, individuals can contribute in decision-making processes affecting prevention services that will be provided in their communities.

Prevention Planning Group members began the process of compiling information for this comprehensive HIV prevention plan soon after the completion of the previous plan in May 2001. Under the leadership of co-chairs, timelines were developed and tasks assigned to each of the work groups: Needs Assessment, Populations and Interventions. The Membership Work Group was responsible for recruiting and orienting new members on the process. Chapters in this comprehensive plan reflect the work of each work group and were approved by the vote of the full PPG membership at monthly meetings.

The final product is a document shared by all members and will be used in grant applications to the Centers for Disease Control and Prevention as well as to other federal, state and local agencies. Working together, the community members and agency representatives are proud of this document as it reflects long hours, meetings and research by individuals who are committed to preventing the spread of HIV in Delaware.

The entire PPG membership voted on the plan in June 2004. Co-chairs and work group leaders signed below to signify their commitment to working with the document and endorsement of the Delaware Comprehensive HIV Prevention Plan 2005-2009.

Sincerely,



Deborah Cheatwood
Delaware HIV Prevention Planning Group Community Co-Chair

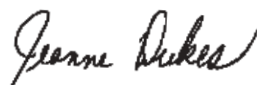


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Dedication

This plan is the coordinated effort of many individuals who have a dedication and commitment to seeing a system of prevention and care for those living with and at-risk for HIV/AIDS in Delaware. The Delaware HIV Prevention Planning Group would like to thank all current and past PPG members, Delaware HIV Consortium staff, and Delaware Division of Public Health staff for their long hours and hard work. We would like to especially thank Judith Gendler-Epstein for her continual support for HIV prevention as a staff member at DPH and as the writer of this plan. Judith, we miss you and thank you.

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Executive Summary

National

The Centers for Disease Control and Prevention (CDC) spearheads efforts in the United States to slow the advancement of HIV disease and prevent new HIV infections. Through the Division of HIV/AIDS Prevention, CDC works with other governmental agencies to promote cooperation between health departments and community partners. CDC works to develop new testing methodology and HIV prevention interventions aimed at reducing barriers for testing. Health departments coordinate HIV counseling and testing programs with assistance from CDC.

The Health Resources and Services Administration (HRSA) focuses on providing medical care and treatment to individuals already infected with HIV. Other federal agencies, including the National Institutes of Health and Substance Abuse and Mental Health Services Administration (SAMHSA), work within their purview to reduce risk-taking behaviors of at-risk populations and research new laboratory methods, medicines and therapies.

CDC authored the *Advancing HIV Prevention* initiative geared towards increasing HIV testing, improving medical care and treatment, and reducing barriers to early HIV diagnosis. The initiative, released in April 2003, has four key strategies:

1. Make HIV testing a routine part of medical care
2. Implement new models for diagnosing HIV infections outside medical settings
3. Prevent new infections by working with persons diagnosed with HIV and their partners
4. Further decrease perinatal HIV transmission

Along with the *Advancing HIV Prevention* initiative, CDC released the *Guidance for HIV Prevention Community Planning* in 2003. Taken together, these documents provide structure for health departments to organize their HIV prevention efforts in their jurisdictions. The *Guidance for HIV Prevention Community Planning* is actually a revision of previously distributed documents, updating the goals and objectives and improving upon the evaluation methodology. Attributes deemed critical to community planning by CDC are included in this updated guidance document.

The revised guidance incorporates aspects of the CDC *HIV Prevention Strategic Plan Through 2005* by focusing communities and health departments on decreasing the number of persons in the United States at high-risk for acquiring or transmitting HIV infection. The decrease in new HIV cases should be the result of targeted, sustained and evidence-based HIV prevention activities. Community planning groups identify and prioritize at-risk populations to work with toward reducing HIV transmission in the jurisdiction. Based on discussions and work products of the community planning group, intervention activities are selected for these prioritized at-risk populations.

Local

Organizations and individuals interested in joining the fight against HIV/AIDS in their community can participate in the Delaware community planning process. This process brings many voices to the table, allowing all perspectives to be shared and heard from. The result of Delaware's community planning process is this Comprehensive HIV Prevention Plan 2005-2009, developed with input and participation from the communities at-risk, governmental partners and community-based agencies.

Delaware's HIV Prevention Planning Group (PPG) members wrote the Comprehensive HIV Prevention Plan 2005-2009. The plan serves as a statewide collection of recommendations made to the Division of Public Health (DPH) and HIV prevention agencies, focusing the reader on HIV prevention activities needed in local communities. The plan reviews specific populations at-risk and HIV prevention interventions that could work within the community to reduce HIV transmission. The document includes reports from each work group: Needs Assessment, Populations and Interventions, outlining the steps taken to develop their work products and how the steps fit together to complete the process and accomplish this endeavor. Listed below are brief introductions to the chapters in this Comprehensive HIV Prevention Plan 2005-2009. The results of the planning process are included.

Introduction

This chapter introduces the concept of the Comprehensive HIV Prevention Plan, reviews Delaware HIV Consortium organizational structure, and provides resources to the reader for further information about the planning cycles.

Epidemiologic Profile

The scientific data gained through epidemiologic activities, serves as the basis for the HIV community planning process. HIV/AIDS Surveillance staff in the Delaware Division of Public Health is responsible for collecting, verifying and analyzing data on individuals diagnosed with HIV/AIDS in the state. The compilation of the data and an analysis of pertinent supplemental studies are included in the Epidemiologic Profile found in Chapter 2.

Needs Assessment/ Community Services Assessment

The work product of the Needs Assessment Work Group is found in Chapter 3. This work group was responsible for accomplishing three goals: development of a needs assessment, completion of a resource inventory, and compilation of the results into a gap analysis. The work product, known as a community services assessment (earlier versions of the *community planning guidance* refer to it as a needs assessment), describes the prevention needs of populations at risk for HIV infection, the prevention activities/ interventions implemented to address these needs and an analysis of what service gaps exist. Typically, a needs assessment is a process to collect information and determine the services currently provided and needed by either a specific group of people (population) or in a geographic area. The

resource inventory lists HIV prevention activities currently provided in the area, along with related resources, education and prevention activities that might be linked to HIV risk reduction. A gap analysis is a description of the unmet HIV prevention needs within the high-risk populations defined in the epidemiologic profile.

Priority Populations

Chapter 4 describes the prioritized target populations as determined by the Populations Work Group. With its limited resources, Delaware must focus HIV prevention efforts on individuals considered most at-risk for HIV infection, also called a target population. Working with the Delaware HIV Consortium Community Planning Specialist and DPH staff, the Populations Work Group identified at-risk groups as most in need of continued programming. The background data and process for selection of these populations are found in the chapter. The prioritized populations are listed at the end of the Executive Summary.

Interventions

For each identified target population prioritized by the Populations Work Group, the Interventions Work Group was responsible for selecting and recommending appropriate HIV prevention interventions or activities. These recommendations are provided to the Division of Public Health for consideration when developing the contracts with community agencies to serve the at-risk communities. The Division of Public Health will fund intervention studies as funding permits. The Division of Public Health, Delaware HIV Consortium and HIV Prevention Planning Group will review data on emerging populations to ensure appropriate and adequate intervention activities are occurring with these at-risk groups in a timely manner. More specific background on the process of selecting these interventions, citations of the interventions and additional detail is offered for the reader in Chapter 5. The recommended interventions are listed at the end of the Executive Summary.

Coordination and Linkages

Chapter 6 reviews examples of coordination and linkages between HIV prevention and treatment service providers and improve service delivery and client acceptance of interventions.

Goals, Objectives and Recommendations; Technical Assistance

The Division of Public Health offers the goals and objectives from the annual grant application in Chapter 7. This section is included for the reader and is likely to be updated each year with changes to the grant guidance issued by CDC and grant application completed by the Division of Public Health.

Evaluation

Chapter 8 offers a glimpse at three membership-related objectives in the *community planning guidance* and how the Delaware HIV Prevention Planning Group is meeting the objectives. Through membership recruitment efforts, orientation sessions and the C.H.A.T. initiative, the PPG is working toward parity, inclusion and representation. Evaluating past performance and success in meeting the objectives is key to refining and improving upon the planning

process. Future evaluation strategies will include a review of membership evaluation tools, analysis of the cultural competency of PPG members and HIV prevention service providers, and an evaluation of whether the recommendations included in this plan are carried out in the next planning cycle. This chapter also informs the reader about evaluation efforts undertaken by the Division of Public Health to meet the critical attributes defined by CDC.

Below is the list of approved prioritized populations and recommended interventions to be implemented from 2005-2009.

Population: Injecting Drug Users who are HIV+

Subpopulations:

1. Black/White; 30+; Male/Female; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720 and 19977
2. Black; 30+; Male/Female; live in 19901, 19904, 19933, 19956, 19963 and 19973

Recommended Interventions:

- Combined Group-Level Intervention and Individual-Level Intervention efforts including Outreach and Counseling and Testing
- Community-Level Intervention
- Syringe Exchange including Group-Level Intervention and/or Individual-Level Intervention
- Outreach with Counseling and Testing and Individual-Level Intervention
- Partner Counseling and Referral Services

Population: Men who have Sex with Men who are HIV+

Subpopulations:

1. Black; 30+; Male; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720 and 19977
2. White; 30+; Male; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720, and 19977
3. Black; 30+; Male; live in 19901, 19904, 19933, 19956, 19963 and 19973
4. Black/White; 30+; Male; live in 19947, 19958, 19971

Recommended Interventions:

- In those areas where MSM can be reached (19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720, 19977, 19947, 19958, 19971)
 - Outreach with Individual-Level Intervention followed by Group-Level Intervention (include Counseling and Testing services for partners)
- In those areas where little is known of the MSM population (19901, 19904, 19933, 19956, 19963, 19973)
 - RARE (Rapid Assessment, Response and Evaluation) Community Assessment followed by a Community-Level Intervention
- Partner Counseling and Referral Services

Population: Heterosexuals who are HIV+

Subpopulations:

1. Black; 30+; Female; live in 19801, 19802, 19805, 19806,

19808, 19809, 19701, 19702, 19703, 19713, 19720 and 19977

2. Black; 30+; Female; live in 19901, 19904, 19933, 19956, 19963 and 19973

Recommended Interventions:

- Individual-Level Intervention followed by a Group-Level Intervention including Outreach and Counseling and Testing
- Community-Level Intervention
- Partner Counseling and Referral Services

Population: Injecting Drug Users who are HIV-

Subpopulations:

1. Black/White; 30+; Male/Female; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720 and 19977

2. Black; 30+; Male/Female; live in 19901, 19904, 19933, 19956, 19963 and 19973

Recommended Interventions:

- Combined Group-Level Intervention and Individual-Level Intervention efforts including Outreach and Counseling and Testing
- Community-Level Intervention
- Syringe Exchange including Group-Level Intervention and/or Individual-Level Intervention
- Outreach with Counseling and Testing and Individual-Level Intervention

Population: Men who Have Sex with Men who are HIV-

Subpopulations:

1. Black; 30+; Male; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720, and 19977

2. White; 30+; Male; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720, and 19977

3. Black; 30+; Male; live in 19901, 19904, 19933, 19956, 19963 and 19973

4. Black/White; 30+; Male; live in 19947, 19958, 19971

Recommended Interventions:

- In those areas where MSM can be reached (19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720, 19977, 19947, 19958, 19971)
 - Outreach followed by Individual-Level Intervention and Group-Level Intervention (ILIs and GLIs do not have to be in a specific order) including Counseling and Testing
- In those areas where little is known of the MSM population (19901, 19904, 19933, 19956, 19963, 19973)
 - RARE (Rapid Assessment, Response and Evaluation) Community Assessment followed by a Community-Level Intervention

Population: Heterosexuals who are HIV-

Subpopulations:

1. Black; 30+; Female; live in 19801, 19802, 19805, 19806,

19808, 19809, 19701, 19702, 19703, 19713, 19720 and 19977

2. Black; 30+; Female; live in 19901, 19904, 19933, 19956, 19963 and 19973

Recommended Interventions:

- Individual-Level Intervention followed by a Group-Level Intervention including Outreach and Counseling and Testing
- Community-Level Intervention

SPECIAL POPULATIONS AND RECOMMENDED INTERVENTIONS

Population: Youth (13 to 19)

Recommended Interventions:

- Combined Group-Level Intervention and Individual-Level Intervention efforts including Outreach and Counseling and Testing
- Community-Level Intervention

Population: Incarcerated who are HIV positive and HIV negative

Recommended Interventions:

- Group-Level Intervention and Individual-Level Intervention
- Counseling and Testing
- Health Communication/Public Information
- Partner Counseling and Referral Services

Population: Seniors (50 and above)

Recommended Interventions:

- Health Communication/Public Information
- Community-Level Intervention
- Partner Counseling and Referral Services

Population: Hispanics (Statewide)

Recommended Interventions:

- In those areas where little is known of the Hispanic population (19801, 19805, 19808, 19720, 19901, 19904, 19947, 19958, 19963, 19971)
 - RARE (Rapid Assessment, Response and Evaluation) Community Assessment followed by a Community-Level Intervention
- Individual-Level Intervention followed by a Group-Level Intervention including Outreach and Counseling and Testing
- Health Communication/Public Information
- Partner Counseling and Referral Services

Data Supporting the Prioritized Populations

Below are excerpts from the Comprehensive HIV Prevention Plan 2005-2009 chapter on prioritized populations. The paragraphs provide a brief glimpse at supporting data available when these populations were prioritized during the planning cycle.

Injecting Drug Users (IDU):

In Delaware, approximately one-third of all new HIV infections are directly related to injecting drug use (IDU). Cases related to injecting drug use, including patients who had heterosexual contact with an

Injecting Drug Users (IDU):

In Delaware, approximately one-third of all new HIV infections are directly related to injecting drug use (IDU). Cases related to injecting drug use, including patients who had heterosexual contact with an IDU, mother was an IDU, and partner of an IDU, represent 55% of the cases. The majority of these HIV/AIDS cases related to IDU in Delaware are African American. New Castle County was noted as the county of residence of more than half of the IDU cases.

Men who have Sex with Men (MSM):

While the HIV/AIDS epidemic started in white MSM in Delaware and nationwide, the local trend has shifted to African American MSM. In the first decade, two-thirds of the MSM cases in Delaware were White, while one-third were African American. In the last decade (1993-2002), just over one-half (55%) of the MSM cases were White, while 41% were African American.

Heterosexuals:

A new trend in the HIV/AIDS epidemic is being seen as more heterosexuals are being diagnosed with HIV/AIDS. In Delaware, most cases in the early 1980's were not in the heterosexual population. Data through December 2002 indicates approximately one in five HIV/AIDS cases are related to heterosexual contact (20%). This includes heterosexual contact with an injecting drug user, bisexual man, transfusion/transplant recipient or person living with HIV/AIDS.

Special populations:

There is insufficient data to provide an explanatory paragraph about each of these special populations: Youth, Incarcerated, Seniors and Hispanics. Data examining the age at HIV/AIDS diagnosis might not reflect the current sexual activity of youth; therefore continued education and prevention efforts are needed in this population. Nationwide, there is an increase in the number of individuals incarcerated. This trend is seen locally and could have an effect on the HIV infection rate among Delaware inmates. With an aging population, there is concern about seniors becoming at-risk for HIV infection as individuals are living longer. Delaware's current Hispanic population continues to grow and will impact upon morbidity rates across all diseases, including HIV/AIDS.

Chapter 1: *Introduction*

This chapter introduces the concept of the comprehensive HIV prevention plan, reviews Delaware HIV Consortium organizational structure and provides resources to the reader for further information about the planning cycles.

I. Why is the plan important?

On a national level, the Centers for Disease Control and Prevention (CDC) allocates funds for HIV prevention services. Each state receives federal funding for HIV prevention in response to a grant application submitted by the health department. The state health department is required to develop a comprehensive HIV prevention plan, which includes an outline of the recommended interventions to prevent HIV transmission in the local area.

In 2003-4, CDC developed and updated a community planning guidance (*Guidance for HIV Prevention Community Planning 2004-2008*¹), which outlined the steps necessary to design and implement a planning process. There are three overall goals for HIV prevention community planning:

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

The final result of the planning process shall be a comprehensive document outlining the process undertaken by community members. The document should include the epidemiologic profile, community services assessment, prioritized target populations, and appropriate science-based prevention activities/interventions. Each of these elements is a chapter in this comprehensive HIV prevention plan.

Delaware's Comprehensive HIV Prevention Plan 2005-2009 provides readers an overview of the planning process; results of surveys and focus groups; and recommendations for priority populations and prevention interventions. This plan will guide the Delaware Division of Public Health's (DPH) development of requests for proposals (RFPs) and application for CDC HIV prevention funding. The plan may be used by community-based organizations (CBOs) and state agencies as part of grant applications. Information contained herein might be helpful to community members to further the knowledge of HIV prevention services available and services needed in Delaware.

II. What is the Delaware HIV Prevention Planning Group?

The Delaware HIV Prevention Planning Group (PPG), formerly known as the Delaware HIV Prevention Committee, is the state's single community planning group (CPG). As indicated in the CDC *Guidance for HIV Prevention Community Planning 2004-2008* (hereafter referred to as *the community planning guidance*), each state

health department must convene a community planning group. This collaboration brings together community members, state agency representatives and medical personnel to discuss and plan appropriate services and programs to prevent HIV transmission in the state. PPG members work to design intervention plans that will meet the needs of communities at risk for or infected with HIV in the state. The Delaware HIV Consortium facilitates and manages the Delaware HIV Prevention Planning Group.

The PPG meets monthly in Dover to draft recommendations for HIV prevention services. PPG leadership outlines the tasks necessary to develop the comprehensive HIV prevention plan and delegates responsibility to work groups to accomplish the tasks in a timely manner. There are membership guidelines (found in Chapter 1, Attachment 2) that provide direction and oversight for the group.

A. Delaware HIV Consortium background

The Delaware HIV Consortium is a statewide non-profit organization established to facilitate collaboration among its members and to ensure that quality, non-duplicative HIV treatment and prevention services are available throughout Delaware. The Delaware HIV Consortium is dedicated to eliminating the spread of HIV/AIDS and to creating a seamless continuum of care for all people infected and affected in Delaware.

Membership in the Delaware HIV Consortium is open to the public and achieved through an application process. The Consortium membership includes public health professionals; HIV/AIDS service providers; business, civic and religious leaders; and persons living with HIV disease. The Board of Trustees oversees operations of the agency, which operates several statewide planning groups. During the current planning process, the Consortium Coordinating Council (C3), leadership from the statewide planning groups met with representatives from the Board of Trustees to update work responsibilities. C3 meets as needed to discuss cross-group topics and provide an opportunity for exchange of ideas between the planning groups. There is at least one representative from the Board of Trustees actively participating in each of the statewide planning groups.

Issues affecting statewide policies, including sterile syringe access, medical treatment provided to incarcerated individuals living with HIV/AIDS and legal matters, are undertaken and discussed by the Policy Committee. The Treatment Services Committee is convened as a requirement of the Ryan White CARE Act (RWCA) grant received by Delaware from the Health Resources and Services Administration (HRSA). As the Ryan White planning body, responsible for developing planning materials to guide medical and supportive

service delivery, the Treatment Services Committee reviews current lists of medicines on the Delaware AIDS Drug Assistance Program (ADAP) formulary; conducts needs assessments and focus group to determine appropriate treatment related services; and prioritizes services available to individuals living with HIV/AIDS and their families. The Prevention Planning Group (PPG) is the third planning group of the Consortium. Details on the PPG are provided previously in this chapter.

In the 2002-2003 planning cycle, the Delaware HIV Consortium conceived the Community HIV/AIDS Advisory Teams (C.H.A.T.) to increase involvement from community members who might not be able to attend regularly scheduled planning group meetings. C.H.A.T. provides a unique forum for these individuals to share their insight with planning group members. Meetings are held four times a year in each county; meetings are scheduled for weekends and evenings. Food, childcare and transportation are provided to encourage participation. The mission of C.H.A.T. is to organize community members within Delaware in order to meaningfully involve individuals in the various HIV/AIDS treatment service and prevention initiatives that exist within their communities. The Community Planning Specialist and Community Membership Liaison are responsible for bringing the key points from C.H.A.T. meetings to the appropriate planning group for discussion and action. The Community Membership Liaison position was eliminated in 2003 with the redistribution of Consortium staff responsibilities.

The Delaware HIV Consortium formulated a strategic plan in 2002. The strategic plan is available from the Consortium by contacting (302) 654-5471. The following are guiding principles of the Consortium:

The Consortium:

- Believes that the HIV/AIDS epidemic is a crisis that requires community planning and action
- Promotes participation from all communities
- Shares the responsibility in an epidemic that affects everyone
- Works for increased awareness of the HIV epidemic and of HIV activities in Delaware
- Seeks to include active participation of those living with HIV in the planning of statewide services
- Creates, implements and helps support treatment-related services and housing assistance to those living with HIV in Delaware
- Disseminates meaningful and accurate information to improve the quality of services to persons living with HIV/AIDS and to reduce the stigma of HIV/AIDS in our communities
- Supports the implementation of housing opportunities for persons with HIV/AIDS so that they are able to live with stability and dignity in order to maximize health-related outcomes
- Works to identify and secure diversified funding streams to address the unmet needs of those living with HIV disease in Delaware

B. Plans for integration of the Prevention Planning Group and Treatment Services Committee

The Division of Public Health and Delaware HIV Consortium are continuing discussions on integrating the Prevention Planning Group and Treatment Services Committee. Both groups are responsible for developing comprehensive planning documents, which include similar elements including needs assessments and epidemiologic profiles. The Delaware HIV Consortium can integrate these similar functions. In fact, CDC and HRSA worked together to fashion a document to assist HIV/AIDS surveillance staff as they develop epidemiologic profiles that must meet the needs of both treatment and prevention planning groups. *The Integrated Guidelines for Developing Epidemiologic Profiles: HIV Prevention and Ryan White CARE Act Community Planning*² were used by DPH staff to focus the data analysis and presentation on questions most appropriate for both planning groups.

In keeping with this national trend, the Delaware HIV Consortium assigned one Community Planning Specialist in 2004 to facilitate both the prevention and treatment planning groups. By making this move, the Consortium recognized the increased need for communication between the planning groups and allowed for coordinated efforts for membership, recruitment and data analysis. Therefore, all membership activities for the PPG, Treatment Services Committee and Community HIV/AIDS Advisory Teams (C.H.A.T.) are coordinated with one Consortium staff person. Preliminary timelines were developed by DPH and Consortium staff with a vision to expand beyond integrating functions and look at whether a partial or complete integration of the planning groups is feasible. Both the PPG and Treatment Services Committee have moved to a 2005-2009 planning cycle, allowing for a timeline that could accomplish one needs assessment, resource inventory and consumer/provider survey for both groups.

This initiative will be pursued and a proposal will be delivered or discussion will be held at a combined retreat of the PPG and Treatment Services Committee at the end of 2004.

III. How was this plan developed?

The Comprehensive HIV Prevention Plan 2005-2009 was developed with assistance from all PPG members. Division of Public Health representatives were responsible for development of certain chapters, as was the Delaware HIV Consortium Community Planning Specialist assigned to this statewide planning group. Reports on progress of each work group were presented to the full group for voting and approval. Once approved, the report was written into a chapter of this plan.

The Division of Public Health receives funding from CDC for grant #04012 – *Health Department HIV Prevention Projects*. From this grant funding, DPH has a contract with the Delaware HIV Consortium for community planning facilitation, which includes an allocation for the development of the Comprehensive HIV Prevention Plan.

A. Work group structures

There were three work groups tasked with specific parts of the comprehensive HIV Prevention plan. The work groups are Needs Assessment, Populations, and Interventions. A Membership Work Group worked with PPG membership on orientation and recruited new members for the overall group.

The Needs Assessment Work Group was responsible for developing the community services assessment. When this work group began focusing on their responsibilities, the CDC had not yet released the current version of the community planning guidance. Therefore, the work group operated under the 1993 guidance for HIV prevention community planning³. While the work products are fairly similar, there was a slight change in how products or documents were named.

The Needs Assessment Work Group examined the current services available and compared them to the services needed in Delaware to prevent HIV transmission. As part of their work, a survey was developed and administered to community-based agencies providing social service and health-related programming in the state. Results from the needs assessment review of epidemiologic data, resource inventory and supplemental data analysis provided the backdrop for the development of a gap analysis. Populations or groups of people thought to be at high risk for HIV infection were identified. The resource inventory listed services available to these groups. The gap analysis identified the groups of people (also referred to as a population in this document) PPG members felt were at high risk of infection and evaluated whether there were adequate services available to prevent HIV transmission.

The Populations Work Group reviewed the data presented by Needs Assessment Work Group members. From this presentation, the Populations Work Group decided which at-risk groups (also called populations) should be targeted for additional research. The Populations Work Group determined whether key informant interviews or focus groups were the best mechanism for gathering qualitative data from members of the at-risk groups. Focus groups were conducted to collect consumer information about service delivery and the need for services. This information might not be easily obtained through a survey of agency providers; rather, it was necessary to gather the data from community members affected by the problems identified in focus groups.

Once all focus groups were completed, information from various data sources was used in connection with focus group results to prioritize populations. The prioritized populations (and sub-populations) were defined by their risk behavior, racial/ethnic group, gender, age and geography. These populations will be the focus of service delivery and recommendations for DPH.

Building on the work of previous work groups, the Interventions Work Group was responsible for developing a list of scientifically appropriate interventions for each of the identified populations. The Interventions Work Group reviewed scientific literature, looking for interventions that might be applicable to the socio-economic conditions in Delaware, would be feasible for our agencies to

conduct and appropriate for the specified populations. The Division of Public Health in developing the grant application for CDC and requests-for-proposal for service delivery by community-based organizations will use these interventions.

The final work group of the Prevention Planning Group is the Membership Work Group. While not directly responsible for a work product in the comprehensive plan, this work group has a vital role in the recruitment and retention of PPG members. Orienting new members to the process requires Membership Work Group members to have a keen understanding of the community planning background and an ability to explain the concepts to interested parties.

B. Who was on the Prevention Planning Group?

PPG membership fluctuated throughout the development of this plan. Current members include representatives from community agencies, Division of Public Health, Division of Substance Abuse and Mental Health (DSAMH), Christiana Care Health Services, community representatives and local universities.

As this process involved a three-year timeframe, the ebb and flow of members presented challenges to the process and affected the diversity of the group. Experienced members can provide historical knowledge of the process and background for PPG members. New members are always encouraged to participate on work groups as new ideas are valuable and welcome. As the PPG moves to a five-year plan, the varied membership will continue to have an impact on decision-making. Work group leaders have changed throughout the process as well, increasing the need for educating the PPG membership on overall process and voting issues.

The Delaware HIV Consortium also experienced turnover in the staff position assigned to the PPG. All historical records and meeting minutes are available to new PPG members and staff assigned from the Consortium and DPH as background materials.

With the introduction of four membership categories in 2004, PPG members can be listed on the roster as 'voting', 'alternate-voting', 'non voting' and 'interested'. Listed below are all PPG members on the roster as of June 30, 2004. For an explanation of the membership categories, refer to Chapter 1, Attachment 2 for the membership guidelines.

PPG membership as of June 30, 2004

Dennika Acker	Karen Freeman	Bennie Stevens
Joseph Adepoju ▼	Star Fuentes ▼	Ginny Succarotte ▼
Patricia Ayers ▼	Armando Gonzalez ■	Jose Varela ■
Renee Beaman ■	Penny Gross	Robert Watson
Bennie Blake	Daniel Hanks	Natalie Way ▼
Stacy Blake	James Harrison	James Welch ●
Margaret Bowers	Vera D. Harrison ▼	Troy Williams ■
Rodney Brittingham ▼	Shantelle Henderson	Gregory Williams
Leondra Brown	Wendelin Henry ▼	Walter Wilson
Jennifer Brown	Steven Hill ▼	Howard Woodlin ▼
Jen Bruhler ▼	Alyson Lang ■	Jeremy Zane ▼
Russel Buskirk ▼	Kristy Lawton	
Saulo Chavez ■	Heather Leininger-Digan	
Deborah Cheatwood ■	Sylvia Lewis-Harris ▼	
Basha Closic ■	Lucy Luta ▼	
Hector Colon ■	Barbara Mason	
Jim Dickinson ▼	Walter Mateja ■	
Dorothy Dillard	Cathy Mosley	
Jeanne Dukes ■	Alfred Onuonga ▼	
Stephanie Dove	Herman Ortez	
Renaldo Epps	John Ray ▼	
James Farmer	Janet Ray ▼	
Michelle Fisher ▼	Ronniere Robinson ■	
Justine Flint ■	Maria Saenz-Weiss ●	
Georgette Foster ▼	Salvatore Seeley ■	

Legend

■: Voting
●: Alternate Voting
▼: Non-voting

As discussed above, individuals can participate on a work group to maximize their contributions to the planning process. Listed below are individuals who participated in the planning process for the development of this plan. Please note this list may include individuals who are no longer PPG members.

Needs Assessment Work Group

Salvatore Seeley - Leader
 Renee Beaman
 Russel Buskirk
 Jim Dickinson
 Jeanne Doe
 Judith Gendler Epstein
 Walter Mateja
 John Ray

Populations Work Group

Ronniere Robinson – Leader
 Dennika Acker
 Pat Ayers
 Saulo Chavez
 Stephanie Dove
 Alyson Lang
 Cathy Mosley
 Alfred Onuonga
 Janet Ray

Interventions Work Group

Rodney Brittingham
 Basha Closic
 Justine Flint
 Star Fuentes
 Armando Gonzalez
 Daniel Hanks, III
 Sylvia Lewis-Harris
 Herman Ortez
 Jose Varela
 Troy Williams
 Jeremy Zane

Membership Work Group

Maria Saenz-Weiss – Leader
 Deborah Cheatwood
 Hector Colon
 Steven Hill
 Walter Parker
 Natalie Way
 Howard Woodlin

C. Membership on PPG

All PPG members are asked to abide by attendance and voting policies. The policy is updated on an annual basis, or as needed. The 2004 attendance and voting policy and procedures are included as an attachment to this chapter (Chapter 1, attachment 2). At the beginning of the planning year, members are asked to sign a letter of commitment. The 2004 letter of commitment is found in Chapter 1, attachment 3.

Through efforts by the Membership Work Group and DHC Community Planning Specialist, PPG members attend orientation sessions and annual retreats to learn about the state's community planning process. Meetings such as the Community Planning Leadership Summit (CPLS), now known as the HIV Prevention Leadership Summit (HPLS), provide members an opportunity to interact with community planning leaders from other jurisdictions and national technical assistance providers. These meetings allow PPG members to learn about methodology and procedures that work in other states.

In the *community planning guidance*, CDC indicates that parity, inclusion and representation (PIR) are among the tenets of community planning. *Parity* is defined as the ability of members to equally participate and carryout planning tasks/ duties. *Inclusion* is defined as meaningful involvement of members in the process with an active voice in decision-making. *Representation* is defined as the act of serving as an official member reflecting the perspective of a specific community.

The Delaware PPG is committed to providing an atmosphere where all members are able to voice their opinion, learn about new community planning trends and techniques and bring their perspective to the group. Group discussions welcome all statements and perspectives. As described in the letter of commitment and attendance and voting policy and procedures, individuals are asked to determine whether they represent an agency perspective or their own perspective from their community. By voting with this in mind, PPG decisions strive to reflect the community needs and desires.

1. Plan for increasing number of community members

Through the C.H.A.T. groups, Delaware HIV Consortium staff is committed to recruiting community members and sharing their views with the DHC statewide planning groups. C.H.A.T. meetings occur in the evenings and on weekends, removing barriers that preclude community members from attending regularly scheduled prevention and treatment meetings. The Delaware HIV Consortium provides transportation, childcare and refreshments to meeting participants as an incentive to participate. C.H.A.T. meetings occur quarterly in each of Delaware's three counties.

C.H.A.T. gives a voice to the community members who have not participated before in a community planning process. PPG and Treatment Services Committee membership indicates an increased representation of the community infected and at-risk for HIV/AIDS. With the extensive education conducted through C.H.A.T. meetings, the new PPG members come to meetings with

a better understanding of the process. In the current planning cycle, C.H.A.T. was instrumental in piloting questions for the Populations Work Group in addition to assisting the Treatment Services Committee revise the priorities and recommendations for their planning process.

Individuals who move from C.H.A.T. involvement and become PPG members are educated about the planning process. Therefore, they are provided with the tools to make a meaningful contribution to discussions and are able to participate in work group activities.

2. Formalization of recruitment efforts

Since the beginning of Delaware's community planning process in the early 90's, the Delaware HIV Consortium and the Division of Public Health have been committed to a process that included representatives from various communities. The process has been continually evaluated with an outside evaluator. Semi-annually, the PPG membership is asked to complete group dynamic and membership surveys. The results of these surveys have shaped recruitment efforts, as the survey identified groups that were missing from the table. PPG members have indicated that persons living with HIV/AIDS (PLWHA) are not well represented on the group. Other individuals who appear to be missing include evaluators, behavioral scientists, and researchers.

The Delaware HIV Consortium leadership, along with DPH, has taken steps to increase and formalize recruitment efforts throughout the planning process. With the creation of the DHC Community Membership Liaison position, it was hoped that committee membership would be increased. There was an increase in visibility of the Delaware HIV Consortium within the faith community, at health fairs and other important community events. The Delaware HIV Consortium continues to educate the Delaware community about the organization and planning groups.

In 2004, the DHC hired an HIV Program Assistant who will spend time in the community actively recruiting members for all planning groups. As the dedicated individual for both the Prevention Planning Group and Treatment Services Committee, the program assistant can identify community members who are interested in working with the HIV/AIDS epidemic and direct their interest to the appropriate planning group. Recruiting efforts will be stepped up at the Christiana Care Health Systems (CCHS) HIV Wellness Clinics. The DHC has identified other potential PPG members and will actively recruit the individuals over the next few months. Reviewing the recommendations from the PPG evaluator will also focus the program assistant on expertise that is currently lacking on the PPG.

In 2004, the Delaware Office of Minority Health (OMH) provided funding to the Delaware HIV Consortium to increase minority participation in the community planning process. Efforts will focus on the Hispanic and African American communities along with individuals living with HIV/AIDS. Funds will be used to educate identified community representatives about the community planning process. DHC staff hopes these representatives will become active participants in one of the statewide planning groups.

D. Timeline to develop the plan

Throughout the process, PPG leaders worked with a timeline to guide work groups in accomplishing the tasks needed for the plan. The timeline was formally documented and updated beginning in August 2002. Each work group was assigned tasks and the timeline was continually updated. The final timeline (as of June 2004) is included as an attachment to this chapter. (Chapter 1, attachment 4)

PPG membership received technical assistance (TA) throughout the planning process to increase understanding of the responsibilities and explore options for completing the work. The Academy for Educational Development (AED) contracted with Adam Tenner to provide a session on prioritizing and rating and weighting methodology in April 2002. This was a joint session between the Treatment Services Committee and PPG. Maryland Department of Mental Health and Hygiene representatives shared their prioritization process with the PPG in May 2002.

Annual retreats held in January of each year provided an opportunity for CDC representatives to share in the excitement and beginning of the planning year. In 2003, Delaware's CDC Project officer, Jessica Gardom joined the PPG. Her presentation focused on the new community planning guidance. Other discussions at the 2003 retreat included attempts at identifying trust issues between community and state representatives. The 2004 retreat was postponed from January to February due to inclement weather. In 2004, CDC and the National Alliance of State and Territorial AIDS Directors (NASTAD) joined with the PPG in an exploration of the community planning guidance and its impact on the Delaware process. The retreat also worked to move through the identified roadblocks to work together as an effective planning group.

E. Future directions for Delaware's Prevention Planning Group

The current planning process took three years and developed a five-year planning document. Beginning in 2004, the PPG will work on a five-year planning cycle: 2005-2009. During the extended cycle, PPG members will work collaboratively with the Treatment Services Committee on the resource inventory and provider capacity and capability survey. Under new leadership, the PPG will develop standard procedures for completing the prioritization processes and work to document these procedures for future PPG members. The request for proposal process will be reviewed by DSAMH, DPH, DHC and CCHS to identify areas of overlap so that duplicate services can be eliminated and funds refocused on areas where services might be lacking (gaps). As the Delaware HIV/AIDS Surveillance unit completes its evaluation of HIV reporting data, there will be an increased emphasis on using HIV/AIDS prevalence data to define populations.

F. Staff contact for more information

If you are interested in more information about the Delaware HIV Community Planning process, please contact the Delaware HIV Consortium at 302-654-5471. Ask for the Community Planning Specialist to find out about the next meeting and how you can be involved! You can also visit the website at www.delawarehiv.org

ACRONYMS

AA African American	HE/RR Health Education and Risk Reduction
AD AIDS Delaware	HIV Human Immunodeficiency Virus
ADAP AIDS Drug Assistance Program	HOP House of Pride
AED Academy for Educational Development	HPLS HIV Prevention Leadership Summit
AIDS Acquired Immune Deficiency Syndrome	HRSA Health Resources and Services Administration
A/PI Asian/ Pacific Islander	IDU Injecting Drug User
BCI Brandywine Counseling Inc	ILI Individual Level Intervention
BGC Boys and Girls Club of Delaware	KABB Knowledge, Attitudes, Behavior and Belief
BGOC Beautiful Gate Outreach Center	K/SCS Kent/Sussex Counseling Services
BRFSS Behavioral Risk Factor Surveillance System	LACC Latin American Community Center
C3 Consortium Coordinating Council	LAR La Red
CADR CARE Act Data Report	MSM Men who have sex with men
CAMP CAMPSafe/ CAMP Rehoboth	MSM/IDU Men who have sex with men and inject drugs
CARE Comprehensive AIDS Resource Emergency	NA Needs Assessment
CBO Community Based Organization	NA/AN Native American/ Alaskan Native
CCHS Christiana Care Health System	NASTAD National Alliance of State and Territorial AIDS Directors
CDC Centers for Disease Control and Prevention	NIR No identifiable risk
C.H.A.T. Community HIV/AIDS Advisory Team	NRR No reportable risk
CLI Community Level Intervention	OMH DPH Office of Minority Health
CP Community Planning	PCM Prevention case management
CPG Community Planning Group	PCP Pneumocystis carinii pneumonia
CPLS Community Planning Leadership Summit	PIR Parity, Inclusion and Representation
CSA Community Services Assessment	PLWA People Living with AIDS
CTR Counseling, Testing and Referral	PLWHA People living with HIV/AIDS
CTS Counseling and Testing Services (also abbreviated C/T)	PPG Prevention Planning Group
CTRPC Counseling, Testing, Referral and Partner Counseling	PSA Public Service Announcement
DCJ Delaware Center for Justice	RARE Rapid Assessment, Response and Evaluation
DHC Delaware HIV Consortium	RFP Request for proposals
DHSS Department of Health and Social Services	RWCA Ryan White CARE Act
DOC Department of Correction	SAFE Serostatus Approach to Fighting the HIV Epidemic
DOE Department of Education	SAMHSA Substance Abuse and Mental Health Services Administration
DPH Delaware Division of Public Health	SCAC Sussex County AIDS Council
DSAMH Delaware Division of Substance Abuse and Mental Health	SCBW Survey of Child Bearing Women
DSS Division of Social Services	SCSN Statewide Coordinated Statement of Need
E1T1 Each One Teach One	SHAS Supplement to HIV/AIDS Surveillance
GLI Group Level Intervention	STD Sexually Transmitted Disease
HAART Highly Active Antiretroviral Therapy	TA Technical Assistance
HARS HIV/AIDS Reporting System	USCA United States Conference on AIDS
HC/PI Health Communication/ Public Information	YRBS Youth Risk Behavior Survey



*Attendance and Voting Policy and Procedure
of the Prevention Planning Group*

It is the intention of the Delaware HIV Consortium to create a community-planning group that reflects the diversity of the epidemic. To that end, the group includes community- and faith-based organizations, public health officials, individual community members, and people infected with and affected by HIV and AIDS. The Prevention Planning Group has made it a point to recruit other members of the community including, behavioral scientists, research scientists, epidemiologists, and program/outcome evaluators.

The PPG meets once a month in Dover, typically on the fourth Wednesday of the month. However, the PPG does not meet in November. The meeting schedule for the following year is typically approved in October of each year. An Annual Retreat is held once a year, typically in December or January. The Annual Retreat is an all-day meeting and will count as two full Group meetings.

I. Types of Membership

Membership on the PPG consists of four types: non-voting members, voting members, alternate voting members, and interested members. All non-voting, voting and alternate voting members are encouraged to actively participate on a Work Group.

- *Non-Voting Member:* Any member of the community may nominate him/herself to be a non-voting member of the Group.
- *Voting Member:* For a non-voting member to become a voting member, they must become a member of the Consortium and follow the attendance policy outlined below. To become a member of the DHC, one must fill out a Membership Application Form.
- *Alternate Voting Member:* If an agency has two or more representatives, one person is identified as a voting member; another person may be designated as the alternate voting member. The alternate voting member must become a member of the Consortium and follow the attendance policy outlined below.
- *Interested Member:* Any member of the community may nominate him/herself to be an interested member of the Group. All interested members are encouraged, but not required, to attend an Orientation Meeting. Interested members are those people who do not or cannot attend meetings or do not wish to establish voting privileges, but are interested in staying informed of the Group's activities. All PPG correspondences will be sent to this member.

II. Attendance and Voting Privileges

(Members who have already established voting privileges according to these new standards will be grandfathered in as voting members on April 29, 2004.)

- *Non-voting members* will become *voting members* after attending one (1) Orientation Meeting and three (3) consecutive meetings within 6 months of the Orientation meeting.

- If a *voting member* misses two (2) consecutive meetings or three meetings over the course of the calendar year, they will have their status changed from *voting member* to *non-voting member*. In order to re-establish voting status, the member must attend three (3) consecutive meetings of the full Group.
- Any *voting or alternate voting member* is to notify either of the co-chairs or the Consortium Liaison if they will be unable to attend a regularly scheduled meeting. After the first absence, a letter from the Consortium will be mailed to that member reminding them of the Attendance Policy. In the event of two (2) consecutive absences or three (3) absences in a calendar year, a letter will be mailed to that member indicating suspension of their voting privileges.
- Any member with three (3) consecutive absences will have their status changed to an *interested member*. For an interested member to gain voting status, they must attend three (3) consecutive meetings of the full Group.
- At the discretion of the Work Group Leaders, Work Group meetings may be scheduled outside of the full Group meetings based on the group's workload. Absence from two work group meetings will count as one full Group meeting absence.
- Any member may resign from the Prevention Planning Group by delivering written notice to the Consortium Liaison.

If unforeseeable circumstances causes a member's absence and that absence would result in the member's loss of voting privileges, the member may request that the co-chairs review the reason for the absence. Upon review, the co-chairs may decide, at their discretion, to allow the individual to retain voting privileges.

III. Agency Representation

If any individual participates on the PPG as a paid employee or volunteer representative of an agency, then he/she is considered to be an agency member and should represent the interests of the agency rather than his/her personal interests.

For agencies that have two or more representatives on the Prevention Planning Group, there will be one voting member and one alternate voting member. (The Consortium must receive in writing from the agency a designation of who the voting and alternate voting members are.) Voting and alternate voting members are assigned in order for the group members to ensure continuity.

If the above applies, each member is responsible for meeting the attendance requirements in order to establish voting status. If the voting member is unable to attend a meeting, he/she must call one of the co-chairs or the Consortium Liaison before the meeting in order for the alternate voting member to have the authority to vote at that meeting.

For information on Consumer Employees see the Community Representation section of this policy.

IV. Community Representation

Individual community members, who are not affiliated with an agency, may become voting members of the Group. However, these members may not designate an alternate to vote in their absence.

The following guidelines apply only to a person living with HIV/AIDS. They do not apply to any other agency representative.

If a consumer (person living with HIV/AIDS) is a paid employee or volunteer representative of an agency that is funded by Division of Public Health to provide HIV prevention services, that member may represent him/herself as a community representative instead of an agency representative under the following circumstances:

- The consumer has taken unpaid leave to attend the PPG meetings;
- The consumer has an agreement with the agency Executive Director or Supervisor that he/she is attending PPG meetings as a community representative and not as an agency representative;
- The consumer and Executive Director or Supervisor has completed and signed the PPG Community Representative Waiver Form (can be obtained by contacting the Consortium).

These guidelines are in place to ensure that consumers are a part of the planning process and are able to establish voting privileges. However, these guidelines do not override an organizations policy about employee benefits and participation on a community-planning group.

V. Voting Procedures

The Group will follow Robert's Rules of Order for all voting actions.

