Implementing Effective Prevention Interventions For People Living With HIV:

Strategies, Guidelines, & Practical Tools

PREVENTION WITH POSITIVES

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CALIFORNIA
STD/HIV PREVENTION
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PURPOSE OF THIS DOCUMENT AND ACKNOWLEDGMENTS

Purpose of this Document

The purpose of this document is to provide a menu of approaches and strategies for local programs to choose from that they believe will be most successful in preventing further transmission of HIV when working with HIV-positive people. These approaches and strategies can be applied among a variety of program types and program settings including:

- prevention and treatment settings,
- public and private programs,
- HIV-focused and STD-focused programs, and,
- any combination of the above.

Due to the unique make-up of agencies and programs, certain approaches may be more effective for some than for others. This document was written based on the philosophy that ultimately each program can best determine the most appropriate and effective strategy or strategies to adopt to meet the distinct circumstances of their target population and their agency.

Acknowledgements

This body of work has been inspired by the many people and communities who have for too long carried the burden of HIV/AIDS, and who have, in spite of stigma and stereotypes, consistently and courageously done everything in their power to prevent the spread of this epidemic.

This document, funded in part by the California Department of Health Services - Office of AIDS, is a product of collective effort. Specifically we would like to acknowledge and thank Gail Bolan, M.D., Alice Gandelman, MPH, AJ King, MPH, and Tim Vincent, MFT, of the California STD/HIV Prevention Training Center.

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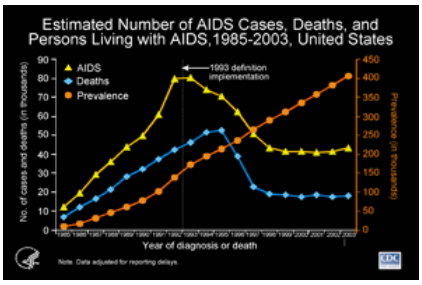
Background



Twenty-five years after the first reported case of what would later become known as *AIDS*, the HIV/AIDS epidemic has taken an enormous toll. In the United States it is estimated that 500,000 people have died from the disease, with over 1,000,000 people currently living with HIV. Worldwide, those numbers are even more staggering, with over 33 million people currently living with HIV, and more than 25 million lives claimed as a result of AIDS.

We are all too familiar with the data, including the disparities that exist among and between affected communities. While prevention efforts have been effective in slowing the epidemic by reducing seroconversion rates in many populations, many other populations are disproportionately impacted by new infections and the overall burden of HIV/AIDS.

Over the past decade, medical advances have resulted in a reduction in annual AIDS cases and deaths, and an overall increase in the number of people living with HIV. While this is encouraging, it also brings about a few challenges related to prevention.

In purely mathematical terms, more people *living with HIV* means that there are more people *able to transmit* HIV to others. Additionally, because many people are living longer and healthier lives, post-diagnosis, than they did earlier on in the epidemic, some may conclude that HIV is not as serious of a disease as it once was.

Without the same perceived level of threat, evidence suggests that some people - both HIV positive and HIV negative - are resuming or in some cases beginning to engage in higher-risk behaviors.

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Challenges to Prevention

"Speaking as a person with HIV, I am a little tired of the prevention message, I feel I have been hearing the same thing over and over, when I feel that drug use primarily speed is the issue." [1]

"We have introduced the term 'syndemic' (Singer M, 1994) to refer to the set of synergistic or intertwined and mutual [sic] *enhancing health and social problems facing the urban poor. Violence, substance abuse, and AIDS, in this sense, are not concurrent in that they are not completely separable phenomena. Rather, they emerge in the lives of participants in our study as closely intertwined threads in the often tattered fabric of their daily lives"* (From Singer M, Romero-Daza N, 1997).

As we learn more about HIV, other factors that accelerate transmission and acquisition are being identified, such as co-infection with many sexually transmitted diseases (STDs). In fact, persons who are co-infected with HIV and STDs are 5 to 20 times more likely to transmit HIV to another person, and those with a pre-existing STD are that much more likely to acquire HIV during sexual activity. (See Section IV for more information).

Regardless of HIV status, many people who have endured this epidemic over the years, especially those from communities hardest hit by HIV, have quite simply grown tired of prevention messages, no matter how they are packaged.

Unfortunately, even when prevention is prioritized and people have the best of intentions to reduce risk of transmission, other life issues may take precedence. For example, many people living with HIV also suffer from mental health problems, substance use issues, violence, and/or homelessness.

The term "syndemic" has been used to describe what happens when two or more epidemics co-exist and synergistically wreak havoc among people and populations. Understandably, the struggle against HIV becomes even more complex given this context.

[1] The CA PTC is conducting a needs assessment of HIV prevention and care providers in California to determine the challenges encountered in supporting risk-reduction efforts of their clients/patients living with HIV. Unless otherwise indicated, all quotes in this document are from this needs assessment.

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Shifting the Paradigm

Because the relationship between HIV disease, prevention and treatment is dynamic and ever-changing, it is essential to remain vigilant, flexible and innovative in our prevention efforts.

The shift in prevention strategies from focusing primarily on HIV-negative persons to emphasizing prevention with HIV-positive persons is one such innovation.

"As a positive man, I want to do all I can to prevent HIV transmission -- most of my poz friends feel the same."

While the term *Prevention with Positives* is a relatively new one for many in the field of HIV Prevention, both the concept and the practice have been around since the beginning of the epidemic. In fact the vast majority of people living with HIV, as a group, have always taken precaution and care to not transmit the virus utilizing whatever information was available to them at the time. And they did so - and do so - even in the face of stigma, discrimination and blame.

It is well documented that for the most part, people living with HIV are very concerned about preventing transmission to others. Of course for some, prevention may not be a priority, for reasons ranging from apathy to abstinence.

What is *Prevention with Positives*?

In programmatic terms *Prevention with Positives* can be defined as any activity, intervention or strategy designed for HIV-positive persons that ultimately aims to decrease the risk of HIV transmission.

While *Prevention with Positives* represents a logical shift to many and holds great promise as a prevention strategy, it is not without its challenges.

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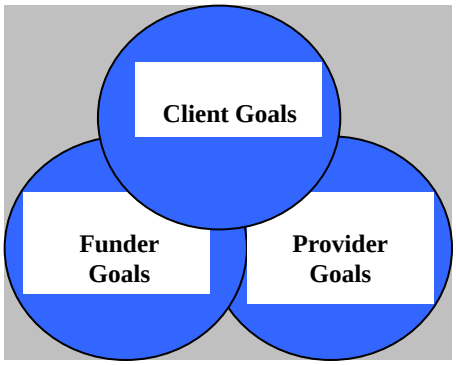

Perhaps the greatest challenge when operationalizing PwP in its myriad forms is *encouraging* the prevention efforts of those living with HIV while not further *stigmatizing* or *blaming* them for the spread of the very disease they are burdened with. Perhaps contrary to some beliefs, prevention of HIV is not the sole responsibility of those infected by it. Just as there are many factors that facilitate the HIV epidemic, there are many factors also that will cause the epidemic to retreat.

Another challenge related to *Prevention with Positives* is that of competing goals. Few would argue that those engaged in the practice of *Prevention with Positives* are all working towards the same ultimate goal: to prevent the spread of HIV and to improve the quality of life for people living with HIV. Depending on one's perspective, however, *how* one goes about achieving that goal may differ.

For example, from a funder's perspective, ensuring that organizations have the resources and capacity to deliver effective and cost efficient prevention and care services may be a top priority. Thus, funders may be very concerned with numbers: how many clients did X agency serve? How much did it cost to deliver those services? What is the cost/benefit ratio?, etc.

For a client living with HIV, perhaps their top priority at a given moment is to decide whether or not to disclose their status to a new sexual partner, considering issues of abandonment, stigmatization and pity.

Providers, on the other hand may be very interested in encouraging a client to change his or her behavior to ultimately engage in less risky behaviors and/or more health promoting behaviors. Of course, the goals of providers will

likely vary, depending on their particular disciplines and perspectives.

While the goals of funders, clients and providers are not always at odds, at times it can be quite challenging to balance the needs of all parties. Clearly providers should strive to prioritize the clients' goals. However, delivering services in a "client-centered" manner, a philosophy often promoted, is a practice that is not always easy to implement, especially when a client's goals are seemingly unrelated to a provider's goals or the goals of a funder.

An Opportunity for Integration & Collaboration

By its very nature, a focus on *Prevention with Positives* presents a rare opportunity to merge efforts across fields (HIV and STD) and perspectives (prevention and care) that have for too long been separated by philosophical differences.

HIV and STD

Although HIV programs originated out of STD and communicable disease programs, today many STD and HIV programs are not integrated, with staff having little opportunity to network and coordinate related activities.

Integrated efforts are evident in the collaboration of epidemiology and surveillance activities which serve to better understand the characteristics of newly infected persons, and where transmission is occurring. These collaborations are critical for laying the foundation of STD/HIV comprehensive services for prevention and care programs.

