

VIRGINIA HIV COMMUNITY PLANNING COMMITTEE

2008 Comprehensive HIV Prevention Plan

SUBMITTED TO THE VIRGINIA DEPARTMENT OF HEALTH

2008 COMPREHENSIVE HIV PREVENTION PLAN

Developed by the Virginia HIV Community Planning Committee
In collaboration with the Virginia Department of Health, Division of Disease Prevention

Copies can be downloaded at:
<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/HCPC/index.htm>
or
Requested through the Disease Prevention Hotline at:
1-800-533-4148

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The 2008 Comprehensive HIV Prevention Plan was developed between 2004 and 2007 through the coordinated effort of individuals serving as Virginia HIV Community Planning Committee (HCPC) members or as support staff from the Virginia Department of Health (VDH). The following individuals dedicated many hours to research and reviewing information and spent time away from their families and friends to volunteer in the planning process.

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The 2008 Comprehensive HIV Prevention Plan is the culmination of work completed between 2004 and 2007 by the Virginia HIV Community Planning Committee (HCPC) in collaboration with the Virginia Department of Health (VDH). The 2008 Comprehensive Plan was completed in compliance with the 2003-2008 HIV Prevention Community Planning Guidance put forth by the Centers for Disease Control and Prevention (CDC). While the 2008 Comprehensive Plan cannot fully address or prioritize all HIV prevention needs in Virginia, the HCPC, in collaboration with VDH, combined science, data and the wisdom of affected communities to identify effective strategies for the populations most in need of prevention services with the goal of reducing the greatest number of new infections.

The 2008 Comprehensive HIV Prevention Plan includes the following seven sections:

- ◆ A description of the Epidemiology Profile for HIV/AIDS in Virginia;
- ◆ Community Services Assessment;
- ◆ Prioritization of Target Populations;
- ◆ Selection of HIV Prevention Interventions;
- ◆ Taxonomy and Standards for HIV Prevention Interventions;
- ◆ A description of Research Initiatives completed between 2004 and 2007; and
- ◆ Recommendations by the Virginia HCPC for HIV prevention services.

The 2008 Comprehensive HIV Prevention Plan replaces the Plan released in 2003, with some distinct differences in the document.

- ◆ The Community Services Assessment includes a needs assessment, resource inventory, and gap analysis. These processes were done as separate entities in the past.
- ◆ Racial and ethnic minorities have been separated to be more inclusive of HIV prevention needs of different racial and ethnic minority groups, creating three distinct populations: Blacks, Latinos, and Asians/Pacific Islanders.
- ◆ A new model was developed to prioritize populations, which utilized both quantitative and qualitative data.
- ◆ Interventions selected for priority populations now include the Diffusion of Effective Behavioral Interventions (DEBIs), stressing the importance of utilizing evidence-based interventions that have shown to be effective in reducing HIV risk factors.
- ◆ The prioritization of HIV prevention interventions is no longer required by the CDC's 2003-2008 HIV Prevention Community Planning Guidance.

The 2007 Epidemiology Profile for HIV/AIDS in Virginia was developed by the Health and Research Informatics staff of the Virginia Department of Health (VDH), Division of Disease Prevention in conjunction with the Research Subcommittee of the Virginia HIV Community Planning Committee (HCPC). Sections of the Epidemiology Profile were written by various VDH staff and members of the Virginia HCPC.

The Epidemiology Profile was produced to give city and county governments, community-based organizations, health care planners and educators the data they need to plan and evaluate HIV/AIDS prevention and care services. The profile is printed as a separate document and is a vital part of the 2008 Comprehensive HIV Prevention Plan. The populations discussed in the profile follow those determined by the Virginia HCPC as being priority populations or populations of special interest for HIV prevention services in the Commonwealth of Virginia as well as other at-risk populations.

A copy of the 2007 Epidemiology Profile can be downloaded from Division of Disease Prevention website at <http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Profile2007.htm> or requested through the Virginia Disease Prevention Hotline at 1-800-533-4148.

A community services assessment identifies the HIV prevention needs of populations at risk for HIV, the current prevention interventions in place to address these needs; and the met and unmet needs of these populations. This includes a needs assessment, resource inventory, and gap analysis, which, in the past, had been conducted separately.