- The usual method of taking a vote will be by show of hands, except when nominating / electing a Co-chair.
- The responsibility of announcing, or declaring, the vote rests upon the co-chairs.
- A majority vote is sufficient for the adoption of any motion, except to adopt a motion that suspends or modifies a rule of procedure, where a two-thirds vote is required.
- Since the possibility of a tie is present at every vote, one of the Co-chairs will be able to vote. However, the Co-chairs vote will only be taken into account if there is a tie. The following limits exist:
 1. A Co-chair may not vote twice, first to make a tie and then give the casting vote.
 2. In the event that both Co-chairs do not have voting privileges, the Community Co-chair will cast the deciding vote.

VI. Community Co-Chair Requirements / Terms / Voting Privileges

Requirements

Eligible group members will have established at least six months of membership and have met the attendance and voting requirements outlined in this policy.

Terms

- The Group may appoint a Community Co-chair Elect to begin functioning as co-chair up to 6 months prior to the start of their 2-year term.
- Elected co-chairs will serve a two-year term beginning after the Annual Retreat.
- A co-chair may be re-elected by the Group, but may serve no more than 2 two-year terms during their entire tenure on the Group.
- Nominations for the Co-chair Elect will occur before August 1st.
- Nominees must be present at the August PPG meeting.
- A list of eligible nominees along with a biography for each nominee will be provided to the Group prior to the August meeting. Bios must include a description of involvement with the PPG (including how long they have been a member, any leadership roles, participation on a work group, etc.)
- Elections will be made at the August meeting by secret ballot.

Voting Privileges

- If the Community Co-chair is the only representative of an agency or if they are a community representative, the Community Co-chair may participate in the voting process.
- If the Community Co-chair is a representative of an agency that has two or more members on the Group, the agency must designate a representative other than the Community Co-chair as the voting member. Community Co-chairs may be alternate voting members.

VII. State Co-Chairs

The Delaware Division of Public Health appoints the State Co-Chair. There are no term limits or requirements for the State Co-Chair. However, they must abide by the attendance and voting policies in order to remain in good standing as a member of the Group.

Voting Privileges

- If the State Co-chair is the only representative of the Delaware Division of Public Health, they may participate in the voting process.
- If the Delaware Division of Public Health has more than one representative on the Group, they must designate a representative other than the State Co-chair as the voting member. State Co-chairs may be alternate voting members.

**2004 Letter of Commitment
Prevention Planning Group
DELAWARE HIV CONSORTIUM**

As a member of the Delaware HIV Consortium Prevention Planning Group, I, _____
(representative's name)
of _____ commit to the following:
(agency/organization/community member)

- Attend all meetings in accordance with the membership guidelines of the Prevention Planning Group convened by the Delaware HIV Consortium.
- Thoroughly prepare for each meeting carefully by reading all pre-distributed materials.
- Actively participate in all Prevention Planning Group meetings from beginning to adjournment.
- Actively participate in all assigned PPG work (telephone conference calls, face-to-face meetings, material review, report writing, etc.).
- Facilitate communications among local community groups and members of the Prevention Planning Group.
- Act on behalf of all HIV-infected and –affected communities in Delaware in decision-making.
- Understand that I am participating in a Delaware-wide planning process and make decisions based on that understanding.
- Understand that this is a commitment to a three-year planning process and I will participate accordingly.
- Understand that I will be expected to renew my commitment annually to reflect my total participation.
- Understand that my participation on the Prevention Planning Group will begin January 2004 and I will serve on the PPG through the current year.

Given the responsibilities and time commitment entailed by participation on the Prevention Planning Group and its work groups, I agree to participate as a member.

Chapter 1: Attachment 4 Detailed Plan for the Plan

Includes work group assignments by month. Revised June 2004

	August 02	September 02	October 02	Nov/Dec 02
Full Group	Final Application DPH; Vote on Concurrence; C.H.A.T. Presentation; Work Group Breakout; Community Co-chair election	C.H.A.T. Update; DPH – present 6 month contractor data; Report on USCA; Work Group Breakout	DOE presentation; Evaluation Report; NA Update; Work Group Breakout; Vote on 2003 Mtg Schedule; C.H.A.T. Update	NA Report; Networking Break; Work Group Breakout; CP Jeopardy Game
Needs Assessment	Survey by intern to be completed; What information from focus groups or key informants do we want populations to collect? Look at recommendations/plan – what data was missing?	Review results from intern's survey and develop report – Resource Inventory	Continue work on Resource Inventory	Presentation on Resource Inventory/ vote to accept; Begin working on gap analysis
Populations	Work on methods for each population – key informant, survey, focus group	Continue from August	Continue from September	Outline contact agencies for access to identified populations
Interventions	What information from focus groups/ other methods do you want? Specifically about what interventions will/ will not work with populations?	Look at definitions of the various interventions; create a plan for each member to research interventions that are not yet published in the Compendium	Update the table on p.143 of Plan –what are available/ viable/ effective interventions – research new compendium/ interventions– IDU	Continue from October – focus on one target population for this month - MSM
Membership	New members to work with Community Membership Liaison about what community planning is about, Develop 2003 Meeting Schedule	New Member Orientation Meeting	Present 2003 meeting dates and vote on schedule; Review meeting attendance policy – p.103 of old plan	Present attendance policy to full committee/ vote; work with group on new work group leaders
	January 03	February 03	March 03	April 03
Full Group	RETREAT; DHC & DPH roles in CP; CDC Update- Jessica Gardom; Team building activity; State/Community Group Mtgs; Unifying Activity; 2003 Letter of Commitment signing	DPH - 2002 Counseling & Testing Report; 2003 Contract Summary Report; C.H.A.T. Update; Work Group Reports; Work Group Breakouts; Recap of State/ Community Group Mtgs; Treatment/ Policy Updates	Year End 2002 Evaluation Report; DPH - contractor reporting data; DSAMH presentation; Work Group Breakouts; Update on CP Guidance; Report on CPLS	DHC Annual Mtg.; DHC Activity Report; Treatment Services Committee Report; Prevention Planning Committee Report; Board Business; DPH – Epi Profile Presentation
Needs Assessment	Report on progress with gap analysis	Gap analysis	Update the needs assessment/ survey of providers/ resource inventory	Combine data from DPH, surveys into a final report
Populations	Develop core questions to be asked of all Focus Groups, and population specific questions for each population; Develop list of target populations	Develop a grid of populations and identify the best way to reach each population	Continue to develop core questions for each population	REVIEW and recommend pops for 04 application – to be completed by 5/03 mtg; C.H.A.T. groups work on focus group questions
Interventions	Continue with tasks from Oct 02 – focus on HIV + and Heterosexuals	Compile new interventions (From research and unpublished data) into report	Learn about weighting/ rating	Have list of available interventions ready for each population

Chapter 1: Attachment 4 Detailed Plan for the Plan (continued)

Includes work group assignments by month. Revised June 2004

	January 03	February 03	March 03	April 03
Membership	Implement the new attendance policy			
Other	Address Membership Trust Issues; Co-chairs and DHC staff select scholarship recipients for CPLS	Technical Assistance Months* If necessary – push activities back one month		Work Group Leaders addressed Conflict of Issues and DHC bylaws
	May 03	June 03	July 03	August 03
Full Group	Community Planning Guidance Update; Summer Timeline Presentation; Presentation on CDC's New Initiative <i>Advancing HIV Prevention: New Strategies for a Changing Epidemic</i> ; Complete Membership Survey and Group Dynamic Scale; Work Group Breakouts	Present and Vote on Work Group Recommendations for an Update to the 2002-2004 Comprehensive Plan; Present and Vote on the NA Report for the 2005-2007 Comprehensive Plan; Work Group Breakouts	DPH – draft application, budget and DPH Communicable Disease Branch Structural Chart presentation; Presentation on purpose of Focus Groups	DPH – draft 2004 Prevention Grant Application presentation; Contract Summary Report Addendum; Review and Vote on Letter of Concurrence; Focus Group Facilitator Guide presentation
Needs Assessment	Continue from April	Present and vote on needs assessment for the PLAN		
Populations	Continue to develop focus group questions	Present and vote on populations for CDC APPLICATION	Continue to develop list of target populations	Focus Group Facilitator Training
Interventions	Reformat list of Interventions for the 2002-2004 Plan Update	Present and vote on recommended interventions for APPLICATION		
Membership				
Other	Scholarship applications due for USCA in June			Report on the National HIV Prevention Conference
	September 03	October 03	Nov/ Dec 03	January 04
Full Group	DPH – present contractor/ evaluation data and DPH work/ C&T; 2003 Midyear Evaluation Presentation; Impact of CDC Requirements on CPG; Report on USCA	DOE presentation; C.H.A.T. Update	Group Dynamic Scale; Annual Retreat Agenda reviewed; Work Group Reports and Celebration	Retreat postponed to February 2004
Needs Assessment				
Populations	Finalize questions and population list	Conduct Focus Groups	Conduct Focus Groups	Review Focus Group data; Begin Rating and Weighting Process
Interventions				
Membership	Develop 2004 meeting schedule	Present 2004 meeting schedule; Create a Plan to develop Orientation Guide, Meetings and Mentoring Program; Strategize about Recruitment	Vote on 2004 Meeting Schedule; Orientation Guide and Meeting Presentation created	84 letters of recruitment mailed out

Chapter 1: Attachment 4 Detailed Plan for the Plan (continued)

Includes work group assignments by month. Revised June 2004

	February 04	March 04	April 04	May 04
Full Group	RETREAT – Importance and Purpose of Community Planning; Advancing HIV Prevention presentation; Working strategically and effectively across differences; Recognition of dedication to Delaware CP	Retreat debriefing; Populations Work Group Report and Vote; Interventions and Membership WG Update; C.H.A.T. Update; Policy Committee Update	Interventions Work Group Report and Vote; Attendance and Voting Policy and Procedure Report and Vote; Epi Profile Presentation- DPH; Prioritization Process Presentation –DPH	Meeting Cancelled
Needs Assessment	Edit the work group report	Edit the work group report	Edit the work group report	Final version of the report finished
Populations	Completed the Rating and Weighting Process; Reviewed data used and modified the process; Began identifying zip codes of high prevalence for HIV/AIDS	Finish prioritization process; Develop report/ present and vote on the report	Recommendations for next planning cycle approved by Work Group members	
Interventions		Review list of interventions; Identify interventions based on prioritized populations	Identify interventions; Develop report/ present and vote on report	
Membership	2004 Letter of Commitment Signing; Revised the Mentoring Program; Follow-up on recruitment letters	New Member Orientation Meeting; follow-up on recruitment letters	New Member Orientation Meeting; Revise and Vote on Attendance and Voting Policy and Procedures	
Background	Contractor working with DPH and DHC to write: evaluation section, DPH goals, introduction/ background, executive summary, acronym list, table of contents			Contractor working to write community services assessment; populations and interventions section
	June 04	July 04	August 04	September 04
Full Group	Work Group Leaders and full Membership reviews the Plan; Vote on Plan 2005-2009; Sign a letter of support for the Plan	Intro to CDC application Guidance; HPLS wrap-up; Community Co-Chair nominations; Membership survey	Review CDC Interim Progress Report Guidance; Committee Co-Chair elections	DPH present Interim Progress Report; Vote on concurrence; Presentation on Proposed Integration
Membership	Continue to recruit	Continue to recruit and hold Orientation Meetings	Continue to recruit and hold Orientation Meetings	
Background	Contractor finishes the writing of the Plan	DPH/ DHC work on the printing of plan and posting online		

Chapter 2: *Epidemiologic Profile*

This chapter provides the data, which serves as the basis for the HIV community planning process. HIV/AIDS Surveillance staff in the Delaware Division of Public Health is responsible for collecting, verifying and analyzing data on individuals diagnosed with HIV/AIDS in the state. Supplemental studies afford DPH the opportunity to expand upon routinely collected data and provide additional insight into behaviors that put people at risk for HIV infection.

*The Centers for Disease Control and Prevention (CDC) along with the Health Resources and Services Administration (HRSA) outlined questions that should be included in the epidemiologic profile in their *Integrated Guidelines for Developing Epidemiologic Profiles: HIV Prevention and Ryan White CARE Act Community Planning*¹. The guidance provides structure and assistance to HIV/AIDS surveillance staff as they explore the enormous amount of data available to synthesize and present it in the most consumer-friendly manner possible.*

A. Why is it important to include epidemiologic data?

In order to abide by the *community planning guidance* and carry out scientific process to select appropriate HIV prevention programming, state health departments and community planning groups must understand the epidemic in their jurisdiction. Reviewing the epidemiologic profile allows PPG members a glimpse into populations at-risk of HIV infection as determined by quantitative data.

Five attributes discussed in the *community planning guidance* point to epidemiologic data as critical in the scientific process of community planning.

- The epidemiologic profile provides information about defined populations at high risk for HIV infection for the community planning group (CPG) to consider in the prioritization process.
- Strengths and limitations of data sources used in the epidemiologic profile are described (general issues and jurisdiction-specific issues).
- Data gaps are explicitly identified in the epidemiologic profile.
- The epidemiologic profile contains a narrative interpretation of data presented.
- Evidence that the epidemiologic profile was presented to the CPG members prior to the prioritization process.

B. Where can I get more information?

Interested community members are encouraged to contact the Division of Public Health HIV/AIDS Surveillance office at 302-741-2920 for more information. Quarterly HIV/AIDS statistics are available online as well.

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Executive Summary

Description of the State of Delaware:

The Delaware estimated population for 2001 is 796,165. Delaware's population represents 0.2% of the total United States population of 284,796,887. Seventy percent of Delaware residents live within urban areas. Seventy-five percent of Delaware's residents are White, 19% are Black, 5% are Hispanic and 1% are self-identified as two or more races. Delaware residents had higher incomes, lower unemployment rate, and were more highly educated than United States residents as a whole. Other data shows high rates of teen pregnancy and substance abuse. There is a growing need for services for the homeless, treatment for mental illness and substance abuse services. This suggests that there are a number of populations at risk for contracting HIV.

Epidemiologic Trends in HIV and AIDS in Delaware:

In the year 2002, 0.5% of the AIDS cases in the U.S. were reported among Delaware residents. Delaware ranks 18th among states in the total number of reported AIDS cases and 5th in the rate of AIDS cases per 100,000 population. Seventy percent of HIV/AIDS cases reported in Delaware in 2002 were among men. However, cases diagnosed among women continue to grow from 24% of cases reported in 1997 to 30% of cases reported in 2002. The percentage of HIV/AIDS cases reported among minority groups is disproportionately high. In 2002, sixty-five percent of cases reported were among Blacks and 6% reported among Hispanics. More than 64% of cases reported in Delaware in 2002 were reported among those aged 30-49. Since the new anti-retroviral treatments became available in 1996, HIV infected persons have been living longer and healthier. As a result of the highly active anti-retroviral (HAART) therapy, the number of AIDS cases reported to the Division of Public Health has declined dramatically from 299 cases in 1996 to 152 in 2002. Similarly, people are living longer with HIV. Within Delaware the epidemiology of HIV varies from one area of the state to another. In New Castle County, cases are largely among African American IDUs, while Sussex County cases are for the most part white

men who have sex with men. HIV/AIDS cases in the state are concentrated in the state's 4 largest cities, Wilmington, New Castle, Newark and Dover.

2002 Observations in Behavioral Risk Groups:

The largest risk groups among HIV/AIDS cases reported in Delaware in 2002 are injection drug users (IDU) 30% (n=117), followed by heterosexual transmission 27% (n=107), and men having sex with men (MSM) at 24% (n=94). More than half, 58%, of injecting drug users and 46% of heterosexually infected women reported in 2002 are Wilmington residents. Nearly a third, 29% (n=27) of MSM cases reported in 2002 were living in the City of Wilmington at time of report.

HIV/AIDS in other populations:

There are a number of populations on which adequate data to assess HIV risk is not available. These include smaller groups such as the homeless, transgendered, and mentally ill. There are also populations who are diagnosed through routine screening on whom we have little data, i.e. blood donors and pregnant women. Anecdotal data indicates that less than ten HIV-infected women gave birth to infants in the last year. All the infants followed by Ryan White Title IV programs tested negative. While there may be one or two perinatally-infected infants in recent years, trend data shows an overall decrease in perinatal HIV infection in Delaware.

Other Data on HIV and AIDS:

One percent of publicly funded counseling and testing clients in Delaware are HIV sero-positive. Of those who test positive 70% are men and 30% women. Groups showing the highest seroprevalence rates are Blacks 57%, Whites 29% and Hispanics 14%. Thirty-seven percent of positives are MSM while 20% identified as having no other risk than a sex partner who was at risk for HIV. Heterosexual IDUs comprised 15% of the positive tests in 2002.

Background and Introduction

Delaware has tracked AIDS cases since 1984 and commenced collecting information on the HIV infected population July 10, 2001 by compiling information from health care professionals, laboratories and physicians. An analysis of current AIDS case reporting and incoming HIV data show a continued increase in the number of injecting drug users occurring most significantly in both genders of the African American population. Heterosexual cases, in women of color, are increasing and although White men who have sex with men are still being reported the decrease continues.

Data presented here are current through December 31, 2002.

Community prevention planning groups, health educators, and health planners may use the data to help guide risk reduction and public health interventions aimed at reducing the numbers of HIV-infected individuals in Delaware.

Regulations for the Control of Communicable and Other Disease Conditions were revised in July 2001. The revision includes the reporting of HIV cases, through a name to code system, to the HIV/AIDS Epidemiology office. Seventeen months of HIV data collected through December 31, 2002 are included so as to assist prevention and health planning groups with the full scope of the HIV characteristics and epidemic in Delaware.

Methods

The epidemiologic profile describes the distribution, trends, and impact of human immuno-deficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) on the people of Delaware. The profile provides information for prevention planning and education programs centered on HIV. The plan to integrate the profile by Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) is to provide a comprehensive

document to steer prevention planning and service efforts. The compiled data will justify and award future funding for prevention and medical-social services.

The four main questions used to outline data in this profile are:

1. What are the socio-demographic characteristics of the State of Delaware?
2. What is the scope of the HIV/AIDS epidemic in Delaware?
3. What are the indicators of risk for HIV/AIDS infection in Delaware?
4. What are the patterns of utilization of services in people with HIV in Delaware?

Data from a variety of sources are combined, analyzed and presented in response to each of the main questions. Additional subtopics related to specific Delaware populations are addressed. Sources for data presented include: AIDS surveillance activities, CDC national statistics on HIV/AIDS, HIV counseling and testing annual report, STD data, vital statistics annual report, United States Census Bureau Quick Facts, and Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Data Reports (CADR) from HRSA grantees. If the reader has specific questions, the surveillance office can provide assistance locating appropriate data sources.

Data quality varies among the sources. An overview of the strengths and limitations of data sources are provided below. HIV/AIDS surveillance includes case reports of all HIV sero-positive and AIDS-defined cases in Delaware. The data provided on the HIV/AIDS case reports are only as good as the information provided by the reporting source.

Data Sources - Their Strengths and Limitations

The data source for Delaware demographic information is the United States Census Bureau² located at <http://quickfacts.census.gov/qfd/> on the Internet.

Strengths: Data set is complete and standardized nationwide through 2000.

Limitations: Data collection is in decades with estimates provided in the interim.

*Delaware Vital Statistics Annual Report 2001*³ – produced by the Delaware Health Statistics Center, provides health statistical data on the morbidity and mortality of all residents of Delaware.

Strengths: Data set is complete.

Limitations: Data quality is limited to the information provided by physicians on the birth and death certificates and behavior risk data is unavailable. Due to stigma, confidentiality concerns, failure to test for HIV infections and AIDS related diseases, death data may only reflect immediate cause of death and may not identify an underlying disease status such as HIV/AIDS.

*HIV/AIDS Reporting System*⁴ (HARS) is the software used nationwide for storing of HIV/AIDS data. Medical professionals throughout the state submit HIV and AIDS case report forms that vary in completeness and timeliness. AIDS data are the only consistently reported data across the nation, resulting in population-wide statistics in all states.

Strengths: Data set for AIDS is very complete and provides a historical perspective on trends.

Limitations: AIDS data may not represent all AIDS-defined individuals due to delays in reporting and noncompliance with reporting policies. HIV data does not represent all people-testing positive in Delaware, as confidential results are the only tests reported and the availability and option for anonymous testing remains at specific testing sites in Delaware.

*The HIV/AIDS Surveillance Report*⁵ through 2001, published by the Centers for Disease Control and Prevention, is used frequently in the profile for national data. The report for the period ending 2002 will not be available until after this profile is completed. The report is the compilation of HIV/AIDS surveillance information provided by state reporting systems and aggregated for dissemination to the public through the Internet. The website: <http://www.cdc.gov/hiv/dhap.htm> will provide the reader with a very wide variety of HIV/AIDS information and slide presentations.

Strengths: National data

Limitations: Time delay in release of data.

*Supplement to HIV/AIDS Surveillance*⁶ (SHAS) project is a federally funded grant initiative through which adult HIV/AIDS patients are interviewed for additional information. Surveys address topic including: socio-demographic factors, sexual and medical history, drug and alcohol use, access to medical and social services, gynecological and reproductive histories (females), and preventive therapy. Questions regarding behavior and treatments allow investigators more detail on these topics than from other sources. Since the project involves interviewing patients, data are subjective and from the patient's perspective. Therefore, respondent bias is inherent in this data set. All data from SHAS interviews are confidential and linked to surveillance data through patient numbers and not identifying information. The SHAS survey instrument was revised in 2000 and the data in the 2002 profile reflects information collected in the latest version.

Strengths: Confidential data set.

Limitations: Data are subjective and from the patient's perspective. Responses may be what the patient thinks the interviewer may want to hear versus the actual answer. Data may be skewed toward those healthy enough to participate and participation is voluntary.

*HIV Counseling and Testing Annual Report*⁷ is based on data collected on a standardized data collection form from people seeking counseling and possible testing for HIV. Repeat tests cannot be distinguished in this data set.

Strengths: Standardized data collection.

Limitations: Only represents patients who seek counseling and testing (self-selection) and may include persons who tested multiple times. Clients often defer to "sexual partner at risk", rather than identifying specific risk behavior of sexual partner.

*Sexually Transmitted Infection and Disease Reports*⁸ include the statistical data on sexually transmitted disease (STD) events of gonorrhea, chlamydia and syphilis in Delaware. STD case data is well reported in Delaware but is limited in that the collected data does not

include information, such as gender of sexual partners or drug use, important for HIV planning.

Strengths: Standard data collection. Patients at high risk for STDs are at high risk for HIV.

Limitations: Data may include duplicate cases (multiple events of infections in one person) and private providers may under-report.

*2001 Youth Risk Behavior Survey*⁹ (YRBS) is a self-administered, anonymous, 87-item questionnaire for Delaware high school students. The privacy of the student is assured by allowing for anonymous and voluntary participation. The YRBS is one component of the surveillance system developed by the Centers for Disease Control and Prevention in collaboration with state and local departments of education and health, federal agencies, and national education and health organizations. The YRBS was designed to focus the nation on behaviors among youth related to the leading causes of mortality and morbidity among both youth and adults. The Delaware Department of Education assumes responsibility for the YRBS and more information may be obtained through the Department of Education's Adolescent School Health section at 302-744-4906.

Strengths: Risk assessment ongoing with emphasis on prevention.

Limitations: Data limited to high school students who voluntarily participate in survey and relies upon self-reported information. Survey emphasis is on abstinence and does not include questions about homosexual or bisexual behavior.

*Ryan White CARE Act Data Reports*¹⁰ (CADR) are used to report information about provider and program characteristics providing Ryan White CARE Act services. Data is collected and submitted by grantees of Title II through Title IV to Health Resource and Services Administration (HRSA). At the provider level, the CADR offers unduplicated aggregate counts of all clients served. At the Title I grantee level, the CADR data are duplicated. Utilization of medical and support services, prescription drugs and health insurance coverage are also collected as part of the CADR.

Strengths: Standardized data instrument containing grouped data making it easier to report frequency count data for grouped categories.

Limitations: Unable to perform analysis on data that can not be unduplicated as clients may access services from multiple providers. Data is limited to those who access care, treatment or services for HIV.

Epidemiology

When investigating an epidemic, questions relating to person, place and time are important to sort out pertinent information.

- **Person:** Identifying how a person contracts infections or disease is the first step in the process of prevention. Surveillance staff help characterize a person's mode of exposure to HIV from case report forms, personal interviews and medical record reviews. The exposure is often identified as a risk.
- **Place:** In this epidemiologic profile, place refers to zip code of residence at time a person is reported as testing positive for HIV or an AIDS diagnosis is made. Every effort is made to collect unduplicated information and in this process surveillance extends

to other states. Whenever reporting sources indicate a patient may have been treated elsewhere or was diagnosed in another state or jurisdiction, staff will contact the other state for confidential data-sharing purposes.

- **Time:** Throughout the statistical presentation, date of report and date of diagnosis are used to define time periods. There may be a time lag between when a patient is reported to the Division of Public Health (DPH) and the actual date they first developed an AIDS-defining condition or tested positive for HIV. *Therefore, date of report is used, unless otherwise stated in a statistical table or figure.*
- **Risk:** Individuals are identified by behaviors that put them at risk of HIV infection. CDC established a hierarchy to classify a person's most likely route of exposure or HIV risk. Data collected allows a person to be classified by the risk that most likely exposed the individual.

Two noteworthy timelines in the HIV/AIDS epidemic impact the data in this profile nationally and locally. Increases in reporting are noted in both timelines.

- In 1993 the Centers for Disease Control and Prevention (CDC) revised the AIDS case definition. An increase in cases, around 1993-1994 due to the expanded definition, is noted nationally and locally. The new definition included persons previously unreported until several AIDS indicators were added to the case definition. These indicators include: severe immune-compromised individuals with CD4 counts <200 μ /L or <14%; invasive cervical cancer; recurrent pneumonia; and pulmonary mycobacterium tuberculosis.
- Delaware implemented HIV reporting on July 10, 2001. ***HIV data is combined with AIDS data in 2001 and 2002 and is a contributing factor in the increased number of cases observed in most tables and figures in the profile.*** Unless otherwise stated, all tables and figures that have HIV/AIDS in the title, include HIV data reported from July 10, 2001 through December 2002 combined with AIDS data from 1983 through 2002.

All AIDS patient data is strictly confidential and is collected for epidemiologic purposes. Confidentiality of HIV/AIDS case reports is important to maintain an effective HIV/AIDS surveillance system. The Delaware Division of Public Health's HIV/AIDS Epidemiology office has confidentiality and security protocols outlining physical, operational, and personnel security standards. These standards must be maintained to receive federal funding. *Data-release policies guide the presentation of data to ensure HIV/AIDS data do not allow for individual identification. Tables must not present data in a manner that would allow for individual identification. Reporting small numbers, in a table, may inadvertently cause an individual to be identified. In these cases data in small cells may be combined but are generally identified in the footnote.*

Definition of Terms

Adult/Adolescent case:	Patient is 13 years of age or greater at the time of diagnosis.
Epidemiology:	Study of factors (age, race, and gender) that affect disease distribution in the human population.
Heterosexual:	Persons with a history of sexual contact with a person of the opposite sex, and may include heterosexual relations with: injecting drug user; bisexual male; person who had a transplant or transfusion; or person with AIDS or undocumented HIV infection.
Incidence:	Number of new cases divided by the population at that specific time.
NIR case:	No identified risk – risk was unable to be ascertained through investigation to date. NIR cases are reclassified as information is obtained through a complete epidemiologic investigation.
Pediatric case:	Patient is less than 13 years of age at diagnosis.
Prevalence:	Number of existing cases per standard population.
Rate:	Number of cases divided by specific population of a given group. Rates allow for the direct comparison of different groups by taking into account the varying population size.
Transfusion case:	Person who acquired the virus as a result of receiving blood or blood products.
Year of diagnosis:	Measure when disease event occurred.
Year of report:	Measure of when the HIV/AIDS surveillance office received case report.

Cautions in Using Data

Readers should use caution when reviewing data. Listed below are "hints" to help you understand the report. If you have further questions, please contact the epidemiology office.

Case rate: A rate is a measure of the frequency of an event (disease) compared to the number of persons in the group in which it occurs. An example: if there are 700 White AIDS cases in Delaware and the White Delaware population was 700,000; the case rate would be 100 per 100,000. That means for every 100,000 people, there would be 100 AIDS cases.

Dates: Be careful interpreting trends over time. Though it may be enticing to jump to conclusions about changes over time – look carefully at the data. Are the changes over an extended period? Is it a small percentage change in one year?

Graphs and tables: Examine the title. Does it indicate a time period? Does the graph represent all cases or just one group (men, women, IDU or MSM)? Are data represented as the number of cases, a percentage of cases or as a case rate?

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
A/PI.	Asian/Pacific Islander
CARE.	Comprehensive AIDS Resources Emergency
CADR	CARE Act Data Report
C/T	Counseling and Testing Services
DPH	Division of Public Health
HARS	HIV/AIDS Reporting System (software)
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
IDU	Injecting Drug Users
MSM.	Men who have Sex with Men
MSM/IDU	Men who have Sex with Men and Inject Drugs
NA/AN.	Native American/Alaskan Native
NIR	No Identified Risk
NRR.	No Risk Reported
PWH/A	Person with HIV or AIDS
PLWHA	People living with HIV or AIDS
SCBW	Study of Childbearing Women
SHAS	Supplement to HIV/AIDS Surveillance
STD (STI)	Sexually Transmitted Disease (Infection)

Question 1. *What are the sociodemographic characteristics of the State of Delaware?*

Description of the State of Delaware

Geography:

Delaware is the second smallest state in the U.S., measuring 100 miles from north to south and 30 miles from west to east. Land area accounts for 1,955 square miles and 535 miles of Delaware are covered by water. The geographic center of Delaware is located 11 miles southwest of Dover, the state capital, in Kent County. The Interstate 95 corridor, running from Maine to Florida, crosses through Delaware's northernmost county from Maryland to Pennsylvania, or alternately Interstate 295 to New Jersey and points north via the Delaware Memorial Bridge. The south-eastern portion of Delaware's coast-line with the Atlantic Ocean provides the beach resorts that are the destination of many tourists and split-residency owners of summer homes from the mid-Atlantic region.

Delaware Demographics

Delaware's total population estimate through the end of 2001 is 796,165 according to the U.S. Census Bureau. The proportion of the population, by county of residence, is 64% New Castle County, 16% Kent County and 20% Sussex as depicted in Table 1. The race and ethnicity distribution in the state is 75% White, 19% Black or African American, 4% of Hispanic or Latino origin and the remaining 1% a compilation of Asian, Native Hawaiian and other Pacific Islanders. Seventy percent of the population is urban. Women comprise 51% of the state total population, equivalent to the national distribution by gender. The median age of the Delaware resident is 36 years. Ten percent of Delaware residents report a language other than English is spoken in their home. Median household income of \$47,381 and a per capita income of \$23,305 in Delaware exceed the U.S. incomes \$41,994 and \$21,587 respectively. Eighty-three percent of Delaware residents reported having a high school diploma and 25% a bachelor's degree or higher compared to 80% and 20% for the U.S. respectively.

County Demographics

New Castle County is the smallest county in Delaware, registering 426 square miles according to Quick Facts of the U.S. Census Bureau, with 1,174 persons residing per square mile. The 2001 estimated population for New Castle County is 505,829 or 64% of Delaware's total population. Fifteen percent (n=76,664) of New Castle County's residents live within the City of Wilmington.

The racial distribution in New Castle County is 73% White, 20% Black or African American, 5% Hispanic or Latino and 2% are of multiple other origins. Gender-wise, New Castle County residents are 51% women and 49% men.

Approximately 7% of the county's residents are under the age of 5, with 25% between 5 and 17, the age group 18-64 comprises 66% and 12% are 65 years and older.

Kent County is the second smallest in landmass with 590 square miles and an estimated population in 2001 of 129,066. This represents 16% of the state's entire population with 215 people per square mile. Kent County is the home of the Dover Air Force Base and of the State Capital, Dover.

The racial distribution in Kent county is 74% White, 21% Black or African American, 3% are Hispanic or Latino and the remaining 2% combines multiple other origins and persons of more than one race. The gender distribution in Kent is 52% women and 48% men.

Approximately 7% of the county's residents are under the age of 5, with 27% between 5 and 17, the age group 18-64 comprises 64% and 12% are 65 years and older.

Sussex County is the fastest growing and largest county in landmass, measuring 938 square miles, with 167 persons per square mile. Estimated population, based on Quick Facts of the U.S. Census Bureau, is 161,270 or 20% of the state population.

The racial distribution in Sussex is 80% White, 15% Black or African American. The remaining 5% combine multiple other

origins and persons of more than one race/ethnicity. The gender distribution in Sussex is 52% women and 48% men.

Approximately 6% of the county's residents are under the age of 5, with 23% between 5 and 17, the age group 18-64 comprises 52% and 19% are 65 years and older.

The year around beach population and growth of retirement communities in Sussex are responsible for the 3% increase in population from 2000 – 2001.

Table 1.

U.S. Census Bureau¹ estimates for the population of Delaware through the year 2001

County	2001	
	#	%
New Castle	505,829	64%
Sussex	161,270	20%
Kent	129,066	16%
Total	796,165	100%

Table 2.

U.S. Census Bureau¹ estimates for the population of Delaware by race through the year 2001

County	White	African American	Hispanic or Latino	Other
	%	%	%	%
New Castle	73%	20%	5%	2%
Sussex	80%	15%	4%	1%
Kent	74%	21%	3%	2%
Total	75%	19%	4%	2%

Question 2. *What is the scope of the HIV/AIDS epidemic in Delaware?*

Overview of HIV/AIDS Characteristics:

Unless otherwise specified HIV/AIDS data is based on information from the Delaware HIV/AIDS Reporting System³ (HARS). ***HIV data is combined with AIDS data in 2001 and 2002 and is a contributing factor in the increased number of cases observed in most tables and figures in the profile.***

Through December 2002, a total of 3,810 people were reported to DPH with a diagnosis of HIV or AIDS. A total of 1,566 persons have died, representing 41% of the cases. The racial disparity in cases reported continues as in previous profiles and will be described later in the profile. Table 3 provides a brief overview of demographic characteristics of all reported HIV/AIDS cases in Delaware.

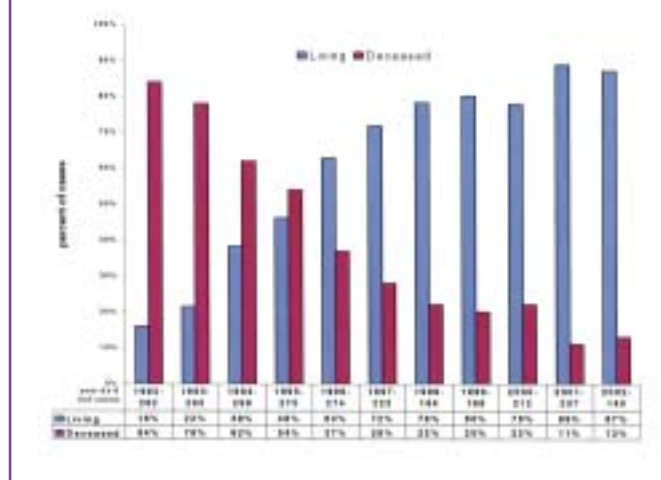
Table 3.

Characteristics of persons reported with HIV/AIDS in Delaware 1983 through 2002, n=3,810

HIV/AIDS Cases Reported in Delaware through 2002			HIV Cases Reported	
	No.	%	No.	%
Total	3,810	100%	705	100%
Gender				
Male	2,755	72%	428	61%
Female	1,055	28%	277	39%
Race/Ethnicity				
White	1,093	29%	207	29%
Black	2,498	66%	455	65%
Hispanic	201	5%	38	5%
Other/Unknown	18	<1%	5	1%
Age Group (yrs)				
<13	42	1%	17	2%
13-19	44	1%	31	4%
20-29	575	15%	166	24%
30-39	1,670	44%	286	41%
40-49	1,077	28%	141	20%
50-59	295	8%	49	7%
60-69	88	2%	12	2%
70+	19	<1%	3	<1%
County				
Kent	361	9%	75	11%
New Castle (Not Wilmington)	1,159	30%	215	30%
Wilmington	1,729	45%	309	44%
Sussex	561	15%	105	15%

National surveillance reports⁴ indicate there are 333,881 persons living with AIDS and 161,711 persons living with HIV through December 2001. The national annual case rate per 100,000 population was 14.9 for January 2001 – December 2001. Delaware's rate per 100,000 population was 25.0 for the same time period. Delaware continues to rank among the top ten states for case rates per 100,000 population.

Figure 1 compares the percentage of people surviving with AIDS who were diagnosed between 1992 and 2002 to the percentage of those who have died through 2002. The graphic clearly illustrates the decrease in fatalities and the increase in the percentage of people living with AIDS. Factors attributing to survival in people diagnosed later in the epidemic are timeliness in referral into care, progress in the medical management of HIV, and the introduction of highly active anti-retroviral therapy (HAART). The difficulty over time will be the burden of disease and financial strain secondary to chronic illness.

Figure 1. Comparison of mortality status in Delaware AIDS cases by year of diagnosis (yr dx'd), 1992 through 2002, n=2,506

Data from the Delaware Health Statistics Center² indicates an overall decline in deaths due to HIV/AIDS. In 1999-2000, HIV was listed as the fourth leading cause of death for 79 residents of Delaware in the 25-44 year age group.

At the end of 2002, there were 1,483 living AIDS cases in Delaware. Living AIDS cases continue to increase across all demographic groups. In 2001, the prevalence rate (living AIDS cases in Delaware) was 173 per 100,000 population. There was a 7% increase in the survival rate in 2002, with a rate of 186 per 100,000 population.

The prevalence rate for female cases in Delaware through 2002 was 183 per 100,000 population (749 AIDS living cases). The prevalence rate for male cases in Delaware through 2002 prevalence rate was 391 per 100,000 (1,511 living AIDS cases).

AIDS defining events often include CD⁴ immune deficiency and an opportunistic infection (OI). Of the 2,997 adult/adolescent AIDS cases reported through 2002, CD⁴ immune deficiency was the single event to initiate case reporting for 1,759 (59%) cases. A single report may include more than one defining illness but the top four opportunistic infections were:

- wasting syndrome - 630 cases
- pneumocystis carinii pneumonia - 618 cases
- atypical mycobacterium avium - 251 cases
- esophageal candidiasis - 249 cases

Table 4.

Comparison of the characteristics of Delaware residents who died of HIV/AIDS in five year time periods from 1983 through 2002, n=1,537

Year of Death	1983-1987		1988-1992		1993-1997		1998-2002		Total	%
Characteristic	No.	%*	No.	%*	No.	%*	No.	%*		
GENDER										
Male	54	87%	276	88%	596	80%	307	74%	1233	80%
Female	8	13%	38	12%	149	20%	109	26%	304	20%
RACE/ETHNICITY										
White	36	58%	141	45%	226	30%	74	18%	477	31%
Black	20	32%	156	50%	482	65%	323	78%	981	64%
Hispanic	6	10%	17	5%	37	5%	19	4%	79	5%
MODE OF EXPOSURE										
MSM	43	69%	153	49%	247	33%	89	21%	532	35%
IDU	6	10%	95	30%	342	46%	216	52%	659	43%
MSM/IDU	6	10%	23	7%	55	7%	25	6%	109	7%
Heterosexual Contact	1	<1%	20	7%	85	11%	76	18%	182	12%
Other/NIR	6	10%	23	7%	16	2%	10	2%	55	4%
TOTAL	62	100%	314	100%	745	100%	416	100%	1537	100%

*percentages may not equal 100 due to rounding

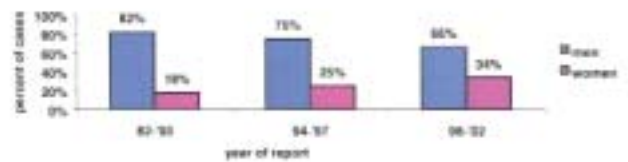
Table 4, above, illustrates how the percentage of deaths in men attributed to AIDS has decreased gradually since the beginning of the epidemic and increased slowly in women. By race, deaths have increased in the black population and decreased in the Hispanic and white populations. A sharp decline is noted in the deaths of MSM cases over time compared to the gradual increase in deaths between IDU and heterosexual cases.

Nationally⁴, the number of deaths declined in the Northeast, West, South; there was a decline and then leveling in the Midwest and decline and slight increase in U.S. territories. The number of deaths related to AIDS declined in all racial groups except American Indian/Alaska Natives. By sex and risk, deaths declined in MSM, male and female IDUs, and MSM/IDUs. Heterosexual cases of both sexes experienced a decline from 1996 to 1998 and then leveled.

HIV/AIDS by Gender and Race/Ethnicity:

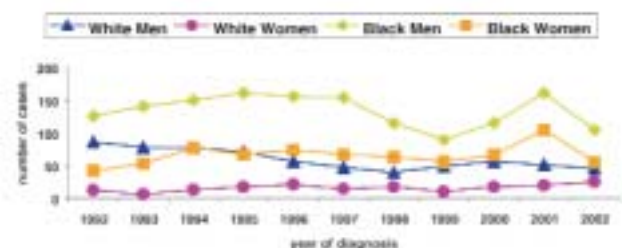
Figure 2 illustrates the distribution of Delaware HIV/AIDS cases by gender and year of report for the time periods 1982 – 1993, 1994 – 1998, and 1999 – 2002. The latest time period, 1999 – 2002 includes the collection of HIV case data implemented in July 2001. A gradual decrease from 82% to 66% is reflected in the percentage of male cases reported through the three time periods. Subsequently, a steady increase of cases in females with HIV/AIDS from 18% to 34% can be seen through the same reporting time periods.

Figure 2. Distribution of Delaware HIV/AIDS cases by gender and year of report through 2002, n=3810



Male HIV/AIDS cases continue to dominate case reports. Males represent 49% of Delaware's population, yet 72% of the HIV/AIDS cases. Females represent 51% of Delaware's population, and 28% of the HIV/AIDS cases. Figure 3 provides a graphical depiction of the racial trends in Delaware. Black men represent the majority of cases followed by Black women. The increase in 2001 is attributed to the onset of HIV reporting.

Figure 3. Comparison of Delaware HIV/AIDS cases by gender and race, diagnosed 1992 through 2002, n=3022



Delaware's HIV/AIDS epidemic continues to disproportionately affect the Black population. Blacks comprise 19% of the state population and 66% of the HIV/AIDS cases. Seventy-six percent of female cases, 61% of male cases and 73% of pediatric cases are within the Black population. Table 5 provides an overview of the racial distribution of Delaware HIV/AIDS cases. The "other" category in the table includes Asian/Pacific Islanders and Native American/Alaskan Natives. The category is compressed, for the protection of any individual case, due to small cell size.

Table 5.

Distribution of Delaware HIV/AIDS cases by race/ethnicity and gender in adult/adolescent cases and pediatric cases reported through 2002, n= 3,810

Race	Adult Male (n=2,734)		Adult Female (n=1,031)		Pediatric Cases (n=45)		Total (n=3,810)	
	#	%*	#	%*	#	%*	#	%*
White	893	33%	192	19%	8	18%	1,093	29%
Black	1,679	61%	786	76%	33	73%	2,498	66%
Hispanic	148	5%	49	5%	4	9%	201	5%
Other	14	1%	4	<1%	0	0%	18	<1%

* percentage may not equal 100 due to rounding

Nationally⁴, as shown below, 42% of all cases reported through December 2001 were White, 38% were Black and 18% were Hispanic and 1% were of another race or two or more races. However, when national gender and age group numbers are viewed, the proportion of cases by race/ethnicity depicts a growing epidemic in Black women and Black children. Through the end of 2001, female AIDS cases reported nationwide were 58% Black, 21% White, and 20% Hispanic. In pediatric cases of AIDS, 59% were Black, 17% White, and 23% Hispanic through 2001.

Table 6.

National distribution of AIDS cases by race/ethnicity and gender in adult/adolescent cases and pediatric cases reported through 2001, n=816,148

Race	Adult Male 13 years + (n=666,026)		Adult Female 13 years + (n=141,048)		Pediatric Cases < 13 years (n= 9,074)		Total Reported Nationally (n=816,148)	
	#	%*	#	%*	#	%*	#	%*
White	312,153	47%	30,156	21%	1,579	17%	343,888	42%
Black	225,836	34%	82,007	58%	5,337	59%	313,180	38%
Hispanic	120,131	18%	27,561	20%	2,060	23%	149,752	18%
Other	7,366	1%	1,243	<1%	85	<1%	8,694	1%
Unknown	540	0%	81	0%	13	0%	634	0%

* percentages may not equal 100 due to rounding

National Statistics in Men by Race

Delaware Statistics in Men by Race

The distribution of cumulative male AIDS cases by race nationally is 47% White, 34% Black, 18% Hispanic and 1% all other races.

Delaware's cumulative male HIV/AIDS cases through 2002 by race are 61% Black, 33% White and 6% in Hispanic and other races.