In addition to gaining a better understanding of the epidemiologic and biologic mechanisms that drive transmission, the integration of HIV and STD provides other opportunities for programs to

learn from each other. Several new strategies have emerged in the HIV field over the last two decades, particularly in the area of behavioral interventions and primary prevention activities that could be of benefit to STD programs. Due to limited funding opportunities, many of these strategies have not been available for STD programs. Integration of services provides an opportunity to identify which behavioral interventions are most applicable in STD program settings.

Similarly, services provided by Disease Intervention Specialists (DIS) have been the cornerstone of STD programs, with partner service activities used as a major vehicle to stop the spread of infection. This is carried out by identifying sexual partners of infected clients and providing testing and treatment to prevent further transmission in a community or jurisdiction.

As partner services were developed to extend into the HIV arena, it became clear that a different approach was needed, which included providing additional disclosure options, as well as a more comprehensive range of clinical and support services for HIV positive clients and their exposed partners. (See Section 5 for more information).

Suggested recommendations to further the collaboration between HIV and STD programs include:

a) improve working relationships between STD and HIV providers and dialogue regarding:
   - philosophical differences, program biases, and approaches
   - goals and differences in outcomes for HIV vs. STD PCRS

- multidisciplinary meetings with program, training, epidemiology, and other updates provided as needed
- development of strategic plan
- opportunities for cross-training
- other issues pertinent to local jurisdiction

b) integrate planning efforts through STD representation in:
- Local Implementation Groups (LIGs)
- care consortia
- multidisciplinary meetings
- other planning efforts

Prevention and Care

HIV prevention and care programs have historically been coordinated through separate funding and administrative mechanisms. While some coordination has occurred with programs integrated in some local jurisdictions, there has been no formal coordinated effort to bridge programs to provide seamless services for HIV-positive clients.

Many HIV prevention and care issues intersect, including PCRS, counseling, testing, early intervention programs, outreach programs that provide access into care, and behavioral interventions in medical settings (e.g., risk reduction, disclosure, etc.). Moreover, the onset of rapid testing will increase the need for prevention and care services to become even more effectively integrated.

Integration of prevention and care through various programs can assist prevention programs in referring HIV-positive clients into care, and likewise, could offer medical providers the resources and expertise to support behavior change efforts among persons receiving care and

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"…HIV is only one issue in many people's lives; their complicated lives include issues around race, class, sexual orientation, relationships, mental health, gender expression, etc…"

treatment services. Service integration could result in greater awareness of available services through increased communication and problem solving between care and prevention providers to link clients into services. Such integration also allows for greater availability of services for partners of HIV-positive people (PCRS, disclosure, risk reduction, couples counseling, etc.).

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As prevention work for people living with HIV is evolving, ideas about what that means and how clients can be helped to reach their prevention goals are also evolving. This section contains some suggestions for considerations prior to implementation of *Prevention with Positives* programs or interventions.

Characteristics of Reputationally Strong Programs

According to the Centers for Disease Control and Prevention[2], reputationally strong programs share these characteristics:

- Clearly defined target audiences, goals, and interventions
- Program flexibility at the administrative level
- Sufficient program resources and internal agency support
- Intervention components based in behavioral/social science theory
- Comprehensive, multi-modal strategies for delivering prevention messages
- Audience-centered approaches that are relevant, appropriate, and culturally competent
- Program staff who are committed to their work and who treat all clients with respect

Typically, programs viewed as reputationally strong have many common characteristics associated with organizational mission, leadership, and program delivery. Program managers may want to consider these characteristics when engaging in strategic planning and/or enhancing existing programs. Researchers may want to focus future studies on how these characteristics shape interventions.

[2] February 25, 2000, CDC National Center for HIV, STD, and TB Prevention Division of HIV/AIDS Prevention

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Plan and Deliver Services from an Asset-Based, Holistic Perspective

"(My) primary responsibility to the client is to help them live to their fullest…"

As many know, living with HIV is fraught with challenges. Even for those who have relative stability in their lives, dealing with HIV-related stigma and health concerns can tax their overall quality of life. Others, who may experience any number of co-occurring disorders, may find themselves constantly responding to stressors, meeting with multiple providers, and having to prioritize and reprioritize their concerns.

Even when working with the most skilled providers, clients can grow tired of focusing on their problems, answering seemingly endless questions and having their "needs" assessed. Because services are often splintered, clients may also grow tired of being seen through the lens of a singular identity (a person living with HIV, a drug addict, a homeless person, etc.). In this context, their strengths and resiliencies are unfortunately often overlooked.

When agencies deliver their services from a holistic, asset-based perspective, they are more likely to see their clients as whole beings, with strengths as well as needs, and resiliencies as well as problems.

From this perspective, client attributes can be cultivated and utilized as a means to respond to the impact of HIV-related stigma and associated challenges. (See Section 7 for sample questions to assess a client's strengths and resiliencies).

Consider *Cultural Competence* as it Relates to People Living with HIV

While cultural competency in HIV prevention usually refers to viewing the large axis of identification which includes categories such as race, ethnicity, gender, and sexual orientation; it might also be helpful to include HIV-positive status as a measure of cultural experience to build provider competence. In this context, living with

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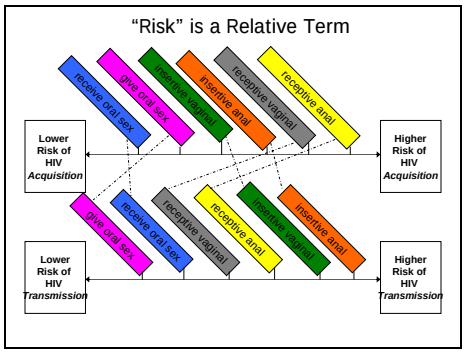
HIV can be thought of as a cultural experience that can impact risk behavior as well as health-seeking behavior.

Although far from homogenous, people who are HIV-positive share certain experiences that can inform beliefs, values, customs, and behaviors. Specifically, common concerns of people living with HIV may include responding to HIV-related stigma, disclosure issues, risk-redefinition (thinking about risk from a transmission versus acquisition perspective), as well as care and treatment issues.

If, in the program planning stage, *before* meeting with clients, agency personnel think through these areas as they pertain to people living with HIV, it may help to improve cultural competency and overall service delivery.



As one example, when applying HIV prevention to people living with HIV, risk-related issues are often not adequately addressed. Typically, approaches used in programs aimed at negative persons are only slightly revised to focus on preventing transmission, rather than acquisition. For example, the illustration of risky behaviors on a typical HIV continuum of risk is usually based on the perspective of HIV negative persons. In reality, levels of risk for various behaviors along the continuum vary considerably if the individual is HIV positive versus HIV negative.

Identifying behaviors that are "more risky" or "less risky" becomes even more complicated when considering other factors such as co-infection with other STDs, HIV-status of partner, sex of partner, viral load calculations, etc.

In this context, when defining HIV positive status as a cultural identity, delivering culturally competent programs means that providers

recognize, understand, and appreciate the range of experiences of their HIV positive clients, particularly as their experiences relate to how they negotiate prevention issues.

Of course, cultural competency also involves a recognition of the *differences* among people living with HIV (as well as the differences between clients and providers). In addition to considering the shared experiences of people living with HIV, it is equally important to consider the diversity of experiences that exist as a result of various cultural identities, and more specifically the ways in which various cultural identities contribute to the choices one *has* and one *makes* regarding prevention issues. Issues pertaining to culture must be acknowledged to ensure optimal selection, design, implementation and effectiveness of interventions and programs.

Know Your Target Population

Due to the urgency of the epidemic, many HIV/STD prevention programs rush to implement an intervention that sounds good, or is allowed (and in some cases is required) by their funders. These interventions may work well for some persons living with HIV, but not as well for others. For a number of reasons, agencies often *do not* or *can not* thoroughly assess their target population prior to choosing an intervention.

To ensure successful implementation it is imperative to have an understanding of the community characteristics of the target populations, the risk behaviors, and the factors affecting those behaviors. This helps agencies better select interventions and strategies that best meet the needs of their clients. Even after selecting an intervention, modifications or adaptations may have to be made to better meet the cultural characteristics of a community.

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Before any intervention is selected or adapted, prevention providers are encouraged to assess the needs of their priority populations and communities to determine what factors are influencing high-risk behaviors for HIV transmission.

Additionally, and equally importantly, providers should consider and inquire about common areas of concern shared by many people living with HIV. Specifically, providers should assess concerns that the target population may have related to disclosure, HIV transmission risk (as well as STD acquisition risk), treatment and care, experiencing and responding to stigma, etc.

Questions that a thorough assessment should strive to answer, include:

a) Who is our *specifically defined* target population?
b) What are the behaviors that place the target population at risk for transmission of HIV?
c) What factors and/or behavioral determinants influence these behaviors?
d) Which 1-2 factors can we/ should we prioritize and address?
e) What data are available to support the above information (e.g., formative assessments, individual interviews, surveys, etc.)?
f) What other concerns, related to or in addition to HIV transmission are prioritized by this community?
g) What specific concerns/challenges do they have regarding:
    - disclosure
    - stigma
    - treatment and care
    - risk redefinition

LAYING THE GROUNDWORK FOR EFFECTIVE PROGRAMS AND INTERVENTIONS

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Most everyone understands the need for community assessments. If done competently, assessments help define the problem or problems and also serve to develop effective solutions. Unfortunately, for a variety of reasons, the vision of better services that we begin our assessments with is often not realized. For this reason, assessments should be designed to be empowering experiences in and of themselves. One way to do this is by conducting participatory research, a type of formative research which involves the people assessed in the assessment process as much as possible. This helps in sharing ownership of the information, and building local capacity.