An ad hoc committee was created to address past issues and to develop an improved process of conducting the community services assessment. Although the HCPC was satisfied with the process used in the past and its outcomes, they felt the methodology was unclear and there was a lack of connection between the needs assessment, resource inventory and gap analysis.

Also, the resource inventory was not truly useful in completing tasks and there was difficulty in showing support for continuation of existing services versus identifying unmet needs. There was also an issue of having an extensive list of needs, many of which could not be funded through the HIV Prevention Cooperative Agreement. A process was also needed to aid members in prioritizing needs, rather than wanting every need to be priority.

The ad hoc committee decided that services should be identified that are meeting the needs of the populations they serve and whether the services should be continued. It was also necessary to identify unmet needs that should be addressed. A list of tasks was created, along with a timeline for completion of each task, to aid the HCPC in completing the community services assessment.

Identifying Populations at Risk and Unmet Needs

The HCPC broke into small groups to review and discuss the 2003 Epidemiology Profile, from which populations, evidence of risk and needs were identified. The list of populations generated from the 2003 Epidemiology Profile included, not only the existing priority populations, but other populations described in the profile. Members utilized the epidemiological data, along with other sources of information, to document the risks and needs of those populations. The HCPC also identified categories of target populations to be used in the community services assessment.

Identifying Additional Needs

Needs of populations identified through the Epidemiology Profile were identified through a variety of sources:

- ◆ Expertise of Committee Members
- ◆ Information from the Resource Inventory
- ◆ Research Highlights
- ◆ 2003 Epidemiology Profile

- ◆ Prevention Provider Survey
- ◆ Informal key informant interviews with target populations

As discussed above, the Epidemiology Profile was utilized to identify needs of target populations. Needs were also identified through expertise of the committee member, information from the resource inventory and highlights from research conducted by the Survey Evaluation Research Laboratory (SERL) for the HCPC.

Furthermore, VDH utilized an online survey tool, Survey Monkey, to conduct an organizational survey of community-based organizations (CBOs) to assess the needs of populations they serve. Questions for the survey were developed by the Standards and Practices Subcommittee of the HCPC. The survey included questions to determine:

- ◆ Populations being served by each organization;
- ◆ Populations being represented by the individual completing the survey;
- ◆ Whether client input is used to develop prevention plans and interventions;
- ◆ What prevention interventions have been most effective or not effective;
- ◆ Whether curricula for Diffusion of Effective Behavioral Interventions (DEBIs) has been adapted for other than intended populations;
- ◆ What services were expected to end due to funding cutbacks;
- ◆ What needs cannot currently be met;
- ◆ Populations most in need of HIV prevention services that cannot be met; and
- ◆ Training needs.

A full list of questions included in the survey can be found in Appendix I.

HCPC members discussed, as a group, the needs that had been identified thus far for each population, at which time additional needs were identified and discussed. HCPC members then volunteered for assignment to specific populations and were asked to survey individuals from those populations to assess any additional needs.

Resource Inventory

The Resource Inventory was developed by contacting agencies with known funding as well as those agencies receiving funds from federal sources and from major HIV/AIDS foundations. A search of national organizations and other state agencies was conducted to identify additional distribution of HIV prevention funding. Agencies identified as having HIV prevention funding were contacted to determine the following:

- ◆ Localities being served by the agency;
- ◆ Populations being targeted;
- ◆ Interventions being provided;
- ◆ Funding amount;

- ◆ Source of funding; and
- ◆ End date of the funding.

The Resource Inventory was reorganized by target populations in order to better assess the needs of those populations. It was then reviewed by the HCPC.

Please note that the following Resource Inventory represents those agencies being funded in 2005, when the gap analysis process was being conducted.