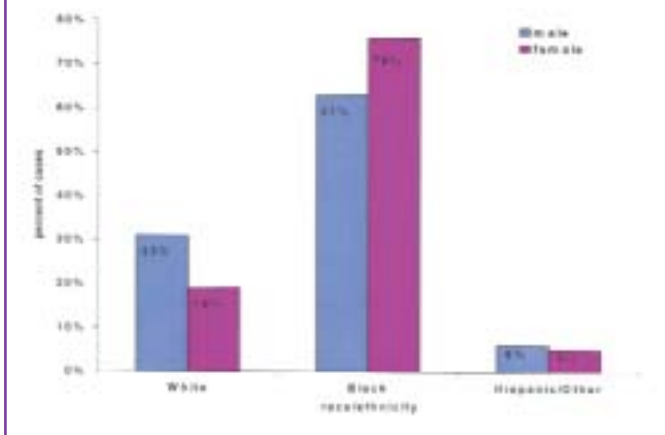
National Statistics in Women by Race

Delaware Statistics in Women by Race

Nationally, there are 141,048 cumulative AIDS cases in women through 2001. The distribution of the cases by race is 58% Black, 21% White, 20% Hispanic and 1% all other races.

Delaware's distribution of female HIV/AIDS cases through 2002 by race is 76% Black, 19% White and 5% Hispanic and other races.

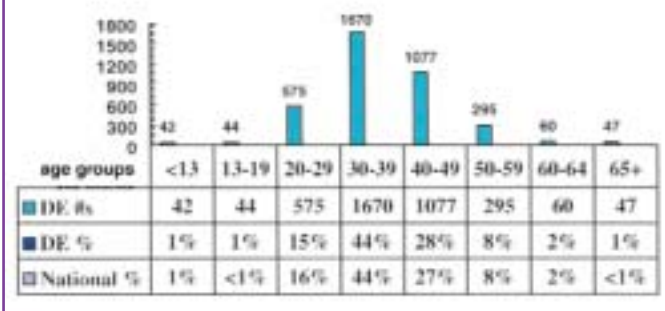
Figure 4. Distribution of Delaware HIV/AIDS cases by race and gender through December 2002, n=3,810



HIV/AIDS by Age Group:

Age group refers to the age a person first tests positive for HIV or age at diagnosis of AIDS. When compared by age group, Delaware's HIV/AIDS statistics through 2002 are similar to the national statistics for 2001. As portrayed in Figure 5, below, the percentages differ little.

Figure 5. Distribution of Delaware HIV/AIDS cases by age groups through 2002, n=3,810



HIV/AIDS by Adult/Adolescent Mode of Exposure:

For surveillance purposes, HIV/AIDS cases are counted only once in a hierarchy of exposure categories established by CDC. Persons with more than one reported mode of exposure to HIV are classified in the category listed first in the hierarchy, except for men with both a history of sexual contact with other men and injecting drug use. They comprise a separate exposure category. This hierarchy of exposure categories in adult/adolescent cases is as follows:

1. Men who have sex with men
2. Injecting drug user
3. Men who have sex with men and inject drugs
4. Heterosexual contact "sex partner at risk"
 - a. sex with an injecting drug user
 - b. sex with a bisexual male
 - c. sex with a person with hemophilia
 - d. sex with a transfusion recipient with HIV
 - e. sex with a transplant recipient with HIV
 - f. sex with a person with AIDS/HIV; with a risk unspecified
5. Transfusion of blood/blood components
6. Transplant of tissue/organs or artificial insemination
7. Worked in a health care or laboratory setting

If a patient admits to certain sexual or drug use behaviors, the patient is ranked along this continuum of possible exposures to HIV. Nationally⁴, 10% of the AIDS cases reported through December 2001 were "no identified risk" (NIR). Surveillance personnel place a high priority on determining risk and 4% of Delaware's cases at the end of 2002 were classified as NIR. This denotes an increase from 2% in 2001, when HIV case reporting regulations were first implemented. The NIR increase actually reflects cases where the reporting source does not have the risk information to report, i.e. private laboratories, blood banks and lab tests conducted during inpatient hospitalizations where results come after discharge. Surveillance staff attempts to resolve the "no risk reported" (NRR) cases when reviewing medical records.

Table 7.

Comparison of all Delaware HIV/AIDS cases by mode of exposure diagnosed through 2001, n=2820 to cases diagnosed through 2002, n=3810

Mode of exposure	through 2001		through 2002	
	No.	%*	No.	%*
Injection drug use (IDU)	1204	43%	1531	40%
Men who have sex with men (MSM)	884	31%	1101	29%
Heterosexual contact with PWA	174	6%	420	11%
Heterosexual contact with an IDU	251	9%	313	8%
Men who inject drugs & are MSM	169	6%	204	5%
No identified risk (NIR)	67	2%	137	4%
Other modes *	71	3%	104	3%
Total cases	2820	100%	3810	100%

* Percentages may not equal 100 due to rounding.

Table 7 illustrates the mode of exposure for all Delaware HIV/AIDS cases and compares the data available last year (through 2001) to the information available through 2002. The mode of exposure or transmission of HIV describes the behavioral characteristics of a person at risk for acquiring HIV infection. Injecting drug use (IDU) remains the greatest percentage of cases for both years. Men who have sex with men (MSM) continue to rank second. The move of heterosexual contact with a person with HIV or AIDS to third (11%) surpassing heterosexual contact with an IDU should be viewed with caution. Risk information on initial case report forms is often revised after medical record reviews reveal the "person with HIV or AIDS" is an IDU or bisexual. Other modes of exposure (*) include pediatric cases infected through mothers, transfusion recipients, and additional transmission modes that resulted in less than 3% of Delaware's HIV/AIDS cases.

National Statistics in Men by Mode	Delaware Statistics in Men by Mode
National statistics through 2001 for AIDS indicate the distribution of male cases by mode are 55% MSM, 22% IDU, 8% MSM/IDU and 5% heterosexual contact. The remaining 10% are related to other modes and cases with risk not identified.	Delaware had 2,734 men reported with HIV/AIDS through 2002. Forty percent (n=1,101) were MSM, 39% (n=1,062) were IDU, and 9% (n=245) were heterosexual contact only. Of the 245 heterosexual contacts, sex with a woman with HIV comprised 56% (n=137). Sex with a woman who was an IDU accounted for 42% (n=103) of the cases and 2% (n=5) were sex with a woman who received blood products or a transfusion. MSM/IDU were reported in 7% (n=204) cases and the remaining 5% (n=125) are related to other modes and cases with risk not identified or reported.
National Statistics in Women by Mode	Delaware Statistics in Women by Mode
Nationally, 26% (n=10,809) of the new AIDS cases reported in 2001 were female. Heterosexual contact accounts for 65% (n=7,066) of the new female cases. Injecting drug use is attributed to 3,410 of cases (32%). Risk not identified/reported, comprise the remaining 333 (3%) national cases.	Delaware had 1,030 case of HIV/AIDS reported in women through 2002. Fifty percent (n=512) of the women with HIV/AIDS in Delaware, at the end of 2002, were infected through heterosexual contact. Sex with a person with HIV comprises 55% (n=283) of the heterosexual cases with 45% (n=210) due to sex with an injecting drug user. The final 5% (n=19) of the heterosexual contacts were sex with a bisexual man and sex with men who had received blood products or transfusions. Injecting drug use accounts for the transmission of HIV in 45% (n=469) of the remaining women and 5% (n=49) risk not reported/identified or other.

The first 10 years of the AIDS epidemic in Delaware (1983 - 1992) is quite a different picture than the most recent 10 years (1993 - 2002). Table 8 compares the top six behavioral groups reported in one ten year period to the other. The number of cases reported in each time period is noted under the year of report. The columns indicate the number of cases in each behavioral group and the percentage is representative of the whole number reported.

Table 8.
Comparison of the first 10 years of HIV/AIDS cases reported to the second ten years by mode through December 2002

Year of Report	1983-1992 n=586		1993-2002 n=3,224	
Total number of cases reported in the period				
Behavioral Risk Group	#	%*	#	%*
men who have sex with men (MSM)	286	49%	815	25%
men who inject drugs (IDU)	123	21%	939	29%
women – with male sex partners at risk	25	4%	487	15%
women who inject drugs (IDU)	56	10%	413	13%
men – with female sex partner at risk	15	3%	230	7%
men who inject drugs & are MSM (MSM/IDU)	47	8%	157	5%
all other modes including NIR or NRR cases	34	6%	183	6%

* Percentages may not equal 100 due to rounding.

As previously demonstrated, the table above illustrates again the decrease in cases of men who are MSM. By comparing the two decades of the epidemic, the percentages in MSM decreased by nearly half, from 49% in the first decade to 25% in the second. The other obvious change is the increase in women with male sex partners at risk. The percentage increased close to 300% where the heterosexual partners of the women were intravenous drug users, bisexual men and/or HIV infected. The percentage of men with female sex partners who are at risk through injecting drug use and/or female partner is HIV infected more than doubled from 3% to 7% from the first to the second decade respectively.

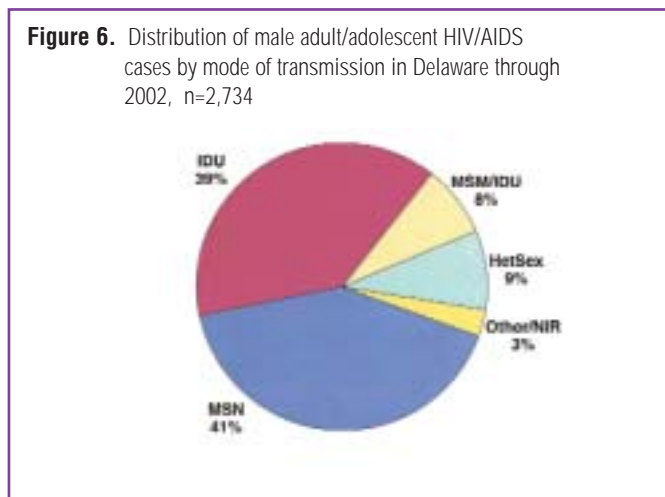
The next portion of the profile continues to address modes of transmission in *adult* and *adolescent* cases of HIV/AIDS. To illustrate any reporting changes, the data is separated into two ten-year periods. An increase of close to 50% (from 16% to 30%) is noted in the percentage of female cases reported.

Table 9.
Distribution of adult/adolescent HIV/AIDS cases by gender in 10 year periods
1983-1992 and 1993-2002 in Delaware cases reported through 2002, (n=3,765)

Year of Report Total cases reported in period	1983-1992 n=579		1993-2002 n=3,186		Total 3,765	
	#	%	#	%	#	%
Gender						
Males	489	84%	2,245	70%	2,734	73%
Females	90	16%	941	30%	1,031	27%
Total	579	100%	3,186	100%	3,765	100%

Adult/Adolescent Transmission Modes in Males:

The modes of transmission for HIV/AIDS in Delaware adult/adolescent male cases have modified over time. At the end of 1992, 58% of the cases were MSM, 25% were IDU, and 10% MSM/IDU. Men infected through sex with a woman with HIV or sex with a woman who injected drugs comprised 3% of the AIDS cases reported. The figure below shows the distribution of modes of transmission through 2002 and illustrates how the percentages have shifted away from MSM and MSM/IDU to increases in IDU and heterosexually infected men in Delaware.



Men Who Have Sex with Men (MSM):

Men who have sex with men represented 58% (n=286) of the 489 male adult/adolescent cases reported in the first 10 years of the epidemic. From 1993 through 2002 the percentage of male cases attributed to MSM decreased to 36% (n=815) of the 2,245 cases reported in men in Delaware. The race and age groups for men who have sex with men are shown below in Table 10 and are split into ten-year periods to compare

any changes in the epidemic among the MSM population from one decade to the other.

Table 10.

Demographic characteristics of race and age group in men who have sex with men by year of report in Delaware 1983 – 2002, n=1,101

Variable	1983 through 1992 (n=286)		1993 through 2002 (n= 815)	
	#	%**	#	%**
Race/Ethnicity				
White	186	66%	446	55%
Black	90	31%	331	41%
Hispanic/Other	8	5%	38	4%
Age Groups				
13-19	0	0%	8	<1%
20-29	65	23%	162	20%
30-39	125	44%	385	47%
40-49	62	22%	181	22%
50-59	30	10%	52	6%
60-69	4	1%	23	3%
70-79	*	n/a	4	<1%

* cases in this age group are merged with previous age group due to small cell size
** percentages may not equal 100 due to rounding.

An increase in the number of MSM cases in men of color is noted in the second time period compared to a decrease in the White population. Additional cases in all age groups from 1993 through 2002 are likely due to the 1993 change in case definition. The presence of cases in the 13-19 age group and a tripling of cases in most all other

age groups are likely representative of the influence HIV reporting lends to the portrait of the epidemic in Delaware.

As of December 31, 2002, a cumulative total of 933 MSM with AIDS had been reported and 168 with HIV for a total of 1,101 with HIV/AIDS. Men who have sex with men represent 29% of the cumulative HIV/AIDS cases reported in Delaware through 2002.

Illustrated in Figure 7, the number of MSM cases reported by race and ethnicity has remained fairly level in men of Hispanic origin with minimal change over the twenty-year period. Though men who have sex with men appear to be most often in the White population on the chart, the number of MSM in the Black population is rising. The increase in all race/ethnic groups in '93-'94 and in '01-'02 are the result of the 1993 AIDS case definition change and implementation of HIV reporting respectively.

Figure 7. HIV/AIDS cases among men who have sex with men (MSM) by race and ethnicity by year of report in Delaware 1983 through 2002, n = 1,101

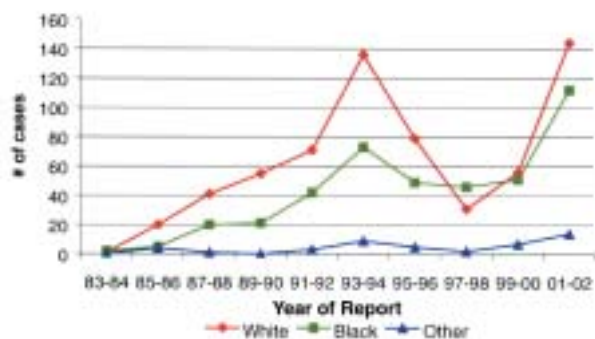
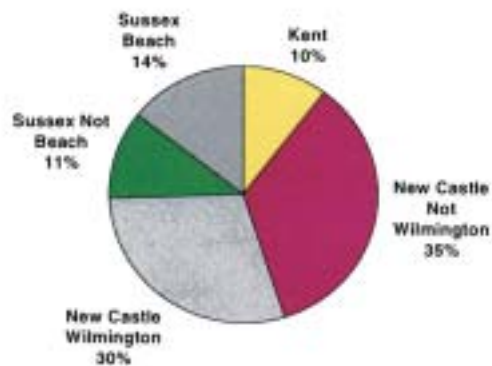


Figure 8 geographically depicts the distribution of MSM cases in Delaware. The figure shows 65% reside in New Castle County with 30% in zip codes 19801, 19802, 19805 and 19806 or the City of Wilmington and 35% in the rest of New Castle County. Twenty-five percent reside in Sussex County with 14% in the five "Beach" zip codes and the remaining 11% in the remainder of Sussex County. Ten percent of the MSM reside in Kent County.

Figure 8. Distribution of men who have sex with men with HIV/AIDS by residence at time of report in Delaware through 2002, n=1,101



Men Who Inject Drugs:

Men who inject drugs represented 25% (n=123) of the 489 male adult/adolescent cases reported in the first 10 years of the epidemic. From 1993 through 2002 almost a 100% increase was noted when male IDU cases rose to 49% (n=939) of the 2,245 cases reported in Delaware. The race and age groups for men who inject drugs are shown below and are split into ten-year periods to compare any changes in the epidemic among the IDU population from one decade to the other. The disproportionate number of IDU in the Black male population is significant.

Table 11.

Men who inject drugs: demographic characteristics of HIV/AIDS cases by race and age group by year of report 1983 – 2002 in Delaware

Variable	1983 through 1992 (n=123)		1993 through 2002 (n=939)	
	#	%**	#	%**
Race/Ethnicity				
White	17	14%	99	11%
Black	92	75%	777	83%
Hispanic/Other	14	11%	63	7%
Age Groups				
13-19	0	0%	0	0%
20-29	17	14%	58	6%
30-39	63	51%	379	40%
40-49	36	29%	395	42%
50-59	7	6%	97	10%
60-69	*	n/a	10	1%
70-79	*	n/a	0	0%

*cases in the 50-79 age groups are merged due to small cell size
** percentages may not equal 100 due to rounding.

The following chart depicts the number of male IDU cases in adult/adolescent HIV/AIDS cases by year of report. Two periods, 1992 to 1993 and 2000 to 2001 reflect nearly a 300% increase in the number of cases reported. *The increase is attributed to the change in the AIDS definition and implementation of HIV reporting occurring in the years respectively.*

Figure 9. HIV/AIDS cases among men who inject drugs (IDU) by year of report in Delaware 1986 through 2002, n=1,062

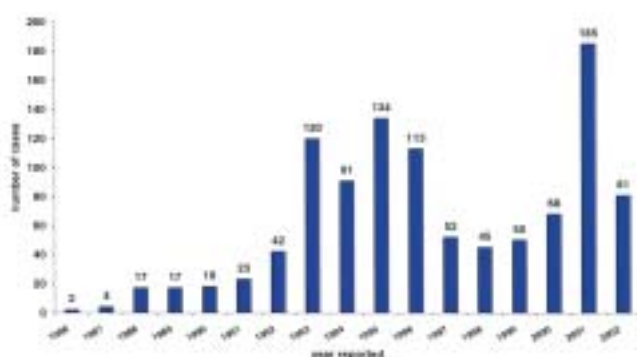
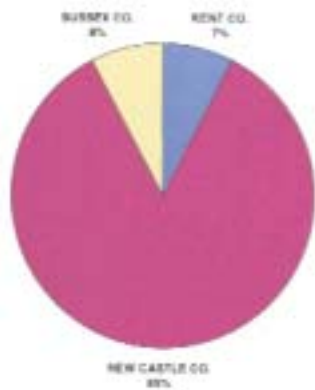


Figure 10. Men who inject drugs by county of residence in Delaware through December 2002, n= 1,062



Men Who Inject Drugs and Who Also Have Sex with Men (MSM/IDU)

Male injection drug users who also have sex with men (MSM/IDU) are the fourth highest behavioral risk in Delaware's HIV/AIDS population. A cumulative total of 204 MSM/IDU cases have been reported through December 2002 representing 5% of the total number of cases. The table below depicts an increase of greater than 160% in the percentage of MSM in the age group 40-49 in the second decade of reporting.

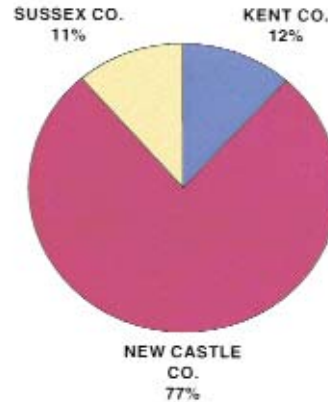
Table 12.

Race and age demographic characteristics in male injecting drug users who also have sex with men by year of report, Delaware 1983–2002, n=204

Variable	1983 through 1992 (n=47)		1993 through 2002 (n= 157)	
	#	%**	#	%**
Race/Ethnicity				
White	16	34%	43	27%
Black	28	60%	104	66%
Hispanic/Other	3	6%	10	7%
Age Groups				
13-19	0	n/a	0	n/a
20-29	10	21%	18	11%
30-39	27	57%	82	52%
40-49	5	11%	46	29%
50-59	5	11%	7	4%
60-69	0	n/a	4	3%
70-79	0	n/a	0	n/a

*percentages may not equal 100 due to rounding

Figure 11. Distribution of men who have sex with men and inject drugs by county of residence in Delaware through 2002, n=204



Men Reported with Heterosexual Mode of Transmission Only:

Nationally⁴, 9% (n=2,762) of the adult/adolescent males reported with AIDS in 2001 were exposed through heterosexual contact. Twenty percent were reported as infected through sex with an injecting drug user and 58% through sex with an HIV-infected woman, risk not specified.

The table below compares the demographics of race/ethnicity and age groups for the two decades of the Delaware epidemic in men who were heterosexually infected with HIV. Both decades indicate Black men and men in the 30-39 year age group are most frequently reported with a heterosexual transmission mode. In the first decade of the epidemic, more than two-thirds (66%) of the heterosexual men were Black and in the second decade three-quarters (77%) were Black. White men who were reported as heterosexually infected have decreased by more than half, from 33% to 15%. The absence of any heterosexual Hispanic men in the first decade is more than likely attributed to lack of HIV education, treatment and/or early intervention in the population.

Table 13.

Demographic characteristics of race and age group in heterosexual men by year of report in Delaware 1983 – 2002, n=245

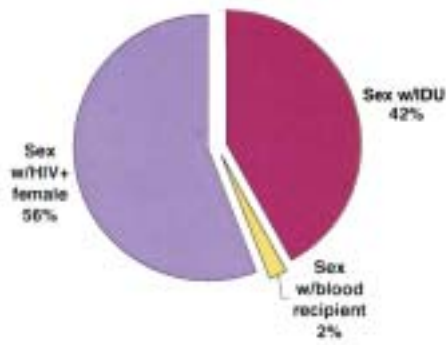
Variable	1983 through 1992 (n=15)		1993 through 2002 (n= 230)	
	#	%**	#	%**
Race/Ethnicity				
White	5	33%	35	15%
Black	10	67%	178	77%
Hispanic/Other	0	0%	17	7%
Age Groups				
13-19	0	0%	*	n/a
20-29	*	n/a	29	13%
30-39	9	60%	98	43%
40-49	6	40%	59	27%
50-59	0	0%	26	11%
60-69	*	n/a	16	7%
70-79	0	0%	*	n/a

*cases in these age groups are merged with the closest age group due to small cell size

** percentages may not equal 100 due to rounding.

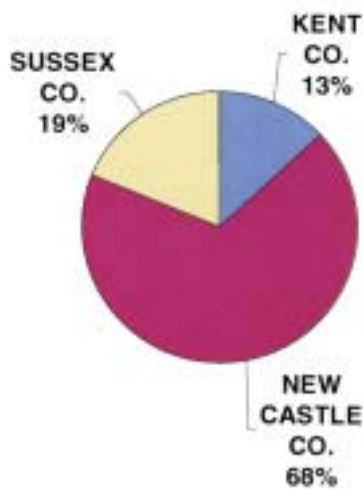
Delaware men infected through heterosexual contact with a woman, represent 9% of the male population reported cumulatively. Figure 12 illustrates that sex with an injecting drug user was indicated in 42% (n=103) of the cases and 56% (n=137) had sex with a woman with HIV, risk not specified.

Figure 12. Distribution of female partner's risk in men reported as heterosexually HIV-infected in Delaware through 2002, n=245



The distribution by county of residence in men reported as infected with HIV through heterosexual contact is shown in the figure that follows. More than two-thirds, 68%, of the heterosexually infected men are residents of New Castle County, 19% from Sussex and 13% in Kent County.

Figure 13. Men reported in Delaware as infected through heterosexual contact with a female sexual partner at risk for HIV by county through 2002, n=245



Adult/Adolescent Transmission Modes in Females

The table below splits the first two decades of the HIV/AIDS epidemic in the female injecting drug users by race and age at year of report. The Black IDU female population is the most affected by the HIV/AIDS epidemic in both decades and the percentage of IDUs in White females more than doubled. And though the 30-39 year age group is clearly the group most often affected in both decades, the nearly 200% increase in the 20-29 year age group is significant as well.

Table 14.

Women who inject drugs: demographic characteristics of race and age group by year of report in Delaware 1983 – 2002, n=469

Variable	1983 through 1992 (n=56)		1993 through 2002 (n= 413)	
	#	%**	#	%**
Race/Ethnicity				
White	4	7%	64	15%
Black	46	82%	335	81%
Hispanic/Other	6	8%	14	3%
Age Groups				
13-19	0	0%	9	2%
20-29	3	5%	53	13%
30-39	39	70%	213	56%
40-49	14	25%	121	29%
50-59	*	n/a	17	4%
60-69	0	0%	*	n/a
70-79	0	0%	0	0%

* cases in this age group are merged with the closest age group due to small cell size
** percentages may not equal 100 due to rounding.

Figure 14. HIV/AIDS cases among women who inject drugs (IDU) by year of report in Delaware 1987 through 2002, n=469

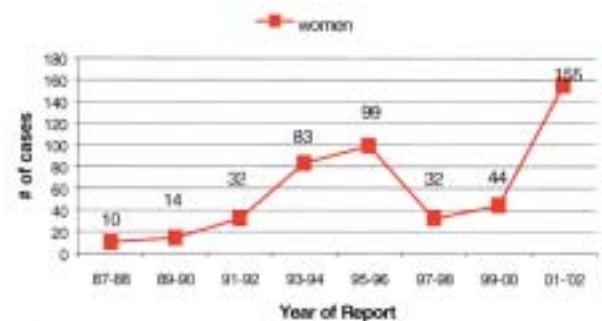
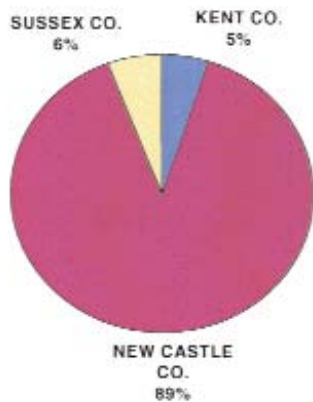


Figure 14, reflects the number of cases reported in two-year periods for women reported with HIV/AIDS who inject drugs. The increase in the number of cases reported in the '93-'94 period is attributed to the change in the AIDS case definition. The rise in 2001 is due to the implementation of HIV reporting.

Figure 15 depicts the distribution of women reported with HIV/AIDS who are injecting drug users by county of residence at time of report. New Castle County is illustrated as home to 89% of the women who inject drugs.

Figure 15. Women with HIV/AIDS who inject drugs by county of residence in Delaware through December 2002, n= 469



Women with Male Sex Partners at Risk (Heterosexual Contact)

Table 15 compares women HIV-infected by a male partner in the periods 1983 –1992 and 1993 –2002. In Black and White women the percentages dropped from 76% to 73% and 24% to 21% respectively. Though there were no Hispanic women reported as infected by a male partner in the first decade, women of Hispanic origin were 6% in the second decade.

Table 15 also denotes a 50% decrease in the percentage of women in the 20-29 year age group who were HIV-infected by a male partner. There was an increase in the number of female cases attributed to heterosexual transmission in both the 30-39 and 40-49 age groups.

Table 15.

Heterosexual contact in women: demographic characteristics of race and age group by year of report in Delaware 1983 – 2002, n=512

Variable	1983 through 1992 (n=25)		1993 through 2002 (n=487)	
	#	%**	#	%**
Race/Ethnicity				
White	6	24%	103	21%
Black	19	76%	354	73%
Hispanic/Other	*	n/a	30	6%
Age Groups				
13-19	*	n/a	20	4%
20-29	12	48%	118	24%
30-39	9	36%	191	39%
40-49	4	17%	110	23%
50-59	0	0%	36	7%
60-69	*	n/a	12	3%
70-79	0	0%	*	n/a

* White and Other races merged due to small cell sizes. Age group with * merged with next closest age group with cases due to small cell sizes. ** percentages may not equal 100 due to rounding.

In Figure 16, the women reported with heterosexually acquired HIV are broken down by the risk of the partner thought to have exposed them. Sex with an injecting drug user was reported as the partner's risk in 41% (n=210) of the cases and 55% (n=283) had sex partners who were HIV positive.

Figure 16. Distribution of male partner's risk in women reported as heterosexually HIV-infected in Delaware through 2002, n=512

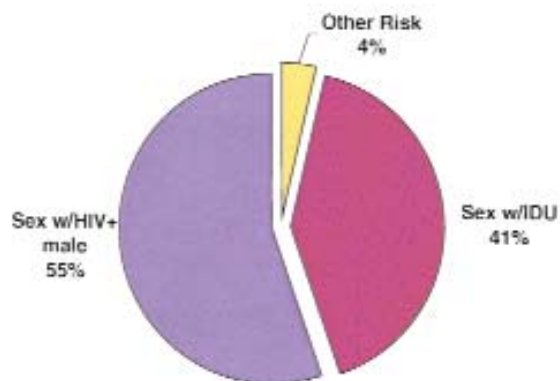
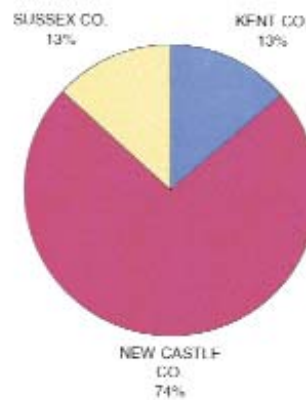


Figure 17 shows the county where the women were residing at the time they were diagnosed with HIV/AIDS. Nearly three-quarters (74%) reside in New Castle County with the remaining 26% distributed evenly between Kent and Sussex Counties.

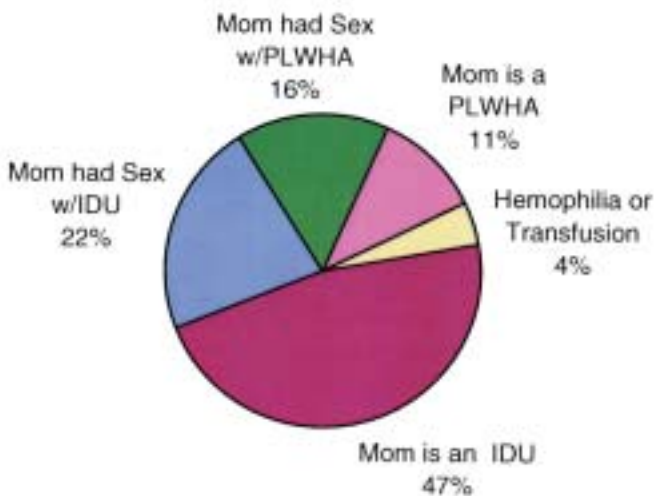
Figure 17. Women reported in Delaware as infected through heterosexual contact with a partner at risk for HIV by county of residence through 2002, n=512



Pediatric HIV/AIDS Cases

Delaware has 45 pediatric cases of HIV/AIDS. Eighteen have HIV infection and 27 are AIDS defined. Thirty-five (78%) of the children are living and 10 (22%) have died. Race/Ethnicity distribution for pediatric cases is 73% Black, 18% White and 9% Hispanic. Geographically, 76% (n=34) were living in New Castle County at diagnosis of HIV/AIDS, 16% (n=7) in Kent County and 8% (n=4) in Sussex County.

Figure 18. Distribution of pediatric HIV/AIDS cases by mode of transmission in Delaware through 2002, n=45



As depicted in Figure 18, forty-seven percent of the pediatric cases were born to mothers who were injecting drug users and 22% to

mothers who had sex with injecting drug users. Sixteen percent of the pediatric cases were born to mothers who had sex with someone with HIV/AIDS and 11% were born to mothers who had HIV/AIDS. The perinatal exposures comprise 96% of the risk for pediatric cases in Delaware with hemophilia, transplant or transfusion risks associated to the remaining 4%.

Nationally⁴, through December 2001, a total of 9,074 children (<13 years of age) had been reported as having AIDS; of these pediatric cases, 5,257 (58%) had died. During 2001, 175 new cases of AIDS in children were reported. Of these, 150 (86%) were attributed to perinatal exposure.

The number of pediatric HIV (not AIDS) cases reported nationally, increased dramatically from 224 cases in children younger than age 13 reported during 2000 to 543 cases during 2001. The cumulative total nearly doubled from 2,134 HIV (not AIDS) cases reported through 2000 to 3,923 HIV (not AIDS) cases reported through the end of 2001. Note that not all HIV cases reported in 2001 reflected new diagnoses; rather, the HIV cases reported include cases diagnosed during earlier years.

HIV/AIDS by Geographical Location:

Table 16.

HIV/AIDS cases through December 2002 by county with the City of Wilmington and Beach populations illustrated separately, n=3,810

County of Residence	Kent County = 361		New Castle County = 2,887				Sussex County = 552			
			WILMINGTON		NOT WILMINGTON		BEACH		NOT BEACH	
Characteristic	No.	%	No.	%	No.	%	No.	%	Total	%
Gender										
Male	257	71%	1197	69%	842	72%	188	94%	269	74%
Female	104	29%	527	31%	321	28%	12	6%	93	26%
Total	361	100%	1724	100%	1163	100%	200	100%	352	100%
Race/Ethnicity										
White	114	32%	206	12%	490	42%	162	81%	122	34%
Black	215	60%	1410	82%	617	53%	34	17%	220	61%
Hispanic	32	9%	101	6%	56	5%	4	2%	20	5%
Other	•	0%	7	<1%	•	0%	•	0%	•	0%
Total	361	100%	1724	100%	1163	100%	200	100%	352	100%
Mode of Exposure										
MSM	114	32%	324	19%	381	33%	159	80%	122	34%
IDU	99	27%	919	53%	400	34%	12	6%	100	28%
MSM/IDU	19	5%	96	6%	63	5%	11	6%	15	4%
Heterosexual Contact	101	30%	308	18%	236	20%	12	6%	102	28%
Pediatric Exposure	7	2%	21	1%	13	1%	0	n/a	5	1%
Other/NIR	21	6%	56	3%	70	6%	6	3%	18	5%
Total	361	100%	1724	100%	1163	100%	200	100%	352	100%

*percentage may not equal 100 due to rounding • merged with Hispanic due to small size

Delaware HIV/AIDS Surveillance has historically distributed morbidity statistics on New Castle County separate from the City of Wilmington. A similarity in the demographic characteristics of people living in zip codes 19801, 19802, 19805 and 19806 and diagnosed with HIV/AIDS illustrated a different epidemic emerging from the downtown area. As depicted in Table 16, more than two thirds (69%) of the City of Wilmington HIV/AIDS cases are male. In excess of three-quarters (82%) of the HIV/AIDS cases in the City are Black and more than half (53%) are injecting drug users. In the remainder of New Castle County the percentage of men with HIV/AIDS is greater than the City of Wilmington at 72%. Modes for transmission of the virus are slightly higher in the City of Wilmington in IDUs at 53% compared to the rest of New Castle County with 34%. The reverse is seen in the MSM population where the City of Wilmington is 19% and the rest of New Castle County higher with 33%. Other modes of transmission are more equally dispersed in both areas.

Although Kent County appears to have the largest percentage of heterosexual cases compared to the other four areas throughout the state, it is because New Castle and Sussex were broken down by zip codes to depict epicenters of HIV disease.

In Sussex County, the beach area HIV/AIDS statistics show cases are 94% male, 81% white and 80% men who have sex with men. The statistics represented in the previous table do not incorporate the men who have sex with men who have retired and established permanent residency on the shore, or those with dual residencies in Philadelphia, Baltimore and the District of Columbia. The beach area is a much different population than the cases residing throughout the remaining zip codes in Sussex County where nearly three-quarters (74%) are male, 61% are Black and modes of transmission are for the most part evenly distributed over MSM, IDU and heterosexual contact.

Question 3. *What are the indicators of risk for HIV/AIDS infection in Delaware?*

To assist community planning groups address populations at risk for HIV infection, this portion of the profile looks at data collected in other databases. Limitations of the data sets were addressed in the methodology section.

- As an extension of HIV/AIDS surveillance, the Supplement to HIV/AIDS Surveillance⁵ (SHAS) project collects risk behavioral information on adults living with HIV/AIDS.
- HIV Counseling and Testing data is collected at all DPH publicly funded test sites. Counselors assess risk behaviors for HIV infection in pre-test and post-test counseling sessions.
- People seeking treatment for sexually transmitted infection (STI) or disease (STD) share one or more risk factors with persons diagnosed with HIV infection. The existence of an STD indicates the individual has had unprotected sex. Sex with someone who has HIV could increase the possibility of transmission of HIV through the sore and into bloodstream.

Supplement to HIV/AIDS Surveillance⁵ (SHAS) Project Data:

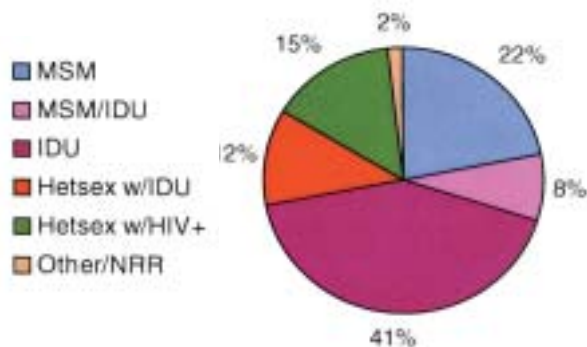
Table 17.

Demographics of SHAS interviews conducted July 1, 2000 through June 2003, n=287

HIV/AIDS Interviews Completed in Delaware July 1, 2000 through June 30, 2003 (n=287)			
		No.	%
Gender	Male	192	67%
	Female	95	33%
Race/Ethnicity	White	64	22%
	Black	211	74%
	Hispanic all races/Other	12	4%
Interview Location	Home	148	52%
	ID/Wellness Clinics	82	29%
	Hospital	9	3%
	DPH	16	6%
	Other	32	11%
Mode of Transmission	MSM	63	22%
	IDU	120	41%
	MSM/IDU	23	8%
	Hetsex w/IDU	34	12%
	Hetsex with PWH/A	42	15%
	NIR/NRR/Other	5	2%
Total		287	100%

Delaware began involvement in the SHAS project as a pilot state in 1991 through supplemental funding from the Centers for Disease Control and Prevention. Through December 31, 2002, SHAS interviews were only conducted with clients diagnosed with AIDS. Upon implementation of HIV reporting in July 2001, subsequent application was made to the Human Subjects Review Board (HSRB) to include people diagnosed with HIV. Approval was granted in the fall of 2002 and inclusion of HIV positive clients into the SHAS project was initiated in January 2003. Application to interview incarcerated people with HIV and AIDS was made in the winter of 2002. The Delaware HSRB accepted the application and approval was granted at the federal level from the Office of Human Research Protection (OHRP) in March 2003. Delaware is the first surveillance office in the nation to interview subjects in correctional facilities. Though little information collected on prison interviews is included in this profile, the information collected through June 30, 2004 may prove valuable to prevention and treatment program planning for the Department of Correction.

Figure 19. Percentage of clients SHAS interviewed July 2000 – June 2003 by mode of transmission reported in HARS, n=287



Most questions relating to behavioral risk in SHAS ask the patient to answer the question in relationship to a time period. One of the following three time periods is used in the data that follows:

- 12 months prior to interview, an anchor date is assigned at onset of interview to simplify the time frame for the participant. An interview conducted June 2003 would cover a calendar year of 12 months back to May 2002.
- Before you tested positive for HIV,
- The last time you engaged in a specific activity.

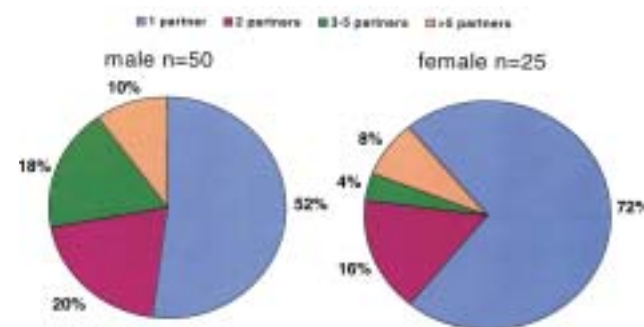
Questions asked of the participants in SHAS that may be used to assess the risk behaviors for the transmission of HIV include:

- Number of sex partners,
- Frequency of condom use or unprotected sex,
- Exchange of money or drugs for sex,
- Injecting drug or other substance use,
- Needle sharing or preventive measures with needle use.

SHAS in Injecting Drug Users (IDU)

Forty-one percent (n=120) of the SHAS participants interviewed in the period July 2000 through June 2003 were identified by the reporting source as IDU. Of the IDU interviewed, 86% (n=103) were black, 11% (n=13) were white and 3% (n=4) were Hispanic/Other. By gender the IDU were 65% (n=78) male and 35% (n=42) were female. In male injecting drug users, 64% (n=50) had sex in the 12 months prior to the interview. In female injecting drug users, 60% (n=25) had sex in the 12 months prior to the interview.

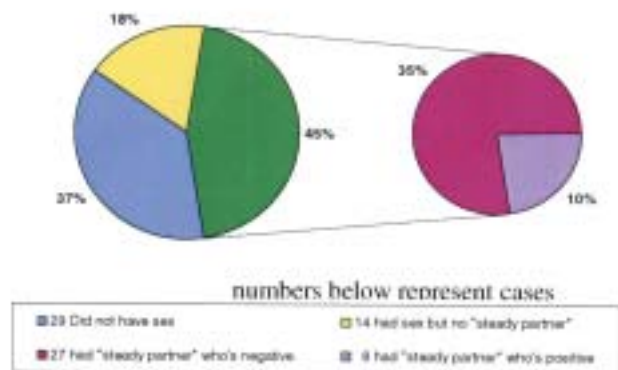
Figure 20. IDU SHAS participants who had sex in the 12 months prior to date of interview by gender and number of partners, n=75



Male IDU SHAS Participants

Seventy-eight of the male SHAS participants were identified by the reporting source as IDU. Twenty-nine (37%) did not have sex in the 12 months prior to the interview. Fourteen (18%) had sex but no steady sex partner. Of the 36 who had a steady partner, 8 (10%) knew their steady partner was positive, 27 (35%) knew their steady partner was negative and 1 (3%) did not know their partner's HIV status and is not illustrated in Figure 21.

Figure 21. Male SHAS participants who are IDU and their sexual activity in the 12 months prior to the SHAS interview, n=78



Eighty-one percent (n=22) of the 27 men with HIV negative partners use condoms during vaginal intercourse.

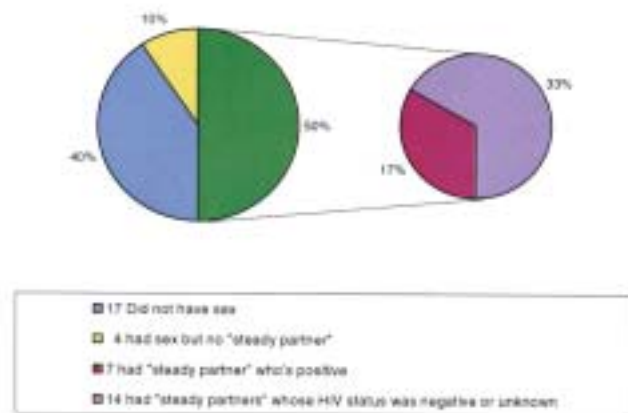
Female IDU SHAS Participants

Forty-two (44%) of 95 female SHAS participants were identified by reporting sources as IDU. Seventeen (40%) did not have sex in the 12 months prior to the interview. Twenty-five (60%) of the 42 female IDU SHAS participants had sex in the 12 months prior to the interview. Of the 25 women, who had sex in the time frame, 4 (16%) did not have a "steady partner" and 21 (84%) had a "steady partner".

- 7 women knew their "steady partner" was positive and
- 14 women knew their "steady partner" was negative or did not know status

Sixty-seven percent of the 21 women with "steady partners" used condoms regardless of the "steady partner's" HIV status.

Figure 22. Female SHAS participants who are IDU and their sexual activity in the 12 months prior to the SHAS interview, n=42



Twenty-nine (24%) of the 120 SHAS participants identified by reporting sources as an IDU at time of report denied ever injecting drugs. Eleven (38%) of those who denied ever injecting a drug also denied ever using any non-injecting drugs as well.

Ninety-one (76%) of the 120 SHAS participants identified by reporting sources as an IDU at time of report responded they had injected a drug. Fifty-one (56%) said the drug they injected most often was cocaine followed by 24 (26%) who chose heroin as their most often used drug. In addition, more than half (52%) of the injecting drug users had used crack in a crack house and 34% (n=16) had sex in a crack house.

Seventy-five (82%) of those 91 SHAS participants who claimed to have injected drugs had shared needles and 45% (n=34) cleaned their syringes "every time" while 11% (n=8) "never" cleaned their syringes. Of the 75 who have shared needles, seven (9%) have used in the 12 months prior to the interview and the needle was obtained "off the street" by 4 participants and 3 other participants got their needle "from a friend", "from a drug dealer" or "refused to answer."

Sixty (80%) of the participants, who used a needle in the 12 months prior to the interview, have been in drug treatment. Twenty-one (28%) had been enrolled in a drug treatment program in the 12 months prior to the interview.

SHAS in Men Who Have Sex with Men (MSM)

Twenty-two percent (n=63) of the SHAS participants interviewed in the period July 2000 through June 2003 were identified by the reporting source as MSM. Of the MSM interviewed, 52% were white, 44% were black and 4% were Hispanic or other.