Another way to make assessment an empowering experience is to assess for and emphasize community and individual strengths and resiliencies. Below are some questions that may be helpful to include towards this end:

a) What strengths do you rely on when faced with the difficulties of living with HIV?
b) What are you most proud of since you found out you have HIV?
c) How do you cope with judgment or rejection?
d) Who supports you when you experience struggles related to living with HIV?
e) How have you resisted stigma and discrimination?
f) When times are tough, from where or whom do you get inspiration to keep going?
g) What sources of strength do you draw from the community or communities that you identify with or belong to?

LAYING THE GROUNDWORK FOR EFFECTIVE PROGRAMS AND INTERVENTIONS

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Know Your Agency

Perhaps equally important to knowing your target population is knowing your agency. Although often overlooked, an assessment of agency capacity as it relates to successful selection, adaptation and implementation of interventions and strategies is essential. *Knowing your agency* includes an assessment of necessary skills for various levels of interventions as well as intervention-specific skills, agency resources, and quality assurance protocols. The following questions should be asked to assess agency or organizational capacity:

a) What specific skills do agency staff need to carry out the chosen intervention/ strategy?
   - intervention-*level*-specific (i.e., skills needed to conduct individual-, group-, or community-level interventions)
   - intervention-specific skills (e.g., intervention content, adherence to protocols, quality assurance guidelines, implementation of all sessions, etc.)
   - staffing requirements (e.g., licensed mental health professional, peer volunteer with community experience, etc.)

b) Do agency staff have appropriate skills for implementation and/or adaptation?

c) If not, how will they be acquired (via training, hiring of appropriate staff, etc.)?

d) Does agency have sufficient resources to effectively implement intervention/ strategy?

e) What is the agency's history and/or capacity in working with the specified target population or community?

LAYING THE GROUNDWORK FOR EFFECTIVE PROGRAMS AND INTERVENTIONS

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Train Providers as Necessary

Training and technical assistance needs and the realities of different program settings must be considered before decisions are made to implement specific interventions or services. As part of a comprehensive approach to preventing transmission in persons living with HIV, activities that increase provider awareness of contextual issues that impact HIV positive clients' prevention efforts; the importance of behavioral counseling strategies; STD/HIV interaction issues; and the role of biomedical approaches in HIV prevention are critical. The following are some suggestions for provider trainings:

a) co-occurring disorders, multicultural concerns, responding to stigma, and dealing with disclosure issues

b) medical provider training on brief behavioral counseling approaches to support patients in reducing HIV/STD transmission to uninfected persons, such as:
   - client-centered counseling
   - behavioral cognitive approaches
   - motivational interviewing
   - stage-based counseling
   - risk reduction/harm reduction counseling

c) STD/HIV interaction issues, including increased likelihood of HIV transmission if STDs are present, due to:
   - increased susceptibility
   - increased transmissibility

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Strive for Inclusion of HIV-Positive People at all Levels

Programs, services, or interventions that include active participation from affected persons and communities are likely to be more effective than those that do not. Agencies should work closely with persons living with HIV in their respective communities to determine the best strategies and approaches for reducing HIV acquisition and transmission.

As much as possible, agencies should also actively recruit qualified people who are living with HIV to serve as Board Members, volunteers, and staff. People living with HIV should be involved in every aspect of program design including planning, implementation and evaluation.

Furthermore, people living with HIV should be included in a manner which is respectful of their skills and experiences and is not "tokenizing" of them.

There are several strategies to facilitate inclusion, such as conducting focus groups to inform program development, pre-testing materials and pilot-testing intervention activities. The formation of Community Advisory Boards (CABs) made up of members of the target population and/or key stakeholders can also assist with quality assurance and can see a program through from beginning to end. Finally, informal, ongoing communication with community members and organizations should not be underestimated as a means to include the voices of people living with HIV.

BEHAVIORAL INTERVENTIONS

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Behavioral interventions aim to reduce high-risk behaviors for STD/HIV by identifying and addressing behavioral determinants, or key influencing factors. Behavioral determinants can be cognitive, psychological, or social in nature and are usually inter-related. Influencing factors can include, but are not limited to: personal perception of risk; knowledge of HIV/STD transmission; self efficacy and skills to enact specific risk-reducing behaviors; power dynamics within relationships; sexual communication and negotiation; and group and community norms that influence behaviors. Many different interventions can be implemented to address the above factors.

Levels of Behavioral Interventions

Most behavioral interventions are divided into three categories: individual-level, group-level, and community-level. These interventions are described below. *Structural-level* is a fourth category of interventions. Because these interventions are not often considered *behavioral* interventions, they are described in a separate section below.

Individual-Level Interventions (ILIs): ILIs are activities conducted between a provider and a client for one or more sessions to support risk reduction behaviors. Individual-level interventions are best used to increase self efficacy, teach specific skills, coach client around sexual communication or negotiation, identify barriers to behavior change, or identify specific activities that a client can adopt to reduce risk.

Effectiveness of interventions increases as the duration and number of sessions between the provider and client increases. Individual level interventions may include:

a) conducting client-centered counseling or motivational interviewing to assess client risk and develop realistic steps *with* patient/client to reduce those risks by determining:
   - personal perception of risk
   - context within which risk behaviors occur
   - barriers to reducing risk
   - level of readiness for changing risk behaviors
   - realistic risk reduction steps patient/client can accomplish

b) implementing Comprehensive Risk Counseling Services (CRCS) for clients with co-occurring disorders or multiple barriers to risk reduction (e.g., homelessness, substance use, addiction, domestic violence, mental illness, etc.). CRCS is typically characterized by:
   - multiple sessions
   - comprehensive use of referrals
   - goals and objectives related to behavior change

c) providing counseling to support client disclosure of HIV status (see also under Section 6) to current and potential sexual or needle-sharing partners, if appropriate, for use in prevention/care settings such as:
   - STD/HIV counseling and testing sites
   - Early Intervention Programs (EIPs)
   - Nursing Case Management Programs (CMP, MCWP)
   - HIV clinical settings
   - CRCS programs
   - STD clinical settings

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Group-Level Interventions (GLIs): GLIs are activities conducted between a provider and more than one client which are skills-based, at least in part. Depending on the goal of the intervention, smaller groups (of 10 or fewer) may be more effective in increasing self efficacy, skills, or social support for risk reduction behaviors. Interventions conducted in larger group settings (such as classrooms) may be effective in influencing peer pressure or changing personal perceptions of risk. Group-level interventions can be conducted by peers (those who share common characteristics of clients), or non-peers; by formally trained professionals as well as para-professionals. As with individual-level interventions, group interventions that consist of multiple sessions have a greater likelihood of being successful. Conducting multi-session group-level interventions may include:

a) implementing peer-led groups that utilize trained persons who share similar past experiences with members, and with whom participants can identify, and may be characteristics on identities such as:
   - substance use
   - living with HIV
   - trading sex for money or drugs
   - runaway youth
   - being incarcerated

b) implementing groups that utilize persons with extensive skills and abilities who can empathize with members, and create a supportive environment which is conducive to acquiring skills necessary for behavior change.

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Community-Level Interventions (CLIs): CLIs are programs or services that are directed at a specific priority population or community and aim to bring about changes by addressing group norms. They are usually conducted over a period of several months or years, and typically address norms regarding knowledge, attitudes, beliefs, or behaviors of a particular community group.

For example, assessments conducted prior to implementation might reveal a low perception of risk for HIV or lack of skills to reduce risky behaviors. One intervention component might be to increase personal perception of risk and risk reducing techniques through a community outreach program. Subsequent evaluation activities would measure perception of risk and determine whether any increases in skills had been achieved as a result of the intervention in that same community compared to skill levels prior to implementation. Community level interventions may be more effective than ILIs or GLIs, in that they can reach more people, however, they can also be more costly. Community-level interventions may include:

a) community outreach activities, using role model stories, such as:
   - AIDS Community Demonstration Projects (Community PROMISE*)

b) empowerment approaches
   - Popular Opinion Leader (POL*)
   - Mpowerment* (also uses community-building strategies)

c) social marketing and media advocacy (more successful in changing *knowledge, attitudes, beliefs; less effective in changing behaviors.)*

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- specific print, electronic or communication media geared for specific communities, such as young adult, Latino, or MSM, to deliver specialized message for an audience.

**See the following web site for additional information on these and other evidence-based interventions: www.effectiveinterventions.org*

Evidence-Based Interventions

Since HIV infection emerged in the United States more than 25 years ago, strategies to reduce acquisition and transmission based on evidence-based approaches have become increasingly more effective. There is growing agreement that HIV prevention interventions that are based on sound methodological designs and found to be effective are preferable to those lacking evidence of effectiveness.