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| People Living with HIV | | | | | | |
|---|--|---|--|----------------|--------------------------------------|-------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| AIDS/HIV Services Group | Charlottesville | HIV+ | PCM, basic outreach, health communication & public information | \$50,000 | VDH - P4P | 12/31/2005 |
| ACCESS | Norfolk | HIV+ youth and adults | Be Proud, Be Responsible Partners in Prevention | \$4,788 | VDH - ASO | |
| Center for Comprehensive Care of Immune Deficiency (C3ID), Eastern VA Medical School | Norfolk | HIV+ | PCM, 5-session group level series | \$50,000 | VDH - P4P | 12/31/2005 |
| Central Virginia Community Services (CVCS) | Lynchburg, Bedford, Appomattox, Campbell and Amherst | HIV+ w/ SA or MH issues for which they seek treatment (adults served by CVCS) | HIV Early Intervention & Prevention: support groups, educational groups, public information, collaboration with faith-based community for outreach | \$100,000 | Federal block grant through DMHMRSAS | |
| Central Virginia Health District | Lynchburg | HIV+ | PCM | \$31,000 | VDH-P4P | ongoing |
| Council of Community Services | Roanoke | HIV+ w/ SA issues, HIV+ MSM | Intensive four-session Individual education/counseling; nine-session group level intervention, "Positive View" newsletter | \$20,000 | VDH - P4P | 12/31/2005 |
| Hampton Newport News CSB | Hampton/Newport News | HIV+ African Americans | GLI, Safety Counts | \$12,000 | VDH - MAP | 12/31/2007 |
| International Black Women's Congress | Norfolk | HIV+ African Americans | GLI, Healthy Relationships | \$7,320 | VDH - MAP | 12/31/2007 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| People Living with HIV (Continued) | | | | | | |
|---|------------------------|---|--|-----------|------------------------------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| K.I. Services | Alexandria | HIV+, HIV+ MSM | PCM, multiple-session GLI, 5-session group-level series for positive females | \$60,000 | VDH - P4P | 12/31/2005 |
| K.I. Services, Inc. | Northern VA | HIV+ African Americans and Latinos | Support group, GLI | \$4,250 | VDH - MAP | 12/31/2007 |
| Positive Livin' | Northern Virginia | HIV + | PCM | \$20,800 | VDH - ASO | 12/31/2005 |
| Serenity | Crater Health District | African Americans w/ HIV & SA/abuse issues both in and out of treatment | Day Support Center that provides: health education, focus groups, social activities, and skills building interventions | \$15,000 | The John Randolph Foundation | |
| Tidewater AIDS Community Taskforce | Norfolk | HIV + | GLI | \$14,310 | VDH - ASO | 12/31/2005 |
| Urban League of Hampton Roads | Norfolk | HIV+ inmates, HIV+ ex-offenders, other HIV+ persons | Individual level intervention, three-session group level, PCM | \$50,000 | VDH - P4P | 12/31/2005 |
| VCU HIV/AIDS Center | Richmond | HIV+ women of color, MSM and IDU | PCM for clients in the Infectious Disease Clinic | \$75,000 | VDH - P4P | ongoing |
| VCU HIV/AIDS Center(PACOCV) | Richmond | PLWHA receiving prevention services in a primary care setting | Coaching for Wellness (peer coaching on prevention, adherence etc.), GLI and ILI | \$70,000 | VDH - ASE | 6/30/2007 |
| VDH and VCU SERL | Central Virginia | newly diagnosed HIV+ | Five session strengths-based case management/Power project | \$132,750 | CDC Linkages to Care | 9/30/2006 |
| Whitman Walker Clinic | Northern VA | Latino HIV+ | Individual level counseling | \$4,000 | VDH - MAP | 12/31/2007 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| Racial / Ethnic Minorities | | | | | | |
|--|---|---|---|----------|--------------------------------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| AIDS Response Effort | Winchester, Clarke, Page, Frederick, Warren County | African American men and women and Latino migrant workers | GLI | \$15,000 | Subcontract to ASG / VDH - ASO | 12/31/2005 |
| AIDS/HIV Services Group (ASG) | Charlottesville, Harrisonburg, Staunton, Waynesboro, Augusta, Rockingham, Albemarle, Fluvanna, Louisa, Greene | African American men and women and Latino migrant workers | GLI | \$15,000 | VDH - ASO | 12/31/2005 |
| AIDS/HIV Services Group | Charlottesville, Harrisonburg, Staunton, Waynesboro, Augusta, Rockingham, Albemarle, Fluvanna, Louisa, Greene | Latino men and women and migrant workers | GLI, counseling and testing | \$50,000 | SAMHSA | 9/30/2005 |
| Basilica of St. Mary of the Immaculate Conception | Norfolk | African American clergy | Clergy forums to encourage HIV prevention and raise awareness, basic outreach, health fairs | \$5,524 | VDH - AAFI | 12/31/2006 |