Of the 63 MSM SHAS participants, 10% (n=6) had been treated for an STD in the 12 months prior to the interview date.

Twelve (19%) of the MSM said they had been given drugs or money for sex, while 13 (21%) responded they had given someone money or drugs for sex in the 12 months prior to the interview date.

The 63 men reported in HARS as MSM self-identified their sexual orientation as:

- 43 (68%) Homosexual/Gay
- 13 (22%) Heterosexual/Straight
- 7 (10%) selected Bisexual/Other

Of the 63 MSM participants 47 (75%) said they had sex in the 12 months prior to the interview date and 16 (25%) had not had sex during the time frame.

Data from the SHAS database, not mutually exclusive, on the 47 MSM who had sex in the time frame:

- Forty (85%) identified their sex partners as male only;
- One (2%) had both a male and female sex partner;
- Six (13%) identified their sex partners as female only;
- Twenty-five (53%) were in a "steady and monogamous relationship";
- Fifteen (32%) had fewer than 5 sex partners in the time frame; and
- Seven (15%) had more than 5 partners in the 12 months prior to the interview.

Twenty (49%) of the 41 MSM who had sex in the time frame engaged in sex where they were an anal receptor of their partner the last time they had sex. Fifteen (75%) of these 20 men used condoms the last time they received anal sex. Fourteen (34%) of the 41 MSM who had sex in the time frame engaged in sex where they penetrated their partners anally the last time they had sex. Of the 14 men who anally penetrated their partners, the last time they had sex, 12 (86%) used a condom.

Twenty (32%) of the 63 MSM participants identified their sexual orientation as heterosexual or bisexual. Six (30%) of the 20 men responded they had sex with a woman in the 12 months prior to the interview. Fifty percent (n=3) of these 6 said the woman was a "new partner" or someone they had sex with for the first time in the 12 months prior to the SHAS interview. All six of the men who had sex with a woman in the past 12 months claimed their partner was either negative or they did not know the female partner's HIV status. When vaginal and oral intercourse took place, condoms were used less than 10% of the time. The six MSM participants who had sex with a female denied anal intercourse with their female partners.

Of the 16 (25%) participants who claimed not to have had sex in the twelve months prior to the interview date the main reason for not having sex was identified as "sexual drive had decreased" in 9 (56%). Seven (44%) responded they "were afraid of infecting someone else with HIV or other STD."

Heterosexual SHAS Participants

From July 2000 through June 2003, heterosexual SHAS participants comprised 26% (n=76) of those interviewed. Heterosexuals in this portion of the profile include: sex with an IDU, sex with a bisexual man, sex with a person who received a blood transfusion and sex with a person with HIV/AIDS. Due to the small number of those who had sex with bisexual men and those who had sex with a person who received a blood transfusion they are combined with the participants who had sex with someone who is HIV positive or AIDS defined. Their risk is not associated with injecting drug use and their partners are HIV positive or AIDS defined. With the merger, 55% (n=42) are heterosexuals who had sex with a person with HIV/AIDS and 45% (n=34) are heterosexuals who had sex with an IDU.

More detailed information regarding sexual activity and condom usage in heterosexual SHAS participants may be found in Appendix A of profile.

Table 18.

Demographics of clients who seek counseling and testing services in HIV Counseling and Testing Sites in Delaware in 2002, n=10,304

Demographic	Number of Clients Counseled	Number of HIV Tests	Number of Positive Tests	Percent HIV Positive*
Gender				
Male	5,064	4,008	59	1%
Female	5,230	4,084	25	1%
Not Specified	10	6	0	0%
Race/Ethnicity				
White	3,751	3,087	24	1%
Black	4,963	3,758	48	1%
Hispanic	1,330	1,076	12	1%
Asian/Pacific Islander	117	65	0	0%
Am Indian/AK Native	23	18	0	0%
Other	97	82	0	0%
Undetermined	11	6	0	0%
Not Specified	12	6	0	0%
Age Groups				
<13	39	31	1	3%
13 - 19	2,057	1,612	6	0%
20 - 29	4,327	3,350	15	0%
30 - 39	2,215	1,734	33	2%
40 - 49	1,208	986	22	2%
>= 50	425	361	7	2%
Age Not Specified	33	24	0	0%
Risk				
MSM IDU	19	19	1	5%
MSM	599	528	31	6%
Heterosexual IDU	414	367	13	4%
Sex Partner At Risk	1,354	1,221	17	1%
STD Diagnosis	2,475	1,770	9	1%
Sex For Drugs/Money	68	62	1	2%
Sex While Using Drugs	1,086	933	1	0%
Hem/Blood Recipient	32	31	0	0%
Victim Sexual Assault	52	49	0	0%
Health Care Exposure	86	82	1	1%
No Acknowledged Risk	440	325	0	0%
Heterosexual/No Other Risk	3,382	2,552	7	0%
Other	64	53	1	2%
Not Specified	233	106	2	2%
Total	10,304	8,098	84	1%

* % HIV positive calculated: # positive tests ÷ # of HIV tests performed.

The demographic information in Table 18, on the previous page, indicates in 2002, the clients *seeking HIV counseling and testing services* (n=10,304) are:

- 51% women;
- 48% Black, 36% White, and 16% Hispanic or other race/ethnicities;
- 42% in the age group 20-29, 21% are 30-39 and 20% are 13-19 years of age.

The demographics for clients *deciding to be tested* (n=8,098) are:

- 50% women;
- 46% Black, 38% White, and 16% Hispanic or other race/ethnicities;
- 41% in the age group 20-29, 21% are 30-39 and 20% are 13-19 years of age.

The demographics for clients testing positive for HIV (n=84) are:

- 70% are men;
- 51% are Black, 29% are White, and 14% Hispanic or other race/ethnicities;
- 39% in the age group 30-39, 26% are 40-49 and 18% are 20-29 years of age;
- 37% of the positives self-identified as MSM.

The data show the majority of the people coming in for counseling and deciding to test are women but the majority testing positive are men. The distribution by race is basically the same for those seeking counseling, those testing and those who are positive; predominantly Black, followed by White and then Hispanic and other races. The age group most often seeking counseling, and deciding to be tested, was 20-29 years of age. The age group testing positive most frequently was 30-39 years of age. Risk behaviors for clients seeking counseling and testing are not always readily given or accurately reported by the client. In addition, a risk of "sexual partner at risk" is vague and not easily analyzed.

Figure 23. Percentage of positive HIV tests by county (as a percent of all positives tests per year) in Delaware 1998-2002

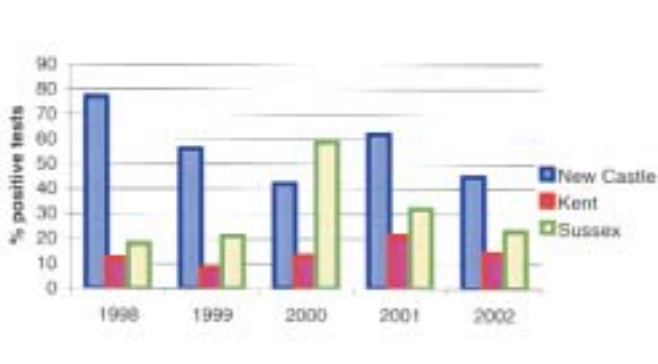
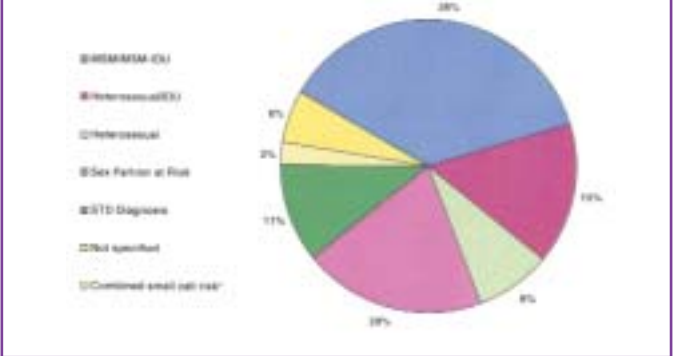


Figure 24. Distribution of Delaware positive HIV tests in 2002 by modes of transmission, n=84



* Combined small risk cells include people who reported they were infected through a sexual assault, through sex while using alcohol or non-injecting drugs, and commercial sex work.

Figure 25. Comparison of clients electing to be tested for HIV to the clients testing positive for HIV antibodies by race in Delaware in 2002

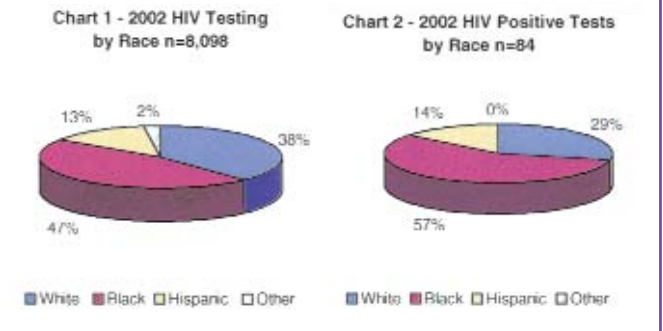


Figure 26. Number of clients pre-test counseled in Delaware HIV counseling and testing sites compared to the number who elected to be antibody tested from 1998 through 2002

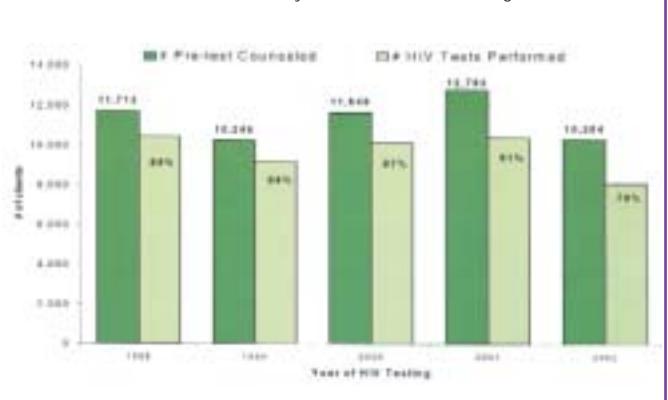
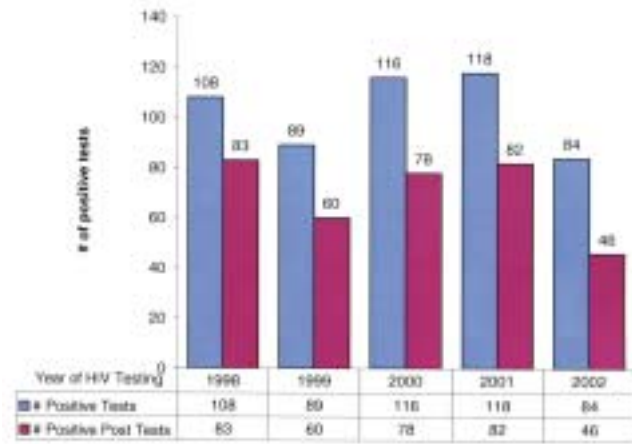


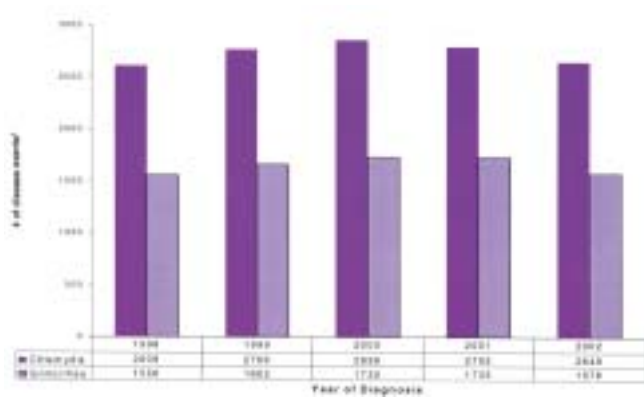
Figure 27. Number of clients testing positive in a Delaware HIV counseling and testing sites compared to the number who returned for results in 1998 through 2002



Sexually Transmitted Infection and Disease Data⁷

In Delaware information on individuals diagnosed with gonorrhea, chlamydia, primary and secondary syphilis is collected at the local level in STD clinics, private physician offices, correctional facilities, outpatient facilities and reported to a centralized office within the Division of Public Health. HIV can be spread through the same unprotected sexual contact that spreads STDs. The presence of an STD can facilitate HIV transmission both by increasing viral load and by providing ulcerations through which HIV can pass. People diagnosed with a sexually transmitted disease (STD) are at increased risk of contracting or spreading HIV.

Figure 28. Number of chlamydia and gonorrhea disease events in Delaware from 1998 to 2002



Due to continued unprotected sexual practices an individual may contract or be diagnosed more than one time in a reporting year. The recurrence of infection or disease, referred to as disease events, may therefore include duplicate diagnoses. According to the Delaware Annual Sexually Transmitted Disease Report⁷, more than 2,600 chlamydia disease events, have occurred every reporting year from 1996 through 2002. Figure 28 above, illustrates the minimal rise and fall in chlamydia and gonorrhea events over a five year period. Each of the events represents behavior that potentially exposes the client to HIV infection.

The figure below shows chlamydia diagnoses by gender. For every male diagnosis, close to four times as many females were diagnosed with chlamydia each year.

Figure 29. Distribution of Delaware chlamydia events by gender from 1998 through 2002

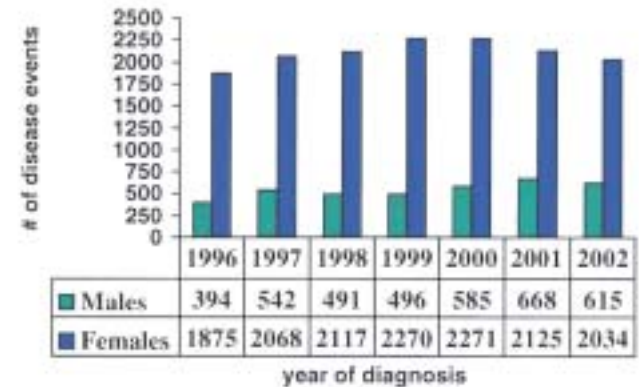
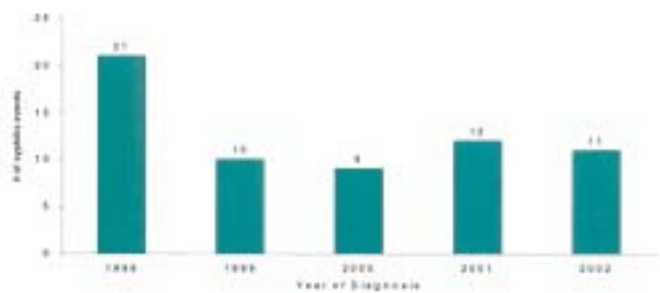


Figure 30 illustrates the number of primary and secondary syphilis cases decreased by 50% from 1998 to 1999. Syphilis events since 1999 have remained fairly stable through 2002.

Figure 30. Number of primary or secondary syphilis disease events diagnosed in Delaware in 1998 to 2002



2001 Youth Risk Behavior Survey⁸ (YRBS) Data:

During the spring of 2001, 2,915 students in 30 Delaware public high schools, participated in the Youth Risk Behavior Survey⁸ (YRBS). The school response rate was 97%, the student response rate was 77%, and the overall response rate was 75%. The results are representative of all students in grades 9-12. The weighted demographic characteristics of the sample are as follows:

Table 19.

Characteristics of students completing the YRBS Survey in 30 Delaware Public High Schools in 2001, n=2,195

Gender	%	Grade	%	Race/Ethnicity	%
Female	51%	9th grade	30%	African American	24%
Male	49%	10th grade	26%	Hispanic/Latino	6%
		11th grade	22%	White	62%
		12th grade	22%	All other races	5%
				Multiple races	3%

Students completed a self-administered, anonymous, 87-item questionnaire. Survey procedures were designed to protect the privacy of students by allowing for anonymous and voluntary participation. Local parental permission procedures were followed before survey administration.

The YRBS is one component of the Youth Risk Behavior Surveillance System developed by the Centers for Disease Control and Prevention in collaboration with representatives from 71 state and local departments of education and health, 19 other federal agencies, and national education and health organizations. The Youth Risk Behavior Surveillance System was designed to focus the nation on behaviors among youth related to the leading causes of mortality and morbidity among both youth and adults and to assess how these risk behaviors change over time. The Youth Risk Behavior Surveillance System measures behaviors that fall into six categories:

1. Behaviors that result in unintentional injuries and violence;
2. Tobacco use;
3. Alcohol and other drug use;
4. Sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies;
5. Dietary behaviors; and
6. Physical activity.

For this profile, highlights from questions three and four will be addressed.

If you are interested in more information about the Youth Risk Behavior Surveillance System you may contact Janet Ray, Health Education Associate at the Department of Education at 302-739-4681.

Of the students surveyed:

- 77.6% had at least one drink of alcohol on one or more days during their life;
- 28.8% had their first drink of alcohol other than a few sips before age 13;
- 46.4% had at least one drink of alcohol on one or more of the past 30 days;
- 27.3% had five or more drinks of alcohol in a row, that is, within a couple of hours, on one or more of the past 30 days;
- 46.9% used marijuana one or more times during their life;
- 12.2% tried marijuana for the first time before age 13;
- 26.3% used marijuana one or more times during the past 30 days;
- 6.3% used any form of cocaine, including powder, crack, or freebase one or more times during their life;
- 2.4% used any form of cocaine, including powder, crack, or freebase one or more times during the past 30 days;
- 10.5% sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times during their life;
- 3.2% sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times during the past 30 days;
- 2.7% used heroin one or more times during their life;

- 6.8% used methamphetamines one or more times during their life;
- 1.7% used a needle to inject any illegal drug into their body one or more times during their life;
- 26.9% were offered, sold, or given an illegal drug on school property by someone during the past 12 months;
- 52.7% had sexual intercourse;
- 16.7% had sexual intercourse with four or more people during their life;
- 39.2% had sexual intercourse with one or more people during the past three months;
- 25.5% had sexual intercourse but have not had sexual intercourse during the past three months;
- Of students who had sexual intercourse during the past three months, 22.1% drank alcohol or used drugs during last sexual intercourse;
- Of students who had sexual intercourse during the past three months, 62.2% used a condom during last sexual intercourse;
- Of students who had sexual intercourse during the past three months, 20.1% used birth control pills during last sexual intercourse;
- 6.4% had been pregnant or gotten someone pregnant one or more times.

Question 4. What are the patterns of utilization of services in people with HIV in Delaware?

HRSA Grantee Provided Data

The reference data for service utilization are for the most part based upon data provided to Health Resources and Service Administration (HRSA), by grantees in Delaware receiving funding through multiple title programs.

Title II funding is awarded to improve the quality, availability, and coordination of health care and support services for people and families with or affected by HIV disease. The funding also assists with access to recommended pharmaceuticals through the AIDS Drug Assistance Program (ADAP).

In 2002, a total of 2,196 clients received services funded through the Ryan White Title II funding and 704 of them were new clients. Of the 2,196 clients 85% (n=1,863) were HIV-infected and 333 were HIV-affected. HIV-affected counts the children, spouses and significant other people in the lives of an HIV-infected person that are not themselves infected with HIV. Table 20 compares the demographic characteristics of the unduplicated HIV-infected clients receiving services that are funded by Ryan White Care Act Title II Programs in 2002 to the distribution of living HIV/AIDS cases in Delaware through 2002. Demographic characteristics of clients receiving Title II funds in 2002 are closely representative of cases reported to surveillance staff through 2002.

Table 20.

Demographic characteristics of clients receiving services funded by Ryan White Care Act Title II Programs 2002 compared to Delaware HIV/AIDS cases through 2002

Characteristics	% of CARE Act Clients N=1,863	% of DE Living HIV/AIDS Cases N=2,258
Ethnicity		
Hispanic or Latino Origin	5%	5%
Non-Hispanic	89%	95%
Unknown/Unreported Ethnicity	6%	0%
Race		
White (Non-Hispanic)	27%	29%
Black (Non-Hispanic)	68%	66%
Other**	2%	5%
Unknown/Unreported Race	3%	0%
Gender		
Male	62%	72%
Female	37%	28%
Unknown/Transgender	1%	0%
Age		
Less than 13 years	2%	<1%
14 - 24 years	3%	3%
25 - 44 years	59%	59%
45 - 64 years	34%	35%
65 + years of age	2%	2%
Unknown/Unreported	<1%	0%

* Percentages may not total to 100% due to rounding error.

** Other includes people of other ethnicities and people of two or more races.

The following table illustrates the five most frequently accessed Ryan White Title II services funded in Delaware. The unduplicated number of clients accessing the services is 1,863.

Table 21.

Utilization of Ryan White Title II service, by service type in 2002 (n=1,863)

	Case Management	Dental	Medical	Mental Health	Substance Abuse
Clients receiving service (number)	611	417	1,308	118	108
Visits per client (average number)	6	3	5	5	4

Additional services provided with CARE Act funds are shown below. More often than not a client may have received multiple services so the numbers are not mutually exclusive.

- 1,464 people were provided Health Education and Risk Reduction
- 894 people were referred for psychosocial/supportive services
- 602 food-bank or home delivery connections were made

- 389 treatment adherence counseling sessions were held
- 357 people were provided with transportation
- 307 people received emergency financial assistance
- 110 referrals to clinical research were arranged
- 61 client advocacy incidents were reported
- 53 assisted housing connections were arranged

In Delaware, Ryan White CARE Act Title II funding was awarded to three provider types. The provider types are:

1. Hospital-Based Clinics that include:
 - duPont Hospital for Children north of Wilmington,
 - Christiana Care Health Services and Division of Public Health jointly sponsored clinics in the following locations:

Table 22.

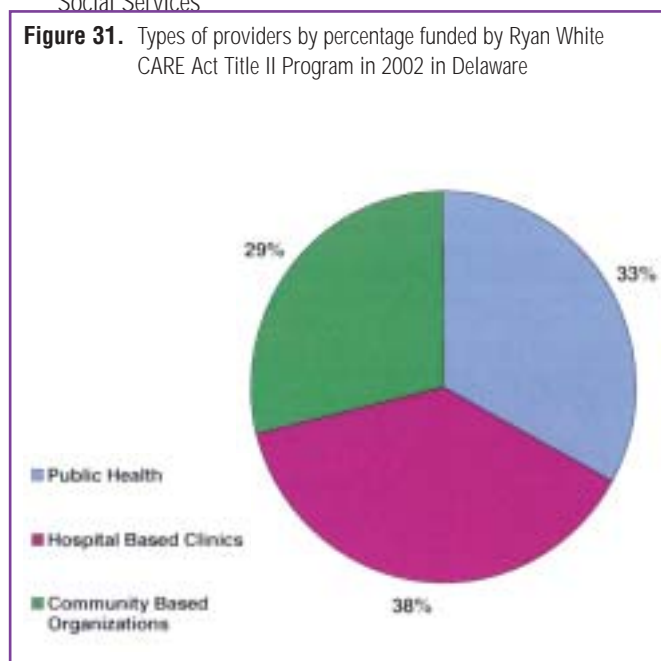
County locations of the HRSA funded and CCHS\DPH sponsored ID-Wellness Clinics in Delaware

New Castle County	Kent County	Sussex County
Wilmington Hospital Annex, Riverfront and Porter State Service Center	Kent Wellness in Smyrna	Sussex Wellness in Georgetown

2. Community Based Organizations that include:

- AIDS Delaware
- American Red Cross
- Beautiful Gate Outreach
- Brandywine Counseling Services
- Case Management Services
- Catholic Charities
- Delaware Center for Justice
- Kent/Sussex Counseling Services
- Ministry of Caring
- Sussex County AIDS Council

3. Division of Public Health, Department of Health and Social Services

Figure 31. Types of providers by percentage funded by Ryan White CARE Act Title II Program in 2002 in Delaware

"Unknown\More than one race" category.

Table 23 illustrates the demographic characteristics of clients in the ADAP program in 2002 compared to the demographics of living HIV/AIDS cases in the HARS database for the same period. The percentages appear similar in most characteristics with the exception of race. In this category, Blacks represent 71% of the living cases in HARS compared to 59% enrolled in ADAP. The difference may be due to the number of clients in the ADAP program designated to the

Table 23.
Demographic Characteristics of clients served through 2002 AIDS Drug Assistance Program (ADAP) compared to living Delaware HIV/AIDS reported cases through 2002

Client Characteristics	ADAP Numbers N=454	ADAP Percent*	Living HIV/AIDS Numbers N=2,258	Living HIV/AIDS Percent
Gender				
Male	329	72%	1,507	67%
Female	115	29%	751	33%
Unknown\Transgender	10	1%		0%
Total	454	100%	2,258	100%
Ethnicity				
Hispanic or Latino	20	4%	127	5%
Non-Hispanic or Latino	434	96%	2,131	95%
Total	454	100%	2,258	100%
Race				
White	136	30%	613	29%
African American\Black	267	59%	1,506	71%
Unknown\More than one race	51	11%	12	<1%
Total	434	100%	2,131	100%
Age				
Less than 2 years	3	<1%	2	<1%
2-12 years	1	<1%	25	1%
13-24 years	6	1%	61	3%
25-44 years	275	61%	1,340	59%
45-64 years	155	34%	793	35%
65 years or older	13	3%	37	2%
Unknown\Unreported	1	<1%	0	0%
Total	454	100%	2258	100%

* Percentages may not total to 100% due to rounding error

Table 24 illustrates the demographic characteristics of 681 clients attending an ID-Wellness clinic that were on HAART therapy at the end of 2002. Of the 1,122 clients, 681 (61%) were on HAART therapy. When the demographics are compared to the number of living HIV/AIDS cases in the HARS database the similarities are significant. Anecdotally, it appears HIV-infected people in Delaware are being equally served regardless of race, age or gender.

Table 24.
 Characteristics of HIV-infected patients prescribed HAART (Highly Active Antiretroviral Therapy) in CCHS\DPH ID-Wellness Clinics throughout Delaware in 2002, (n=681)

Client Characteristics	Highly Active Antiretroviral Therapy (HAART)%	Living HIV/AIDS Numbers N=2,258	Living HIV/AIDS Percent
Gender			
Male	64%	1,507	67%
Female	36%	751	33%
Unknown\Transgender	0%	0	0%
	100%	2,258	100%
Ethnicity			
Hispanic or Latino	5%	127	5%
Non-Hispanic or Latino	95%	2,131	95%
	100%	2,258	100%
Race			
White	22%	613	29%
African American\Black	74%	1,506	71%
Unknown\More than one race	4%	12	<1%
	100%	2,131	100%
Age			
Less than 2 years	0%	2	<1%
2-12 years	0%	25	1%
13-24 years	<1%	61	3%
25-44 years	55%	1,340	59%
45-64 years	43%	793	35%
65 years or older	2%	37	2%
Unknown\Unreported	0%	0	0%
	100%	2,258	100%

* Percentages may not total to 100% due to rounding error.

Table 25 illustrates the demographic characteristics on the 33% (n=379) of the 1,122 clients attending an ID-Wellness clinic on PCP prophylaxis at the end of 2002. When the characteristics of the clinic clients on PCP prophylaxis are compared to the living HIV/AIDS cases, in the HARS database, there are a greater percentage of Blacks and people of Hispanic origin (84% and 3%) respectively on PCP prophylaxis than in the HARS database (71% and <1%) respectively. The greater percentage in people of color on PCP prophylaxis may be due in part to the level of wellness determined on intake into the clinic.

Table 25.

Characteristics of HIV-infected patients prescribed prophylaxis for PCP (*Pneumocystis carinii pneumonia*) in CCHS\DPH ID-Wellness Clinics throughout Delaware in 2002, (n=379)

Client Characteristics	PCP Prophylaxis %	Living HIV/AIDS Numbers N=2,258	Living HIV/AIDS Percent
Gender			
Male	64%	1,507	67%
Female	36%	751	33%
Unknown\Transgender	0%	0	0%
	100%	2,258	100%
Ethnicity			
Hispanic or Latino	4%	127	5%
Non-Hispanic or Latino	96%	2,131	95%
	100%	2,258	100%
Race			
White	12%	613	29%
African American\Black	84%	1,506	71%
Unknown\More than one race	3%	12	<1%
	100%	2,131	100%
Age			
Less than 2 years	0%	2	<1%
2-12 years	0%	25	1%
13-24 years	<1%	61	3%
25-44 years	54%	1,340	59%
45-64 years	44%	793	35%
65 years or older	2%	37	2%
Unknown\Unreported	0%	0	0%
	100%	2,258	100%

* Percentages may not total to 100% due to rounding error.

In addition to HAART and PCP prophylaxis the 1,122 HIV-infected clients attending ID-Wellness clinics also received the following preventive therapies in 2002:

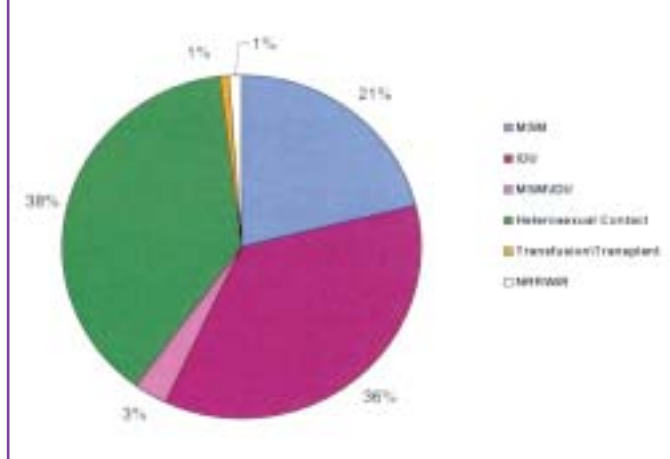
- 1,086 (97%) had a TB skin test (PPD Mantoux), 7 who were treated secondary to positive TB skin test.
- 795 (71%) had screening/testing for syphilis and 3 were positive and treated.
- 44 (4%) had screening/testing for any treatable sexually transmitted infection (STI) other than syphilis and HIV and 27 were treated for an STI other than syphilis and HIV.
- 135 (12%) had screening/testing for hepatitis C and 7 received treatment for hepatitis C.

The 429 HIV-infected females attending ID-Wellness clinics also received the following gynecological/obstetric interventions in 2002. Twelve children were delivered to 14 pregnant HIV-positive women. One of the 12 children was HIV positive. Other health data on the women is shown below.

- 407 (95%) received a pelvic examination and Pap smear during 2002.
- 16 (2%) of the women were pregnant in 2002.
 - 4 entered care in the first trimester
 - 7 entered care in the second trimester
 - 5 entered care in the third trimester
- 14 (88%) of the pregnant women received antiretroviral medication to prevent transmission of HIV to their children.

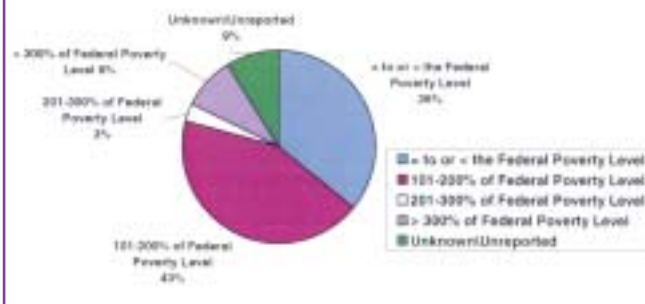
Figure 32 illustrates 38% (n=428) of the clients attending an ID-Wellness Clinic in Delaware in 2002 are clients infected with HIV through heterosexual contact, 36% (n=402) are injecting drug users and 21% (n=236) are MSM.

Figure 32. Distribution of clients attending ID-Wellness Clinics by risk factor for transmission of HIV in 2002, n=1,122



Of the 1,863 HIV-infected Delawareans, receiving services through Ryan White CARE Act funding, 36% (n=667) have income levels equal to or less than the Federal Poverty Level. Forty-three percent (n=808) have income levels between 101% and 200% of the Federal Poverty Level.

Figure 33. Percent of household income of HIV-infected recipients of Ryan White CARE Act funding at the end of 2002 in Delaware, n=1,863



HIV/AIDS Reporting Data

The HIV/AIDS Reporting System provides the states with the capability of collecting user specified data at the local level. Delaware has for several years collected information on where HIV-infected people are getting their health care. The data is generally collected from laboratory results that indicate the requesting providers name or treatment facility, through line reviews with private physicians, ID and Wellness Clinic coordinators, Case Managers, Correctional facilities and through case report forms. The information has become more frequently available since the implementation of HIV reporting in July 2001. Laboratory data is updated as the information becomes available and is generally received no less than twice a year. Due to enhanced laboratory reporting the information on treatment location is considered current for at least the past 12 months. Anecdotally, to receive no data on a client in a 12-18 month time frame may indicate the client has moved to another state, moved to a treatment facility that is out of state, is receiving care through a health care provider who is not requesting CD⁴ or viral load testing or the provider is using a laboratory that is not reporting results to DPH. The final determination that may be made is that the client has dropped out of care.

The following graphs show the utilization of treatment services in Delaware as collected in HARS and extracted for the current profile. Treatment locations are fixed as of December 31, 2002.

Figure 34a. Distribution by treatment location of all living HIV clients residing in Delaware at time of diagnosis through December 2002, n=504

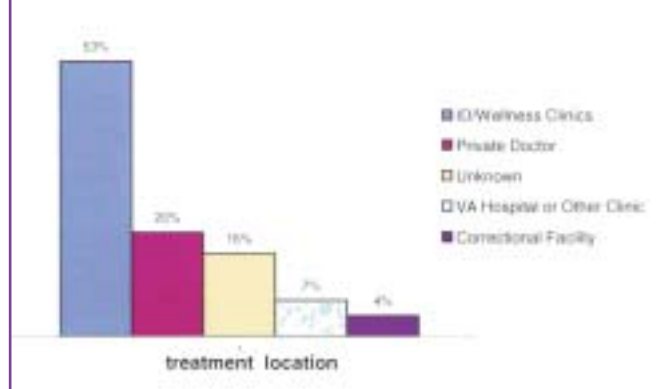
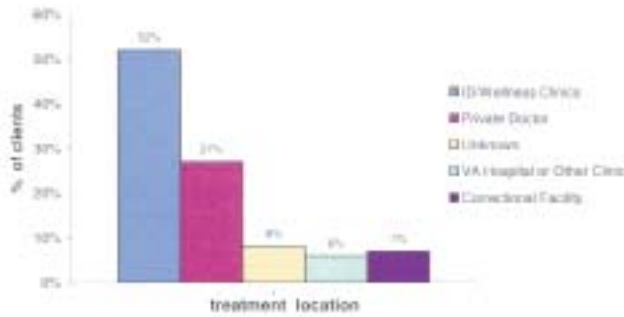


Figure 34b. Distribution by treatment location of all living AIDS clients residing in Delaware at time of diagnosis through December 2002, n=1,448



Figures 34a and b indicate just over half of all HIV and AIDS patients are receiving care through a wellness clinic, with another 25% being treated by private doctors.

Figures 35a and b illustrate the county where the living cases were residing as of December 31, 2002. This figure includes 279 non-residents (cases that were diagnosed in a state other than Delaware but are now residing in Delaware) who received care in 2002. There are also 20 clients residing in Delaware who go outside our state to receive their medical care and they are included in with the Veteran's (VA) or other clinics category. As is illustrated, the majority, 51% of HIV-infected clients living in Delaware is attending a HRSA funded hospital-based clinic.

Figure 35a. County of residence and treatment location for all living HIV cases residing in Delaware and receiving care in 2002, n=504

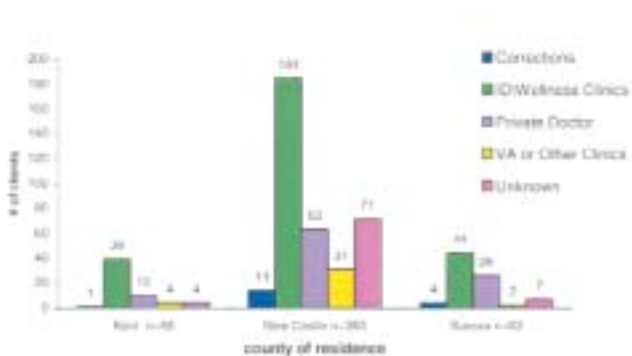
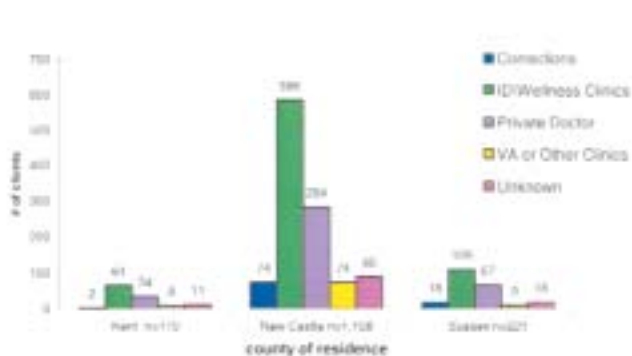


Figure 35b. County of residence and treatment location for all living AIDS cases residing in Delaware and receiving care in 2002, n=1,448



Supplemental HIV/AIDS Surveillance (SHAS) Data

The SHAS interview process collects data through 13 questions regarding HIV Testing and Medical Therapy, 32 questions on Preventive Therapy and 29 questions on Health and Social Services. Information regarding availability and utilization of services in the state is collected through the survey. The results of 287 participants interviewed through the SHAS process from July 2000 through June 30, 2003 are found below.

The answers to the following SHAS questions are shown in percentages.

HIV Testing and Medical Therapy

All participants were asked:

Where were you tested when you had your first positive HIV test?

- 31% Hospital inpatient, outpatient and emergency room;
- 20% in Public Health clinics or "AIDS" clinics;
- 15% in private physician's office;
- 11% in HIV counseling and testing site or mobile access;
- 8% in a community clinic;
- 8% in a correctional facility,
- 3% in a drug clinic;
- 2% at a blood bank;
- 2% in other types of clinics.

When you first tested positive for HIV, what was the main reason you were tested?

- 48% due to illness;
- 27% identified a risk behavior for HIV;
- 7% would not identify reason;
- 6% just wanted to know;
- 4% offered at the clinic;
- 3% insurance pre-requisite, entrance to military, started new relationship
- 3% surgical pre-requisite;
- 2% pregnancy.

When you first tested positive for HIV, what type of test did you have?

- 14% anonymous
- 67% confidential
- 19% do not know

Has anyone (for example, from the health department or a health care provider) ever offered to tell your sex (or drug using) partners that they may have been exposed to HIV so they can be tested?

- 68% responded "no" no one ever offered help with notifying partners
- 31% responded "yes" someone had offered to help notify partners
- 1% responded "don't remember"

The 31% (n=90) who answered "yes" to the preceding question were asked:

What was your response when they offered to tell your partners?

- 70% client chose to notify partners;
- 13% asked the health department or other person to help with notifying partners;
- 8% did not want partners told or refused to respond to questions;
- 6% asked for help with some partners and said they would tell the others;
- 3% answered with an "other" response.

The 8% (n=7) who did not want their partners told were asked:

What was the main reason you chose not to tell your partners?

- 29% responded they were "afraid of what the partner(s) would do to me";
- 14% responded they "didn't trust the health department/person who offered to tell my partners";
- 14% responded they were "afraid my partner(s) would find out it was me who may have infected them";
- 43% responded with an "other" answer that did not fit any of the offered responses in the survey.

All participants were asked:

When did you first get medical care after learning you had HIV/AIDS? This includes examinations and viral load or CD⁴ testing, even if you are not currently taking any anti-HIV medications?

- 52% received care within 1 month of learning their HIV status;
- 13% received care within 3 months;
- 3% received care within 12 months;
- 2% received care within 36 months;
- 6% waited more than 36 months;
- 4% were unable to provide both a month and year of first care that is required to calculate the variable.

During the past 12 months where did you go most often to get medical care for your HIV infection?

- 82% receive their HIV medical care through a HRSA funded clinic;
- 13% through private physician;
- 1% through Veteran's Administration Medical Center;
- 3% through another facility type not specified;
- 1% received no care in the last year.

Not counting payment for HIV medicines, about how much did you pay out-of-pocket for health care for your HIV infection in the past 12 months? This includes insurance premiums, deductibles, co-payments, and any other money you may have paid for your HIV care. (out-of-pocket meaning money you pay out that doesn't get reimbursed).

- 81% paid no out-of-pocket money in the last 12 months;
- 5% paid between \$1 and \$100;

- 2% paid between \$101 and \$200;
- 3% paid between \$201 and \$300;
- 3% paid between \$301 and \$999;
- 6% paid more than \$999.

Has a doctor or health care provider ever told you that your HIV infection had progressed to AIDS?

In the 222 surveys completed with AIDS diagnosed clients the responses were:

- 48% responded "no", they had not been told they had progressed to AIDS;
- 49% responded "yes", they had been told they had progressed to AIDS;
- 3% responded they "did not know or were not sure".

In the 65 surveys completed with clients whose medical/diagnostic status was HIV positive at the time of interview the responses were:

- 97% responded "no", they had not been told they had progressed to AIDS;
- 3% responded "yes", they had been told they had progressed to AIDS.

Has your doctor or health care provider ever told you that you had hepatitis?

- 63% responded "no" they had not been told they had hepatitis;
- 37% responded "yes" that they had been told they had hepatitis.

The 37% (n=105) who responded "yes" to having been told they had hepatitis were asked:

What type of hepatitis was it? (multiple types were recorded where indicated)

- 10% of the participants said they had hepatitis A;
- 36% of the participants said they had hepatitis B;
- 59% of the participants said they had hepatitis C;
- 10% of the participants said they did not know the type of hepatitis they had.

Have you ever had the vaccination to protect against Hepatitis B?

- 51% participants said they had not received the Hepatitis B vaccine;
- 35% participants said they had received the vaccine preventive for hepatitis B;
- 15% participants did not know if they had received the hepatitis B vaccine.

Preventive Therapy

Have you ever taken antiretroviral medicines (an extensive list of antiretrovirals along with generic names is provided to the SHAS participant) to treat your HIV infection?

- 85% responded "yes" they had taken an antiretroviral medication;
- 14% responded "no" they had not taken an antiretroviral medication;
- 1% responded "they did not know or were unsure".

The 14% (n=42) who responded "no" to the preceding question were asked:

What is the main reason you haven't taken antiretroviral medications?

- 17% responded "I recently got into care and haven't had time to start taking any medications yet";
- 36% responded "My doctor said I should wait until later to take medications";
- 12% responded "I feel good, I don't think I need them";
- 19% responded "My CD4 count is still high (or viral load is low) so I decided not to take them";
- 10% responded "I'm worried about medication side effects";
- 5% responded "I never got around to getting into care/never took the time" or "other" answer.

The 85% (n=243) who responded "yes" to having taken an antiretroviral were asked:

In the past 12 months, have you taken a "drug holiday" from your antiretroviral medications? That is, did you not take any doses of one or more of your antiretroviral medications for at least two whole days in a row?

- 22% (n=53) said "yes" they had taken a "drug holiday" in the past 12 months.

When the 53 were asked:

What was the main reason you took a drug holiday from your antiretroviral medications?

The top four responses were:

- 19% said "I just got tired of taking them and needed a break";
- 15% said "Medication has side effects and makes me feel bad";
- 15% said "I was someplace where I couldn't get my medications (on vacation or out of town)";
- 13% said "I felt good and I didn't think it would hurt not to take them."

*Have you ever been told you have *Pneumocystis carinii* pneumonia (PCP)?*

- 2% responded that they "did not know" if they had been told they had PCP;
- 16% responded "yes" that they had been told they had PCP;
- 82% responded "no" that they had not been told they had PCP.

Conclusions

A total of 3,810 cases had been reported to the Division of Public Health through December 31, 2002. Fifty nine percent (n=2,258) of the cases were living at the end of 2002.

Anecdotally, with 2,258 cases living in Delaware and the Ryan White CARE Act Data Reports indicating 1,863 unduplicated people in care, we might reasonably estimate that 83% of the HIV-infected people in Delaware are in care and receiving some type of service funded by Ryan White monies.

The majority, 44% (n=990), of the living cases resides in the City of Wilmington's zip codes 19801, 19802, 19805, and 19806. Thirty-one percent (n=694) reside in other zip codes in New Castle County, 15% in Sussex County and 10% in Kent County.

The impact of the HIV/AIDS epidemic on the Black population continues to present prevention programming with an alarming need for an increase in early intervention through education, outreach and preventive therapies. The majority of the living cases of HIV/AIDS in New Castle County are Black. In the City of Wilmington, 83% of the living are Black and 57% of the living outside the city are Black. Sixty four percent (n=1,001) of the people who have died of HIV/AIDS are Black and 75% (n=753) of the Black cases that have died were men. Sixty-nine percent (n=823) of the deaths in Black cases were residents of New Castle County with 74% (n=609) residents of the City of Wilmington.