Most of the Evidence-Based Interventions (EBIs) now recommended by the CDC and available in the Compendium of Effective Interventions via the *Diffusion of Effective Behavioral Interventions* (DEBI) program, applied rigorous methodological approaches, strong study designs, and strict adherence to critical components, now referred to as *core elements*, which were thought to be responsible for the interventions' effectiveness.

The ability to translate effective research into practice settings via implementation of EBIs is a critical component of agency capacity. Providers in these settings must understand the necessary steps required for successful implementation of an EBI in their practice setting, including its complexity and those elements that can and cannot be changed.

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Specifically, an EBI or promising intervention being considered by an agency should be carefully reviewed to ensure that it is the best fit for their agency as well as for the community receiving services. The following questions should be asked to better assess intervention selection and or adaptation:

a) What level of intervention (ILI, GLI, CLI) is most appropriate for the target community?

b) How does this EBI meet the needs of the target community, including high-risk behaviors and factors influencing those behaviors?

c) What are the theories underlying this EBI?

d) What behavioral determinants does the EBI address?

e) What knowledge or skills will be achieved after the intervention is completed? (Note: should coincide with factors influencing risk behaviors)

f) What are the intervention's:
   - core elements (if DEBI), activities (including duration, frequency, number of sessions, etc.), other pertinent information

g) Can core elements and required activities be implemented and adhered to according to protocols?

h) What changes were (or must be) made to better match community factors?

(See Section 7 for more information).

BEHAVIORAL INTERVENTIONS

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Integrating Behavioral Interventions into STD/HIV Clinical Settings

Brief behavioral interventions that support HIV/STD risk assessment and risk reduction strategies have tremendous potential in clinical settings. Given that clinical services are often delivered in settings where time is extremely limited, efforts should be made to deliver interventions as efficiently as possible. Although physician-delivered messages to patients are powerful motivators for risk reduction, research has also shown that adequately trained non-medical staff can be equally effective in increasing patient perception of risk, developing strategies with patient to reduce risk, decreasing high-risk behaviors, and reducing disease. (*See the following website for more information: http://www.cdc.gov/hiv/projects/respect-2/counseling.htm)*

In fact, some programs have found that staff who are part of a multidisciplinary team and are specially trained to work in clinical settings may be able to spend more time with patients, providing enhanced counseling and/or referral services. Each program should determine which option is most appropriate. Clinical settings which lack the availability of other specialized staff for these purposes may find that brief prevention messages followed by a good referral system is most realistic. Alternatively, settings that can make use of health education and/or psychosocial services may be able to offer more comprehensive behavioral intervention programs.

The following examples include both clinician and non-clinician delivered individual-level interventions:

BEHAVIORAL INTERVENTIONS

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"With HIV+ clients, I feel more of a responsibility to talk about personal risk issues in order to reduce the spread of HIV… including sexual behavior, drug use, mental health issues, etc. I feel more passionate working with HIV+ clients…"

a) ILIs implemented by medical providers (e.g., MD, NP, PA) in clinical settings, using brief motivational, or client-centered counseling techniques to support patient efforts to:
   - reduce number of sexual/needle-sharing partners
   - disclose HIV status to sexual partners if appropriate
   - increase safer sex behaviors
   - increase awareness of STD/HIV interaction and need for STD screening

b) ILIs implemented by non-medical providers (e.g., counselor, case manager, social worker, health educator, medical assistant) in clinical settings to support the above outcomes, with consideration of the following factors:
   - may be preferable for enhanced, specialized counseling
   - may allow for longer sessions
   - due to infrastructure and clinic flow issues, follow-up sessions with non-medical staff may be more realistic

Case Example: ***Comprehensive Risk Counseling Services (CRCS) for Person's Living with HIV Using an Evidence-Based Approach***

- SETTING: HIV Care Clinic

- PROGRAM OBJECTIVES: Conduct enhanced STD/HIV counseling for clients living with HIV who have competing life priorities and significant barriers to reducing risky activities.

- BRIEF DESCRIPTION: Recent client survey data from HIV care clinics indicated that previous prevention case management services did little with regards to counseling clients living with HIV around their risk taking behaviors. Wanting to implement an evidence-based intervention, the clinic coordinator decided to implement CRCS and utilize the 4-sessoion RESPECT counseling model for persons living with HIV who continued to have barriers to reducing their risk. Clients who were enrolled in CRCS were counseled to increase their personal perception of risk by exploring the circumstance and context in which risk behaviors occurred, barriers to reducing risk, and level of readiness for changing risk behaviors. An achievable risk reduction step was negotiated to support them realistically achieving their goal.

- PROGRAM EVALUATION STRATEGIES (How You Can Tell if This Works):
  - Determine if Clients Have More Accurate Perception of Personal Risk (if applicable): Do clients have a more accurate perception of their personal risk for STD/HIV after attending sessions, compared to before participation?*
  - Determine if Clients Can Identify Barriers/Facilitators to Risk Reduction: Are participants better able to identify specific circumstances that make risk reducing behaviors more challenging, as well as those situations where they are better able to practice safer practices?
  - Determine if Clients are Able to Identify Specific Context of Client Risk: Is client's risky behavior a pattern or an infrequent behavior? Asking the client to describe what occurs, when and where behaviors occur, and whether behavior is frequent or occasional will better guide him/her in identifying the context of the specific risk.
  - Determine if Clients are Better Able to Develop Realistic Goals and Feasible Steps to Achieve Them: Based on information gathered from the above step and the client's level of readiness to adopt a risk reduction behavior, is a realistic behavior change goal identified with action steps to help attain that goal?
  - Long-term Behavioral and/or Biological Outcomes: Over time, did these sessions result in improved behavioral outcomes (e.g., fewer unprotected sexual encounters, increased use of condoms, less exchange of blood, semen, or vaginal secretions, etc.), and/or biologic outcomes (decreased incidence of new STD or transmission of new HIV infections)?

See also www.effectiveinterventions.org for more information on RESPECT

*Requires a baseline measure (see Section 7 for more information)

Case Example: ***Peer-Led Group-Level Intervention for Injection Drug Users (IDUs)***

- SETTING: Drop-In Center for IDUs

- PROGRAM GOALS OR OBJECTIVES: Convene a peer-led, 6-session weekly support and skills-building group for IDUs to increase self efficacy and skills to negotiate safer sexual and needle-sharing practices, and identify power dynamics that influence risk behaviors in partner relationships

- BRIEF DESCRIPTION: The coordinator of a local needle-exchange program was encouraged by the number of IDUs who frequented her drop-in center and exchanged their used needles for clean injection equipment. The coordinator was well known within this community and noticed that many clients hung around the center during the day while waiting for local shelters to open for the evening. During conversations with them, she became aware that many were engaging in high-risk behaviors despite having clean injection equipment. Some clients always used clean injection equipment, but didn't reduce risky sexual behaviors. The coordinator recruited a volunteer to co-facilitate a 4-session group to discuss these issues and provide skills and support to reduce risky injection and sexual practices. One session was devoted entirely to talking to partners about condom use, with participants pairing up as each other's partners and coaching each other on how to negotiate safer sex practices. Participants were paid a small stipend for attending each session and also received a food voucher from a nearby grocery.

- PROGRAM EVALUATION STRATEGIES (How You Can Tell if This Works):

  Count total number of participants and total number of sessions attended by each participant.

  Did clients who attended group sessions:
  - Gain personal awareness of their sexual risk for STDs?
  - Gain knowledge about how STD infection could facilitate HIV transmission more effectively to others?
  - Gain awareness of HIV/STD interaction issues?
  - Increase their self efficacy around negotiating condom use with partners?*.

  Was there a difference in client outcomes based on the number of sessions attended?

*Requires baseline measure (see Section 7 for more information)

Note: See also www.effectiveinterventions.com (HHRC, Safety Counts)

Case Example: ***Social Marketing Campaign to Increase Awareness of STD/HIV Interaction***

- SETTING: Local Health Department

- PROGRAM GOALS: Increase awareness of the role of STDs in facilitating acquisition and transmission of HIV; increase testing for syphilis and other STDs

- BRIEF DESCRIPTION: STD and HIV program staff in a local health department noticed increases in syphilis in their county at rates 2-3 times higher than those reported in the past 5 years. Unlike previous years, incidence was primarily occurring in gay/MSM communities. Of most concern for STD/HIV program staff was that over 75% of new cases were among HIV+ men, many of whom had numerous and/or anonymous partners. Neither positive nor negative clients in the community were aware of the increased likelihood of transmitting/acquiring HIV if they had an STD. Both STD and HIV programs decided to work together to increase community awareness of these issues and pooled some of their program resources to develop a social marketing campaign. HIV-positive persons helped develop a poster that would effectively reach gay-identified communities and provided recommendations to health department staff for a second poster, targeted for non-gay-identified MSM, of negative or unknown HIV status.

  Activities for this project included recruitment of community members, and the design, printing, and distribution of posters. Posters included information about the increased likelihood of transmitting HIV if co-infected with an STD such as syphilis, basic prevention messages, and locations where free STD testing was available, with local phone numbers. Viewers were told to mention the poster when calling for an appointment to receive free testing and condoms. Receptionists were trained to ask callers if they had seen the posters to help determine the effectiveness of the poster campaign.

- PROGRAM EVALUATION STRATEGIES (How You Can Tell if This Works):

  - Monitor Awareness: During a designated time period (e.g., 1-3 months after posters are distributed), outreach workers in designated areas can ask clients if they have noticed the posters, and gauge reactions (short 3-5 question qualitative survey can be developed to gather consistent data and compare by street venue).
  - Evaluate Effectiveness of Poster: Community members for whom the poster was designed can be asked what specific area, if any (free tests, free condoms, new information), motivated them to seek testing or to call for more information.
  - Monitor Impact on Testing: Clinic sites offering STD testing can measure the number of persons from the community who sought testing before and after the posters were distributed to determine what increases, if any, have resulted.*

*Requires baseline measure (see Section 7 for more information)

Case Example: ***Brief Behavioral Interventions by Clinicians for Patients Receiving Medical Services***

- SETTING: HIV Medical Care Clinic

- PROGRAM GOALS OR OBJECTIVES: Conduct brief interventions with HIV+ patients receiving medical care to identify behaviors that increase risk of STD/HIV acquisition or transmission and support patient in adopting risk reducing behaviors.

- BRIEF DESCRIPTION: During a review of medical records, an HIV treatment clinic realized that only 20% of records contained information regarding patient sexual histories or risk assessments. Less than 10% had any information pertaining to risk reduction measures, such as patient sexual behaviors, safer sex practices, or disclosure of status to sexual partners. The clinic administrator decided to conduct a brief survey to assess how important these issues were for patients receiving services in the clinic. For a two-month period, a brief 5-question anonymous survey was distributed to patients as they registered with the receptionist. In addition to optional demographic questions (age, race, ethnicity, sexuality, gender, etc.), patients were asked 1) whether their providers had ever talked to them about HIV prevention issues such as safer sexual practices, numbers of partners, or strategies to reduce STD/HIV acquisition or transmission, 2) whether they had ever experienced challenges in disclosing their HIV status to potential or current sexual partners, 3) if they knew that acquiring an STD made it more likely for them to transmit HIV to a sexual partner, 4) if they would like assistance in developing strategies to reduce current risks, and 5) how they would feel about their providers talking to them about these issues.

  Over 200 surveys were collected from patients, 50% of whom indicated they had experienced challenges around partner safer sex and disclosure issues. More surprising, nearly 75% of respondents stated they would like assistance from providers on how to deal with these issues.

  The medical providers, many of whom were initially not comfortable discussing these issues with their patients, agreed that this provided a critical opportunity because of their established on-going relationships with their patients. The clinic manager arranged for a brief, clinician-focused training to deal with the specific areas of sexual history taking and risk reduction strategies, including safer sex practices and disclosure, to better support their patients.

➢ PROGRAM EVALUATION STRATEGIES (How You Can Tell if This Works):

- Evaluate Training: After completion of training, should evaluate the extent to which medical providers believed they had increased their ability to incorporate skills learned in training into their practice.

- Review Medical Records 1-3 Months Following Training: Compare number of notes in medical records to determine if there are increased entries documenting discussion of risk assessment and risk reduction issues (sexual practices, safer sex activities, disclosure issues, etc.), before, during, and after completion of training*.

- Evaluate Self-Reported Behaviors Among Patients: Review patient records if
  clinicians have appropriate location for entries, or through follow-up anonymous surveys with patients again, to identify extent to which these issues are being discussed between providers/patients, and whether patients have increased safer sexual practices, or discussed serostatus disclosure with current or potential sexual partners.

*Requires baseline data (see Section 7 for more information)

POLICY RECOMMENDATIONS AND STRUCTURAL LEVEL INTERVENTIONS

4

"In my experience, the HIV+ clients have a greater understanding of HIV transmission and acquisition. This tends to lend to more hands-on involvement with their care, protecting themselves and others from other STDs and a sense of activism for HIV/AIDS related concerns."

Although structural-level interventions may not be as common as other levels of intervention, they can be extremely effective in preventing HIV. Structural-level interventions can be defined as any intervention that strives to change the physical, social, or legal environment in such a way that will alter the context within which risk behaviors are typically likely to occur. While individual-, group-, and community-level interventions focus on counseling, skills acquisition, and norms, SLIs focus on issues related to access (e.g. condoms, treatment), physical structures (e.g. housing), and social structures (policies that facilitate or constrain behaviors such as needle exchange laws). See the following reference for more information on SLIs[3]

Effective policies that promote *Prevention with Positives* programs will provide a range of options that are appropriate for individual programs and health jurisdictions. Policies, however, are only as good as the plans in place to make them a reality. For example, policies that require new standards to be implemented will not be very successful if they do not provide the resources, training, and or technical assistance for them to be carried out. Effective implementation requires that strategies be put in place to ensure their success.

Structural-level interventions are often developed as a result of policies that are based on new research or information. For example, the law requiring all passengers to wear seat belts while driving was enacted as a result of research showing that seat belt use significantly reduced the number of deaths due to automobile accidents. In HIV programs, many local communities began implementing needle-exchange programs after research showed that exchanging needles reduced the number of used

[3] An STD/HIV Prevention Intervention Framework. AIDS Patient Care STDs. 2000, Jan; 14 (1): 37-45. Cohen, DA, Scribner, R.

syringes and needle equipment on the streets as well as new HIV infections. Structural-level interventions can have large-scale impacts when compared to individual- , group-, or community-level interventions. However, they often take many years to develop and require significant investments of time, resources, and networking among stakeholders who may have very discordant views. Consequently, not all agencies have the capacity to implement structural level interventions.

Mechanisms to implement structural and environmental interventions may be developed through coalitions, networks, or collaborations. Before undertaking interventions on a structural level, agencies may want to engage community leaders, politicians, and/or other stakeholders to determine the level of support for these activities and assess what barriers or challenges will need to be overcome to achieve these changes. The following are some potential areas where SLIs may be considered:

a) structural and environmental interventions to reduce sexual transmission in:
   - bath houses
   - sex clubs
   - public sex environments
   - correctional facilities
   - internet-based venues
   - other venues where unsafe sexual activity occurs

POLICY RECOMMENDATIONS AND STRUCTURAL LEVEL INTERVENTIONS

"Providers need to realize that HIV+ clients live a very different lifestyle and have more issues to deal with than just going to work everyday, i.e., substance abuse, other illnesses, health treatment, social life, risky behaviors, etc.".

b) structural and environmental interventions to address unsafe needle-sharing practices, such as:
   - pharmacy legislation to legalize purchase of syringes
   - increased drug treatment programs
   - needle-exchange sites
   - provider reimbursement of PCRS, other relevant services
   - other interventions as appropriate

c) policies to address barriers to healthcare delivery, such as:
   - reimbursement for risk reduction counseling
   - reimbursement for PCRS

Case Example: ***New Policy Initiative to Integrate HIV Prevention and Care Services - Emphasis on Counseling, Testing, Partner Counseling and Referral Services (PCRS), and Treatment***

- SETTING: State Health Department HIV Program

- PROGRAM GOALS OR OBJECTIVES: Ensure comprehensive, seamless HIV prevention and care services to persons living with or at increased risk of HIV

  BRIEF DESCRIPTION: The State Health Department funded numerous well-established HIV counseling and testing sites in local health jurisdictions (LHJs) throughout the state. Over the last several years HIV positivity rates had consistently declined to less than 1% in most jurisdictions. For cost-efficiency reasons, the State Health Department was faced with decreasing the number of counseling and testing (C/T) sites.

  State managers from HIV prevention and care services discussed the challenges to local programs, and decided to identify some alternative approaches that would allow them to integrate services by more efficiently using resources. It was decided that funds could be used to provide PCRS services in prevention and care settings, as well as other enhanced services for clients in these programs. Since Prevention with Positives (PwP) programs were being required through new HIV prevention initiatives, many staff had experienced challenges reaching persons living with HIV, as their programs had traditionally provided services for uninfected persons.

  Alternatively, care providers had expressed difficulty implementing behavioral interventions, such as risk reduction counseling, support groups, and disclosure assistance for their positive patients for several reasons. Many didn't have enough time to discuss such issues with their patients; others didn't feel comfortable talking about sexual practices and drug behaviors; still others didn't believe this was their role. State funds to support prevention-care integration helped address some of these issues and provided a mechanism that would offer more comprehensive services for clients.

  The state HIV program director convened regional meetings with local directors of HIV prevention and care programs to discuss integrating ideas and gather feedback. After meetings, plans were slightly revised to enhance integration of HIV prevention and care services, with emphasis on counseling, testing, PCRS, and referrals for care and treatment.