Nearly two thirds (63%) of the cumulative male cases in Delaware are Black and more than three quarters (76%) of the cumulative female cases are Black. In Kent County 65% of the living cases are Black whereas in Sussex County 49% of living cases are White.

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APPENDIX A

Heterosexual SHAS Participant Sexual Activity and Condom Use

Of the 14 heterosexual men who were infected with HIV through sex with an IDU, 3 abstained from sex and eleven (79%) had sex with a woman in the 12 months prior to the interview. Eight (73%) of the men, who had sex with a woman, had a single partner only. Two men had between 4 and 6 female partners and one male stated he had sex with 30 women in the 12 months prior to the interview.

Seven (67%) of the 11 men who had sex with a woman, in the time frame, identified themselves as having a "steady sex partner". Of the seven, 86% (n=6) used a condom when engaging in vaginal intercourse with their partner.

Of the four men who did not have a steady sex partner, 3 (75%) used a condom when engaging in vaginal intercourse. None of the four men had anal sex with their female partner or had given the women oral sex. Three (75%) of the four men had received oral sex from a female partner and 2 (67%) used a condom.

Of the 20 female heterosexuals who were infected through sex with an IDU and interviewed with SHAS, 8 had abstained from sex in the 12 months prior to the interview date.

Of the 44 heterosexuals who had sex with a person with HIV/AIDS, 73% (n=32) are female and 27% (n=12) are male.

Within the female participants, 81% (n=26) had sex with a man in the 12 months prior to the interview date and 77% (n=20) of the 26 had a single partner in the time frame. Five participants had sex with 2-3 male partners and one with 50 or more. Eight (25%) of the 32 women interviewed had a sexually transmitted disease in the 12 months prior to the interview date.

Four (13%) of the 32 participants who had sex with a person with HIV/AIDS had received drugs or money for sex but only one in the 12 months prior to the interview. Only one of the females had ever paid for sex and not within the 12 months prior to the interview.

Thirteen (68%) of the 19 women, who had a steady sex partner in the 12 months prior to the interview date, had vaginal intercourse with their steady sex partner and used a condom. Five (26%) of the 19 females were recipients of oral sex and one (5%) used a barrier or dental dam. Seven (37%) of the 19 women had given their partners oral sex and 3 (16%) of the 7 had used a condom. None of the 19 females engaged in anal intercourse.

Of the seven women who did not have a steady sex partner in the 12 months prior to the interview date, the number of sex partners ranged from 1 to 3. Of the seven women, 4 (57%) had vaginal intercourse and used a condom, 3 (43%) were recipients of oral sex and only one used a barrier or dental dam. Two (29%) of the 7 women without steady sex partners had given oral sex to a man and did not use a condom. None of the seven women had engaged in anal intercourse in the 12 months prior to the interview date.

Within the 12 heterosexual males who participated in a SHAS interview and had sex with a person with HIV/AIDS, 10 (83%) had sex with a woman in the 12 months prior to the interview date. Eight (80%) of the 10 had a steady female sex partner in the time frame. When having vaginal intercourse with their steady female partner, 70% (n=7) used a condom.

Of the 12 male heterosexual SHAS participants, two (17%) had been treated for a sexually transmitted disease in the 12 months prior to the interview period.

Chapter 3: *Needs Assessment/ Community Services Assessment*

This chapter outlines the work completed by the Needs Assessment Work Group in 2003 and provides the basis for development of the Comprehensive HIV Prevention Plan 2005-2009. The Needs Assessment Work Group will update this report as necessary and incorporate new epidemiology data and focus group information into the report.

The Needs Assessment Work Group was responsible for reviewing available data, conducting a survey of available services that Delawareans can access to prevent HIV transmission, and determining if there are gaps in service delivery. The following report is a compilation of results from the needs assessment, resource inventory and gap analysis.

While the new *community planning guidance* refers to the work product as a community services assessment, the Needs Assessment Work Group began its process before the *community planning guidance* was released. Therefore, the report was referred to as a needs assessment (NA) rather than the community services assessment (CSA). According to CDC, the community services assessment should describe the prevention needs of populations at risk for HIV infection, the prevention activities/ interventions implemented to address these needs and service gaps. Typically, a needs assessment is a process to collect information and determine the services currently provided and needed by either a specific group of people (population) or in a geographic area. The resource inventory lists HIV prevention activities currently provided in the area, along with related resources, education and prevention activities that might be linked to HIV risk reduction. A gap analysis is a description of the unmet HIV prevention needs within the high-risk populations defined in the epidemiologic profile. An unmet need can be identified by reviewing data from the needs assessment and resource inventory.

In the *community planning guidance*, CDC provides attributes identified as critical to community planning. Several of these relate to the community services assessment and gap analysis. They are outlined below. The reader should recall that the Needs Assessment Work Group began developing their work plan and responsibilities before CDC provided these attributes. Therefore, future updates to the Comprehensive HIV Prevention Plan 2005-2009 may further elaborate on elements that match these attributes to be in sync with CDC requirements.

- The CSA focuses on one or more high priority populations (i.e., substantially contributing to new HIV infections in a jurisdiction) identified in the epidemiologic profile.
- Data are gathered that define populations' needs in terms of knowledge, skills, attitudes, and norms.
- Data are gathered that define populations' needs in terms of access to services.
- The CSA details the target populations being served.
- The CSA details the interventions provided to each target population.
- The CSA describes the geographic coverage of interventions or programs.

- A gap analysis specifically identifies both met and unmet needs.
- The gap analysis identifies the portion of needs being met with CDC funds.

1. What methods did the Needs Assessment Work Group use?

The Needs Assessment Work Group began by reviewing the completed tasks and data reviewed by the Needs Assessment Work Group for the 2002-2004 Comprehensive HIV Prevention Plan. The work group worked through tasks outlined in the needs assessment guide published by the Academy for Educational Development (Assessing the Need for HIV Prevention Services August 1999)¹.

Data was gathered from a variety of sources, including the 2001-2002 Delaware Epidemiologic Profile², 2001 Youth Risk Behavior Survey (YRBS) Results from Delaware and US³, 2002 Delaware HIV Counseling and Testing (C&T) annual report⁴, 2000 National Household Survey on Drug Abuse⁵, 2000-2001 US Census estimates⁶, and 2002 Delaware School Based Wellness Center reports⁷. Data was used to create an overview for each population identified in previous planning cycles. Each population overview consisted of a list of information derived from various data sources; the list helped work group members sort which populations needed additional data and which populations had met or unmet needs. Epidemiologic information, population estimates, counseling and testing data and drug abuse data (if appropriate) was sorted for the various populations listed as infected in the epidemiologic data.

The second step of the process involved soliciting input from community providers about available HIV prevention related services. A survey was developed to solicit service provider information about the perceived service needs of HIV-infected people in Delaware. This survey served as the basis for the resource inventory. Much information was collected through this process, including agency description (which populations the agency serves), program description (full-time and part-time staff; prevention services offered at the agency for all clients and HIV-positive clients) and program challenges and barriers. Relevant data was entered into an ACCESS database and analyzed using SPSS software.

In December 2002, after presenting information on the resource inventory, the Needs Assessment Work Group decided on the tasks related to developing the gap analysis. This process required significant time and research by work group members. Results from this gap analysis are included, along with an explanation of how the group achieved consensus.

The Needs Assessment Work Group members reviewed the report, edited and provided changes as necessary. Work group leaders presented a preview of the report and an opportunity to discuss results in May 2003. The needs assessment, resource inventory and gap analysis were presented to the full HIV Prevention Planning Group in June 2003. The report was finalized in June 2003 and copied to all PPG members.

II. How did the Needs Assessment Work Group collect data?

Step 1:

The Needs Assessment Work Group modified a matrix used previously and suggested by the AED guide to collect relevant data on populations (Academy for Educational Development *Assessing the Need for HIV Prevention Services* August 1999)¹. The work group decided to base population descriptions on the epidemiologic data and use additional data sources as supplementary/ supportive data. The group members also decided to use a numerical scale of 1-5 to estimate met needs (available resources) and unmet needs (need additional services/ resources). Previously, the Needs Assessment Work Group used words (met, somewhat met, somewhat unmet, unmet) to describe the scenarios. Moving to the numerical scale required all work group members to understand and come to consensus on the scale, what numbers represented, and how the "gap" would be calculated.

The following list of questions was used to outline the matrix and guide tasks assigned.

1) How will each population be described?

In December 2002, work group members decided to base population descriptions on the following variables, listed in order of importance: Transmission mode, geography (county and city), race, gender, age and serostatus

2) How will total need be estimated for HIV Prevention services?

The work group members decided in December 2002, to describe the populations using the following data sources:

- Epidemiologic Profile 2001-2002²
- HIV Counseling and Testing Data 2001-2002⁴
- 'HIV Reporting' Report 2002⁸
- STD data 2002⁹
- Census data 2001⁶
- School based Wellness center data on risky behavior 2002⁷
- YRBS data 2001³
- DSAMH treatment data – reviewing the number of individuals in treatment by county/ race/ etc. 1986-2001¹⁰

Work group members also agreed to use a matrix for compiling the information for each population by appropriate variables. When describing age groups, the work group came to consensus on the following age groups: 6-9 y; 10-13y; 14-19y; 20-25y; 26-29y; 30-39y; 40-49y; 50-59y; 60+. A sample grid follows:

By RACE –

COUNTY	New Castle	Wilmington	Kent	Sussex
Census #s				
# AIDS Cases				
# HIV cases				
# agencies providing types of services (based on resource inventory survey)				
# DPH funded agencies and # interventions and # served				

3) How will differences between need and demand be defined?

Work group members struggled with this definition. While the service might be seen in the community as a "need", the service might not be used and therefore "demand" might not be high. As an example, there could be data pointing to a large risk for HIV transmission among African American heterosexual women in Rehoboth Beach, but the demand of HIV prevention services from this group could be low. Therefore, there is a distinct difference between the need (as defined by data sources) and the demand (as defined by the actual service utilization).

4) How will barriers to HIV Prevention services be defined?

With the resource inventory data, work group members were able to list barriers identified by service providers related to HIV Prevention service delivery. These barriers are included in the descriptions of each population. While little quantitative data was available to quantify the extent of the barriers, work group members felt it important to list the identified barriers.

5) How will the group assess the suitability of available services?

The work group members agreed to use a ranking scale of 1-5 (1-low, 3-neutral, and 5-high). In previous planning cycles, the Needs Assessment Work Group used words to describe the suitability of services (such as: not at all, a little, somewhat, all). This shift to a quantitative scale was the first step to move the Needs Assessment Work Group, and eventually the PPG, to more scientific analysis and decision making based on data, rather than perception of population service needs.

6) How will the group identify the portion of met need that CDC HIV Prevention dollars are responsible for meeting?

One of the early tasks of the Needs Assessment Work Group was to define met and unmet needs for HIV prevention services in the state of Delaware. The work group decided to review existing provision of HIV prevention services that are offered by agencies in the state. To accomplish this task, the work group relied on a variety of data that included the Epi Profile, HIV prevention contractor evaluation information and census information.

The group then decided to create a scale from 1-5 to give a numerical weight to the process. Both met and unmet needs would use the same 1-5 scale. Next was a review of the existing provision of services that

agencies offered. The group looked at the unmet and met needs of clients, where the AIDS epidemic is concentrated. Areas where a concentration of HIV/AIDS cases existed but lacked service provision would be an unmet need. After looking at data, the group would determine if there was a need in each county and then assign it a numerical weight for the met need.

It was difficult to quantify the portion of the met need that CDC funding provided for in Delaware. Agencies receive funding from several sources and were not able to divide their budgets by specific dollar amounts from the individual source.

7) How will the group estimate met need for population?

The work group members agreed to use a ranking scale of 1-5 (1-low, 3-neutral, and 5-high). In previous planning cycles, the Needs Assessment Work Group used words to describe the suitability of services (such as: not at all, a little, somewhat, all). As described previously (item 5 above), Needs Assessment Work Group members decided to shift to using quantitative scales rather than qualitative scales to be in line with national expectations to use data more scientifically in the decision making process.

8) How will the group estimate unmet need for population?

Work group members agreed to use a ranking scale of 1-5 (1-low, 3-neutral, and 5-high). In previous planning cycles, the Needs Assessment Work Group used words to describe the suitability of services (such as: not at all, a little, somewhat, all).

The work group discussed that data collected would provide a glimpse of what the demographics of the population are, what the potential need for services is, what services are provided and therefore calculate the GAP based on a formula of

$$[\text{Need for service} - \text{service provided} = \text{gap in service}].$$

Step 2:

The next step for the needs assessment process was to complete a table with relevant data and proceed to collect additional data and complete the table. [Table appears as attachment 1]. The table includes data describing the population, resources and gaps in services.

Tables for each possible population were developed and work group members were asked to list all data sources applicable. Work group members were asked to complete the table with relevant data to show that the particular population should (or should not) be considered a population for the Populations Work Group to prioritize.

III. What was the Resource Inventory?

The Needs Assessment Work Group worked closely with the Delaware HIV Consortium to complete the resource inventory. Beginning in April 2002, the entire HIV Prevention Planning Group was involved with this process. Needs Assessment Work Group members worked alongside Intervention Work Group members in reviewing the past surveys and developing new ideas for questions. In May 2002, PPG members were encouraged to provide agency names, contact information and addresses for agencies to be contacted and solicited to participate in the resource inventory.

Once the survey was finalized, an intern with the Delaware HIV Consortium worked over the summer 2002 to contact a list of providers to complete the survey. The intern faxed or mailed the survey to the listed agency contact, made a phone appointment and completed the survey over the phone. Seventy-three surveys were completed with the intern's assistance and provided to the Needs Assessment Work Group for data entry. A sample survey can be found as Attachment 2.

Needs Assessment Work Group leaders developed a Microsoft ACCESS database, into which the data was entered. A contract employee with the Delaware HIV Consortium completed data entry. Once the surveys were completed and reviewed, work group leaders realized that the survey included questions and incredible amounts of detail that would not be helpful to the process, nor would it be possible to effectively analyze the data in a timely manner. Since there was a significant amount of data collected that would not be used, several variables were left out of the ACCESS database.

Work group leaders analyzed the data in SPSS and provided results to the work group members. This process consumed three months and more than 30 hours, from the creation of the survey instrument, data entry into ACCESS, and data analysis. A preview of data was provided to the PPG in October 2002. A more comprehensive resource inventory report was provided in December 2002.

Preliminary results from the resource inventory were provided to the Delaware HIV Consortium for use in creation of the resource guide (online and printed versions). The Delaware HIV Consortium resource guide is a combination of treatment and prevention services for all people infected with and at risk for HIV/AIDS in the state of Delaware. The Populations Work Group leaders also received an update on individuals who responded to the survey. This data was helpful in determining where focus groups could occur. The Delaware HIV Consortium Community Membership Liaison received a list of individuals who responded to the survey and were interested in learning more about joining the Delaware HIV Consortium or participating in a planning group.

In December 2002, work group leaders presented resource inventory data to the Prevention Planning Group. This discussion raised issues and questions that needed to be addressed in the final report and were developed into suggestions for future work groups. These issues are discussed below and reflected upon in the 'recommendations/ improvement suggestions' section. In addition, work group members took note of issues and concerns throughout the process.

Questions and issues raised at the December 2002 presentation:

- Do zip codes include DPH sites? In the current survey, the analysis includes a question on zip codes. It needs to be clear whether the agency representative is responding to questions about where the agency is located or where the clients live. The data in tables and presentations also needs to reflect the question accordingly.
- There is a need to review questions about how the agency is funded. If an agency is funded primarily to work with one population, the responses should indicate that it is the population they are serving.
- Agencies that receive funding from the Division of Public Health in essence receive federal funding that is funneled through the state.

This needs consideration in future analyses on how best to reflect the situation.

- Survey tools must include a standard definition of each HIV prevention service listed. There is great potential for confusion about the various services and a need to ensure all are using the same definition for services such as individual level intervention (ILI), group level intervention (GLI), and health communication/public information (HC/PI).
- During the discussion, analytic questions were suggested. They include an examination of the agencies listed as providing the service and whether the agency is privately funded or DPH funded.

IV. What is the Gap Analysis?

The final step in the process was compilation of the results of the needs assessment and resource inventory and development of the gap analysis. For each population analyzed, the questions listed previously under the needs assessment process (details of data collection) were answered. Data was compiled into tables, which are included as Attachment 1. The final question for each population involved deciding whether the population had an overall unmet or met need. The Needs Assessment Work Group members also developed recommendations for each population listed.

To help orient the reader to the charts attached, the first column identified the target populations that were examined in this process. Work group members were assigned a population to examine and bring data to the group members. Epidemiologic data, counseling and testing data, Youth Risk Behavior Survey and other data were brought to discussion. The second column of each chart lists relevant data for each population that the Needs Assessment Work Group members felt were appropriate. Once compiled, the population was assigned a "service need" – how great is the need for services for this population. The scale was 1=low, 3=neutral and 5=high. The third column of this chart design allows the group member to list current services, as identified through the resource inventory. This section also allowed for inclusion of perceived barriers or challenges to meet this population. Again, a scale of 1 to 5 (1=low, 3=neutral and 5=high) was used to estimate the met need. This estimation took into account the suitability of current services, barriers, and how the funding from CDC or Division of Substance Abuse and Mental Health (DSAMH) was meeting the need.

Finally, the last column used a simple formula to calculate the unmet need. Subtracting the met need from the service need resulted in a number, which identified the level of unmet needs for the population in question. The same scale of 1 to 5 was used. In this column, work group members were encouraged to think creatively about recommendations that would assist in developing appropriate programs for the future.

The first table below reviews information on the 'heterosexual' population. The Needs Assessment Work Group decided the service need was neutral, met need was close to high, and therefore the unmet need was low (score=1).

The injecting drug user/ substance abuser (IDU/SA) population data review appears in the second table below. The estimated service need

for this group was high (score=5). The estimated met need was neutral and the resulting unmet need was 2 (close to low). The third table below presents data on men who have sex with men (MSM). The service need was estimated at 4 (close to high). The estimated met need was also set at 4, which would theoretically result in no unmet need for services. However, the work group members acknowledged there is always a need for services, and therefore set the unmet need for this group at 1, corresponding to a low unmet need.

The last table is for youth. Limited HIV/AIDS surveillance data is available for youth. Since HIV can take up to ten years to present itself as an AIDS diagnosis, the large number of individuals who are diagnosed with AIDS in their 20's implies that there is a group of individuals partaking in risky behaviors in their teens. Therefore, combined with HIV/AIDS surveillance data and data from the Youth Risk Behavior Survey (YRBS) indicating over half had sex, the service need for this population was medium (score=3). The current services available are focused in New Castle and Sussex Counties. The estimated met need was close to low (score=2). The unmet need was estimated at 1, corresponding to a low unmet need.

V. Conclusions from the Needs Assessment Work Group

Briefly, the Needs Assessment Work Group was responsible for developing data recommendations and determining which populations had a service need or gap and which populations were adequately being served by current services.

The Needs Assessment Work Group developed recommendations and suggestions to improve the next cycle. Much discussion about data sources and availability of appropriate data occurred throughout the process. With assistance from the state's HIV/AIDS Surveillance unit, it would be helpful to review the data collected in the Supplement to HIV/AIDS Surveillance (SHAS) project to determine feasibility of redistributing risk of individuals reported without a known risk (no reportable risk – NRR).

In developing questions for the focus groups in the next planning cycle, work group members suggested a review of questions asked in the resource inventory survey about availability and access to services. Similar questions on accessibility of services should also be asked of consumers to verify that community members' perceptions of availability match those of agencies.

Other recommendations from the group were to review all questions on the resource inventory survey to ensure all data collected would be useful in analysis. When entering the data into the database, it is important to enter the agency name and connect it to the agency identification number to match the paper survey with the electronic version. (This was not done in the current process). It will also be necessary to include current definitions of each of the various HIV Prevention services listed. These are also referred to in some publications as interventions. (See question 9 of the resource inventory survey– Which of the following STD/HIV/AIDS prevention services does your agency offer?) There was a chance of considerable confusion about the exact definition and its variance from agency to agency, depending on the knowledge of the respondent.

This needs consideration in future analyses on how best to reflect the situation.

- Survey tools must include a standard definition of each HIV prevention service listed. There is great potential for confusion about the various services and a need to ensure all are using the same definition for services such as individual level intervention (ILI), group level intervention (GLI), and health communication/ public information (HC/PI).
- During the discussion, analytic questions were suggested. They include an examination of the agencies listed as providing the

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Chapter 3: Attachment 1 - Needs Assessment Work Group Results Table

TARGET POPULATIONS	NEED	MET NEED	UNMET NEED
Identify potential target populations (review of Epi profile and other data sources)	Identify data that indicates that this group should be considered a population (identify stats from Epi profile and other sources to indicate a need)	Identify current services provided to the population. What are the barriers to the services? How suitable are the services? How much of need are CDC \$ or DSAMH \$ responsible for? Make some estimate of met need.	Identify unmet need of this population.
Heterosexual	24% of DE AIDS cases are female 58% of female cases in DE contracted HIV through sex with a partner who is an IDU 38% of female cases in DE contracted HIV through sex with an infected individual 57% of Kent County cases are largely infected through heterosexual contact 59% of female AIDS cases in Sussex County were infected through heterosexual contact 2003 Epi presentation shows an increasing trend in heterosexual cases SERVICE NEED= 3	Current services: New Castle County: AD (hotline), BGOC (GLI, Outreach, HC/PI), E1T1 (GLI, Outreach, HC/PI), LACC (GLI, Outreach, HC/PI) Kent County: K/SCS (GLI, Outreach), HOP (GLI, Outreach), BGC (GLI, Outreach) Sussex County: LAR (Outreach, HC/PI), SCAC (GLI, Outreach, HC/PI) Barriers: Allow partners to decide whether condom was going to be used – found it difficult to insist if partner resisted Serious discussions about sex are taboo Access related (not aware of agency offering services, access to primary health care, don't like to go to agencies, hours of operation, small community, lack of services, lack of extended outreach, language barriers, transportation and expense) Education related (education, schools uncomfortable with HIV education, ignorance) Emotional/ individual/ personal (fear, denial, embarrassment, intolerance, and apathy) Estimate MET NEED = 4	Estimate UNMET NEED= 1 Recommendation: Continue to evaluate SCAC programs for at least one year Numerous programs need additional evaluation (more time) to determine adequate funding levels or appropriateness and effectiveness of service delivery

Chapter 3: Attachment 1 - Needs Assessment Work Group Results Table *(continued)*

TARGET POPULATIONS	NEED	MET NEED	UNMET NEED
<p>Identify potential target populations (review of Epi profile and other data sources)</p>	<p>Identify data that indicates that this group should be considered a population (identify stats from Epi profile and other sources to indicate a need)</p>	<p>Identify current services provided to the population.</p>	<p>Identify unmet need of this population.</p>
		<p>What are the barriers to the services?</p> <p>How suitable are the services?</p> <p>How much of need are CDC \$ or DSAMH \$ responsible for?</p> <p>Make some estimate of met need.</p>	
<p>Injecting Drug User/ Substance Abuser (IDU/SA)</p>	<p>43% of DE AIDS cases are IDU</p> <p>33% of HIV cases are IDU</p> <p>9% of DE AIDS cases are heterosexual contact with an IDU</p> <p>40% of DE AIDS cases in males are IDU</p> <p>51% of DE AIDS cases in females are IDU</p> <p>82% of IDU AIDS cases in DE are African American</p> <p>86% of IDU AIDS cases are diagnosed in New Castle County</p> <p><u>YRBS:</u></p> <p>78% of youth use alcohol</p> <p>47% of youth use marijuana</p> <p>22% had sex during the last three months and used drugs before the sex act</p> <p><u>National Household Survey on Drug Abuse:</u></p> <p>Approximately 53,000 DE residents over the age of 12 use illicit drugs</p> <p><u>DSAMH:</u></p> <p>About 22% of admissions during FY2002 reported a lifetime history of needle use</p>	<p>Current services:</p> <p>New Castle County: AD (hotline), BCI (GLI, ILI, Outreach, HC/PI)</p> <p>Kent County: K/SCS (GLI, Outreach, HC/PI)</p> <p>Sussex County: SCAC (GLI, ILI, Outreach, HC/PI)</p> <p>Barriers:</p> <p>Access to treatment</p> <p>Stigma related to HIV/AIDS and chemical dependency</p> <p>Untrained staff relating to information on HIV and/or chemical dependency issues</p> <p>Incarcerated individuals may be denied services and protection</p> <p>Case management problems – problems coordinating medical and psychosocial services for those in need</p> <p>Lack of proper assessment tools – case managers are screening for one problem but not both</p> <p>Other risk factors:</p> <p>Hepatitis, other infectious disease, other physical problems</p>	<p>Estimate UNMET NEED= 2</p> <p>Recommendation:</p> <p>Continue to evaluate SCAC programs for at least one year</p> <p>Data is unavailable for commercial sex workers, incarcerated; therefore recommend investigate methods of data collection</p>
	<p>ESTIMATE SERVICE NEED=5</p>	<p>Estimate MET NEED = 3</p>	

Chapter 3: Attachment 1 - Needs Assessment Work Group Results Table *(continued)*

TARGET POPULATIONS	NEED	MET NEED	UNMET NEED
Identify potential target populations (review of Epi profile and other data sources)	Identify data that indicates that this group should be considered a population (identify stats from Epi profile and other sources to indicate a need)	Identify current services provided to the population. What are the barriers to the services? How suitable are the services? How much of need are CDC \$ or DSAMH \$ responsible for? Make some estimate of met need.	Identify unmet need of this population.
Men who have sex with men (MSM)	<p>31% of DE AIDS cases are MSM</p> <p>29% of DE HIV cases are MSM</p> <p>41% of male cases in DE contracted HIV through MSM sex</p> <p>64% of AIDS cases in Sussex County are MSM</p> <p>43% of AIDS cases in Kent County are MSM</p> <p>6% of DE AIDS cases are MSM/IDU</p> <p>Risk behavior themes for MSM: Little risk discussion before sexual activity</p> <p>50% engaged in discussion</p> <p>13.6% never engaged in discussion</p> <p>sensitivity issues about condom usage</p> <p>sexual behavior (promiscuous, unprotected sex)</p> <p>SERVICE NEED= 4</p>	<p>Current services:</p> <p>New Castle County: AD (GLI, ILI, Outreach, HC/PI, hotline)</p> <p>Kent County: no agency identified as providing services</p> <p>Sussex County: CAMP (GLI, ILI, Outreach, HC/PI, chat room)</p> <p>Barriers:</p> <p>Access related (not aware of services, access to primary health care, don't like to go to agencies, hours of operation, small community, lack of services, lack of extended outreach, language, transportation and expense)</p> <p>Alcohol and drug use</p> <p>Emotional/ individual/ personal behavior (fear, denial, embarrassment, intolerance, relapse)</p> <p>Education related (education, stereotypes, ignorance)</p> <p>High degree of homophobia in rural communities</p> <p>Estimate MET NEED = 4</p>	<p>Estimate UNMET NEED= 1</p> <p>Recommendation: Not have duplication of services in other counties</p> <p>Encourage agency development in Kent County to serve the MSM population</p> <p>DPH should re-bid the needs assessment activities for Kent AA MSM activities</p> <p>Encourage current MSM providers to explore activities targeting MSM/Kent</p> <p>Current provider of Kent services should explore including MSM in their scope of services</p>
Youth	<p>1% of AIDS cases in 2002 were diagnosed in patients under age 19</p> <p>3% of clients testing positive in 2001 through C&T were between ages 13-19</p> <p>2001 YRBS data indicates: 53% of youth responding had sex</p> <p>62% used a condom in their last act of intercourse</p> <p>SERVICE NEED = 3</p>	<p>Current services:</p> <p>New Castle County: E1T1 (GLI – Lifomercials and ACT Smart)</p> <p>Sussex County: SCAC (GLI)</p> <p>Barriers:</p> <p>Need to work with the Department of Education to ensure continued education programming</p> <p>Emotional/ individual/ personal fear of discussing the subject</p> <p>Estimate MET NEED = 1</p>	<p>Estimate UNMET NEED = 1</p> <p>Need to develop programs for youth in Kent County</p> <p>Need to evaluate all current programs for long-term effectiveness</p>

PART 1: AGENCY DESCRIPTION

1. Which best describes your organization/agency? **(Check only one)**

- 1. Community Based Organization
- 2. Public Health Agency
- 3. College/University/Community College
- 4. Community Mental Health Center
- 5. Housing/Shelter
- 6. Religious Institution
- 7. Adult Corrections
- 8. Youth Corrections
- 9. Migrant Worker Service Provider
- 10. Community Health Center
- 11. Other: _____

2. Which sub-types best describes your organization/agency? **(Check only one)**

- 1. AIDS service organization
- 2. Gay/lesbian/bisexual service org.
- 3. Family planning agency
- 4. Drug and alcohol treatment service
- 5. Maternal/child health clinic
- 6. STD clinic
- 7. Health care facility
- 8. Women's center
- 9. Youth service agency
- 10. HIV counseling, testing, & referral site
- 11. Other: _____

3. Which best describes the geographical area your organization/agency primarily serves?

- 1. Statewide (serve all counties)
- 2. County

If regional, check the counties you serve:

- 1. New Castle
- 2. Kent
- 3. Sussex

List ZIP codes or cities served below:

4. Please indicate the category/source of the funding for your HIV prevention program(s):

- 1. Federal Funds
- 2. State Funds
- 3. City / County Funds
- 4. Private Funding
- 5. Individual / In-Kind Contributions
- 6. Fee for Services
- 7. Other: _____

5. What best describes the communities you serve?

- 1. Urban (communities of 50,000 or more)
- 2. Rural
- 3. Resort
- 4. Institutional Setting (incarcerated, etc.)
- 5. Other (specify): _____

6a. What is the estimated breakdown of the agency's clients by racial/ethnic background? (Include clients accesses ALL services your agency provides)

Ethnicity

- 1. Hispanic or Latino _____ %
- 2. Not Hispanic or Latino _____ %

6b. Race

- 3. White _____ %
- 4. American Indian/Alaskan Native _____ %
- 5. Asian _____ %
- 6. Black or African American _____ %
- 7. Native Hawaiian or Other Pacific Islander _____ %
- 8. More than One Race _____ %

PART 2: HIV/AIDS PREVENTION PROGRAM DESCRIPTION

7. Please indicate how many staff members (on average) your organization had working on HIV Prevention services for 1999 and 2000 (expected)?

(NOTE: count only time dedicated to HIV prevention services. Ex.- If a full time employee is split equally between HIV Prevention services and another program, that employee would be listed as "part-time" below.)

2002

Full-time (35+ hrs/wk): _____

Part-time (<35 hrs/wk): _____

Volunteer : _____

8. What is the estimated breakdown of the program's clients by racial/ethnic background? (Include ONLY clients accessing the HIV prevention services your agency provides)

- 1. Black or African American _____ %
- 2. White or Caucasian _____ %
- 3. Hispanic _____ %
- 4. American Indian and Alaskan Native _____ %
- 5. Asian or Pacific Islander _____ %
- 6. Other: _____ %

9. To which population(s) is your agency's HIV Prevention program(s) targeted.
(Check all that apply)

- 1. Men who have sex with men _____
- 2. Substance abusers _____
- 3. Young adults (13-24) _____
- 4. Bisexual Men & Women _____
- 5. Heterosexuals _____
- 6. Women _____
- 7. Persons with HIV/AIDS _____
- 8. General Population _____

Individuals who are:

- 1. Pregnant
- 2. Infected with STDs
- 3. Medical Professionals
- 4. Homeless
- 5. Low social-economic status
- 6. Sex workers/prostitutes
- 7. Substance abusers
- 8. Incarcerated
- 9. Mentally ill
- 10. Visually/hearing impaired
- 11. Migrant workers
- 12. Vacationing/seasonal
- 13. Developmentally disabled
- 14. Other: specify _____

10. Which of the following STD/HIV/AIDS prevention services does your agency offer to with what frequency?

	<u>Frequency that Service is Provided</u>		
	Everyone	HIV+	Evaluate
<input type="checkbox"/> On-site HIV counseling, testing, and referral (CTRPC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Outreach HIV CTRPC (i.e. bars, parks, mobile vans, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 1. Individual risk reduction counseling and education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 2. Multi-session support groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 3. Safer sex skills building groups, workshops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 4. Targeted HIV prevention programs for those in alcohol /drug treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 5. Peer education programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 6. School based education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 7. Mass media campaign (billboards, news papers/magazine/TV ads, PSAs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 8. Condom drop off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 9. Literature drop off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 10. Telephone information and counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 11. HIV prevention case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 12. STD screening and treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 13. Non HIV CBO based education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part 3 will mostly consist of probing questions. Here is a guideline to what the interviewer will ask.

PART 3: PROGRAM CHALLENGES AND NEEDS

The following questions ask about your agency's experience relative to barriers encountered while providing HIV prevention services to the programs target population(s). Please relate only those barrier encountered *specifically and directly* by your organization. The accurate reporting of these challenges is very important when planning for funds/ training/ remedies/ solutions to these challenges. The challenges facing programs targeted to different populations may be (often are) significantly different and will need specific and targeted solutions. Again, please report only those barriers/challenges experienced by your agency's program *first-hand*.

11. What are the *significant (major)* barriers to providing HIV prevention services in your service area?
(Check all options that apply and number the one you have checked in order of significance: 1 being most significant, 2 being of lesser significance, etc.)

- 1. ___ Limited hours of operation
- 2. ___ Lack of available training for staff
- 3. ___ Limited funding and staffing
- 4. ___ Small size of target population
- 5. ___ Target population not aware of services
- 6. ___ Problems of accessibility for the target population
- 7. ___ Staff retention
- 8. ___ General public apathy about HIV/AIDS/STD prevention
- 9. ___ Insufficient coordination, collaboration among prevention providers
- 10. ___ Excessive duplication of services (splitting target population)
- 11. ___ Lack of bilingual materials. Specify languages needed:

- 12. ___ Other; specify: _____

12. Please indicate with a check mark below how you would rate accessibility to HIV/AIDS/STD prevention services in your organization.

ACCESSIBILITY FEATURE	1	2	3	4
	VERY ACCESSIBLE	MODERATELY ACCESSIBLE	NOT ACCESSIBLE	DOES NOT APPLY
a. Parking				
b. Proximity to public transportation				
c. Transportation tokens provided				
d. Handicap parking				
e. Proximity to target population/predominant community served				
f. Proximity to other agencies to which your agency refers				
g. Proximity to hospitals/clinic which your clients use				
h. Child care				
i. Non-English language interpreter/translation				
j. Sign language				
k. Staff representative of the target population				
l. Other; specify:				

PART 4: COMMUNITY NEEDS/SERVICES

13. Please rate the level to which HIV/AIDS/STD prevention services are being provided to the following populations in your service area (but not necessarily by your agency), by using the following scale:

- 0 = not provided at all
- 1 = somewhat provided but not sufficient quantity or quality to meet demand/need.
- 2 = adequately provided
- 3 = well provided
- 4 = excessive: duplication of services

<p>HIV/AIDS/STD PREVENTION SERVICES PROVIDED IN YOUR AREA (If you have questions about how to fill out this grid, please call Jim Dickinson at (302) 855-9037)</p>	ELDERLY	HOMELESS	COMMERCIAL SEX WORKERS	INCARCERATED	PREGNANT WOMEN	HETEROSEXUALS	WOMEN	HIGH-RISK YOUTH	GAY/BI MEN	INJECTED DRUG USERS	PERSONS WITH HIV/AIDS
<p>EXAMPLE: <i>If the only HIV Prevention Services for HIV Negative Persons in my area was a health education program targeted to inmates and IDUs, then the rating may look like this.</i></p>	0	0	0	3	0	0	0	1	0	3	0
<p>HIV Prevention Services for HIV Negative Persons: includes health education/risk reduction counseling, behavioral change counseling, referrals, etc.</p>											
<p>HIV Prevention Services for HIV Positive Persons: includes health education/risk reduction counseling, behavioral change counseling, referrals, etc.</p>											
<p>HIV Counseling, Testing, Referral, and Partner Notification: includes services that provide client centered, confidential/anonymous, opportunities for individuals to learn their sero-status, receive prevention counseling and referrals.</p>											
<p>HIV Prevention for Groups: includes health education/risk reduction education, skills building/information presentations for groups</p>											
<p>Community Level Interventions: programs that target entire communities and attempt to alter community norms, involve community members in the planning, delivery, monitoring, and tailoring of the program.</p>											
<p>Public Information Campaigns/Programs: Services that target specific communities and aim to dispel myths, encourage volunteerism for HIV prevention programs, reduce HIV related discrimination, etc.</p>											
<p>HIV Prevention Capacity Building: Services that strengthen the public health infrastructure (public and private), ensure quality of services, improving access to services, and provide technical assistance and encourage community level self sufficiently relative to HIV prevention.</p>											

PART 4: COMMUNITY NEEDS/SERVICES *(continued)*

Interviewer at this point probes representative of agency about barriers.

Ex: You mentioned barriers – what are they, etc. If training issues is a barrier – use chart.

14. What critical HIV/AIDS/STD prevention training needs does your agency staff or volunteers have?

TRAINING NEEDS	¹YES	²NO
a. Program development		
b. Knowledge of effective intervention strategies		
c. Working with the media		
d. Program evaluation		
e. Culturally sensitive programs		
f. Risk reduction/behavioral change		
g. Counseling and Testing		
h. HIV+ speakers		
i. Human sexuality		
j. HIV/AIDS update		
k. Other; specify:		

Final questions:

Would you be interested in joining the Community Planning Group?

Would you like a copy of the plan when it is developed?

Chapter 4: *Priority Populations*

This chapter describes the prioritized target populations as determined by the Populations Work Group. With its limited resources, Delaware must focus HIV prevention efforts on individuals considered most at-risk for HIV infection, also called a target population. The Populations Work Group reviewed the data presented by the Needs Assessment Work Group to identify populations that require HIV prevention efforts due to their rates of HIV infection and risky behaviors.

Working with the Delaware HIV Consortium Community Planning Specialist and DPH staff, the Populations Work Group identified these at-risk groups as most in need of continued programming:

1. Injecting Drug Users who are HIV-positive
2. Men who have Sex with Men who are HIV-positive
3. Heterosexuals who are HIV-positive
4. Injecting Drug Users who are HIV-negative
5. Men who have Sex with Men who are HIV-negative
6. Heterosexuals who are HIV-negative

Special Populations

- A. Youth (13 to 19 years of age)
- B. Incarcerated who are HIV positive and HIV negative
- C. Seniors (50 and above)
- D. Hispanics (Statewide)

The four populations listed as *special populations* reflect the need for further observation of these groups noted by Populations Work Group members. While quantitative data might not indicate specific trends occurring in the at-risk groups in Delaware, there is a need to continue close monitoring of the data about these individuals. Populations Work Group members feel programming should continue for these populations so that future generations of youth, Hispanics, seniors and incarcerated individuals show reduced HIV infection rates. In addition, these populations have different needs, in terms of language, access to services and knowledge base such that programming must be tailored.

I. Why is it important to prioritize populations?

By prioritizing populations, DPH and the Delaware Prevention Planning Group can work to prevent HIV transmission in groups most at-risk. If the list did not exist, then the state and the PPG would not know which groups to target for prevention programs. This could potentially increase the rate of HIV infection among at-risk populations. Spreading the money around all populations at-risk would not be cost-effective and would not help to reduce the spread of HIV in Delaware.

The Centers for Disease Control and Prevention created a new initiative in 2003, *Advancing HIV Prevention*, that calls for a national emphasis on prevention programs for HIV-infected persons. Because

of this new initiative, CDC requires the prioritization of people living with HIV/AIDS as the first prioritized population for all community planning groups. Individuals can only become infected through interaction with a person already infected with HIV; therefore working with those who are HIV-positive to stop the spread of HIV can help reduce the transmission.

The Populations Work Group was asked to review quantitative data (number of people infected with HIV) and qualitative information (opinions expressed by community members) to focus their attention on populations most at-risk. This process is designed to be scientific, following a standard set of steps, so future PPG members can understand and potentially use a similar process for updates to the plan.

Reviewing quantitative data is part of the fifth community planning objective listed in the *community planning guidance*. As stated in earlier chapters, CDC defined critical attributes for each objective related to community planning. The fifth objective ensures that priority target populations are based on an epidemiologic profile and a community services assessment. The following five attributes refer to target populations:

- Evidence that the size of at-risk populations was considered in setting priorities for target populations.
- Evidence that a measurement of the percentage of HIV morbidity (i.e. HIV incidence or prevalence), if available, was considered in setting priorities for target populations.
- Evidence that the prevalence of risky behaviors in the population was considered in setting priorities for target populations.
- Target populations are defined by transmission risk, gender, age, race/ethnicity, HIV status, and geographic location.
- Target populations are rank ordered by priority, in terms of their contribution to new HIV infections.

II. What process did the Populations Work Group follow?

The Populations Work Group conducted several processes to develop their final list of prioritized populations. Through these exploratory exercises, the Populations Work Group gained insight into the strengths and weaknesses of each data source, difficulties in comparing rates, and then integrating the information into a

concise list. Each process contributed to the final results and will be briefly explained below.

The first process involved developing questions and conducting **focus groups** with at-risk populations. A formal prioritization process, including weighting and ranking of populations was completed in April 2004. Finally, with assistance from DPH, quantitative data was used to develop the PPG-approved list of populations with details on risk behavior, racial/ ethnic group, age, gender, HIV status and geographic area.

Populations Work Group members learned the **prioritization process**. Because quantitative and qualitative data sources varied based on the data source and the population being prioritized, the process became confusing. After several months of work, the Populations Work Group realized results were not consistent across the data sources. Though this time-consuming process was educational for work group members, it was decided to use a more scientific process because of statistical calculation and data problems that occurred in the prioritization efforts. A brief discussion of the prioritization process is included in this chapter with references available in the attachments.

The final process, listed as **scientific data review** process later in this chapter, allowed the Populations Work Group a streamlined process and methodology. Using consistent data from DPH, the work group finalized their list of populations. Results from this process were presented to the PPG and approved in March 2004.

A. Focus Groups

1. Methodology

As the planning cycle began, the Populations Work Group reviewed populations that were identified in the 2002-2004 Comprehensive HIV Prevention Plan. The Populations Work Group also reviewed results from the December 2002 Needs Assessment Work Group presentation to determine where focus groups could be conducted (as stated in Chapter 3). Since the Needs Assessment Work Group focused their results on quantitative data, it was important for the Populations Work Group to hear from the community members and add their perspectives, as qualitative data, to the process.

The Populations Work Group used a multi-prong approach to their assigned tasks. Work group members were asked to develop questions for use in focus groups and key informant interviews. Key informant interviews were not conducted in this planning cycle. Future planning cycles may have adequate time built into the timeline to complete the interviews. Simultaneously, the members were asked to identify which populations they felt would be best suited for focus groups and which populations would be appropriate for key informant interviews. Work group members were also asked to identify leaders in the communities where focus groups could potentially occur. This would assist in pulling people together for the focus group sessions. Putting the results of these discussions together, the Populations Work Group identified populations they could contact for focus groups and had questions ready for these sessions.

PPG members were asked to participate as focus group leaders or facilitators. If possible, they were asked to coordinate or assist with organizing the groups – working with the logistics of the group: time, location, refreshments or assisting with recording the sessions. In August 2003, individuals who volunteered to serve as a focus group leader were provided with training and a facilitator's guide. Delaware HIV Consortium staff assisted with finalizing locations, obtaining tape recording devices, and other required equipment. The focus groups were completed by winter of 2003 with the following six groups:

- 1) Incarcerated women
- 2) Incarcerated men
- 3) Heterosexual women
- 4) Hispanic heterosexuals
- 5) In school male youth
- 6) In school female youth

The tapes and notes from each session were secured at the Delaware HIV Consortium for future need and used by a contractor for data analysis. A contractor was hired to review all data collected through this process. Results were collected and reviewed by January 2004.

2. Results

Salient points from the discussions are provided in attachment 2. The main focus of the participants was on prevention and testing. Focus group participants encourage increasing knowledge about HIV in the community. They provided suggestions on marketing campaigns, messages to use and locations where their peers would most like to see the messages. Participants recommended that doctors need to incorporate messages into routine medical sessions, as physicians are seen as trustworthy in some communities. Participants cited the need to increase the mobility of HIV testing options. Incorporating HIV testing into a routine doctors visit would allow more people to get tested and learn their serostatus. Focus group members also cited fear of needles as a reason people did not get tested. There is a need to continue informing the public about the confidentiality of testing procedures and results, especially within the correctional system. Their suggestions mimic two goals of the CDC *Advancing HIV Prevention*¹ initiative (routinizing HIV testing in medical care and implementing new models for diagnosing HIV infections outside medical settings).