➢ PROGRAM EVALUATION (How You Can Tell If This Works):

- Assess program priorities and personnel needs: Assess local programs to determine how prevention-care integration gaps could be addressed.
- Identify number of persons living with HIV referred to prevention staff: Document the number of clients enrolled in care/treatment programs who are referred to HIV prevention staff, and compare with those who were referred prior to integration.
- Determine prevention service increases in care settings: Document the number and type of prevention services, such as risk reduction counseling, disclosure assistance, or referrals into support groups, implemented in care settings after program integration. If significant gaps continue to exist (e.g., for client referrals, training needs, clinic flow issues, etc.), identify alternative strategies if possible.
- Determine number of referrals into care and treatment programs: Identify number of persons referred into care and treatment programs by HIV prevention staff and determine if this is a result of improved coordination and communication among prevention and care staff.

Case Example: ***Integration of Planning and Implementation Activities to Improve HIV/STD Services to Gay/MSM Communities***

- SETTING: Local Health Department HIV and STD programs
- PROGRAM GOALS OR OBJECTIVES: Develop more effective strategies to reach HIV+ gay men with syphilis, and improve internal communication and coordination between local STD/HIV programs
- BRIEF DESCRIPTION: During the past year, local health departments in several urban areas noticed significant increases in syphilis cases among gay/MSM communities. In addition, approximately 65% were HIV-positive. Traditional efforts to elicit names of exposed sexual partners--so they could be notified of such exposure--were repeatedly unsuccessful. Partner service staff could not easily obtain contact information of partners, as many clients had numerous, anonymous partners. Due to the infectious period for syphilis transmission, exposed partners needed to be contacted for testing and treatment in a timely manner. However, when staff made repeated visits to clients, many became uncomfortable and felt they were being harassed. Word-of-mouth spread that partner services staff were insensitive and invading the privacy of HIV+ persons with syphilis. This presented a dilemma for staff of both HIV and STD programs. Persons living with HIV who were exposed to syphilis were much more likely to acquire an STD, and also more likely to transmit HIV to uninfected persons, so timely notification of exposed partners was paramount. On the other hand, relations between HIV and STD programs were weakening, due to mistrust among HIV+ persons with syphilis who had been contacted several times. Both programs realized that new strategies needed to be developed.

  A meeting between STD and HIV program managers was scheduled to discuss new strategies for resolving these issues. All agreed that it was important to prevent further transmission of HIV, syphilis, and other STDs among gay/MSM communities, and to provide treatment to persons with syphilis. Once this goal was established and agreed on by all, an action plan was developed to address the steps necessary to accomplish this. New ideas to improve notification and treatment outcomes that were respectful of unique client needs were discussed. Several ideas emerged that STD and HIV program managers and staff believed could be incorporated into existing efforts.

  They included: 1) providing other referral options for notifying exposed partners, such as self-referral (client tells partners himself) or dual-referral (client tells partners with provider assistance, if needed), 2) identifying venues associated with syphilis outbreaks, or where high-risk activities occur (e.g., bathhouse, sex clubs, bars, public sex environments, etc.), to offer counseling, testing, and treatment referrals, 3) contacting medical providers and encouraging them to screen their high-risk patients and offer counseling and treatment, if applicable.

  Partner service staff agreed to give many of their business cards to the original clients with syphilis that they had initially contacted. It was agreed that if these clients decided to disclose their STD and/or HIV status to partners themselves by self-

referral, they could refer partners for treatment by using the business cards. The cards would enable partners to receive treatment at their local health departments free of charge.

- PROGRAM EVALUATION STRATEGIES (How You Can Tell If This Works):

  - Document Referral Follow-Ups Among Exposed Partners: Contact health departments to establish a system for collecting referrals (from partner service staff business cards), and keep track of the number received to document referral follow-ups among exposed partners.
  - Monitor STD and HIV Rates At Specific Venues: After counseling and testing services are established at venues associated with outbreaks, monitor the number of positive syphilis and other STD results. If infection continues to be detected, continue services; however, if rates are <2%, consider moving to another high-risk venue.

  Identify Increases in Testing, Counseling, or Treatment: Revisit medical providers after initial contact has been made (2-6 months) to determine if increase in STD testing, counseling, and treatment has occurred.

BIOMEDICAL APPROACHES

5

The STD-HIV Connection

"Prevention work becomes primarily about keeping my clients healthy, then keeping them from spreading HIV. We do lots of education around how unprotected sex can really affect… CD4 counts and viral loads if they get an STD… It becomes about keeping them healthy."

Biomedical approaches are not typically viewed as *Prevention with Positives* activities, chiefly because they are not primary prevention strategies; however STD screening and treatment programs can have a considerable impact on HIV prevention.

There is substantial biological evidence demonstrating that the presence of some STDs increases the likelihood of both transmitting and acquiring HIV. In fact, individuals who are infected with some STDs are at least two to five times more likely than uninfected persons to acquire HIV if they are exposed to the virus through sexual contact. Furthermore, if a person with HIV is infected with another STD, that person is more likely to transmit HIV through sexual contact, than other persons with HIV. Increased chances for acquisition and transmission can be attributed to two factors:

1. Increased susceptibility: Genital ulcers (e.g., syphilis, herpes, chancroid) cause breaks in the genital tract lining or skin, creating a portal of entry for HIV. Non-ulcerative STDs (e.g., chlamydia, gonorrhea, and trichomoniasis) increase the concentration of cells in genital secretions that can serve as targets for HIV (e.g., CD4+ cells).

2. Increased infectiousness: HIV+ people who are also infected with an STD have more HIV in their genital secretions. For example, men with both gonorrhea and HIV are more than twice as likely to shed HIV in their genital secretions than those who are infected only with HIV. Furthermore, the median concentration of HIV in semen is as much as 10 times higher in men who are infected with both gonorrhea and HIV than in men with HIV only.

BIOMEDICAL APPROACHES

5

Integrating STD and HIV Testing and Screening Activities

"I focus on prevention for positives, which means medication adherence, providing information that supports clients in not contracting other infectious diseases, and which communicates to my clients an understanding of the mental health issues that may complicate their consistent follow-through with adequate medical care".

Intervention studies have demonstrated that detecting and treating STDs can substantially reduce HIV transmission. Treating STDs in persons with HIV decreases both the amount as well as the frequency of viral shedding. In addition, studies found that ongoing, continued access to effective STD treatment services can be successful in reducing HIV infection, especially in areas where STD rates are high.

Early detection and treatment of STDs are important components of a comprehensive HIV prevention program. The following strategies provide some examples of how services can be integrated in both STD and HIV programs:

a) Offer STD screening in public and private HIV clinical care settings to:
   - identify bacterial and viral STDs
   - alert patient to STD/HIV interaction issues
   - inform patients about lack of STD symptoms and need for prompt treatment if infected

b) offer HIV counseling and/or testing in STD clinical venues:
   - conduct enhanced counseling and testing for patients with history of repeat STDs, if available resources allow
   - alert patient to STD/HIV interaction

c) offer STD counseling and/or screening in traditional and non-traditional HIV testing venues, such as:
   - confidential testing sites
   - drug treatment programs
   - mobile testing sites (e.g., mobile vans)
   - bath houses
   - other relevant venue

Case Example: ***Integration of STD Screening and Treatment in HIV Primary Care Settings***

- SETTING: HIV Medical Care Clinic

- PROGRAM GOALS OR OBJECTIVES: To reduce the incidence of STDs among program patients and ensure good health outcomes from treatment

- BRIEF DESCRIPTION: Clinicians noted a sharp increase of STDs presenting among their gay male clients, some with several repeat infections over the past few months. A policy was implemented to screen every client for gonorrhea (GC), syphilis, and chlamydia (CT) at least annually and high risk clients every six months. Treatment was provided for those testing positive for the above STDs. Intake staff also conducted a brief risk assessment of each patient prior to clinician visit. Clinicians then discussed the information with the patient, delivered a brief prevention message, and made referrals to mental health/social work staff for enhanced risk reduction counseling. Clients reported being grateful that a clinician asked about their sexual risk taking. They also expressed an increased level of concern about contracting an STD for personal health reasons, and likewise and increased level of concern about transmitting HIV to partners.

- PROGRAM EVALUATION STRATEGIES (How You Can Tell If This Works):
  - Determine Number of Patients Screened Before vs. After Implementation: After implementation of screening policy, the number of tests for gonorrhea (GC), syphilis, and chlamydia (CT) performed for high-risk patients should be compared to those conducted before implementation of screening policy.*
  - Identify Number of Patients Treated for STDs: For those patients who tested positive for GC, syphilis, or CT, determine how many were effectively treated, and compare these treatment rates to the number of patients treated prior to policy implementation, to further evaluate whether treatment influenced reduction of STD rates among patients and reduced potential transmission to partners.*
  - Identify Number of Self-Reported Risk Reduction Behaviors: To determine whether STD testing, treatment, and risk reduction counseling was effective in reducing future high-risk behaviors, self- reported patient behaviors prior to and after implementation of the above services should be collected and recorded in patient records or in a separate location for easier collection.*
  - Determine Patient/Client Comfort Level Discussing Risk Reduction Activities With Medical Or Other Providers: After staff are sufficiently trained and have incorporated brief risk reduction discussions into their visits, survey patients/clients to identify how they feel about discussing these issues with their medical providers, and if this has helped them adopt safer behaviors to prevent transmission.

*Requires baseline data (see Section 7 for more information)

Case Example: ***STD Screening in an Early Intervention Program (EIP)***

- SETTING: Early Intervention Program

- PROGRAM GOALS OR OBJECTIVES: Offer STD education, counseling, screening, and treatment to EIP clients

- BRIEF DESCRIPTION: The EIP in a metropolitan county noticed that more of their MSM/gay clients were beginning to ask about syphilis. The County had experienced a 60% increase in primary and secondary cases among MSM/gay communities during the past year. Of those cases, 65% were among HIV+ men. Many clients were unaware that they were more likely to transmit HIV if they also had an STD such as syphilis. The EIP began to offer STD screening for syphilis, gonorrhea (GC), and chlamydia (CT) at least yearly for their MSM/gay clients, and more frequently for those with multiple and/or anonymous partners. Inservices were conducted for staff to offer information about STD/HIV, provide referral resources, and answer additional questions. Positive clients were treated and encouraged to bring their partners in to the health department for treatment, or to arrange for PCRS.

  Over time, EIP staff were informed of STD/HIV interaction issues and better able to answer clients' questions regarding increased potential for HIV transmission and acquisition (for partners). They also increased coordination with their HIV prevention programs and had multidisciplinary meetings to strategize how to more effectively link their prevention and care services.

- PROGRAM EVALUATION STRATEGIES (How You Can Tell If This Works):
  - Monitor screening for CT, GC, and syphilis: Determine whether any differences in positivity rates are linked to other behavioral factors (e.g., number of partners, types of sexual practices, frequency of unprotected sexual among main or non-main partners, etc).
  - Monitor changes in Provider Knowledge, Attitudes, or Behaviors: Identify whether any changes in knowledge, attitudes, or behaviors occurred among providers after receiving education and training on STD/HIV interaction issues and the importance of risk reduction counseling and screening.
  - Determine Increases in Client Referrals: Review medical charts to determine whether additional referrals were made for enhanced risk reduction counseling, prevention case management, PCRS, etc., after provider training.
  - Monitor Number of Partners Referred for Screening and Treatment: Monitor the number of partners referred to the health department for testing and treatment and the number of clients who utilized PCRS.

PARTNER COUNSELING AND REFERRAL SERVICES

6

Background

Partner Counseling and Referral Services (PCRS) can be defined as an array of voluntary and confidential services available to HIV positive persons and their sex and/or needle-sharing partners as an integral part of a comprehensive HIV prevention program.

Providers in medical settings have tremendous opportunities to discuss partner-related issues with their patients/clients, since ongoing, existing relationships are likely to be established. If sufficient time is not available during the course of a medical exam, PCRS can be provided by other trained staff, if available, or referrals to other programs can be made. As disclosure issues may become more critical for the client at different stages during the course of their infection, providers should be skilled in discussing these issues at any time, based on client needs.

Because one method does not work for everyone, a menu of options should be offered for HIV positive clients to inform their sex or needle-sharing partners of potential exposure. In addition, referrals for clinical care and other supportive services should be provided for those partners who test positive. Several options for clients who want their exposed partners to be notified are included below.

a) coach clients/patients to support **self referral** of HIV status:
   - patient discloses HIV/STD status to partner/s
   - provider coaches patient regarding disclosure*
   - assists patient in anticipating and addressing consequences (e.g., partner reaction, maintaining confidentiality, etc.)

PARTNER COUNSELING AND REFERRAL SERVICES

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- disclosure discouraged if threat of domestic violence or other negative consequences anticipated
- provides or arranges for follow-up referrals for both patient and partner/s

**Guidelines available from CA PTC*

b) assist clients/patients with **provider referral** when self referral is not preferable for client:
   - provider elicits partner information from patient
   - refers to Disease Intervention Specialist (DIS) or similar staff for confidential field notification
   - assists patient in anticipating and addressing consequences
   - disclosure discouraged if threat of domestic violence or other negative consequences
   - provides or arranges for testing, counseling, and treatment referrals for partner/s

c) assist with **dual referral**, if self disclosure in presence of provider is desired by client/patient:
   - provider coaches patient on disclosure process
   - assists patient in anticipating and addressing consequences
   - disclosure discouraged if threat of domestic violence or other negative consequences
   - provider facilitates patient disclosure to partner
   - provides testing, counseling, and treatment referrals for partner/s, and/or follow-up visits with provider if desired

PARTNER COUNSELING AND REFERRAL SERVICES

d) provide referral services for persons recently notified of their exposure, for counseling, testing, medical care, and other potentially supportive services, such as:
   - HIV counseling and testing
   - STD counseling and testing
   - medical care services (e.g., early intervention, ADAP, etc.)
   - case management services
   - support groups

A Bridge between Prevention and Care

PCRS offers a continued opportunity to provide comprehensive services by bridging prevention and care programs for persons living with HIV. Exposed but uninfected partners at increased risk can participate in a variety of behavioral interventions to help them stay uninfected. Exposed persons who are not aware of their HIV status can be referred to counseling and testing services. For persons who test positive, efforts can be made to enroll them in medical care or related services to monitor health status and take advantage of appropriate treatment options. Over 18% of those who received PCRS and tested positive were not aware of their status and had not previously tested. This is an important consideration, when compared to the greater than two percent positivity rate through state-wide anonymous HIV testing programs. Furthermore, approximately fifty percent of those contacted via PCRS are first-time testers.

The following activities provide some examples of how PCRS activities can strengthen the bridge between prevention and care services:

PARTNER COUNSELING AND REFERRAL SERVICES

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a) integrate PCRS to increase linkages among:
   - Early Intervention Programs (EIPs)
   - Case Management Programs
   - HIV clinical settings
   - STD clinical settings

b) integrate PCRS in HIV prevention settings, including:
   - Comprehensive Risk Counseling Services (CRCS)
   - confidential HIV testing sites, with provider reimbursement for clients receiving PCRS
   - other appropriate settings where individual-level interventions are being implemented

c) identify local sites for HIV public and private providers to refer clients, including referrals from:
   - managed care organizations
   - public and private HIV clinical care settings
   - reproductive health care settings

Case Example: ***Integration of PCRS in a Private Provider Setting***

- SETTING: Health Maintenance Organization (HMO) with Large HIV Clinic in Metropolitan Area

- PROGRAM GOALS OR OBJECTIVES: Increase awareness of and referrals for PCRS by medical providers delivering care to HIV-positive patients

- BRIEF DESCRIPTION: The medical director of an HIV clinic at an HMO attended an HIV conference sponsored by the local health department, where she was informed about PCRS and related services. The positivity rate of partners who were reached and decided to test was nearly 20%, significantly higher than high-risk patients who sought testing at her clinic. She learned about several services that could be offered to persons living with HIV, including disclosure assistance. She also learned that referrals for testing, medical care, and support services were provided for notified partners, and wondered how PCRS could be provided in her clinic setting. The director realized that neither she nor her colleagues had ever discussed partner issues with their patients.

  The medical director spoke with the PCRS presenter and asked how such services could be provided in her private care setting. A meeting was arranged between health department PCRS staff and other HIV service providers at the HMO. After staff defined PCRS and how it might work in this setting, additional in-services and trainings were provided for medical and ancillary staff at the clinic. HIV providers learned how to effectively discuss disclosure, risk reduction, and other partner issues with patients seen at the HIV clinic. Due to time constraints of medical staff, it was decided that health educators and social workers at the clinic would spend time describing the full array of services available to interested patients, following referrals from their providers. A new section was created in medical charts to document 1) risk reduction, 2) disclosure issues, 3) referrals to support staff or other services, 4) whether a self, dual, or provider referral for notifying exposed partners was decided, and 5) any scheduled follow-up visits with patients.

- PROGRAM EVALUATION STRATEGIES (How You Can Tell If This Works):
  - Document the number and type of HMO providers in attendance at follow-up meetings and trainings, newly acquired skills, and additional requests for training and technical assistance.
  - Review charts periodically to determine the extent to which PCRS and risk reduction were discussed by providers and patients.
  - Determine whether some providers discuss PCRS more than others, and identify reasons for discrepancies if possible (e.g., time, skill, comfort).
  - Record number of partners contacted and those choosing to test, if HIV status unknown.
  - Document number of HIV positive partners referred to other services (e.g., medical care—to HMO, and other providers, counseling, etc.)

TOOLS AND RESOURCES

7

"HIV+ people think if prevention differently. Prevention empowers HIV+ individuals to see that they do need to continue exercising choices that keep them healthy… Prevention needs to emphasize choice, hope, and dialogue in long-term provider relationships".

Resources included in this section:

- Agency Readiness Tool
- Sample Assessment Questions for Individual Clients
- Questions to Guide Programs: Assessing Community, Assessing Interventions, and Assessing Agency Capacity
- Evaluation Terminology

Prevention with Positives: Agency Readiness Tool

Before you provide prevention services for people living with HIV, consider the following:

1. Are you duplicating services? (What makes your program/ intervention unique?)

2. Do you have a large enough number of people living with HIV in your service area who are seeking or will seek your services?