Facilitators conducted assessments on all focus groups to provide future PPG members with perspectives on how to engage the individuals, which focus groups worked well and what did not work. The assessment form discussed whether the facilitator felt it was a good group, functioned well and whether the group members participated equally or if discussion was dominated by a few.

B. Prioritization process

The second process conducted by the Populations Work Group involved a process using factors, and rating and weighting scales. In April 2003, a consultant from the Academy for Educational Development taught this process to PPG and Treatment Services

Committee members. As discussed in the chapter introduction, results from this process were not used in the final prioritized list of populations. Data for some of the factors was misused and misinterpreted. The methodology is included in attachment 3 for the education of future PPG members.

C. Scientific Data Review

1. Methodology

With the PPG leadership and staff changes at the Delaware HIV Consortium and DPH, it was necessary to use a more careful review of data from the HIV/AIDS Reporting System (HARS) and Counseling and Testing System (CTS). This process was accomplished in a short time frame to meet deadlines set by the PPG for the Populations Work Group. Parts of the process also overlapped with the work responsibilities of the Interventions Work Group. For this report, the steps will be addressed in the chapters for each work product.

The objectives of the process were:

- ✔ To identify the most at-risk populations
- ✔ To describe the geographic area where the populations live
- ✔ To describe the demographics of the populations in the geographic areas/ environment identified

Populations Work Group members had to accept a set of assumptions from which the work process would be launched. The assumptions were:

- The presence of HIV must be the first consideration in identifying any population or geographic area.
- Given a relatively stable epidemic and the historical failure of other indicators and data sources to predict shifts and trends within Delaware's epidemic, additional data sources (STD rates, BRFSS data, census data, and focus group data) should not be used to identify at-risk populations.
- These additional data sources are vital to describing the conditions and behaviors within the identified populations/ geographic areas.
- Funding realities demand that the PPG focus efforts and resources on specific populations, areas, and behaviors as identified by epidemiology.

The Populations Work Group then began an intensive process involving ten steps. The first seven apply directly to the task of prioritizing populations, while the remaining three steps required interaction with the Interventions Work Group. Therefore, the final three steps will be discussed in the next chapter.

Step 1: For the time period 2001-2003, DPH staff sorted the HARS and CTS databases by zip codes.

Step 2: From HARS data, staff calculated prevalence rates of each zip code to identify those that have the highest prevalence of HIV. From the CTS, staff calculated the incidence of HIV positive results for each zip code (by client residence) to identify those zip codes that have the highest rate of positive tests.

Step 3: DPH staff compared the two data sources for concurrence.

Step 4: DPH staff compiled a list of the zip codes occurring in both data sets and examined it for outliers of statistical relevance.

Step 5: The Populations Work Group worked with DPH staff to retrieve specific risk behavior and demographic data from the HARS and CTS databases to describe the populations in these zip codes.

Step 6: The Populations Work Group retrieved specific risk behavior and demographic data from supplemental data sources to further describe the populations in these zip codes.

Step 7: DPH staff and the Populations Work Group members produced a report of findings.

2. Results

In Delaware, there are approximately 100 zip codes. Of these 100 zip codes, 21 were identified that have an above average prevalence of HIV and an above average number of clients receiving HIV positive test results. The data indicates 87% of Delaware's HIV epidemic is located in these 21 zip codes. Trend data shows that for the past three years, the prevalence rate in these zip codes has been roughly twice the state average.

Delaware's HIV epidemic has mimicked the national trend, moving from large infection rates among men who have sex with men (MSM) to injecting drug users (IDUs). In Delaware, the shift from white MSM to African American IDUs occurred over the last ten years. The zip codes recording the highest prevalence and HIV positive test incidence have not varied significantly. In the last five years, there has been an increase in African Americans infected through heterosexual contact. While Delaware's overall population is approximately 20% African American, about 65% of the state's HIV cases and 65% of the AIDS cases are in African Americans. Delaware's epidemic among African Americans appears to strike a larger percentage than across the nation. According to CDC, through December 2002, 39% of AIDS cases nationally are African Americans.

New Castle County continues to see the greatest impact of the HIV epidemic, as 73% of all living HIV/AIDS cases in the high-risk zip codes are in the county. Seventy percent of the living cases in New Castle County are in the city of Wilmington. Sussex County accounts for 13% of the living HIV/AIDS cases in the high-risk zip codes, while 7% of the living cases in the high-risk zip codes are in Kent County.

The remaining 7% of living HIV/AIDS cases are dispersed throughout the state. Targeting the small population of individuals living with HIV/AIDS that are not located in the high-risk areas would not be cost-efficient given current funding.

The Populations Work Group concluded their process with a vote on the final prioritized populations list. The populations, and sub-populations, were categorized using the following diagram:

Zip Code ▶ **Mode of Exposure** ▶ **Race/Ethnicity** ▶ **Age** ▶ **Biological Sex**

The following are the target populations and their sub-populations.

1. Injecting Drug Users who are HIV+
 - a. Black/White; 30+; Male/Female; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720, and 19977
 - b. Black; 30+; Male/Female; live in 19901, 19904, 19933, 19956, 19963 and 19973
2. Men who have Sex with Men who are HIV+
 - a. Black; 30+; Male; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720 and 19977
 - b. White; 30+; Male; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720 and 19977
 - c. Black; 30+; Male; live in 19901, 19904, 19933, 19956, 19963 and 19973
 - d. Black/White; 30+; Male; live in 19947, 19958, 19971
3. Heterosexuals who are HIV+
 - a. Black; 30+; Female; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720 and 19977
 - b. Black; 30+; Female; live in 19901, 19904, 19933, 19956, 19963 and 19973
4. Injecting Drug Users who are HIV-
 - a. Black/White; 30+; Male/Female; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720 and 19977
 - b. Black; 30+; Male/Female; live in 19901, 19904, 19933, 19956, 19963 and 19973
5. Men who have Sex with Men who are HIV-
 - a. Black; 30+; Male; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720 and 19977
 - b. White; 30+; Male; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720 and 19977
 - c. Black; 30+; Male; live in 19901, 19904, 19933, 19956, 19963 and 19973
 - d. Black/White; 30+; Male; live in 19947, 19958, 19971
6. Heterosexuals who are HIV-
 - a. Black; 30+; Female; live in 19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720 and 19977
 - b. Black; 30+; Female; live in 19901, 19904, 19933, 19956, 19963 and 19973

Special Populations

7. Youth (13 to 19 years of age)

Even though there is no data to support this population having a high-prevalence, there is data showing that a large number of people are AIDS-defined and in their 30's. It is recognized that

people can live with HIV for 10-15 years before becoming AIDS-defined. Therefore, that population would have been infected in their teens and 20's. There is also a need to target prevention programs to this population in order to reduce risky behaviors later on in their lives.

8. Incarcerated who are HIV positive and HIV negative –

Nationwide, there is an increase in the number of individuals incarcerated. This trend is seen locally and could have an effect on the HIV infection rate among Delaware inmates. Zip code 19977 (Smyrna) has a prevalence rate of 0.68% in 2003, with most of those cases being accounted for at the Delaware Correctional Center (DCC). The Populations Work Group included these cases in the New Castle County statistics. It should be noted that the 5 major correctional institutions in Delaware have high-prevalence rates for HIV/AIDS. Targeted programming needs to continue among this population as well as better data collection to determine the actual populations most infected and affected.

9. Seniors (50 and above)

With an aging population in Delaware, there is concern about seniors becoming at-risk for HIV infection as individuals are living longer. Even though this population is included in the sub-populations above, there needs to be special emphasis on reducing barriers to testing among this age group that are different than other age categories and collecting better data on this population.

10. Hispanics (Statewide)

Across the United States and in Delaware the Hispanic population continues to grow and will impact upon morbidity rates across all diseases, including HIV/AIDS. It is widely thought that Hispanics are unlikely to seek medical services, including testing and treatment for HIV. Many barriers exist to serving this population, including language and cultural disparities among service providers. Needs assessments should concentrate on identifying how to reach this population, how to educate them about the disease, and how to provide the most effective HIV prevention and treatment services.

Additional information on the major priority populations selected.

Injecting Drug Users (IDU):

In Delaware, approximately one-third of all new HIV infections are directly related to injecting drug use (IDU). However, if the data is examined for all patients with a risk behavior related to injection drug use, which includes heterosexual contact with an IDU, mother was an IDU, and partner of an IDU, the percentage of cases related to IDU increases to approximately 55%. The majority of HIV/AIDS cases related to IDU in Delaware are African American. Among the male adult IDU cases, 85% were residents of New Castle County when diagnosed, while 89% of the female adult IDU cases resided in the county when diagnosed.

Through December 2002, CDC reported an estimated 240,268 cases of AIDS related to IDU. This calculates to 27% of adult AIDS cases reported to CDC.

Men who have Sex with Men (MSM):

While the HIV/AIDS epidemic started in white MSM in Delaware and nationwide, the local trend has shifted to African American MSM. In the first decade, two-thirds of the MSM cases were White, while one-third were African American. In the last decade (1993-2002), just over one-half (55%) of the MSM cases were White, while 41% were African American.

Delaware data points to an overall decrease in new HIV cases diagnosed among MSM. However, MSM continue to comprise approximately 30% of the AIDS cases in the state. Nationwide, CDC reported 420,790 MSM cases through December 2002 or approximately 47% of national cases.

Heterosexuals:

A new trend in the HIV/AIDS epidemic is being seen as more heterosexuals are being diagnosed with HIV/AIDS. In Delaware, most cases in the early 80's were not in the heterosexual population. Data through December 2002 indicates approximately one in five HIV/AIDS cases are related to heterosexual contact (20%). This includes heterosexual contact with an injecting drug user, bisexual man, transfusion/ transplant recipient or person living with HIV/AIDS. Delaware heterosexual male HIV/AIDS cases represent 6% of the overall HIV/AIDS cases through December 2002, while the 512 female HIV/AIDS heterosexual cases represent 13% of the overall cases through the same time frame. CDC received reports of 135,628 heterosexual AIDS cases through December 2002 (15%).

III. Recommendations for future planning

Future PPG members can learn from the experiences of the past. The Populations Work Group was able to review their process and develop recommendations for the next planning cycle. Based on the target population prioritization process, the work group recommends the following for HIV prevention planning in 2005-2009:

- **Special Populations:** The Populations Work Group noted four special populations that require continued attention throughout the next planning cycle (Youth, Incarcerated, Seniors and Hispanics). Work group members recognize the need to monitor the data for a potential increase in the number of people becoming infected.
- **HIV Testing and Counseling:** Information reported may be inaccurate due to testers filling out paper work incorrectly. Some populations are not being represented due to lack of testing data. Individuals conducting HIV tests need to be held accountable for completing paperwork accurately, timely and responsibly.
- **STD Information:** Additional data should be collected on individuals tested for STDs so that the data can be useful for comparison with HIV/AIDS data. This includes collecting data on sexual orientation. STD data should be collected from Family Planning Centers, Public and Private Clinics, and the School-based Wellness Centers. STD Reports from the Division of Public Health should mimic HIV Counseling and Testing Reports.
- **Contractors Data:** Community-based organizations contracted through the Division of Public Health to provide HIV prevention services should be collecting data on the populations they serve, including types of risky behaviors, key indicators, complexity of needs, and barriers to reaching this population.

- *Contractor evaluation data was not consistently available for this process. There was limited evaluation data available from the Lutber system, which collected many variables from all DPH funded HIV prevention contractors. Among the data included in this data set were the number of clients, sessions completed, and types of materials distributed. Monthly reports provided to DPH by these contractors also described in greater detail the activities conducted as well as including quantitative information on the clients served. With limited DPH staff to review these reports, it was difficult to provide aggregate data to the Populations Work Group on the HIV prevention contractors. Delaware will be implementing a new process, called the XPEMS (external prevention evaluation monitoring system), which will comply with CDC's system. XPEMS will collect all CDC-required information in addition to the Delaware-specific data that will be helpful to future PPG processes. More information on XPEMS is available from DPH.*

- **Data on the Incarcerated:** Data should be collected on Incarcerated Adults and Youth, including sexual orientation, types of risky behaviors, key indicators, complexity of needs, and barriers to reaching this population. For Incarcerated Youth data should be collected on the number of HIV and STD tests performed and the number of positive results.
- **Seniors (50+):** Data should be collected on seniors, including sexual orientation, types of risky behaviors, key indicators, complexity of needs, and barriers to reaching this population.
- **Data Collection:**
 - When the Prevention Planning Group conducts Focus Groups they should target each of the newly identified populations in more detail. A few very specific questions should be asked about barriers to receiving services and complexity of reaching that population with prevention messages.
 - Due to a lack of data on the Hispanic population and Youth populations, it is important to actively seek out these populations to collect data on them, whether through focus groups and/or one-on-one interviews.
- **Planning for the 2005-2009 Planning Cycle:** The Prevention Planning Group should create a Standard Operating Procedure for conducting needs assessments, prioritizing populations, and selecting interventions. The PPG should be updating the reports based on new statistics and data instead of re-inventing the wheel for each planning cycle.

TOPIC: Prevention

- Focus on adolescents
- Include infected persons, particularly those in later stages
- Include more diverse populations in messages; focus messages on more diverse groups
- Television and radio are preferred methods for providing HIV prevention messages among all groups.
- Women prefer shock ads.
- Statistics are effective in HIV prevention messages.
- Pictures of people with STDs affected adolescent males.
- There is a consensus that schools do not do enough in regards to HIV prevention.
- Adults prefer billboards as a means for HIV prevention messages.
- Peer education is preferred among incarcerated populations and in-school females.
- Adults trust churches to provide accurate HIV information.
- Doctors and other healthcare providers are also considered trustworthy sources for accurate HIV information.
- Fear and lack of exposure to information seem to be the most common reasons people do not receive HIV prevention information.
- Participants knew that abstinence and condom use were effective means of protection.
- Participants noted that protection from HIV is about taking personal responsibility.
- The most common response as to why people engage in risky behavior is that they believe they are invincible; that they are above HIV.
- People also engage in risky behavior because they are unwilling to change a lifestyle (e.g. "player" or drug addiction).
- Education is the key to getting people to protect themselves.
- A number of participants noted that people engage in risky behavior because they trust their sex and/or drug using partners not to be putting them at risk.
- People do not talk about protection with partners primarily because they fear being rejected.

TOPIC: Testing

- Incarcerated populations do not trust the medical provider to conduct confidential testing.
- Incarcerated populations prefer DCJ or another outside provider.
- Fear of the test results and stigma are the primary reasons people do not get tested.
- Many participants noted that people do not get tested because of a fear of needles.
- Lack of confidentiality (perceived and real) is also a primary reason people do not get tested.
- A number of participants noted that lack of testing sites contributed to low testing rates.
- A number of participants noted the effectiveness of the mobile testing van.
- To encourage people to be tested, getting tested must be made a positive activity. Must dispel the myth that a positive HIV test result is a death sentence. Should show people with HIV/AIDS living happy productive lives.
- All but a few of the participants knew at least one HIV testing site.

Population: INCARCERATED

Where do you get information on HIV?

- DCJ (both)
- Seminars (both)
- DPH (women)
- Infirmery (men)
- Peer educators (men)

What are the known prevention messages?

- HIV doesn't discriminate (women)
- 1 in 50 Blacks (women)
- Get tested (men)

Has the information changed how you think or act?

- Consensus among women – YES
 - Gained self respect, realized seriousness, brought it closer to home, touch families, will change behavior
- Consensus among men – YES
 - Looked at behaviors, sought information on how to deal with infected people, realized seriousness

Have you shared the information?

- Consensus among females that topic is discussed
- Discuss with family, particularly children
- Invited family members to World AIDS Day event
- No consensus among males – some discuss; others do not

Has information resulted in testing?

- Most yes (both)
- A few NO – because no free testing and no guaranteed confidentiality

What is the preferred means of prevention?

- Peer Education (both)
- Women: Public Health Bulletins, updated posters, special events, outside organizations – Not DOC medical
- Men: Videos, movies and TV

Where can you get tested while incarcerated?

- Consensus among women that they would NOT get tested while in prison because don't trust medical and because charge fee.
- Men mentioned testing at the infirmery and by the University but also noted would prefer testing on the units with swabs and by DCJ or peer educators.
- Consensus among both men and women that medical provider is not trusted.

Population: HETEROSEXUAL HISPANIC

Who is at risk?

- Families who share needles for medication because can't get free needles.
- Poor people.
- Young people.
- Alcoholics.

How can you share information with your family?

- Brochures
- Difficult to talk to opposite gender family members

How important is it to know your status

- Important – future depends on it

How important is it to know your partner's status?

- Important

How comfortable are you discussing HIV with your partner?

- Difficult to discuss; others may assume trying to tell HIV positive; need trust to discuss

How comfortable are you discussing condom use?

- Difficult; need to discuss prior to getting in bed; need to discuss during time getting to know each other

Population: IN-SCHOOL MALE YOUTH

Who is your best source of information?

- Doctor
- Clinic
- Parents
- Counselor

What information changed your behavior?

- STD pictures
- The News
- TV

Why do young people have unprotected sex?

- Young and dumb
- "Sprung" (in love) with partner
- Peer Pressure
- Feels better

What do you need to protect yourself from HIV and STDs?

- Condoms
- Saran Wrap

How can we help make condoms more desirable?

- Billboards
- Commercials
- Stores
- Schools
- More accessible

What is the best way to promote abstinence?

- Show people with good celibate relationships
- Masturbation

Would TV or radio help promote condom use or abstinence?

- Music
- Videos

What is the motivation to take a workshop?

- Co-ed workshops
- Use sex to sell workshop

Population: HETEROSEXUAL WOMEN

Where do you get information in your community?

- Church/BGOC
- Media
- Hair Salon
- BET
- Girlfriends

How would you prefer to learn about HIV?

- Summit
- Conferences
- Billboards
- Bumper stickers

Has any information changed your behavior?

- Statistics – made paranoid in a good way

Describe messages you have seen or heard:

- Wrap It Up Commercial
- Skits at Bethel
(3 or 4 women with same man; Do you have the time)
- 1 in 50
- Dr. Roberts of CDC

What would help to make condoms more desirable?

- Flavored condoms
- More sensation, textures
- Glow in the Dark
- Condom in the can – spray it on
- Motion Lotion

What would encourage seeking more services?

- More places to go
- Mobile Van
- More advertising
- Door to Door
- Condom Van (Van shaped like condom)
- Make people feel that services are confidential and professional

What motivates you to take a prevention workshop?

- Statistics
- Food
- Prizes
- Guest Speakers
- Right time, right location, right information
- Skits

NOTE: *This attachment includes sample charts used in the prioritization process. They are included for educational purposes only and data in the tables should not be used for data interpretation.*

Populations Work Group members selected factors to use in the process. For each factor, data sources were identified and the factor was assigned a weight. The factors, and their assigned weights, chosen for this process were:

FACTOR	WEIGHT
✓ AIDS incidence	4
✓ AIDS prevalence	4
✓ HIV incidence	5
✓ HIV prevalence	5
✓ Key indicators	4
✓ Riskiness of population behaviors	4
✓ Complexity of population needs	3
✓ Barriers to reaching target population	3

Example of how a rating scale is applied to the factors.

Each factor was also assigned a rating scale, to be consistent between the populations studied in the process. Data is compared against the rating scale. For each population and each factor, numbers are assigned under the rating column.

FACTOR	RATING SCALE	DATA	RATING
AIDS Incidence	5 = 176+		
• What number of new AIDS cases are members of the target population (2001-2003)?	4 = 126-175 3 = 76-125 2 = 26-75 1 = 0-25	61	2
AIDS Prevalence	5 – +50%		
• What percentage of the number of living AIDS cases are members of the target population (2001-2003)?	4 – 30–49% 3 – 20–29% 2 – 10–19% 1 – 0–9%	45	4

Please note: the sample chart includes an example of the misuse of data for AIDS Prevalence.

The final step in the prioritization process required Populations Work Group members to put all the data together. By listing all populations, factors, weights, and rates, each population was assigned a score. Total scores were then tabulated for the populations and ranked from highest to lowest to determine the prioritized populations.

Example of scoring worksheet.

Data for all factors for one population is listed, along with weights and rates. The score is the product of the weight multiplied by the rate. Total score is listed at the bottom of the worksheet.

SCORING WORKSHEET				
Population	Factor	Weight	Rate	Score
SAMPLE TABLE	AIDS Incidence	4	2	8
	AIDS Prevalence	4	4	16
	HIV Incidence	5	2	10
	HIV Prevalence	5	4	20
	Key Indicators	4	3	12
	Riskiness	4	4	16
	Complexity	3	3	9
	Barriers	3	5	15
Total Score				106

Chapter 5: *Interventions*

H*IV Prevention planners must decide what types of programs to fund and implement for the most effective, cost-efficient methods of delivering the educational message. Using scientifically proven programs, also known as interventions, community based agencies can reach into their communities to educate their peers with the goal of reducing HIV transmission. The Interventions Work Group developed a list of appropriate interventions for the prioritized populations. The list of interventions approved by the PPG along with DPH definitions of intervention types is included in this chapter.*

I. Why is it important to list interventions?

The Comprehensive HIV Prevention Plan serves as a map and a guide for health planners within the PPG and DPH. Providing recommendations on interventions that could work in the Delaware socio-economic reality, with existing community based agency ability and capacity, and funding levels is important to guide the development of requests for proposals (RFPs) and subsequent program development. Selecting the most appropriate interventions, therefore, is integral to this process.

There are seven critical attributes, listed by CDC in the *community planning guidance*, that relate to selecting appropriate interventions. These attributes relate to scientific effectiveness and cultural appropriateness of the interventions. The attributes are:

- Demonstrated application of existing behavioral and social science, and pre- and post-test outcome evidence (including evaluation date, when available) to show effectiveness in averting or reducing high-risk behavior within the target population.
- Evidence that the prevention activity/ intervention is acceptable to the target population.
- Evidence that the prevention activity/ intervention is feasible to implement for the intended population in the intended setting.
- Evidence that the prevention activity/ intervention was developed by or with input from the target population.
- Prevention activities/ interventions are characterized by focus, level, factors expected to affect risk, setting, and frequency/ duration.
- Each prevention activity/ intervention is also characterized by scale and significance.
- Prevention activities/ interventions are prioritized by risk population and their ability to have the greatest impact on decreasing new infections.

CDC requires all health departments to evaluate the interventions funded in their communities. To assist with standardizing this process on a national level, CDC instituted definitions for each type of intervention. Delaware's Division of Public Health HIV/AIDS Administration further defined these interventions on a local basis. The complete list of intervention definitions is attached for review (Attachment 1).

There are 9 intervention types, according to Delaware DPH. They are:

- Individual Level Intervention (ILI)
- Group Level Intervention (GLI)
- Outreach
 - Materials distribution
 - Promotional contact
 - Rapport Building contact
 - Standard contact
 - In-depth contact

The sub-definitions of the outreach intervention are Delaware-specific.
- Prevention Case Management (PCM)
- Partner Counseling and Referral Services (PCRS)
- Health Communication/ Public Information (HC/PI)
 - Electronic media
 - Print media
 - Hotline
 - Clearinghouse
 - Presentations/ Lecture
- Other (including Community Level Intervention – CLI)
- Early Intervention
- Advertising

The last two interventions listed, early intervention and advertising are defined as Delaware-specific programs.

All intervention types described in the intervention definitions have accompanying evaluation questions, outcome monitoring and process evaluation and monitoring points (Attachment 1). This allows DPH HIV/AIDS Administration staff to compare interventions offered by different agencies to determine effectiveness. Contractors provide data to the Division of Public Health. DPH aggregates data and forwards it to CDC on a semi-annual basis. Reports include the number of contacts, clients reached, materials distributed and other required information.

II. What process did the Interventions Work Group follow?

A. Background

As the work product developed by the Interventions Work Group is theoretically last in the chain of comprehensive plan development by the PPG, work group members took a proactive approach. While waiting for the final prioritized list of populations, the Interventions Work Group began researching new, unpublished and innovative HIV prevention programs for discussion. The Interventions Work Group was responsible for completing the following objective:

- To investigate interventions most likely to work with the populations in the geographic areas/ environments identified.

B. Methodology

As described in Chapter 4, the Prevention Planning Group developed several steps to guide the process of prioritizing populations and selecting interventions. While the Populations Work Group completed the first seven steps, the Interventions Work Group was responsible for the final three steps.

Step 8: Identify interventions that have been researched and proven to work with the identified high-risk populations and behaviors.

Step 9: Examine the protocols to assess the potential of the interventions to work relative to Delaware specific economic, social, political infrastructure and funding conditions.

Step 10: Produce report of findings, get PPG approval and include in the plan.

Once the Populations Work Group determined the final prioritized list of populations, the Interventions Work Group was able to select the most appropriate interventions for each population. The group made recommendations for each prioritized population, for all populations, and for the system as a whole. In most cases, the group did not make recommendations for the sub-populations identified.

The Interventions Work Group developed a list of 161 potential interventions through review of Internet articles, peer-reviewed journals and other publications¹⁻³. The list of potential interventions was subdivided by populations that were noted in the article. The list of potential interventions appears as Attachment 2 to this chapter. Please note that interventions could be listed more than once. The following are the populations used by the Interventions Work Group to sort this preliminary list of possible interventions.

Populations noted in possible interventions researched by the Interventions Work Group

- Women
- Women of Color
- Women Injecting Drug Users/Partners of Substance Users
- Heterosexuals
- Injecting Drug Users (IDU)
- Youth/ IDU
- Men who have Sex with Men (MSM)

- MSM of Color
- Youth MSM
- HIV + / Partners
- Youth
- Youth of Color
- Youth and Drugs
- Minority Populations (African American/ Hispanic/ Asian Pacific Islander)
- Incarcerated
- Community Interventions
- General
- Misc. Populations
 - Mothers of HIV+ caregivers
 - Mentally Ill
 - Faith-based communities

The Interventions Work Group identified the demographics of the people being served by the programs to see if they matched with Delaware's prioritized populations. The next step was to determine what type of intervention(s) the program utilized, either Individual-Level Intervention, Group-Level Intervention, Community-Level Intervention, Outreach, Counseling and Testing, Health Communication/Public Information, and/or Partner Counseling and Referral Services.

The list of approved interventions by populations follows the recommendations section of this chapter. Table 1 provides a more in-depth review of effective HIV prevention interventions by the prioritized populations. Also included in table 1 are specific citations noted by the Interventions Work Group for each recommended intervention.

III. Recommendations

The Interventions Work Group offers the following recommendations for future planning and implementation of the interventions in the next RFP cycle.

- **Individual-Level Interventions:** Individual-Level Interventions (ILIs) include Prevention Case Management (PCM).
- **Group-Level Interventions:** Group-Level Interventions (GLIs) need to be based in theory and should concentrate on skills building of participants. The majority of the literature suggests that GLIs are most effective if conducted for a long time period (e.g., 3-hour sessions every day for a week). This may be possible in residential drug treatment centers and similar venues. However, process monitoring data has shown that it is very difficult (and probably not cost-effective) to recruit many of the high-risk populations being served in Delaware to a program this lengthy, often resulting in a high drop-out rate. Therefore, it is recommended that GLIs be supplemented with Individual-Level Interventions (ILIs). It is best if programs alternate between holding a GLI and an ILI.
- **Community-Level Interventions:** Community-Level Interventions (CLIs) must be a priority for the State of Delaware. It is recommended that Delaware create a CLI that will have the same message for all populations, but is marketed differently to each prioritized population. CLIs should include establishment of clinic sites, policy reform and capacity building. Structural interventions should be considered as well. The Division of Public Health

recognizes the importance of developing statewide, coordinated efforts for community level interventions. To this end, DPH will be working with social marketing experts to design materials, which will target populations at-risk, along with the general public. Campaign messages will include increasing knowledge about HIV and encouraging HIV testing.

- A few suggestions for CLIs include reducing stigma, raising awareness of HIV, and encouraging HIV testing for at-risk populations. It is also recommended that Community Leaders be targeted by CLIs. Community Leaders include Faith-Based Religious Leaders, Local/State/Federal Government Leaders, Corporate Leaders, etc.
- **Outreach:** Four types of outreach have been added to the definitions list from the previous Comprehensive HIV Prevention Plan, these include: Standard, In-Depth, Rapport and Promotional.
- **Incentives:** A number of research papers reviewed showed success of programs because incentives were given to participants. In order to replicate the success of these programs, Delaware must consider using incentives. Therefore, when determining the budget for GLIs, incentives must be included. Examples of acceptable and proven use of incentives can be found in:
 - Safety Counts (Safety Point)⁴ holds two or more social events for participants, including sharing a meal and socializing with other participants, allows participants to utilize food bank services, distributes food coupons, bus tokens, personal hygiene kits, and has prize drawings.
 - Outcomes of Intensive AIDS Education for Male Adolescent Drug Users⁵ in Jail gave each participant \$5.
 - Becoming A Responsible Teen⁶ gave each participant \$5 for every hour of their participation, a T-shirt and a personalized certificate of completion.
 - Client Centered Prevention Counseling with HIV+ Individuals and Their Partners at the KC Free Clinic in Missouri⁷ offers Safer Sex Buffets and Gay Men's Health Nights to participants.
 - Tarzana HIV Services⁸ based in Los Angeles provides emergency housing as a first step toward recruitment of HIV infected substance abusers that are homeless.
 - Effectiveness of an Intervention to Reduce Transmission Risks in HIV-Positive People⁹ gave participants \$10 for each group session and \$35 for completing each assessment.
- **Indigenous Outreach Workers:** It is strongly recommended that an indigenous worker conduct all types of outreach for all populations. However, it is recognized that this may not be possible at all times. Indigenous workers must meet the minimal qualifications as established by the Division of Public Health in its current contract requirements in the 2004 contracts. The Prevention Planning Group endorses these qualifications.
- **Outcomes Monitoring Data:** In order for the Interventions Work Group to determine the effectiveness of these recommendations, outcomes monitoring data must be made available during the next planning cycle.
- **Trainings:** Trainings for those, including indigenous workers, who are conducting Outreach, GLIs and ILIs are strongly recommended. The following basic skills trainings are recommended, including but not limited to, HIV 101 and updates, basic counseling skills, motivational interviewing, cultural competency and diversity training.

It is also recommended that those conducting GLIs and ILIs be trained on applying theory to their program. Intervention workers must be trained on how to conduct interventions that are based in theory.

Note: *It is recognized by the Populations Work Group and the Interventions Work Group that there are no interventions aimed at people from 20-29 years of age. At this time, there was no reliable data to support this population being prioritized. This may be because data for HIV incidence and prevalence only began to be collected in June 2001. And it typically takes four years for data to be validated. However, it is recognized that when data becomes available that updates may be made to the Comprehensive HIV Prevention Plan 2005-2009.*

IV. Recommended Interventions by Populations

Injecting Drug Users who are HIV+

- Combined Group-Level Intervention and Individual-Level Intervention efforts including Outreach and Counseling and Testing
- Community-Level Intervention
- Syringe Exchange including Group-Level Intervention and/or Individual-Level Intervention
- Outreach with Counseling and Testing and Individual-Level Intervention
- Partner Counseling and Referral Services
(Group-Level Interventions can be peer based with active supervision by a qualified professional and non-peer based)

Men who have Sex with Men who are HIV+

- In those areas where MSM can be reached (19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720, 19977, 19947, 19958, 19971)
 - Outreach with Individual-Level Intervention followed by Group-Level Intervention (include Counseling and Testing services for partners)
- In those areas where little is known of the MSM population (19901, 19904, 19933, 19956, 19963, 19973)
 - RARE (Rapid Assessment, Response and Evaluation) Community Assessment followed by a Community-Level Intervention
- Partner Counseling and Referral Services
(Outreach and Group-Level Interventions can be peer-based with active supervision by a qualified professional)

Heterosexuals who are HIV+

- Individual-Level Intervention followed by a Group-Level Intervention including Outreach and Counseling and Testing
- Community-Level Intervention
- Partner Counseling and Referral Services
(Group-Level Interventions can be peer-based with active supervision by a qualified professional)

Injecting Drug Users who are HIV-

- Combined Group-Level Intervention and Individual-Level Intervention efforts including Outreach and Counseling and Testing
- Community-Level Intervention
- Syringe Exchange including Group-Level Intervention and/or Individual-Level Intervention
- Outreach with Counseling and Testing and Individual-Level Intervention

(Group-Level Interventions can be peer based with active supervision by a qualified professional and non-peer based)

Men who Have Sex with Men who are HIV-

- In those areas where MSM can be reached (19801, 19802, 19805, 19806, 19808, 19809, 19701, 19702, 19703, 19713, 19720, 19977, 19947, 19958, 19971)
 - Outreach followed by Individual-Level Intervention and Group-Level Intervention (ILIs and GLIs do not have to be in a specific order) including Counseling and Testing
- In those areas where little is known of the MSM population (19901, 19904, 19933, 19956, 19963, 19973)
 - RARE (Rapid Assessment, Response and Evaluation) Community Assessment followed by a Community-Level Intervention

(Outreach and Group-Level Interventions can be peer-based with active supervision by a qualified professional)

Heterosexuals who are HIV-

- Individual-Level Intervention followed by a Group-Level Intervention including Outreach and Counseling and Testing
- Community-Level Intervention

(Group-Level Interventions can be peer-based with active supervision by a qualified professional)

Youth (13 to 19)

- Combined Group-Level Intervention and Individual-Level Intervention efforts including Outreach and Counseling and Testing
- Community-Level Intervention

(Group-Level Interventions can be peer based with active supervision by a qualified professional and non-peer based)

(Interventions for youth should be conducted among those in school and out of school, including those in the prison system.)

Incarcerated who are HIV positive and HIV negative

- Group-Level Intervention and Individual-Level Intervention
- Counseling and Testing
- Health Communication/Public Information
- Partner Counseling and Referral Services

(Group-Level Interventions can be peer-based with active supervision by a qualified professional)

Seniors (50 and above)

- Health Communication/Public Information
- Community-Level Intervention
- Partner Counseling and Referral Services

Hispanics (Statewide)

- In those areas where little is known of the Hispanic population (19801, 19805, 19808, 19720, 19901, 19904, 19947, 19958, 19963, 19971)
 - RARE (Rapid Assessment, Response and Evaluation) Community Assessment followed by a Community-Level Intervention
- Individual-Level Intervention followed by a Group-Level Intervention including Outreach and Counseling and Testing
- Health Communication/Public Information
- Partner Counseling and Referral Services

(Group-Level Interventions can be peer-based with active supervision by a qualified professional)

(All Services must be culturally and linguistically sensitive)

Table 1: Effective HIV Prevention Interventions by Prioritized Populations

Prioritized Population	Intervention	Citation
<i>Injecting Drug Users who are HIV+</i>	Combined GLI and ILI (with Outreach and C&T)	Positive Wellness and Renewal program (POWER) – AIDS Project Los Angeles ¹⁰
		Tarzana Treatment Center HIV Services – Los Angeles (Prevention with HIV-infected persons project) ⁸
		SAFETY COUNTS: A Cognitive Behavioral Intervention to Reduce HIV Risks Among Active Drug Users ⁴
	CLI	AIDS Community Demonstration Project ¹¹
		PROMISE ¹¹
		HIV Stops With Me ¹²
	Syringe Exchange including GLI and/or ILI	Point for Point – Needle Exchange for Injection Drug Users ¹³
		Outreach with C&T and ILI
	Partner Counseling and Referral Services	Effects of Outreach intervention on risk reduction among IDU. Neaigua, Sufian (1990) ¹⁵
		The Outreach Assisted Model of Partner Notification with IDUs. Levy & Fox, 1998 ¹⁶
Efficacy of partner notification for HIV infection. Giesecke, Ramstedt, Granath, Ripa, Rado & Westrell, 1991 ¹⁷		
<i>Men who have Sex with Men and are HIV+</i>	Outreach with ILI followed by GLI (Outreach and C&T)	Client Centered Prevention Counseling with HIV+ Individuals and Their Partners – Missouri KC Free Health Clinic ⁷
		Effectiveness of an Intervention to Reduce HIV Transmission Risks in HIV-positive people. Kalichman, et al (2001) ⁹
		GLI – Healthy Relationships ¹⁸
		GLI – Stop AIDS Project – San Francisco ¹⁹
	RARE Community Assessment	Seattle RARE Project Final Report and Recommendations ²⁰
	Partner Counseling and Referral Services	Program of the U.S. Department of Health and Human Services ²¹
<i>Heterosexuals who are HIV+</i>	ILI followed by a GLI (Outreach and C&T)	Client Centered Prevention Counseling with HIV+ Individuals and Their Partners. Missouri KC Free Health Clinic ⁷
		Positive Wellness and Renewal program (POWER) – AIDS Project Los Angeles ¹⁰
		Effectiveness of an Intervention to Reduce HIV Transmission Risks in HIV-positive people. Kalichman, et al (2001) ⁹
		GLI – Healthy Relationships ¹⁸
	CLI	Long-term effectiveness of a peer-based intervention to promote condom and contraceptive use among HIV-positive and at-risk women. Fogarty et al (2001) ²²
		AIDS Community Demonstration Project ¹¹
		PROMISE ¹¹
	Partner Counseling and Referral Services	HIV Stops With Me ¹²
		Padian, O'Brien, Chang, Glass & Francis, 1993 ²³
		HIV Partner Notification Cost and Effectiveness Data From an Attempted Randomized Controlled Trial. Toomey, Peterman et al, 1998 ²⁴
	Partner Notification and Focused Intervention as a Means of Identifying HIV-positive Patients. Jordan & Tolbert, 1998 ²⁵	

Table 1: Effective HIV Prevention Interventions by Prioritized Populations *(continued)*

Prioritized Population	Intervention	Citation
<i>Injecting Drug Users who are HIV-</i>	Combined GLI and ILI (Outreach and C&T)	Reducing HIV Needle Risk Behaviors Among Injecting Drug Users in the Midwest: An Evaluation of the Efficacy of Standard and Enhanced Interventions. Siegal, Falck, Carlson, Wang (1995) ²⁶ Psychoeducational Group Approach: HIV Risk Reduction in Drug Users. Sorensen, London, Heizmann, Gibson, Morales, Dumontet, Acree (1994) ²⁷ Project SMART – AIDS Education Interventions for Drug Users in Short-Term Treatment (Lewis) ²⁸ SAFETY COUNTS: A Cognitive Behavioral Intervention to Reduce HIV Risks Among Active Drug Users ⁴
	CLI	AIDS Community Demonstration Project ¹¹ PROMISE ¹¹
	Syringe Exchange including GLI and/or ILI	Point for Point – Needle Exchange Program for Injection Drug Users ¹³
	Outreach with C&T and ILI	Risk behavior and HIV seroincidence among out-of-treatment injection drug users: A four-year prospective study. Wiebel, Jimenez, Johnson (1996) ¹⁴ Effects of outreach intervention on risk reduction among IDUs. Neaigua, Sufian (1990) ¹⁵
<i>Men who have Sex with Men who are HIV-</i>	Outreach with ILI and GLI (C&T)	Valdiserri, Lyter, Leviton, Callahan, Kingsley & Rinaldo. 1989 (peer and non-peer based) ²⁹
	RARE Community Assessment	Seattle RARE Project Final Report and Recommendations ²⁰ Project of the U.S. Department of Health and Human Services ²¹
<i>Heterosexuals who are HIV-</i>	ILI followed by a GLI (Outreach and C&T)	Project Respect ³⁰
	CLI	Long-term effectiveness of a peer-based intervention to promote condom and contraceptive use among HIV-positive and at-risk women. Fogarty et al (2001) ²² AIDS Community Demonstration Project ¹¹
<i>Youth (13 to 19)</i>	Combined GLI and ILI (Outreach and C&T)	PROMISE ¹¹ Huckleberry Youth Programs – Peer Education Services ³¹
	CLI	Taking it to the streets: HIV testing, treatment information and outreach in a Los Angeles neighborhood coffee house. Weinstein (1998) ³² GLI – Get Real About AIDS (1992) ³³ GLI – Intensive AIDS Education in Jail ⁵ Real AIDS Prevention Project RAPP. Lauby, Smith, Stark, Person & Adams (1998) ³⁴ CDC Prevention Marketing Initiative ³⁵

Table 1: Effective HIV Prevention Interventions by Prioritized Populations *(continued)*

Prioritized Population	Intervention	Citation
<i>Incarcerated who are HIV+ and HIV-</i>	GLI and ILI	AIDS Community Demonstration Project ¹¹ PROMISE ¹¹ Peer Education Model: Centerforce ³⁶
	C&T	Project Connect – Maryland (Prevention with HIV-infected Persons Project) ³⁷ HIV+ Jail Inmates: Pre- and post-release. The Homebase Project, San Francisco; Grinstead (1999) ³⁸
	Health Communication/ Public Information	Peer Education Model: Centerforce ³⁶
	Partner Counseling and Referral Services	HIV Prevention for Women Visiting Incarcerated Partners: Centerforce ³⁹
<i>Seniors (50+)</i>	Health Communication/ Public Information	Public health communication strategies for HIV prevention: past and emerging roles. AIDS 1997:11. ⁴⁰
	Partner Counseling and Referral Services	Padian, O'Brien, Chang, Glass & Francis. (1993) ²³ HIV Partner Notification Cost and Effectiveness Data from an Attempted Randomized Controlled Trial. Toomey, Peterman et al. (1998) ²⁴ Partner Notification and Focused Intervention as a Means of Identifying HIV-positive Patients. Jordan & Tolbert. (1998) ²⁵
	RARE Community Assessment	Seattle RARE Project Final Report and Recommendations ²⁰ Project of the U.S. Department of Health and Human Services ²¹
<i>Hispanics (Statewide)</i>	ILI followed by GLI (Outreach and C&T)	Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES) ⁴¹ Evaluation of Two AIDS Education Programs for Impoverished Latina Women. Nyamathi, Flaskerus, Bennett, Leake & Lewis (1994) ⁴²
	Health Communication/ Public Information	Public health communication strategies for HIV prevention: past and emerging roles. AIDS 1997:11. ⁴⁰
	Partner Counseling and Referral Services	Padian, O'Brien, Chang, Glass & Francis. (1993) ²³ HIV Partner Notification Cost and Effectiveness Data From an Attempted Randomized Controlled Trial. Toomey, Peterman et al. (1998) ²⁴ Partner Notification and Focused Intervention as a Means of Identifying HIV-positive Patients. Jordan & Tolbert. (1998) ²⁵





*DELAWARE HEALTH
AND SOCIAL SERVICES*

Delaware Division of Public Health

HIV Prevention Program Intervention Definitions 2004

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Division of Public Health
HIV/AIDS/STD Program

ILI: Individual Level Intervention

Target Population

1. All HIV infected or uninfected people who wish to work on risk reduction through one-on-one work with a risk reduction counselor.
2. Providers should focus on high-risk populations with demographics that match those described in the comprehensive plan.

Goals & Objectives

1. For HIV- clients: to reduce the risk of acquiring new infection.
2. For HIV+ clients: to increase self-disclosure of serostatus and to reduce the risk of re-infection and the risk of passing the virus to others.
3. To promote HIV counseling and testing, DIS Services, treatment and other related services as appropriate.

Definition of Service

1. This is **not** an anonymous service.
2. ILIs are provided to one individual at a time.
3. ILIs are documented in a client file on the web based reporting system.
4. Assist the client in making plans for *individual behavioral change*.
 - a. The client has shared specific and individualized goals for behavioral change with the counselor and the counselor has helped the client produce a specific and individualized plan for achieving those goals using methods and techniques acceptable to the client.
 - b. Must include skills/capacity building. For instance: role-playing serostatus disclosure, negotiation skills, role modeling, barrier use, arranging for convenience of risk-reduction tools, needle cleaning, partner reduction etc.
5. Assisting the client in making plans for *on-going appraisals* of their own behavior.
 - a. The client has agreed to regular check-ins with the counselor to discuss attempts to change behavior and to continue work to eliminate barriers to safer/ risk reduction behavior.
 - b. The client has left the session with a specific plan with goals, objectives, and deadlines or target dates for accomplishing the changes and has specific measures by which to measure success. *Optional: client has agreed to revisit counselor if specific goals are not achieved and the client wishes additional help in processing remaining barriers.*
6. Facilitates linkages to other services in support of risk reduction.
 - a. This is NOT case management or service brokerage.
 - b. The counselor provides appropriate referral to related services - within or outside of the agency providing the ILI – but neither provides these services directly nor manages a client benefit program (i.e. Medicaid, Medicare, SSI disability, etc.) to access these referrals.
 - c. The counselor facilitates the client's plan to act on the referral and access the services on his or her own.

7. An ILI may or may not lead to a C&T session. Ideally, ILIs involve more than 1 session with the client and, as a general rule, should aim for 2 or more sessions. For a single session to qualify as an ILI, the session must include skills building in the interaction. **No sessions are anonymous.** All sessions must be documented. ILIs do not focus on providing education as an end goal.

Health education is used as a necessary part of behavioral change, but teaching and facilitating a process that includes self-risk-assessment, planning for behavioral change, planning for self appraisals of their own behaviors, identifying needed skills/resources, and supporting behavioral change should be the primary objective. While it is technically true that C&T and Prevention Case Management (PCM) are both services provided to individuals, C&T has its own system of reporting (scan forms) and PCM differs from other ILIs in important ways (see definition below) and must be reported separately. If an ILI proceeds to a C&T session, the ILI should be recorded as such and the C&T session will be recorded through the existing C&T database system. The agency will be given credit for performing both services.

It is **NOT** to be recorded as an ILI if:

1. The session(s) has been solely focused on education/lecturing and involved no skills building or self-assessment/risk-reduction planning by the client.
2. There was more than one client present in the session (Couple counseling is considered a GLI).
3. It was a C&T session. (This is recorded through the CTR system/scan form)
4. The session(s) did not engage the client relative to any individualized behavioral change/risk reduction issue.

Possible Evaluation Points for ILI

Process Evaluation and Monitoring

1. Is the intervention based on a consistent curricula / procedure?
2. To what extent are standardized forms and tools used consistently and reliably?
3. To what extent are services adherent to the DPH/CDC definition of ILI services?
4. Are clients successfully recruited to the service?
5. To what extent does the recruited client population match the demographics of the target population specified in the contract?
6. Length and content of sessions.
7. To what extent do clients complete the protocol/curricula or attend more than one session.
8. Number/percent of clients developing and leaving sessions with an individualized plan for HIV infection risk reduction behavioral change.
9. Number/percent of clients developing and leaving session with an individualized plan for ongoing appraisals behavioral change.
10. Number/percent of clients that are linked/referred to appropriate services.

11. Number of clients completing initial risk assessment/behavior intake forms (pre-survey).
12. Number of clients completing follow-up risk assessment/behavior post survey 3 months post intervention.
13. Number of clients completing follow-up risk assessment/behavior post survey 6 months post intervention.
14. Materials distributed.
15. Qualifications of provider.
16. FTE Hours devoted to this intervention.
17. Other resources devoted to this service.

Outcome Monitoring Points

1. Knowledge about the routes of HIV infection
2. Knowledge of where to get free condoms
3. An reduction in sexual partners
4. An increase in use of barriers during sexual intercourse
5. An increased use of barriers during sexual intercourse.
6. Frequency of sharing needles.
7. Client's self-rated confidence in negotiating risk-reduction before sexual contact.
8. Percent of clients that self report to have negotiated a specific risk reduction plan /agreement with primary partner.

GLI: Group Level Intervention

Target Population

1. All HIV infected or uninfected people who wish to work on risk reduction through group work with a group of peers facilitated by a risk reduction counselor.
2. Providers should focus on high-risk populations with demographics that match those described in the comprehensive plan.

Goals & Objective

1. For HIV- clients: to reduce the risk of acquiring new infection.
2. For HIV+ clients: to increase self-disclosure of serostatus and to reduce the risk of re-infection and the risk of passing the virus to others.
3. To promote HIV counseling and testing, DIS Services, treatment and other related services as appropriate.

Definition of Service

1. GLIs have all the same goals and aspects of ILIs (as defined above), but the audience shifts from individuals to small groups.
2. GLIs use peer and non-peer group models and/or curricula to encourage and/or maintain individual behavioral change toward risk reduction for HIV infection.
3. GLIs include a skills-building component as described in the ILI section above.

NOTE: *The title of this intervention can be confusing and many want to include presentations and lectures to large groups of people in this intervention. The critical thing to remember is that GLIs are focused on fostering and supporting the risk reduction/behavioral change of*

individuals by using the dynamics within a small group setting and by providing ongoing support and skills building.

Peers are used to provide models, examples, problem-solving and behavioral alternatives to those in the group. The effectiveness of a GLI relies on the interaction of its members in pursuit of similar/supportive goals. Alcoholics Anonymous and similar groups are good examples of perpetual GLIs. "Be Proud, Be Responsible", and "Mpowerment" are good examples of curricula-based or short-period GLIs. The ideal size for this kind of group is between 10-12 clients, though groups may be smaller or slightly larger than this. (*NOTE: couples counseling is recorded under GLL.*) Relatively small groups are needed to ensure participation of all members. Larger groups often evolve into presentations/lectures or fail to engage the majority of individuals within the sessions.

It is **NOT** a GLI if:

- There are fewer than 2 and more than 15 participants. There may be a few exceptions to this upper number (the large numbers of youth in a "Be Proud, Be Responsible" curriculum, for instance). Again, the ideal size of a group for this kind of work is generally thought to be 10-12 clients.
- The focus is mainly on education or lecture with minimal group interaction.
- It does not include a skills building component.

Possible Evaluation Points for GLI

Process Evaluation and Monitoring

1. Is the intervention based on a consistent curricula/procedure?
2. To what extent are standardized forms and tools used consistently and reliably?
3. To what extent are services adherent to the DPH/CDC definition of GLI services?
4. Are clients successfully recruited to the service?
5. To what extent does the recruited client population match the demographics of the target population specified in the contract?
6. Length and content of sessions.
7. To what extent do clients complete the protocol/curricula or attend more than one session.
8. Number/percent of clients that are linked/referred to appropriate services.
9. Number of clients completing initial risk assessment/behavior intake forms (pre-survey).
10. Number of clients completing follow-up risk assessment/behavior post survey 3 months post intervention.
11. Number of clients completing follow-up risk assessment/behavior post survey 6 months post intervention.
12. Materials distributed.
13. Qualifications of provider.
14. FTE Hours devoted to this intervention
15. Other resources devoted to this service

Outcome Monitoring Points

1. Knowledge about the routes of HIV infection.
2. Knowledge of where to get free condoms.
3. A reduction in sexual partners.
4. An increase in use of barriers during sexual intercourse.
5. Use of barriers during sexual intercourse.
6. Frequency of sharing needles.
7. Client's self-rated confidence in negotiating risk-reduction before sexual contact.
8. Percent of clients that self report to have negotiated a specific risk reduction plan/agreement with primary partner.

Outreach**Target Population**

1. All HIV infected or uninfected people.
2. Providers should focus on high-risk populations with demographics that match those described in the comprehensive plan.

Goals & Objective

1. For HIV- clients: to reduce the risk of acquiring new infection.
2. For HIV+ clients: to reduce the risk of passing the virus to others.
3. To promote HIV counseling and testing and other related services.

Definition of Service

Outreach workers express that there are many types of outreach interactions and have tried many ways of classifying them over the years. Most attempts to categorize the outreach contacts have focused on the duration of the interaction or the process of delivery ('style') of the service (e.g. street, fixed, drop-off, etc.). The assumption was that the length of a contact was directly related to: 1.) The amount of information that could be (and was) exchanged with the client and 2.) The overall quality of the interaction. Practical experience in the field indicates that the quality and duration of the contact is not always directly related. For instance, a 5-minute interaction with a client with which the worker has already established rapport and a first-contact interaction of the same length could be radically different in content/quality.

Similarly, while the style of the outreach has a direct effect on the likelihood that the intended target population will be reached, it does not in any way provide information on the quality of any individual contact made. An interaction in which the contact simply takes a brochure and does not enter into conversation can happen on the street, behind a table at a health fair, or at a material drop-off center where no worker is even present. Again, experience in the field would indicate that the relationship between the style of outreach and the quality of the interaction is not highly correlated.

The CDC definition of outreach provided in [Evaluating CDC-Funded Health Department HIV Prevention Programs: Guidance, Volume 1](#) is as follows: "...educational intervention generally conducted by peer or paraprofessional educators face-to-face with high risk individuals in the client's neighborhoods or other areas where clients typically

congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials . . ."

The following definitions have been created to supplement the CDC guidelines and to meet the need of outreach workers to describe the quality of the continuum of interactions experienced in the field.

Material Distribution

- Materials dropped at an unmanned site for access by target audience without staff contact. This would be recorded by number of items left at each site and number of units taken.
- The primary objective of this service is to *provide an easy point of access* to materials and equipment used to educate and to reduce risk of HIV/STD infection.

Promotional Contact (No minimum time)

- An interaction in which the program's promotional materials are distributed directly to the contact by the outreach worker to increase awareness of the services the program provides and does not involve educational/risk-reduction materials or conversation that is directly related to risk reduction/skills building for HIV/AIDS/STD infection.
- The primary purpose of this interaction is to *advertise* the program and its services.

Rapport Building Contact (No minimum time)

- An interaction in which promotional and educational/risk-reduction materials are distributed directly to the contact by the outreach worker and includes a rapport building conversation ('small talk') in which information directly related to risk reduction/skills building is not the primary content.
- The purpose of this interaction is to *establish rapport* with the contact that can be built upon during a subsequent interaction.

Standard Contact (minimum time: 10 minutes for traditional outreach, 5 minutes for indigenous/peer modalities for hard to reach populations)

- An interaction in which promotional and educational/risk-reduction materials are distributed by the outreach worker directly to the contact and in which education directly related to skills building risk reduction is provided. This interaction does not delve into the client's personal risks, but rather provides general education materials, skills that the client applies to him/herself without assistance from the worker.
- The purpose of this interaction is to provide general education relative to skills building/risk reduction and to provide referrals, reference materials, and/or equipment for future use.

In-Depth Contact (minimum time: 15 minutes)

- An interaction in which promotional and educational/risk-reduction materials are distributed by the outreach worker directly to the contact and in which education directly related to skills building/risk reduction specific to the contact is provided. In this interaction, the client reveals personal risks and asks the worker to provide specific education/materials that the client applies to him/herself with assistance from the worker. Though, the contact may or may not result in a plan for behavioral change, it generally does not involve a formal plan for follow-up (as in an ILI).

- The purpose of this interaction is to provide *client-specific, in-the-moment*, education relative to skills building /risk reduction as requested by the client and to provide referrals, reference materials, and/or equipment for future use.

Possible Evaluation Points for Outreach

Process Evaluation and Monitoring

1. Is the intervention based on a consistent curricula/procedure?
2. To what extent are standardized forms and tools used consistently and reliably?
3. To what extent are services adherent to the DPH/CDC definition of Outreach services?
4. To what extent does the contacted client population match the demographics of the target population specified in the contract?
5. Length and content of sessions.
6. Number/percent of clients that are linked/referred to appropriate services.
7. Materials distributed.
8. FTE Hours devoted to this intervention
9. Qualifications of provider.
10. Other resources devoted to this service.

Outcome Monitoring

1. Number of clients referred from outreach to other services.

PCM: Prevention Case Management

Target Population

1. All HIV infected persons with multiple and complex problems and risk reduction needs that are not accessing treatment case management services *OR* that are accessing these services but wish to work on HIV transmission issues with someone other than the treatment case manager.
2. Providers should focus on high-risk populations with demographics that match those described in the comprehensive plan.

NOTE: *The highest priority clients have multiple risk factors. For instance, a client may have multiple sexual or needle sharing exposures with multiple partners of unknown/opposite serostatus within the last 3 months, AND have psychosocial issues that impact those risk factors (mental illness, homelessness, violence/coercion.)*

NOTE: *"...multiple and complex problems and risk reduction needs..." is defined as a combination of two or more of the following: substance abuse, domestic violence, rape and associated counseling, violence/coercion, homelessness, mental or physical disability, multiple sexual or needle sharing exposures with multiple partners of unknown opposite serostatus within the last 3 months, and/or other psycho-social issues that impact HIV infection risk factors.*

Goals & Objective

1. For HIV+ clients: to increase self-disclosure of serostatus and to reduce the risk of re-infection and the risk of passing the virus to others.

2. To promote HIV counseling and testing, DIS Services, treatment and other related services as appropriate.

Definition of Service

As mentioned earlier, PCM is a form of ILI but differs from other ILIs in significant ways. The primary difference between PCM and other ILIs is the addition of 'service brokerage'. A broker manages the day-to-day aspects of a service for a client.

"A 'service broker' helps the client make a plan, assists negotiation for funding, helps to organize and monitor the services, and acts as a 'fixed point of contact' between the service user and the whole system of social services. The broker is usually independent from the organization that holds money for services, and from the agencies that offer services. The broker is often likened to a travel agent, who gives advice and information, and makes practical arrangements but has no control over decision-making. [...]"

The role of service broker is distinctive because it combines two qualities: firstly, the broker is independent from the fund-holding and service provider agencies, [...] But secondly, they are nevertheless acknowledged within the system of social services as having a role in the process of planning services and allocating public funds. In this respect, their position is significantly different from that of the independent advocate, who aims to influence services, but without an acknowledged functional role with the service system."

What PCM shares with other ILIs:

- The service is provided to one individual at a time.
- The counselor assists the client in making plans for *individual behavioral change*.
- The counselor assists the client in making *on-going appraisals* of their own behavior.
- The sessions include skills building activities. (i.e. negotiations skills, barrier use, needle cleaning, partner reduction, etc.)

How PCM is different from other ILIs:

- Clients are dealing with multiple, complex problems and risk reduction needs. (i.e. addiction, homelessness, abuse, etc.)
- PCM includes intensive services that are ongoing, for a minimum of 3 sessions and often lasting from 3 to 18 months.
- The worker does not just make referral to other services, but acts as a broker for those services, bringing the focus back to HIV risk-reduction as other needs are filled/addressed.
- PCM service must interact with other programs to facilitate service brokerage.
- It is NOT/ CANNOT BE anonymous.

Possible Evaluation Points for PCM

Process Evaluation and Monitoring

1. Is the intervention based on a consistent curricula/procedure?
2. To what extent are standardized forms and tools used consistently and reliably?
3. To what extent are files maintained.
4. To what extent are services adherent to the DPH/CDC definition of PCM services?

5. Are clients successfully recruited to the service?
6. To what extent does the recruited client population match the demographics of the target population specified in the contract?
7. Length and content of sessions.
8. To what extent do clients complete the protocol/curricula or attend more than one session.
9. Number/percent of clients that are linked/referred to appropriate services.
10. Level of service brokerage per client
11. Number of clients completing initial risk assessment/behavior intake forms (pre-survey).
12. Number of clients completing follow-up risk assessment/behavior post survey >3 months.
13. Number of clients completing follow-up risk assessment/behavior post survey > 6 months.
14. Materials distributed.
15. FTE Hours devoted to this intervention
16. Qualifications of provider.
17. Other resources devoted to this service.

Outcome Monitoring

1. Knowledge about the routes of HIV infection will increase.
2. Knowledge of where to get free condoms will increase
3. A reduction in sexual partners.
4. An increase in use of barriers during sexual intercourse.
5. Use of barriers during sexual intercourse.
6. Frequency of sharing needles.
7. Client's self-rated confidence in negotiating risk-reduction before sexual contact.
8. Percent of clients that self report to have negotiated a specific risk reduction plan/agreement with primary partner.

PCRS: Partner Counseling and Referral Services

This service is essentially the same as traditional partner notification services provided by DPH Disease Intervention Specialists.

NOTE: *In Delaware there are currently no contracted providers of partner notification services and, to limit legal complications, the service will be limited to DPH staff. Therefore, PCRS service should not be included in any contract language for HIV prevention services.*

Target Population

1. All identified partners of HIV positive or AIDS defined clients.
2. Providers should focus on high-risk populations with demographics that match those described in the comprehensive plan.

Goals & Objective

1. For HIV- clients: to reduce the risk of acquiring new infection.
2. For HIV+ clients: to reduce the risk of passing the virus to others.
3. To promote HIV counseling and testing and other related services.

4. To identify and offer services to individuals who may have been placed at high risk and are unaware of their serostatus.

Definition of Service

- A systematic approach to *notifying* the sex and needle-sharing partners of HIV Infected persons to inform the partner of the potential for infection and offer HIV CTRPS.
- Helps partners gain earlier access to risk reduction counseling to prevent infection or subsequent passing of the virus if already infected.
- Helps infected partners access treatment services.

It is **NOT** a PCRS if:

- Partners of HIV uninfected people are being notified. *(This aspect of this definition may be particular to Delaware as it has been determined that the limited resources for PCRS need to be focused on identifying infected persons and limiting secondary infections and that pursuing partners of HIV negative partners, even if the index client has indicated an associated high risk behavior, is less likely to lead to discovery of new or unknown infections.)*
- HIV testing and referral for other services are not offered.

Possible Evaluation Points for PCRS

Process Evaluation and Monitoring

1. Is the intervention based on a consistent curricula/procedure?
2. To what extent are standardized forms and tools used consistently and reliably?
3. To what extent are files maintained.
4. To what extent are services adherent to the DPH/CDC definition of PCRS services?
5. To what extent are services adherent to federal and state law?
6. Are clients successfully recruited to the service?
7. Number of contacts elicited per client.
8. Number of named contacts located.
9. Number of secondary contacts elicited.
10. Number of elicited secondary contacts located.
11. Number/percent of clients/contacts that are linked/referred to appropriate services.
12. Materials distributed.
13. FTE Hours devoted to this intervention.
14. Qualifications of provider.
15. Other resources devoted to this service.

Outcome Monitoring

1. Number of contacts receiving CTRPS.
2. Number of contacts that access other prevention services.
3. Number of secondary contacts receiving CTRPS.
4. Number of secondary contacts that access other prevention services.
5. Number of new HIV infections discovered.

6. Number of persons discovered to have HIV that are successfully connected to treatment services.

Health Communication and Public Information (HC/PI)

Target Population

Variable, but highest priority should be given to those at highest risk as described in the comprehensive plan.

Goals & Objective

1. To increase knowledge and awareness of HIV and AIDS in affected communities.
2. For HIV- clients: to reduce the risk of acquiring new infection.
3. For HIV+ clients: to reduce the risk of passing the virus to others.
4. To promote HIV counseling and testing and other related services.
5. To identify and offer services to individuals who may have been placed at high risk and are unaware of their serostatus.

Definition of Service

Delivery of *planned* HIV/AIDS prevention messages to target audiences to:

- support safer behaviors
- support *personal* risk-reduction efforts
- Inform *at-risk persons* of available services.

HCPIs are akin to GLIs in that the intent is to influence individual behavior through a group appeal, but is different from GLIs in that it is essentially anonymous. It also differs from ILIs, GLIs and PCM in that, rather than affecting behavior directly through skills building, etc. - HCPIs attempts to create an environment in which these more in-depth HIV prevention services may be more readily welcomed and received. HCPIs use a "scatter-shot" message sent out in the hope that individuals in need/at risk within a specific target population will see and respond to the message or will be influenced by a member of their peer group who has seen the message.

It is essential to note that the definition specifies that the message/intervention be *planned*. This means that spontaneous and unsolicited interviews by media does not get recorded as an HC/PI unless the person interviewed has been prepared to deliver a message consistent with a larger campaign. (*Spontaneous and unsolicited media coverage would be reported in the narrative of the monthly report.*) The HC/PI assumes a planned and methodical utilization of the media in order to communicate a specific and, ideally, cumulative message to individuals within a larger population. In most cases, the larger population will be the 'general public', but this may not always be the case if publications targeting specific populations are used (i.e. *Letters from CAMP Rebooth* serves the general population but has a significantly higher percentage of MSM in its readership than many other local publications.)

HC/PI may use the following channels to deliver messages:

Electronic Media

Radio, television, public service announcements, news broadcasts, infomercials, etc. *reaching a city, region, or statewide audience.* This generally does not include chat rooms and other web-based interaction. However, if messages meeting the definition above are posted on list-serves, electronic bulletin boards, etc. and subscription/membership numbers can be obtained the posting may be reported under this category.

Print Media

Newspapers, magazines, pamphlets and billboards and transportation signage *reaching a large-scale or nationwide audience.* Please note that even pamphlet distribution must reach a *large-scale audience.* This implies that in order to be recorded here, a pamphlet must be mass-mailed or included within another mass audience media. Pamphlet distribution during outreach, ILI, Lectures, or GLI should be recorded under those headings.

Hotline

Telephone service (local or toll-free) offering up-to-date information and referral to local HIV/AIDS related services.

Clearing House

Interactive electronic outreach systems using telephone, mail, and Internet/World Wide Web to provide *responsive* information service to *the general public as well as high-risk populations.*

The keys to this definition are the words 'interactive' and 'responsive'. A telephone conversation is two-way (even automated lines are 'responsive' in that they provide a list of options and responds to the requests of the caller's selection from those options.). Mail must be opened, read, and a response made. Web sites that list many options that the 'surfer' may select from various links in order to get specific information would also be acceptable here and a 'hit meter' would be able to track specific client access information.

It is **NOT** a clearinghouse if:

- There is only one page of information on the web site and the site is not responsive to 'surfer' requests.
- The automated phone system provides a message that is not responsive to caller choices or simply refers the caller to another number/service.

Presentations/Lectures

Information only activities conducted in group-settings. Often called '*one-shot*' education interventions.

- These are by far the most common intervention provided by 'Health Educators'.
- Though many record these activities as GLI because the presentations are given to groups, these differ from GLIs in that they are focused on providing educational information.
- Are not suited to *individual* processing or skills building within the group setting.
- They are often much larger groups than would be addressed through a GLI.

- It is not expected that the educator will see the specific group again for continuing and cumulative work.
- This would include all AIDS 101 and similar presentations.

Other (including CLI)

- Anything HIV prevention activity that cannot be described in the above categories.

NOTE: This should be a rare occurrence as the more specific categories of interventions as defined in this document are the primary source for the construction of Delaware contracts. A high number of activities reported as 'other' without specific language in the contract will be considered an indication that programs are not being properly prioritized to contracted populations or activities.

Community Level Interventions

CLIs are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with small groups (GLI) or individuals (ILI/Outreach/C&T). This is accomplished by altering the social norms, policies, and/or environmental characteristics of the entire community.

Examples:

1. Altering Social Norms – this may include:
 - Altering a community's attitudes about a particular issue through repetition of a mass message in varied settings and in various forms meant to highlight a specific aspect of the issues, but always reinforcing the same basic message over time. (Such as the seat belt safety and stop smoking campaigns).
 - Altering a population's attitudes toward medical providers from distrustful to perceived partnership.
 - Making prophylactic use normative in 'a time of medical crisis' within any population with historical prohibitions against and/or traditionally low use of prophylactics.

The altering of social norms may, but does not always, lead to behavioral change. CLIs seek to create an environment in which work to affect behavioral change is better received.

2. Altering Policies – this may include:
 - Changing a school district's policies on condom distribution in the school.
 - Getting HIV education included in the community's Boy/Girl Scout troop.

NOTE: No HIV Prevention Funds issued by the federal/state government may be used for political lobbying.

3. Environmental Characteristics – this may include actions like:
 - Improve a whole community's access to a service by establishing a new HIV service center within a high prevalence area.
 - Establishing a program to safely pick-up and dispose of used needles littered in a specific area/neighborhood.

Where as GLI uses individual process within a shared group setting to affect change and HC/PI uses mass appeal to increase awareness and/or access to resources/information that may facilitate individual behavior change, a CLI uses a mass approach to alter mass/community perception and/or environment. The effects of CLIs are often measured

through mass surveys/statistics and are generally impersonal and anonymous. (Fictitious example: In 1995, only 50% of Delawareans use their seatbelts regularly. In 1998, 75% of Delawareans used their seatbelts regularly.)

Early Intervention

Target Population

1. HIV infected persons who are aware of their positive serostatus but may not be aware of or accessing case management, treatment services, prevention counseling or Partner Counseling and Referral Services (DIS).
2. HIV infected persons who are not aware of their positive serostatus and may not be aware of or accessing case management, treatment services, prevention counseling or Partner Counseling and Referral Services (DIS).
3. Services should be prioritized to high-risk populations as define in the *comprehensive* plan.

Goals & Objective

1. To facilitate access to relevant services for all HIV infected persons and to reduce the risk of passing the virus to others.
2. To identify and offer CTRPS services to individuals who have been/are at high risk and are unaware of their serostatus.
3. To promote HIV counseling and testing and other related services.

Definition of Service

Early Intervention interventions are designed to reduce the number of HIV infected people who are unaware of their HIV serostatus and/or are aware of their status but who are not accessing services to treat the infection or to help prevent secondary infections. EIs can be a combination of all the other intervention types (ILI, GLI, Outreach, etc.) with the combination dependent on the characteristics and needs of the target populations.

For instance, an EI for MSM may recognize that the gay population is generally complacent about HIV testing and may organize an early intervention program around an attempt to work with this complacency (emotional neutrality or fatalism) within that community by encouraging HIV testing to become a routine part of gay male health care and providing easy access to the service. A similar program could recognize that non-self-identified bisexual or gay men may be dealing with a discomfort with the testing process itself as well as the social repercussions of a positive test and may organize the intervention around an attempt to stimulate an overwhelming responsibility to be tested in order to protect their loved but 'uninformed' partners from secondary infection. An EI prioritized to AA males might organize the intervention around the issue of protecting their children, if that is found to be a major concern of this population.

The approach to designing an EI around any of those issues may involve a combination of Outreach, GLI, HC/PI, and other types of interventions. However, the focus of all of those activities is prioritized to HIV infected persons who are aware of their positive serostatus but may not be aware of or accessing case management, treatment services, prevention counseling or Partner Counseling and Referral Services (DIS) and to HIV infected persons who are unaware of their positive serostatus and may not be aware of or accessing case management, treatment services, prevention counseling or Partner Counseling and Referral Services (DIS). If the focus of these activities begins to generalize to all the members of any target population regardless of serostatus then, by definition, the intervention ceases to be an EI.

Possible Evaluation Points for Early Intervention

Process Evaluation and Monitoring

1. Is the intervention based on a consistent procedure?
2. To what extent are standardized forms and tools used consistently and reliably?
3. To what extent are services adherent to the DPH/CDC definition of Early Intervention?
4. Are clients successfully recruited to the service?
5. To what extent does the recruited client population match the demographics of the target population specified in the contract?
6. Number/percent of clients that are linked/referred to appropriate services.
7. Materials distributed.
8. Qualifications of provider.
9. FTE Hours devoted to this intervention.
10. Other resources devoted to this service.

Outcome Monitoring

1. Number of high-risk clients receiving HIV CTRPS.
2. Number of clients newly discovered to be HIV positive.
3. Number of clients newly discovered to be HIV positive that are successfully connected to relevant treatment services for the first time.
4. Number of clients that are known to be positive that are successfully connected to relevant treatment services for the first time.
5. Number of clients that are known to be positive that are successfully reconnected to relevant treatment services.
6. Number of positive clients successfully referred to and accessing DIS services.
7. Number of clients entering ILIs, GLIs, and other prevention interventions.

Advertising

Target Population

1. Variable, but should be prioritized to high-risk populations as described in the comprehensive plan.

Goals & Objective

1. To promote all services provided by HIV prevention contracted providers, DPH, and other providers.

Definition of Service

This encompasses the production and distribution of any material that is primarily intended to promote or announce services: type of service, hours of operation, location of service, provider, etc. This includes all material that is primarily promotional in content, even if it contains brief educational/factual messages.

Possible Evaluation Points for Advertising

Process Evaluation and Monitoring

1. Number of venues the ad is placed.
2. Number of persons exposed to the ad.
3. Content and presentation of ad.
4. Cost of the ad.
5. Public reaction to ad.
6. Development process for the ad.
7. FTE Hours devoted to this intervention.
8. Other resources devoted to this service.

Outcome Monitoring

1. Number of clients accessing services and citing the ad as the motivator.
2. Level of public debate/conversation generated by the ad (via newspapers, etc.)

Population: *Women*

1. Prevention Model: Peer Education and Outreach
 - a. Sexually-Active Women – "Women's Outreach – K.I.S.S. (Keeping It Simple and Safer)" [G]
 - b. Sexually-Active Women [G]
2. Prevention Model: Community-Level Intervention
 - a. *Real AIDS Prevention Project (RAPP)* [E]
3. Women Luncheons [G]
4. The effects of HIV/AIDS Intervention Groups for High-risk Women in Urban Clinics [C]
5. HIV-related risk reduction among women offenders in jail and in the community [D]
6. Reducing Inner-City Women's AIDS Risk Activities: A Study of Single, Pregnant Women [C]
7. Personal Communication: Choices Project [D]
8. Development and Evaluation of an HIV-Risk Reduction Program for Female College Students [C]
9. Outcomes of a randomized community-level HIV prevention intervention for women living in 18 low-income housing developments [D]
10. A community-level HIV prevention intervention for inner-city women: Results of the Women and Infants Demonstration Project [A]
11. How effective are AIDS education program for high-risk populations? An evaluation of 4 AIDS prevention programs in Chicago [D]
12. Effects of condom skills training and HIV testing on AIDS prevention behaviors among sex workers [D]
13. Effects of counseling on HIV risk behaviors in patients at a NYC sexually transmitted disease clinic [D]

Population: *Women of Color*

14. Prevention Model: Peer Education and Outreach
 - a. Asian Pacific Islander Coalition on HIV and AIDS
15. Prevention Model: Comprehensive Women's Health Promotion Model
 - a. Women of Color AIDS Council
16. Prevention Model: Multifaceted Empowerment Model for Women
 - a. Mujeres Unidas y Activas
17. Prevention Model: Cultural Affirmation Model
 - a. Amassi Center L.A.
 - i. Sustaining our Sisterhood
 - ii. Black Women's Exchange
 - iii. Rites of Passage Program
18. Prevention Model: Community-Level Intervention
 - a. Community-Led HIV Intervention Programs Helps Reduce AIDS Risk Among Inner-City Women
19. A Randomized controlled trial of an HIV sexual risk-reduction intervention for young African-American Women [C]

20. A randomized, controlled trial of a behavioral intervention to prevent STD among minority women [D]
21. Evaluation of Two AIDS Education Programs for Impoverished Latina Women [C]
22. Project S.A.F.E.: An Intervention to Prevent STDs Among Minority Women [F]
23. Sista Project: A Peer-Led Program to Prevent HIV Infection Among African-American Young Women [E]
24. Prevention Method: Intervention Combination
 - a. An intervention for changing high-risk HIV behaviors of African-American, drug dependent women [D]

Population: *Women IDU's/Partners of Substance Users*

25. AIDS Risk Reduction Among Females IDU's and Female Sexual Partners [D]
26. Building Skills of Recovering Women Drug Users to Reduce Heterosexual AIDS Transmission [C]
27. 15-Month Follow-up of Women Methadone Patients Taught Skills to Reduce Heterosexual HIV Transmission [A]
28. An experiential program to reduce AIDS risk among female sex partners of injections drug users [D]
29. Evaluations of an HIV risk reduction intervention for women entering inpatient substance abuse treatment [D]
30. Evaluation of a peer outreach HIV prevention program for female partners of IDUs in NYC [D]
31. The Health Intervention Project: HIV Risk Reduction Among African American Women Drug Users [A]
32. Women with a Point [G]
33. Preventing HIV/AIDS in Drug-Abusing Incarcerated Women through Skills Building and Social Support Enhancement: Preliminary Outcomes [C]

Population: *Heterosexuals*

1. Heterosexual partners working together: California Partners Study II [H]
2. Efficacy of Risk Reduction Counseling to Prevent HIV and STDs: A Randomized Controlled Trial [A]
3. Reduction of High-risk Sexual Behaviors among Heterosexuals Undergoing HIV Antibody Testing: A Randomized Controlled Trial [C]

Population: *Injecting Drug User*

1. Prevention Model: Individual-Level Intervention
 - a. Effects of an Intervention Program on AIDS-related Drug and Needle Behavior Among IDUs [C]
2. Prevention Model: Group-Level Intervention
 - a. Outcome of Psychoeducation of HIV Risk Reduction [C]
 - b. Prevention of HIV Infection in Street-Recruits [D]
 - c. AIDS and the Transition to Illicit Drug Injection – Results of a Randomized Trial Prevention Program [C]

- d. Peer-Delivered Intervention Reduces HIV Risk Behaviors Among Out-of-Treatment Drug Abusers [D]
 - e. AIDS Education for Drug Abusers: Evaluation of Short-term Effectiveness [A]
 - f. Psychoeducational Group Approach: HIV Risk Reduction in Drug Users [C]
3. Prevention Model: Community-Level Intervention
 - a. Impact of a Longitudinal Community HIV Intervention Targeting Injecting Drug Users: Stage of Change for Condom and Bleach Use [D]
 - b. Increasing the Use of Bleach and Condoms Among Injecting Drug Users in Denver: Outcomes of a Targeted, Community-level HIV Prevention Program [C]
 4. Prevention Model: Outreach
 - a. Outreach in Natural Settings: The Use of Peer Leaders (Latkin) [D]
 - b. Outreach Based HIV Prevention for Injection Drug Users (Coyle) [D]
 - c. Reducing HIV Needle Risk Behaviors Among Injection-Drug Users in the Midwest: An Evaluation of the Efficacy of Standards and Enhanced Interventions [C]
 - d. Risk Behavior and HIV seroincidence among out-of-treatment injection drug users: A four-year prospective study [D]
 5. Prevention Method: HIV C & T
 - a. Psychological and Behavioral Impact among IDUs of learning HIV test results [D]
 - b. Effects of Outreach intervention on risk reduction among IDUs [D]
 6. Project SMART – AIDS Education Interventions for Drug Use in Short-Term Treatment [F]
 7. Risk Reduction in Sexual Behavior: A Condom Giveaway Program in a Drug Abuse Treatment Clinic [C]
 8. *Safety Counts – A Cognitive-Behavioral Intervention to Reduce HIV Risks Among Active Drug Users* [F]
 9. Sniffer – Working with Heroin Sniffers to Prevent Drug Injection [F]
 10. Turning Point – HIV Risk Reduction for IDUs and Their Sex Partners [F]
 11. UFO Project – IDUs under the age of thirty [H]
 12. Project Access: Drug users and HIV testing and counseling [H]
 13. Prevention Method: Needle Exchange Programs (Just have article reference unless otherwise noted)
 - a. Point for Point – Needle Exchange Program for IDUs [F]
 - b. No Time to Lose: Getting More from HIV Prevention [D]
 - c. Evidence-based findings on the efficacy of syringe exchange programs: an analysis of the scientific research completed since April 1998 [D]
 - d. Interventions to Prevent HIV Risk Behaviors [D]
 - e. Preventing HIV Transmission: The Role of Sterile Needles and Bleach [D]
 - f. The effectiveness of AIDS Prevention efforts [D]
 - g. Hawaii's Statewide syringe exchange program [D]
 - h. The Public Health Impact of Needle Exchange Programs in the United States and Abroad [D]
 - i. Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy [D]
 - j. The Twin Epidemics of Substance Use and HIV [D]
 14. Prevention Method: Methadone Treatment (Just have article reference) [D]
 - a. Effectiveness of methadone treatment in reducing HIV risk behavior and HIV seroconversion among injecting drug users.
 - b. Drug Abuse Treatment: A National Study of Effectiveness.
 - c. Methadone maintenance treatment modalities in relation to incidence of HIV: results of the Amsterdam cohort study.
 - d. Retention, HIV risk, and illicit drug use during treatment: methadone dose and visit frequency.
- Population: Youth/IDU**
15. HIV Prevention for Adolescent IDUs at a storefront needle exchange program in Hollywood, CA [D]
 16. Outcomes of Intensive AIDS education for Male Adolescent Drug Users in Jail [A]
- Population: MSM**
1. Prevention Model: Group-Level Intervention
 - a. The '800 Men' project: a systematic evaluation of AIDS prevention programs demonstrating the efficacy of erotic, sexually explicit safer sex education on gay and bisexual men at risk of AIDS [D]
 - b. Stress-reduction training changed numbers of sexual partners but not immune function in men with HIV [D]
 - c. AIDS prevention in homosexual and bisexual men: results of a randomized trial evaluating two risk-reduction interventions [C]
 - d. Behavioral interventions to reduce AIDS risk activities [C]
 - e. A skills-training group intervention model to assist persons in reducing risk behaviors for HIV infection [C]
 2. Prevention Model: Community-Level Intervention
 - a. Popular Opinion Leader [E]
 - i. HIV Risk Reduction Following Intervention with Key Opinion Leaders of Population: An Experimental Analysis [A]
 - ii. Community AIDS/HIV risk reduction: The effects of endorsements by popular people in three cities [C]
 - iii. Social diffusion models can produce population-level HIV risk-behavior reduction: field trial results and mechanisms underlying change [D]
 3. Prevention Model: Outreach
 - a. Evaluation of an HIV prevention intervention for men who have sex with men at cruising areas in the Netherlands [D]
- Population: MSM of Color**
4. Prevention Model: Outreach
 - a. African-American Men Who Have Sex With Men Outreach: Missouri [G]
 - b. African-American/General Population Men Who Have Sex With Men – The Phoenix Project – Missouri [G]
 - c. African-American Men Who Have Sex With Men Street/Community Outreach – Missouri [G]

5. Prevention Model: Group-Level Intervention
 - a. Evaluation of an HIV Risk Reduction Intervention among African-American Homosexual and Bisexual Men [C]
 - b. *Many Men, Many Voices* [B]
6. Hot, Healthy and Keeping It Up! AIDS and Sexual Health Group Counseling for Asian & Pacific Islander Gay & Bisexual Men [F]
7. Brother to Brother – Hot, Healthy and Safe [F]
8. Hermanos de Luna y Sol [H]
9. The efficacy of brief group counseling in HIV risk reduction among homosexual Asian and Pacific Islander men [D]
10. High-risk behavior and condom use among gay and bisexual African-American men [D]
11. African-American Men's Health Study [H]

Population: *Youth MSM*

12. Factors mediating changes in sexual HIV risk behaviors among gay and bisexual male adolescents [D]
13. MPowerment Project – Intervention for Young Gay Men [E]
 - a. The Mpowerment Project: A community-level prevention intervention for young gay and bisexual men [A]
14. Young Asian Men's Study [H]

Population: *HIV+/Partners*

1. Prevention Model: Group-Level Intervention
 - a. Bay Men [H]
 - b. Positive Images (Curriculum) [A]
 - c. Healthy Relationships: A Small-Group Intervention for Men and Women Living with HIV [E]
2. The Unity Project [H]
3. SAFE (Serostatus Approach to Fighting the Epidemic) [A]
 - a. Prevention for HIV-Infected Persons Project (PHIPP) [A]
4. Enhancing Prevention Skills for People Living with HIV (Curriculum) [A]
5. Client Centered Prevention Counseling with HIV+ Individuals and Their Partners – Missouri [G]
6. HIV Positive Persons – "Retreats and HIV University" [G]
7. HIV+ Persons Support [G]
8. Prevention of Heterosexual Transmission of HIV Through Couple Counseling [C]
9. Holistic Harm Reduction Program: A Harm Reduction Intervention for HIV-positive Injection Drug Users [E]
10. Efficacy of a prevention intervention for youths living with HIV [D]
11. Teens Linked To Care: An Intervention to Change the Behavior of Young People Living with HIV [E]
12. Using a community partnership and motivational interviewing to serve HIV+ gay and bisexual men [D]
13. Effectiveness of an Intervention to Reduce HIV Transmission Risk in HIV-positive people [A]

Population: *Youth*

1. Prevention Model: Group-Level Intervention (Adolescent Pregnancy Prevention Coalition of North Carolina)
 - a. Carrera Model Programs
 - b. I Have A Future
 - c. Safer Choices
 - d. Teen Talk
 - e. Wise Guys
 - f. Teen Outreach
 - g. Becoming a Responsible Teen (BART) [C]
 - h. Be Proud, Be Responsible [C]
 - i. Focus on Kids [C]
 - j. Get Real About AIDS [C]
 - k. Street Smart: Reducing HIV risk Among Runaway and Homeless Youth [E]
 - l. Reducing the Risk: Impact of a new curriculum on sexual risk taking [C]
 - m. An Evaluation of an AIDS Risk Reduction Education and Skills Training (ARREST) Program [C]
 - n. Stay Safe
 - i. Adolescents Living Safely: AIDS Awareness, Attitudes and Actions (Curriculum)
2. Prevention Model: Community-Level Intervention
 - a. The School/Community Community Program for Sexual Risk Reduction Among Teens (Adolescent Pregnancy Prevention Coalition of North Carolina)
3. Intervention to Reduce Sexual Risk for the Human Immunodeficiency Virus in Adolescents, 1985-2000
4. Healthy Oakland Teens Project (HOT) [H]
5. Effect of HIV Antibody Testing and AIDS Education on Communication About HIV Risk and Sexual Behavior (College Students) [C]
6. Family/Media Approach to HIV Prevention: Results with a Home-based, Parent-Teen Video Program [C]
7. Effects of an institutional AIDS prevention intervention: moderation by gender (College Students) [D]
8. Helping teenagers postpone sexual involvement [D]
9. School-wide Effects of a Multi-component HIV, STD, and Pregnancy Prevention Program for High School Students [D]
10. Effects of a skill-based intervention to encourage condom use among high risk heterosexually active adolescents [D]
11. Reducing Adolescent Pregnancy through school and community-based education [D]
12. Youth At Risk – Missouri [G]
13. Youth At Risk Retreat and Mentoring Program – Missouri [G]
14. New Jersey Teen Prevention Education Program (NJ Teen PEP) [G]
15. School Health and the HIV Connection – North Carolina [G]

*Example Organization: Metro Teen Aids

Population: *Youth of Color*

16. AIDS risk reduction among a multi-ethnic sample of urban high school students [C]
17. Abstinence and safer sex HIV risk reduction interventions for African-American Adolescents: A randomized controlled trial [D]
18. Does the promotion and distribution of condoms increase teen sexual activity? Evidence from an HIV prevention program from Latino youth [C]

Population: *Youth and Drugs*

19. Outcomes of an Intensive AIDS Education for Male Adolescent Drug Users in Jail (Duplicate - also listed under IDU/Youth) [A]

Population: *Minority Populations*

(African American/Hispanic/Asian Pacific Islander)

1. Condom Skills Education and STD Reinfection [A]
2. Effects of an HIV risk reduction project on sexual risk behavior of low-income STD patients [D]
3. Voices/Voces – Video Opportunities for Innovative Condom Education and Safer Sex [E]
 - a. Reductions in STD infections subsequent to an STD clinic visit: Using video-based patient education to supplement provider interactions [A]
 - b. Effectiveness of a Video-Based Motivational Skills-Building HIV Risk-Reduction Intervention for Inner-City African American Men [D]
4. NIMH Multi-site HIV Prevention Trial: Reducing HIV sexual risk behavior [D]

Population: *Incarcerated*

1. Inmates teach about HIV in prison: Centerforce [H]

Population: *Community Interventions*

1. Doing Something Different – Group Counseling at STD Clinics to Promote Condom Use [A]
2. Promise: Peers Reaching Out and Modeling Intervention Strategies for HIV/AIDS risk Reduction in their Community [E]

Population: *General*

1. The CDC AIDS Community Demonstration Projects Research Group: Community-Level HIV intervention in 5 cities: Final outcomes data from the CDC AIDS Community Demonstration Projects [A]
2. Evidence for the Effects of HIV Antibody Counseling and Testing on Risk Behaviors [C]
3. Does HIV/STD Prevention Counseling Work? Results from a Multi-center, Randomized Controlled Trial Evaluating Counseling Among STD Clinic Patients (Project RESPECT) [D]
4. Prevention Method: Partner Notification
 - a. The Outreach-assisted Model of Partner Notification with IDUs [D]
 - b. Efficacy of a partner notification for HIV infection [D]

- c. HIV Partner Notification Cost and Effectiveness Data from an Attempted Randomized Controlled Trial [D]
 - d. Partner Notification and Focus Intervention as a Means of Identifying HIV-positive Patients [D]
 - e. Partner Notification for control of HIV: Results after 2 years of a State-wide Program in Utah [D]
 - f. Results of a Randomized Trial of Partner Notification in Cases of HIV infected in North Carolina [D]
 - g. Partner Notification and the Control of HIV Infection. Two years of experience in San Francisco [D]
5. North Carolina Non-Traditional Counseling, Testing and Referral Sites [G]

Miscellaneous Populations

Population: *Mothers of HIV+ Caregivers*

1. Prevention Model: Study
 - a. Maternal Caregivers Study [D]

Population: *Mentally Ill*

1. Let's Chat – A Brief Behavioral Skills Intervention to Prevent HIV Infection among Chronic Mentally Ill Adults [C]
2. HIV sexual risk reduction in homeless men with mental illness [D]

Population: *Faith-Based Communities*

1. Faith-Based HIV/STD Curriculum – Train Seminarians and Faith-Based Leaders to Begin HIV/AIDS Ministries [G]
2. "Ending the Silence: The Faith Community Speaks Out" [G]
3. Baker Street Ministries HIV Prevention Project [G]
4. AGAPE Program

Interventions are listed with a letter (A-H) after each title. These letters refer to the source of the intervention description used by Interventions Work Group members.