3. Do you have a recruitment plan?

4. Do you have adequate referrals for people living with HIV?
    a) Have you visited them?
    b) Do you have updated contact information?
    c) Do you have/need any Memoranda of Understanding (MOUs)?
    d) Do you have a plan to assess your referrals?

5. Do you have trained staff to work with people living with HIV? Consider:

    - Experience with HIV-positive people (includes work and/or life experience)
    - Knowledge of *prevention with positives* and how it differs from *prevention with HIV-negative people*
    - Knowledge of STD-HIV co-infection issues
    - Knowledge and skills to address the impact of stigma
    - Client-centered counseling skills
    - Skill relevant to level of intervention (e.g. group facilitation skills)
    - Knowledge and skills to address Co-Occurring Disorders (mental health, substance use, etc.)

6. Are *all your staff and volunteers* (not just those who are specifically providing PWP services) sensitive and respectful to people living with HIV?

7. Have you completed a Community Assessment? Have you reviewed recent secondary data and/or conducted your own research to assess:

    - Risk behaviors for HIV transmission (if any - don't assume that just because someone is HIV-positive, they are at risk for transmission)
    - Factors influencing risk behaviors
    - An overall readiness to change behavior/ stage of change
    - The level and type of intervention that potential clients might prefer
    - Other issues that may be relevant: disclosure issues, stigma, grief, etc.

8. Do you have goals and objectives for you program/ intervention?

9. Do you have a plan to evaluate your goals and objectives, as well as client satisfaction with services?

Sample Assessment Questions for Individual Clients:

Strengths & Resiliencies:

Please tell me about your strengths?
From where do they get your resiliency?
From where or whom do you get support?
What about your life is working well?
What areas of your life might you want to improve?

Context:

How long ago did you find out you were HIV-positive?
Do you belong to any communities that have been adversely impacted by HIV/AIDS? If so, do you feel a connection to that community or communities?

Stigma:

Have you experienced HIV-related stigma? If so, how has it affected you?
In what other areas of their lives do you experience stigma, if at all?
How have you managed to cope with being stigmatized?

Care & Treatment:

Do you have access to HIV meds?
Do you have access to other alternative types of treatment and care?
Do what degree do you want to engage in treatment and care, and why?
Are you experiencing and side effects?
Are you able to adhere to your meds?

The shifting paradigm of "Risk"

What information do you have about HIV transmission risk versus acquisition risk?
Are you concerned about other STDs and/or Hepatitis C?
Do you have accurate information about the transmission and acquisition of other STDs?
Are you concerned about/ have accurate information about *re-infection*?

Questions to Guide Programs
Assessing Community, Assessing Interventions, and Assessing Agency Capacity*

A) Suggested Questions to Assess Your Community/Target Population

1) Who is your specifically identified target population?
2) What is your agency's history and/or capacity in working with the specified community?
3) What are the behaviors that place the target population at risk for acquisition or transmission of HIV?
4) What factors influence the above behaviors?
5) Which 1-2 factors can be prioritized and addressed by your agency?
6) What data do you have to support the above information (e.g. formative assessments, individual interviews, surveys, etc)?
    a. If available, how many persons are represented by the data?

B) Suggested Questions to Assess Potential Evidence-Based Interventions (EBIs)

1) What level of intervention is most appropriate for your community (ILI, GLI, CLI)?
2) Which EBI did your agency select?
3) Why was this intervention selected?
4) How does it meet the needs of your community (specifically areas A1, 3, and 4, above)?
5) If a non-EBI was selected, how will it better meet your community's needs?
6) What are the theories that underlie this EBI?
7) What behavioral determinants are addressed by this EBI?
8) What knowledge or skills will be achieved after the intervention is completed? (Note: should coincide with factors identified in A4, above).
9) Provide a summary of the selected intervention, including:
    Core elements
    Intervention activities (including duration, frequency, # of sessions)
    Other pertinent information

C) Suggested Questions for Adaptation of an Intervention

(Note: complete this section only if you plan to adapt an existing EBI; if not move to Section D)

1) Specify the activities and/or components that you propose to adapt, and why this better meets the needs of your community or target population.
2) What data supports your proposed changes?

D) Suggested Questions to Assess Agency Capacity

1) What are the specific skills required by your agency staff to carry out the selected intervention?
   intervention-level specific (i.e., skills needed to conduct individual, group, or community-level interventions)
   EBI-, or intervention-specific skills (e.g., strict adherence to protocols, quality assurance guidelines, implementation of all sessions, etc)
   staffing requirements (e.g., licensed mental health professional, peer volunteer with community experience, etc)
2) Does your agency staff possess the above skills?
3) If not, how will you acquire them (via training, hiring of appropriate staff, etc)?

E) Suggested Evaluation Activities

1) Process Monitoring:
   a. Does your agency have a system to identify the number of persons served, demographics, number of sessions received, and proportion of the total number intended to receive services (%)?
   b. Who will collect, enter, and tabulate data?
   c. How will this data be used in future program planning?

2) Process Evaluation:
   a. Briefly describe your plan for determining the extent to which the intervention was implemented as intended , including the activities carried out according to intervention protocol (e.g., correct # of sessions implemented, specified target population recruited, curricula or other intervention-specific materials used, use of appropriate staff, etc)
   b. If intervention was adapted, please indicate how you will determine whether the changes were successful

3) Outcome Monitoring (for adapted interventions only)
   a. How will you determine whether your adapted intervention is leading to the desired knowledge, attitude/belief, behavior, or skills (KABBS) changes? Alternatively are you able to measure intentions to change behaviors at the conclusion of the intervention?

(Note: In the questions above, outcomes are related to the behavioral determinants addressed by the intervention, e.g., increasing self efficacy for safer sex negotiation, changes in community norms for cleaning injection equipment, increased perception of personal risk, etc)

*Adapted from ***Assessing Community Needs and Agency Capacity – An Integral Part of Implementing Effective Evidence-Based Interventions,*** Gandelman, A., DeSantis, L., Rietmeijer, C., AIDS Education and Prevention, 18, Supplement A, 32-43, 2006.

Evaluation Terminology*

Formative Evaluation

Collects data describing the needs and resources of the priority population (similar to needs assessment and/or resource inventories).

Identifies and or establishes the following:

- Performance strengths
- Performance gaps
- Trends in services
- Emerging issues
- Baseline measures

Answers questions such as:

- How should an intervention be designed or modified to address the needs of the population?
- What knowledge, skills or behaviors should be addressed by our intervention/ services?

Process Monitoring

Collects data describing the characteristics of the population served, the services provided and resources used to deliver the services.

Measures the following:

- Number of sessions conducted
- Number of participants served
- Types of participants served
- Other demographic information (e.g., age, race/ethnicity, location)

Answers questions such as:

- How many people received services?
- How many sessions did participants attend?
- Who received services?
- What was their education, or occupational background?
- What was the age range, and racial/ethic background of the participants?

Process Evaluation

Collects more detailed describing how the intervention was delivered, differences between the intended population and the population served, and access to the intervention.

Measures the following:

- How sessions were conducted
- Were core elements adhered to (if relevant)
- What materials were used
- Extent to which intended population was served
- Strengths and or weaknesses of program (e.g., location, appropriateness of materials, etc.)

Answers questions such as:

- Was the intervention implemented as intended?
- Did the intervention reach the intended audience?
- Were correct materials used?
- What was their education, or occupational background?
- What barriers did participants experience in accessing services (e.g., location, duration, cost, etc.)?

Outcome Monitoring

Collects data about changes in knowledge, attitude, skills, behavior, etc. among clients.

Measures the following:

- Increases in knowledge
- Changes in attitudes and/or beliefs
- Changes in intentions to adopt desired behaviors
- Acquisition of new skills
- Changes in actual behavior

Answers questions such as:

- Did the intervention outcomes occur?
- What changes *did* occur among target population?

Outcome Evaluation

Collects data to see if the intervention caused the outcomes (behavioral changes) to occur by comparing data to a similar group that did NOT receive the intervention.

Measures the following:

- Increases in knowledge
- Changes in attitudes and/or beliefs
- Changes in intentions to adopt desired behaviors
- Acquisition of new skills
- Changes in actual behavior

Answers questions such as:

- Did the intervention cause the outcomes?

Outcome evaluation is usually based on research design, is more costly and therefore not always feasible for many programs to conduct. In general, programs are not required to conduct outcome evaluation.

Impact Evaluation

Collects data about HIV at the jurisdictional, regional or national level.

Measures the following:

- Morbidity
  - Prevalence
  - Incidence
- Mortality
- Disease trends

Answers the questions:

- What are the disease trends in a particular jurisdiction or setting?
- What are the trends over time?
- Are some population more affected than others?

Impact evaluation is typically not required of local programs.

*Adapted from *Assessment & Evaluation for STD/HIV Prevention Programs*, Participant Manual, CA STD/HIV Prevention Treatment Center

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