CODE:

- A Compendium of HIV Prevention Interventions with Evidence of Effectiveness
- B Procedural Guidance
- C What Intervention Studies Say About Effectiveness: A Resource for HIV Prevention Community Planning Groups
- D Synopsis from Seattle and King County Health Department
- E www.effectiveinterventions.org
- F HIV/AIDS Prevention Program Archive
- G Synopsis from Bright Ideas 2001: Innovative or Promising Practices in HIV Prevention and HIV Prevention Community Planning
- H CAPS

Chapter 6: *Coordination and Linkages*

Individuals, community agencies, planning groups and governmental partners can benefit from coordinating programs for HIV prevention and treatment.

Providing referrals and education to clients, they become empowered to make decisions about the services available, selecting the most appropriate service with assistance from informed case managers and agency staff. Individuals are given the options and allowed to make their own decision – the decision that is right for them taking into account their level of understanding, comfort and environment. These empowered clients are able to reduce their risky behavior and educate their peers with messages that use their language, spirit and ideas.

Within the community, agencies need to understand what programs are offered for their clientele. This can eliminate duplication in service delivery and promote linkages between the existing programs. Cross training and providing education to case managers, treatment providers, and prevention providers increases the knowledge base in the community. Therefore, when called upon, these service providers can inform their clients about the availability of alternate programs, primary and secondary prevention messages and treatment facilities that can increase client's acceptance of the options presented.

Government agencies need to link their programs when applying for funding as well as when coordinating programmatic goals. Developing smooth systems for referring patients between the agencies can eliminate unnecessary paperwork and duplication of efforts. Connecting newly diagnosed HIV-positive clients with treatment providers as quickly as possible is key to decreasing the spread of HIV as well as improving health outcomes of the individual.

Community planning groups, like the Delaware PPG, should take into account the existing collaborations on the state agency level as well as the coordinated efforts among community-based organizations (CBOs) when planning interventions or prevention activities to reach at-risk populations. Working with prevention and treatment facilities can allow agencies more access to the individuals at-risk to promote both primary and secondary prevention messages.

How have linkages and coordinated efforts worked in Delaware?

To effectively plan and make the most of limited resources, the Delaware HIV Consortium (DHC), Division of Substance Abuse and Mental Health (DSAMH), Division of Public Health (DPH), and community-based agencies must coordinate efforts. Starting in 2002, DSAMH and DPH collaborated for the request for proposal (RFP) process, combining funding streams to create HIV Prevention contracts that would be monitored centrally by DPH staff. Within the Division of Public Health, HIV/AIDS and OMH programs work closely to monitor agencies receiving funding from both programs, to strengthen their efforts in reaching into minority communities and preventing HIV transmission.

Delaware DPH has successfully integrated clinics for HIV/AIDS, Sexually Transmitted Disease, Family Planning and Hepatitis C programs along with the administrative offices. To continue this integration and effectively expand it to the community level, program administrators hope to meet with representatives from a variety of agencies to develop and plan for combined services for prevention and treatment. Administrators anticipate building a collaborative or coordinated system with DPH, DSAMH, Department of Correction (DOC), Christiana Care Health System (CCHS), and DHC.

This initiative, slated to start in 2005, will focus on meeting the following three objectives over the next planning cycle:

1. To examine the variety of projects being offered to CBOs/agencies from multiple sources in order to eliminate duplication of services and increase efficiency.
2. To develop a formal system for maintaining awareness of the collection of services being contracted and devise a method of assessing the agency's capacity to provide the combination of programs planned and subsequently awarded.
3. To develop ways in which our programs can achieve a higher level of synergy through cooperative contracting, shared resources and persistence/consistency of community presence and service delivery.

In 2004, the Division of Public Health, Division of Substance Abuse and Mental Health and Delaware HIV Consortium worked to provide technical assistance for CBOs, with emphasis on those serving minority communities. The approach, to be continued through 2009, is to couple traditional training seminars with increased on-site technical assistance and capacity building services to small minority-based CBOs to improve business practices, increase long-term sustainability, and develop reasonable and workable plans for program expansion.

DHC, DPH, the Department of Correction and its medical provider are working to ensure confidential HIV counseling and testing is available to all inmates and results are delivered quickly to inmates. Community based organizations, selected through a competitive RFP process, will continue to provide discharge case management to all HIV infected inmates released from custody. This initiative will be continued with emphasis on improving delivery and evaluation of HIV CTR services and discharge case management services provided within the correctional setting.

Tuberculosis (TB) prevention and treatment messages are important to include in HIV prevention programming. The TB program office is coordinating efforts within the Division of Public Health, Communicable Disease Branch. This ensures information is provided to HIV Prevention providers for inclusion in presentations to community groups, correctional settings and drug treatment facilities.

The Department of Education (DOE) participates in a national survey of high school youth, the Youth Risk Behavior Survey (YRBS). Data from the survey is used in HIV Prevention planning and surveillance efforts and has been discussed in Chapter 2. Coordinated efforts to increase HIV prevention messages to at-risk youth through the JUST for Youth program (Justice, Unity, Safety and Tolerance) are spearheaded by the Department of Education. DOE staff will continue collaborating and participating with the Delaware HIV Consortium and the planning groups to bring the education perspective to the discussion.

Linkages are vital to encouraging newly diagnosed HIV-positive patients to enroll in an HIV-treatment program. Building partnerships between HIV counseling and testing facilities and the local HIV-clinic system has benefited both the client and the care provider. Christiana Care Health System (CCHS) operates five HIV treatment clinics throughout the state. The treatment clinics are supported by Christiana Care, and also receive funding through HRSA grants from the Ryan White CARE Act and state and private contracts. Several clinics are co-located within HIV counseling and testing sites. In these settings, easy access allows clients the chance to meet providers in a non-threatening environment and to receive appropriate medical care.

DPH will continue to coordinate evaluation efforts with CDC and HRSA requirements. Specific approaches to be investigated for improving coordination and linkages are included in Chapter 7 - goals and objectives.

Chapter 7: *Goals, Objectives and Recommendations; Technical Assistance*

Each year, the Division of Public Health (DPH) and Division of Substance Abuse and Mental Health (DSAMH) submit grant applications to the federal funding partners that include goals and objectives the agency hopes to meet during the funding cycle. The goals outline broad-based efforts that can take several years to accomplish, while the objectives are more specific, targeting part of the overall goal. Technical assistance plans are also part of all grant applications. Future technical assistance needs of the PPG are described at the end of the chapter. The Centers for Disease Control and Prevention (CDC) provides guidelines for DPH to follow when applying for funding. These guidelines include evaluation guidances that will be further discussed in Chapter 8 (Evaluation).

The Substance Abuse and Mental Health Services Administration (SAMHSA), which funds DSAMH, and the Health Resources and Services Administration (HRSA), which funds the Ryan White CARE Act program, also provide guidelines for grant applications and evaluation. Since the focus of this plan is HIV prevention, goals and objectives from the HIV Prevention program are included in this chapter for the reader.

The DPH HIV Prevention grant application is submitted in response to the HIV Prevention Cooperative Agreement issued by CDC. The application reviews how Delaware DPH will develop a comprehensive HIV prevention program. The program must include components related to laboratory support, technical assistance, health education, risk reduction, data collection and reporting. Community planning is a big part of the overall comprehensive HIV prevention program; with the development of the Comprehensive HIV Prevention Plan a major output of this effort.

The HIV Prevention Cooperative Agreement requires DPH to evaluate the program through measurable indicators, known as Program Performance Indicators. To be consistent across all states receiving HIV prevention funding, CDC provides DPH with guidance on how to calculate the data. For more information on the indicators, please contact the Division of Public Health, HIV Prevention Program office.

When developing the HIV Prevention grant application, program administrators must link their goals and objectives to the programs funded, and develop reasonable expectations for future program development. Full detailed goals and objectives are found in the annual grant application, which is submitted in late summer to the PPG for review. The three major goals appearing below are broad in nature, to provide the reader a perspective of the work DPH must complete during the five-year planning cycle.

Goal 1:

Increase consistency and efficiency of HIV prevention and treatment services while working to decrease duplication of effort of community-based agencies.

Objective 1: The Division of Public Health, HIV/AIDS Prevention and Treatment programs will coordinate with the Delaware HIV Consortium, Division of Substance Abuse and Mental Health, Christiana Care Health Systems and CBOs to facilitate coordination of HIV/AIDS program planning.

Objective 2: The Division of Public Health HIV/AIDS Prevention program will work with technical assistance (TA) providers to ensure on-site, customized TA is available to agencies upon request. Standard operating protocols and training programs will be developed for delivery via web or other multimedia options. Technical assistance and cross-training sessions will be offered to agency staff to increase their knowledge in order to provide service delivery to meet the needs of specific at-risk populations.

Objective 3: The Division of Public Health HIV/AIDS Prevention program will seek additional funding from corporate sponsors and prevention partners (CCHS, DSAMH, OMH, and DOE) to implement a five-year, statewide campaign that focuses on these objectives:

- a. To increase the identification of new cases of HIV infection through targeted HIV counseling and testing programs to high risk populations.
- b. To encourage individuals who are newly HIV-diagnosed or individuals who have been diagnosed with HIV but never sought care to enroll in secondary prevention and treatment programs that would provide them a link to the continuum of services available.
- c. To increase the number of HIV-positive clients enrolled in programs that provide treatment and prevention messages throughout the service spectrum.
- d. To create a unified identity and community presence for all agencies participating in the formal collaborative efforts. The "logo" would be transferable to any individual agency or service provider that joins the effort.

Objective 4: The Division of Public Health HIV/AIDS Prevention program will facilitate regular meetings and seek to develop formal working relationships between prevention and treatment service providers. This endeavor will increase the flexibility with which client needs are met.

Goal 2:

Increase the level of coordination among community providers, to achieve an integrated continuum of service delivery, similar to that established by DPH administration and clinic settings for HIV/AIDS, STD, Family Planning and Hepatitis C.

Objective 1: The Division of Public Health will propose to integrate case managers cross-trained in HIV prevention case management and Medicaid eligibility directly into the HIV Wellness Clinic system in order to access HIV-infected people that engage in high-risk activities and speed evaluation of client benefit eligibility.

Objective 2: The Division of Public Health will investigate incorporating Hepatitis C testing into HIV counseling, testing, referral and prevention services.

Note: Evidence indicates¹ that individuals who become aware of their HIV- positive status often spontaneously reduce their high-risk behavior for 6 months or more. It is reasonable to expect that those infected with Hepatitis C may also spontaneously reduce high-risk behavior upon learning of their Hepatitis C- positive status. As the highest risk behavior for Hepatitis C infection is needle sharing and the highest mode of HIV transmission in DE is needle related, it is also reasonable to expect that a reduction in high risk needle sharing among those who are Hepatitis C-positive and HIV-negative may prevent those individuals from becoming HIV-positive.

Objective 3: The Division of Public Health will work with community-based organizations to develop and implement interventions that support and advance prevention and treatment services. Initiatives to be investigated include:

- a. Continuing to educate policy makers and legislators about needle-exchange issues.
- b. Continuing to develop and improve DPH level evaluation capacity to relieve CBO providers of primary responsibility for program evaluation.
- c. Coordinating contracting for local, technical assistance and capacity building services for treatment/case management/prevention providers.
- d. Increasing clarity and specificity of contract service descriptions and monitoring processes.

Objective 4: The Division of Public Health will expand rapid HIV testing to as many testing sites as the technology and capacity of providers allows.

Goal 3:

Deliver efficient and prompt services to those most at-risk.

Objective 1: The following three approaches are recommended if a community lacks the capacity to provide services for the identified at-risk populations:

- a. Funds targeted to the specific at-risk population will be directed to developing capacity for an agency located in the community that is unable to perform the needed HIV prevention intervention. This will develop a viable HIV prevention service provider as quickly as possible.
- b. Funds will be allocated to existing DPH contracting agencies until the capacity of a local community based organization is at a level to perform the required services, if a potential service provider does not exist within the community.
- c. Funds will be directed to programs for 'other' prioritized populations, if a potential service provider does not exist within the community and no DPH-funded agency is located in the community, until a suitable candidate for capacity building is identified.

Objective 2: Agencies implementing PPG endorsed intervention definitions (Chapter 5, attachment 1) will be prioritized for funding. Staff at the agency should maintain the minimum qualifications described in the PPG endorsed Intervention Worker Minimum Qualifications (Chapter 7, attachment 1). Funding levels should be adequate for agencies to provide programs that meet DPH criteria as outlined in RFPs.

Technical Assistance

Technical assistance is the provision of education to agencies, individuals or community planning groups to improve the understanding of concepts or service delivery. Technical assistance is available to PPGs, individual members and DPH to assist the planning partners in meeting the goals and objectives set forth in the Plan and subsequent grant applications. During the development of this plan, PPG leadership identified the following TA needs for future planning cycles:

- **Cultural competency:** The PPG will evaluate cultural competency level and understanding among PPG and Treatment Services Committee members, workers, and prevention and treatment provider agencies. As services are targeted to populations most at-risk, agencies must confront racial disparities, language barriers, and other cultural competency issues to adequately provide appropriate services.
- **Leadership training:** Training is needed as the PPG and Treatment Services Committee leadership explore collaboration. As new leaders for both planning groups are selected they need to understand their roles and responsibilities.
- **Minority recruitment and participation:** Focused recruitment of Hispanics, African Americans, Women, Youth and People Living with HIV/AIDS (PLWHA) will include education and orientation for all prospective PPG members. These efforts must inform prospective members about community planning and ways to become involved in the process. Recruitment will continue throughout the next planning cycle.

The responsibility for properly training employees rests with the contracted agencies. DPH will provide capacity building training as requested from agencies, but agencies are responsible for hiring employees with the needed skills and/ or capacity to quickly obtain the needed skills.

Universal

1. All providers must be able to pass a DPH administered test on HIV/AIDS transmission, prevention, disease progression and the definition of the intervention(s) they have been hired to administer within 60 days of hire.
2. All providers must be trained in HIPAA regulations and have a signed confidentiality agreement on file at their employers offices at all times.
3. All providers working with populations that speak a language other than English must be bilingual and fluent in English.
4. All providers must be familiar with the literature approval process for all materials to be used in providing services under this contract.
5. All providers must demonstrate ability with the computer needed to use the web-based reporting system or have a clearly identified person to enter the data for them. There will be no exceptions.

For ILI

Preferred

NEW HIRES

Worker must have at least an associate degree in human services, counseling, behavioral science, health care, or related field - OR -
3 years relevant experience and documented education relevant to the knowledge and skills needed to provide services as defined in the *HIV Prevention Intervention Definitions for 2004*.

CURRENT EMPLOYEES

If not meeting the requirements for NEW HIRES (above), the worker must be actively enrolled in a degree/certificate program (as described above) or in a continuing education program with a specific curriculum designed to maintain and/or improve knowledge and skills needed to provide services as defined in the *HIV Prevention Intervention Definitions for 2004*. Must be enrolled within 60 days of the contract start date.

Alternative

IF NO CANDIDATE MEETING THE PREFERRED QUALIFICATIONS IS AVAILABLE.
Supervisor has associate or bachelor degree in an appropriate field and provides active supervision.
And
Worker can document satisfactory completion of formal training in the following:
1. Basic counseling skills (i.e. CTR training, motivational interviewing, etc)
2. Behavior change theory

For GLI

Preferred

NEW HIRES

Worker must have at least an associate degree in human services, counseling, behavioral science, health care, or related field - OR -
3 years relevant experience and documented education relevant to the knowledge and skills needed to provide services as defined in the *HIV Prevention Intervention Definitions for 2004*.

CURRENT EMPLOYEES

If not meeting the requirements for NEW HIRES (above), the worker must be actively enrolled in a degree/certificate program (as described above) or in a continuing education program with a specific curriculum designed to maintain and/or improve knowledge and skills needed to provide services as defined in the *HIV Prevention Intervention Definitions for 2004*. Must be enrolled within 60 days of the contract start date.

Alternative

IF NO CANDIDATE MEETING THE PREFERRED QUALIFICATIONS IS AVAILABLE.
Supervisor has associate or bachelor degree in an appropriate field and provides active supervision.
And
Within 60 days of the start of the contract the worker must document enrollment in acceptable training in the following:
1. Basic counseling skills (i.e. CTR training, motivational interviewing, etc)
2. Behavior change theory
3. Group dynamics and/or therapeutic facilitation

For PCM

Preferred

NEW HIRES

Bachelors or Masters of social work, counseling, behavioral science or related field.

CURRENT EMPLOYEES

If not meeting the requirements for NEW HIRES (above), must have previous case management experience and be actively enrolled in a degree program (as described above) or in a program of continuing education to maintain and improve knowledge and skills needed to provide services as defined in the *HIV Prevention Intervention Definitions for 2004*. Must be enrolled within 60 days of the contract start date.

Alternative

IF NO CANDIDATE MEETING THE PREFERRED QUALIFICATIONS IS AVAILABLE.

Supervisor has Masters or bachelor degree in an appropriate field and provides active supervision.

And

Worker must have an associate or bachelors degree in human services, counseling, behavioral science, health care or related field.

And

Within 60 days of the start of the contract the worker must document enrollment in acceptable training in the following:

1. Case management and service brokerage
2. Basic counseling skills (i.e. CTR training, motivational interviewing, etc)
3. Behavior change theory

Outreach

Preferred

Within 60 days of the start of the contract the worker must document satisfactory completion of acceptable training in the following:

1. Safety practices for outreach workers.
2. The definitions of the various outreach types (and pass a DPH administered test).
3. Basic counseling skills (i.e. CTR training, motivational interviewing, etc)

HIV Counselor

Preferred

Within 60 days of the start of the contract and before providing any CTR services the worker must document satisfactory completion of acceptable training in the following:

1. HIV CTR Training and OraSure use.
2. Client crisis management.
3. Facilitation of referrals and knowledge of available services.
4. Methods of encouraging partner notification services.
5. Proper manner of filling out the HIV CTR forms (and pass a DPH administered test)
6. Satisfactorily pass skills inventory within 60 days of completion of course to include review of #3, 5

Health Communication/Public Information – Presenter

Preferred

Within 60 days of the start of the contract and prior to providing any HC/PI services:

- Worker must have formal training in health education/presentation either through DPH, provider in-house training or other training program using a curriculum approved by DPH.
- Supervisor must ensure the presenter has passed a skills inventory certifying the individual can present.
- Individual must attend an annual update and content of update (conferences or trainings) must be approved by contract manager to determine if are appropriate
- Contract manager must be able to conduct on-site and unscheduled site visits for observations and will submit observation forms to supervisor for review

Chapter 8: *Evaluation*

Why is evaluation important to Community Planning?

Evaluations are critical to ensuring that HIV prevention programs provide the best services available and meet the needs of clients. Evaluation of planning, implementation and results allows health departments and CPGs to feel confident that they are doing the most they can with available resources and to improve when necessary. Evaluation also provides concrete data for accountability to stakeholders and funders.

Delaware DPH and PPG will conduct evaluation activities as required in the CDC *community planning guidance*. The *community planning guidance* includes three objectives related to supporting broad-based community participation in HIV Prevention planning. These objectives are:

- A. Implement an open recruitment process (outreach, nominations, and selection) for CPG (PPG) membership.
- B. Ensure that the CPG (PPG) 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.
- C. Foster a community planning process that encourages inclusion and parity among community planning members.

While previous chapters of this plan discussed the critical community planning attributes, it is important to refer to these three objectives when discussing evaluation, specifically evaluation of recruitment and membership activities. As previous chapters dealt with the work product of the Needs Assessment, Populations and Interventions Work Groups, this chapter will include references to the Membership Work Group and their work product.

Membership efforts

The Membership Work Group produced an orientation guide, conducts orientation meetings and is responsible for revising the attendance and voting policy and procedures for the PPG. As the planning cycle continues, the HIV Program Assistant at the Delaware HIV Consortium will work closely with this work group to actively recruit additional members for the PPG. This individual will also work with the work group in implementing and monitoring a mentoring program. The Membership Work Group will also create a Conflict of Interest Policy as well as Grievance Procedures.

To help the PPG and Treatment Services Committee meet their respective membership-related planning objectives, the Delaware HIV Consortium developed the Community HIV/AIDS Advisory Team (C.H.A.T.) in 2002. The mission of C.H.A.T. is to organize community members within Delaware in order to meaningfully involve individuals in the various HIV/AIDS treatment services and prevention initiatives that exist within their communities. C.H.A.T. members can advise the decision-making process by providing suggestions to improve the quality and type of services delivered to their peers.

C.H.A.T. meets quarterly in each county. Meetings are held on weekends or evenings reducing barriers by providing transportation, childcare and food, while holding the meetings at times convenient to the membership. Sessions have covered the planning processes associated with HIV prevention and treatment, introduced participants to hands-on opportunities to give feedback to planning group leadership, and encouraged participants to become members of the planning groups if their schedules permit.

By providing opportunities for community members to be involved in and educated about the process, the PPG seeks to meet the parity, inclusion and representation objectives outlined above. Participants evaluate each C.H.A.T. session to ensure their voices are being heard. After the first year of meetings, C.H.A.T. had 93 unduplicated and 163 duplicated community members as participants. Participants have represented service providers, church members, community leaders and those infected and affected by HIV/AIDS. The evaluation completed after each session allows DHC staff members to determine representation of the membership and how inclusive the session was compared to the local epidemic. The first evaluation report on C.H.A.T. is included for reference. (Chapter 8, Attachment 1)

Evaluation efforts during the writing of this plan

In Delaware, previous planning cycles incorporated an outside evaluator who assisted the PPG in determining compliance with parity, inclusion and representation (PIR) as discussed in the objectives listed above. The evaluator also examined, through interviews with PPG members and surveys, acceptance of the community planning process, group dynamics and membership issues. An outside evaluator attended all PPG meetings, including work group leader meetings and work group meetings as time allowed. The Year-End 2003 Evaluation Report summarizing the latest findings is attached for reference. (Chapter 8, Attachment 2)

Future evaluation efforts

However, with the recent changes in the guidance, DPH will comply with the requirements outlined by CDC, completing the membership matrix and performance indicators for grant applications and progress reports. All community planning attributes and objectives in the community planning guidance will be evaluated. Three additional potential evaluation efforts for the next planning cycle are:

- Reviewing the evaluation tools included in the community planning guidance (including the membership matrix and

performance indicators) to determine if there are additional items the PPG would like to evaluate about their process.

- Completing a survey of PPG members and prevention contractors on cultural competency. Data will be analyzed and results will indicate types of technical assistance needed and for which audience (PPG, service provider or DPH).
- Evaluating the operationalization of the Comprehensive HIV Prevention Plan 2005-2009. The PPG will analyze the populations identified as most at-risk in the plan over the next planning cycle. This analysis will determine if the interventions selected were the most appropriate for the needs of the populations identified. PPG members will also evaluate whether the recommendations were used in developing contracts for service delivery.



Community HIV/AIDS Advisory Team

Collaborative project between the Delaware HIV Consortium's Prevention Planning and Treatment Services committees

Background

The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA), federal agencies that administer prevention and treatment dollars for HIV/AIDS services, respectively, require that community-planning groups are representative of the populations they are serving. In the past, Delaware's community planning groups have attempted to be inclusive in their membership. Their attempts have included open recruitment to the committees, creating marketing materials to publicize the groups, asking service providers to bring one new person to each meeting, etc. These attempts have brought new community members to the table, but have not had lasting effects on the membership of the committees.

The Prevention Planning Group gathered information about how to better include community members, especially those who are infected with HIV/AIDS, into their planning process. Barriers affecting community members not becoming involved in the Prevention Planning Group included the time of the meetings, the location of meetings, transportation issues, childcare issues, and no orientation process for new members. The Treatment Services Committee faced the same issues when trying to recruit new members.

Creation of the Community HIV/AIDS Advisory Team

In May 2002, the Delaware HIV Consortium (DHC) started brainstorming ideas concerning how they could better facilitate the recruitment of community members to the two committees. In July 2002, a presentation was made to the Co-chairs of the Prevention Planning and the Treatment Services Group, introducing them to the concept created by the DHC to remedy this problem. The Co-Chairs suggested ways to break down the barriers that community members face and helped create a timeline for implementation. In August 2002, the concept was presented to the two committees and was approved. In September 2002, the Delaware HIV Consortium launched the Community HIV/AIDS Advisory Team (C.H.A.T.).

The Mission of the Community HIV/AIDS Advisory Team is to organize community members within Delaware in order to meaningfully involve individuals in the various HIV/AIDS treatment services and prevention initiatives that

C.H.A.T. was created to provide a vehicle by which community members can advise the decision making process as to the quality of existing services and to identify gaps in services. It is meant to provide a forum for all members of the community to have a say in the planning of HIV services in the State. Participation in C.H.A.T. is open to all community members, those infected and/or affected by HIV/AIDS.

C.H.A.T. meetings are held four times a year in each county (a total of 12 meetings a year). In order to break through the barriers that hinder people from attending the committee meetings, the meetings are held in the evening in Kent and Sussex Counties and on a Saturday afternoon in New Castle County. Transportation, childcare and food are provided for the convenience of the participants.

CHAT Meeting Topics

During the first year, C.H.A.T. participants have been given hands-on experience with the planning process. Participants have been given the opportunity to learn about the Delaware HIV Consortium, the Treatment Services Committee and the Prevention Planning Committee. They piloted the 2003 HIV/AIDS Consumer Survey, the Prevention Planning Group has utilized their knowledge in creating focus group questions, and they have advised the Treatment Services Committee on revisions to be made to the List of Priorities and Recommendations for treatment services.

Evaluation

Meetings have been held during the following months: September 2002, November 2002, January 2003, April 2003, and July 2003. At the end of each meeting, participants are asked to complete an Evaluation Form. The form consists of demographic questions, questions evaluating the meeting, and marketing questions. At the end of each round of meetings, a Narrative Report and Demographic Summary is presented to each of the two committees.

After a complete year of meetings, C.H.A.T. has seen 93 unduplicated and 163 duplicated community members as participants. Participants have represented all aspects of their communities; from those infected with HIV/AIDS, to those who are affected by the disease, to service providers, to church members, to community leaders.

Table 1 and Figures 1-3 are breakdowns of those members who have self-disclosed that they are infected with HIV/AIDS in comparison to the epidemic in the State of Delaware.

Table 1.

Demographic Category	Infected Participants (N=35)	Epidemic – 2003 HIV/AIDS Data (N=3,810)
Sex		
Male	57%	72%
Female	43%	28%
Ethnicity		
Hispanic	3%	5%
Non-Hispanic	97%	95%

Figure 1. Race comparison of infected C.H.A.T. participants and the epidemic

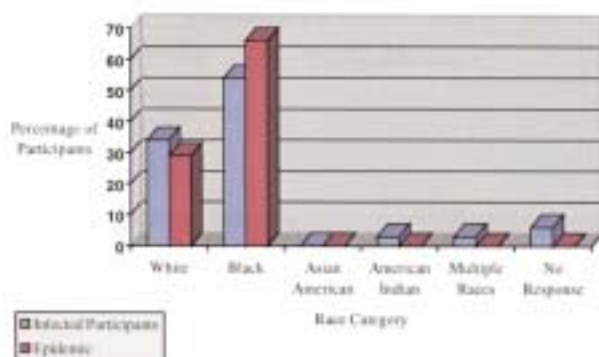


Figure 2. County of residence comparison between infected participants and the epidemic

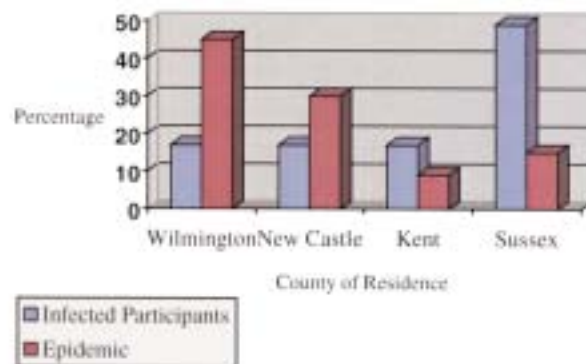


Figure 3. Age category comparison between infected participants and the epidemic

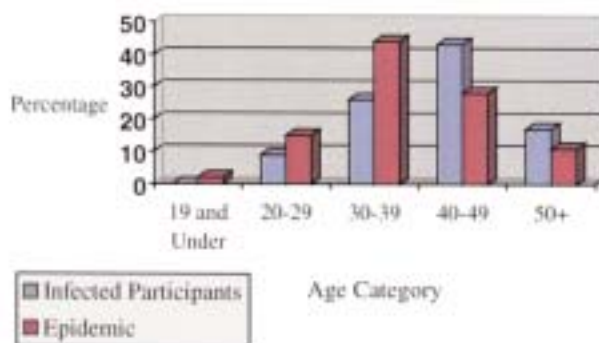


Table 2 and Figures 4-6 are breakdowns of all participants in comparison to the population of the State of Delaware.

Table 2.

Demographic Category	C.H.A.T. Participants (N=97)	Delaware Census - 2000 (N=783,600)
Sex		
Male	46%	49%
Female	54%	51%
Ethnicity		
Hispanic	9%	5%
Non-Hispanic	91%	95%

Figure 4. Race comparison between participants and Delaware population

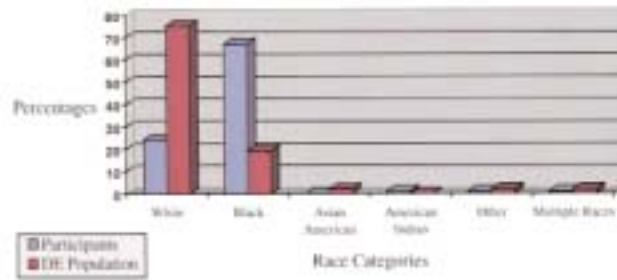


Figure 5. County of residence comparison of participants to Delaware population

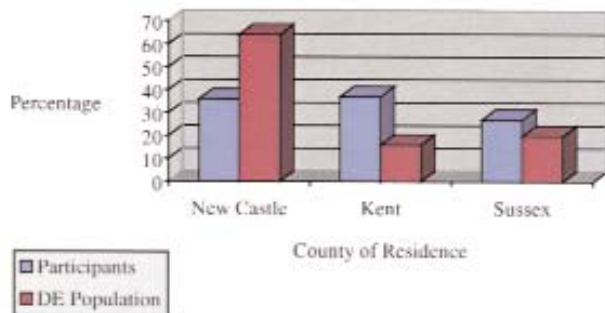


Figure 6. Age category comparison between participants and Delaware population

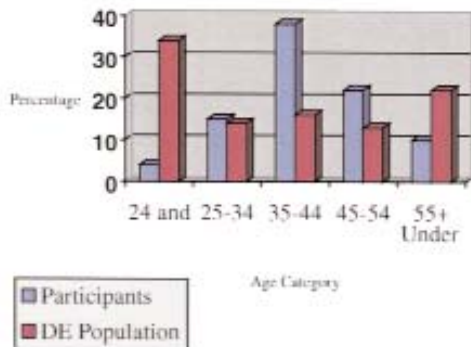


Table 3.

Number of Unduplicated Participants for each County

County of Residence	# Of Participants	Percentage
New Castle	34	37%
Kent	34	37%
Sussex	25	26%

Delaware's Prevention Planning Group Year End Evaluation Report Executive Summary

January 2004

Report prepared by Dorothy Dillard, Ph.D.

Submitted to the Delaware Department of Health and Social Services, Division of Public Health

Introduction: The following report provides an overview of the activities of Delaware's Prevention Planning Group (PPG), also known as the HIV Prevention Committee, undertaken between January and December 2004. It serves as the Executive Summary to the full report. Refer to the full report for a more thorough assessment and additional data.

Membership: At the end of 2003, the PPG roster included 52 members. The PPG membership is comprised of 28 active members, 9 DPH advisors including the two members who regularly attend meetings and 15 interested members. On average, 22 members attend the monthly PPG meetings. Typically, 19 active members and 3 DPH advisors are present at meetings. Attendance has been declining. In 2002, the average number of members attending the monthly PPG meeting was 25. During both years, an average of 3 DPH advisors attended the meetings so the concerted effort to reduce DPH attendees in an effort to address the trust issues discussed in the mid-year report (June 2003) does not account for the decline in attendance. In the beginning of 2003, 26 members attended PPG meetings by the end of the year 19 to 16 members were attending.

In 2003, four new members joined. Three are African American women and one is a Hispanic male. Two are from New Castle County and the other two from Kent County. All are service providers, one with a faith-based organization and the remaining three with community based organizations.

PPG Activities: The primary focus of the PPG during 2003 was developing the 2005-2009 Comprehensive Plan. The tasks related to completing the Comprehensive Plan are divided among the work groups. The tasks and accomplishments of each work group during 2003 are described below.

- **Needs Assessment Work Group** – The Needs Assessment Work Group has completed the first draft of the needs assessment, including a gaps analysis. The draft report includes both the needs assessment and the gaps analysis. The work of the Needs Assessment Work Group fulfills CDC Goal 2 Objective D.
- **Populations Work Group** – The Populations Work Group was given the task of collecting supplemental qualitative data aimed at better understanding the HIV prevention needs, knowledge and issues of the primary target populations. Six focus groups were conducted and the information was compiled in a report prepared by a consultant. The work group has initiated the prioritization process, including completing the recommended CDC worksheets.
- **Interventions Work Group** – In 2003, the Interventions Work Group researched new interventions and identified 59 new interventions. The work group summarized the interventions using the format in the current Comprehensive Plan. The work group will also use the CDC recommended forms to identify and recommend interventions for the Plan.
- **Membership Work Group** – The Membership Work Group, in coordination with Delaware HIV Consortium staff, has continued to provide orientation to new members. The work group has also identified orientation and new member support needs.

In addition, the PPG has addressed a number of process or group functioning issues. The major areas addressed by the PPG are described below.

- **CDC Changes** – The PPG was educated on the changes. Overall very few changes are necessary. Although the PPG recognizes the need to formalize the recruitment process, no changes have been made. The evaluation effort has also been revised to reflect the CDC changes.
- **Leadership** – Throughout the year, the work group leaders have discussed the need to recruit new work group leaders. During 2003, four of the seven work group leaders resigned their positions. The average rating on the Group Dynamic Scale dropped slightly between midyear and end of year 2003 but had dropped significantly from the previous year rating (See PPG Functioning below). Recruiting and orienting new leaders is a critical need of the committee.
- **Orientation** – The Membership Work Group continues to work on improving the orientation process. However, the changes described above have not been implemented and the orientation materials have not been updated to reflect the CDC changes.
- **Conflict of Interest** – The work group leaders reviewed a number of PPG conflict of interest policies and decided to ask the Delaware HIV Consortium Board of Trustees to consider revising the existing policy to meet the CDC requirements. To date, the Consortium Board had not responded and, thus, no formal changes have been made. In addition, the recommended educational session has not been conducted with the PPG to ensure that all members are aware of and understand the policy.
- **C.H.A.T.** – The Delaware HIV Consortium has increased the amount and frequency of information about C.H.A.T. to the PPG. The C.H.A.T. groups provided feedback on the focus group questions. Although the work group leaders identified additional ways to include the C.H.A.T. groups in the work of the PPG, no further action has been taken.

- Technical Assistance – The work group leaders identified three technical assistance areas. A training related to group dynamics was offered by the Delaware HIV Consortium but not well attended. Technical assistance in regards to working effectively across differences (cultural, professional approaches and other differences) is planned for the annual retreat. In response to CDC's increased focus on linking treatment and prevention, technical assistance in this area was also suggested but has not been addressed.

PPG Functioning: From its initiation, the Delaware PPG members have rated how well the group functions. Group functioning has been tracked over the years as an indicator of growth as well as a means to identify areas to be addressed. Ratings dropped slightly since the last administration of the scale in June 2003. Of particular concern is the increased number of members rating domains as less than OK. At the last administration, only two domains, trust and participation, received ratings less than OK. At the December 2003 administration, however, 5 of the 8 domains received ratings less than OK.

Comparison of the ratings over the past three years also indicates the need to address several areas of group functioning. The goals and creativity domains remained the same. The participation, diagnosis, decisions and trust average ratings improved. The average rating on the feelings and leadership domains both decreased slightly. Although members rated more domains as less than OK, the average rating compared to past years either remained the same or improved. This difference indicates a "split" in individual member ratings. In other words, the number of members rating domains as good has increased at the same time that the number of members rating domains as less than OK or poor has increased. In sum, at this point, there is not a consensus among members about the functioning of the PPG.

The Group Dynamic Scale was expanded to allow PPG members to identify, for each domain, things the group does well and things that need to be improved. Comments indicate areas of improvement that if addressed may increase average ratings. The comments clarify the ratings, particularly the negative ratings. Based on the ratings and the comments, it appears that leadership, decision-making, creativity and growth need to be addressed to improve the PPG's functioning.

CDC Goals and Objectives: The PPG activities and functioning ultimately must meet the CDC goals and objectives. This section provides an assessment of the degree to which the CDC goals and objectives are being met.

Goal 1: Community planning supports broad-based community participation in HIV prevention planning.

- A. *Implement an open recruitment process (outreach, nominations, and selection) for PPG membership.* The process is open and informal. In the last report it was recommended to review the processes and formalize them so that they meet the CDC requirements. To date, no action has been taken and the need still exists.

- B. *Ensure that the PPG 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.* Members do desire increased participation from a more diverse group, particularly from HIV positive persons, clergy and youth.
- C. *Foster a community planning process that encourages inclusion and parity among community planning members.* In general, this objective is being met. Responses to the Group Dynamic Scale related to inclusion and parity suggest the need for increasing input from members.

Goal 2: Community planning identifies priority HIV prevention needs in each jurisdiction.

- D. *Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.* Through the work of the Needs Assessment Work Group, this objective has been met in 2003. However, responses on the Member Survey indicate the need to better connect the needs assessment process with meeting this objective.
- E. *Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.* At the time of this report, the Populations Work Group results had not been presented to the PPG. However, based on the process undertaken, this objective is being met.
- F. *Ensure that prevention activities 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 culture appropriateness, relevance, and acceptability.* The Interventions Work Group is still in the process of identifying appropriate prevention activities. Although this objective is being met, about one quarter of the members indicated on the annual Member Survey that they were unaware or unclear of the process. As such, it is recommended that the Interventions Work Group continue its efforts and members be informed of the process.

Goal 3: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV Prevention Plan.

- G. *Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the health department application for federal HIV prevention funding.* Assessment of the link between the Comprehensive HIV Prevention Plan and the most recent health department application has not been made. Previous assessments, however, indicate a direct link. Most members agree that there is a direct link. It is recommended that an assessment of the link between the plan and the application be made.

H. *Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.* The most recent annual Member Survey administered in May 2003 showed that most members agree that there is a link. In addition, a direct link between the plan and funded interventions was made two years ago and demonstrated a link. Since that time, however, the health department has made changes in the contracting process and has awarded new interventions and agencies. As such, it is recommended that an assessment of the link be made.

Discussions and Recommendations

The PPG has continued to meet the CDC goals and objectives. It has adapted to the CDC changes although there are several processes that need to be fulfilled to fully comply with the CDC requirements, including formalizing the recruitment process, reviewing the conflict of interest policy and assessing the linkages between the Comprehensive Plan, the CDC application and the funded interventions.

Members for the most part understand the process as well as the CDC goals and objectives. There are a few areas in which additional education, training or attention need to be given, including connecting the needs assessment process to the CDC objective, better explaining the work of the Interventions Work Group and education on the conflict of interest policy and procedures. Members for the most part also feel that the PPG functions well. There are several areas that member ratings indicate need attention. Members recognize the need for new and expanded leadership. They feel that the creativity and growth of the PPG is stagnating and that diagnosis of problems is too cumbersome and lengthy.

These responses point to the critical stage of the PPG. The evaluation results clearly point to the loss of momentum. For several years, the energy of members has been strong and evident. Leadership was strong and dedicated to the process of developing the Comprehensive Plan. Over the past year, however, attendance has decreased, almost half of the work group leaders have resigned their leadership positions and ratings on the creativity, leadership and diagnosis scales have decreased.

It is difficult to point to the exact reasons for this decrease in momentum but several factors may contribute. Two years ago the PPG members undertook an extremely intensive process to develop the Comprehensive Plan. Although the outcome was impressive and rewarding, the process was taxing. Many of the members who assumed leadership positions during that process continue to be the PPG leaders. The PPG immediately initiated the process to develop the 2005-2009 Comprehensive Plan. There was little or no break for members in general and no break for most of the leaders. It appears that the continued intensity of developing the Comprehensive Plans without the influx of new leaders and new members is taking its toll on both the members and the leaders.

Also during 2003, the PPG addressed CDC changes. Although the PPG has addressed the necessary changes, it has been unable to formalize some of the changes. The Needs Assessment final report has

not been completed, the recruitment process has not been formalized, the orientation materials have not been updated and revised to reflect the CDC changes and the orientation process changes, the conflict of interest policy has not been finalized, there has not been follow through on suggestions to better connect to the C.H.A.T. groups and TA suggestions have not been addressed.

The issue appears to be a time and resource problem. The PPG relies heavily on a few members, mostly the work group leaders and co-chairs, to accomplish the work of the group. This lack of energy and follow-through suggests not only the need to nurture new and expanded leadership but also to expand the group and to re-energize existing members. New members would mean more people to get the work done and new leaders would bring renewed commitment and energy to the PPG.

PPG members have noted for several years that although they feel that the PPG represents the epidemic, new members are needed. Specifically, the PPG would benefit from HIV positive persons, clergy and youth as members. It lacks evaluators and researchers as well as representatives from mental health agencies, homeless services, research centers, business and labor, and HIV care and social services.

In an effort to progress through this transitional period, it is recommended that the PPG focus its efforts. As such, only three recommendations are made:

1. Identify and nurture new leadership.
2. Recruit new members and expand the membership.
3. Address the unfinished tasks including:
 - a. completing the Needs Assessment report;
 - b. formalizing the recruitment process;
 - c. developing and revising the orientation materials and process;
 - d. finalizing the Conflict of Interest policy and provide education/training to PPG members;
 - e. incorporating C.H.A.T. participants into the PPG tasks and efforts;
 - f. providing technical assistance on linking prevention and treatment; and
 - g. updating the linkages assessment.

Chapter 9: *Glossary*

The following terms are included here along with definitions as a reference for the reader. This list is not a comprehensive or exhaustive list of terms. Additional resources are available from the Delaware HIV Consortium or the Division of Public Health, HIV Prevention program. Several entries below reflect language from the CDC community planning guidance. Entries denoted with an asterisk (*) are brief excerpts from the HIV Prevention Program Intervention Definitions document that is found as Chapter 6, Attachment 2.

<i>Capacity building</i>	Activities designed to strengthen the infrastructure of an organization allowing it to conduct effective HIV/STD prevention activities. Capacity building activities include: fund raising development, board development, personnel policy development, program planning and development.
<i>Community Level Intervention*</i>	An intervention that seeks to improve the risk conditions and behaviors in a community through focus on the community as a whole, rather than by intervening only with the individuals or small groups, i.e., community mobilizations, social marketing campaigns, community-wide events.
<i>Early Intervention</i>	Efforts aimed at identifying and linking individuals infected with HIV to primary medical care and other essential services. These include HIV counseling and testing and targeted outreach to special populations (incarcerated, pregnant women, substance users).
<i>Formulary</i>	Listing of medicines that are approved on a health insurance plan.
<i>Group Level Intervention*</i>	An intervention working with small groups, either using peer or non-peer models or curricula to encourage and/or maintain behavioral change toward risk reduction for HIV infection. Group Level Interventions include a skills building component.
<i>Intervention</i>	A specific activity designed and intended to bring about HIV risk reduction, in a particular population, using a common strategy for delivering the message, with distinct process and outcome objectives.
<i>Individual Level Intervention*</i>	An intervention working with one individual at a time, assisting the client in making plans for individual behavioral change, on-going appraisals and facilitating linkages to other services in support of risk reduction. Individual Level Interventions include a skills building component.
<i>Health Communication/ Public Information*</i>	Delivery of planned HIV/AIDS prevention messages to target audiences to support safer behaviors, personal risk-reduction efforts and inform about available services. This intervention can take the form of electronic media, print media, hotline, clearinghouse, and presentations/lectures.
<i>Outreach*</i>	An educational intervention conducted by peer or paraprofessional educators face-to-face with high risk individuals in the client's neighborhoods or other areas where clients typically congregate. Outreach interventions in Delaware include material distribution, promotional contact, rapport building contact, standard contact, and in-depth contact.
<i>Prevention Case Management*</i>	A one-on-one session with a prevention case manager and client, where the case manager acts as a service broker for HIV prevention services and the client is dealing with multiple problems and risk reduction needs. The service is ongoing and interacts with other programs, works with the client for on-going appraisals of the individual behavior change plans.

Primary prevention

Prevention of transmission of HIV to a non-infected person.

Public Information

Media or other publicity programs delivering HIV information to the general public.

Secondary prevention

Prevention of advancement of HIV disease in a person living with HIV.

Technical assistance (TA)

The delivery of expert programmatic, scientific, and technical support to organizations and communities in the design, implementation, and evaluation of HIV prevention interventions and programs.

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