| Basilica of St. Mary of the Immaculate Conception | Norfolk | African American General Population | Fixed-site outreach and recruitment for other interventions, World AIDS Day recognition | \$10,156 | VDH - AAFI | 12/31/2006 |
| Coalition for HIV Awareness and Prevention | Lynchburg | African Americans and faith community | Outreach, health fairs, presentations, public information | \$2,000 | VDH - ASO subcontract | 12/31/2005 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| Racial / Ethnic Minorities (Continued) | | | | | | |
|--|--|----------------------------------|---|----------------|--------------------------------|-------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Council of Community Services | Roanoke, Abingdon, Martinsville and Lynchburg | African Americans | GLI, basic street outreach, community level | \$22,610 | VDH - ASO | 12/31/2005 |
| Ethiopian Community Development Council | Northern Virginia | African immigrants | Real AIDS Prevention Program (RAPP) | \$350,665 | CDC - 04064 | 9/30/2006 |
| Fan Free Clinic | Richmond | African American faith community | Community level intervention and hotline | \$6,925 | VDH - ASO | 12/31/2005 |
| Fredericksburg HIV AIDS Support Services | Fredericksburg, Spotsylvania, Stafford, Orange | African American men and women | GLI, street outreach and ILI | \$10,000 | Subcontract to ASG / VDH - ASO | 12/31/2005 |
| International Black Women's Congress | Norfolk | African American men and women | PCM | \$12,200 | VDH - MAP | 12/31/2007 |
| International Black Women's Congress | Norfolk | African American men and women | Community Promise | \$14,640 | VDH - MAP | 12/31/2007 |
| K.I. Services | Alexandria, Arlington, and Fairfax | Latinos | OraSure testing and | \$17,000 | VDH - MAP | 12/31/2007 |
| Korean Community Services Center of Greater Washington (KCSC) | Fairfax County | Korean Newcomers | Basic street outreach | \$45,000 | VDH - MAP | 12/31/2007 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| Racial / Ethnic Minorities (Continued) | | | | | | |
|--|-----------------------------|--|---|----------------|---------------|-------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| NOVAM | Northern Virginia | Newly arrived Hispanic youth immigrants, 18-24 | Mobile outreach - reduce risks and prevent HIV infection and substance abuse | \$250,000 | SAMHSA | |
| Pittsylvania Community Action Agency | Danville | African Americans | STD 101 presentations | \$12,000 | CSPS | 12/31/05 |
| St. Paul's Baptist Church AIDS Ministry | Richmond | Racial / ethnic minorities | Public information, referrals for testing and services | \$0 | Volunteers | NA |
| Tidewater AIDS Crisis Taskforce | Norfolk | African Americans and Latinos | GLI, street outreach and ILI | \$42,930 | VDH - ASO | 12/31/2005 |
| Wholistic Family Agape Ministries | Alexandria | African American under age of 40 | Young Adult HIV/AIDS Prevention Program: positive decision-making as it relates to risk of HIV/AIDS infection | \$0 | Volunteers | NA |
| Wholistic Family Agape Ministries | Alexandria | African American under age of 40 | Street outreach in public housing areas, HIV/AIDS prevention information, | \$0 | Volunteers | NA |
| Wholistic Family Agape Ministries | Alexandria | African American adults | Presentations and public information in faith-based settings | \$0 | Volunteers | NA |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| IDU and Other Substance Abusers | | | | | | |
|--|-----------------------------|--|--|----------------|---|-------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Alexandria CSB | Alexandria | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$70,470 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |
| Arlington CSB | Arlington | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$74,363 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |
| Blue Ridge Behavioral Health Care | Roanoke | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$107,210 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |
| Central Virginia CSB | Lynchburg | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$92,864 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |
| Chesapeake CSB | Chesapeake | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$93,321 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |
| Colonial CSB | Williamsburg | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$19,498 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| IDU and Other Substance Abusers (Continued) | | | | | | |
|---|---|--|--|----------|---|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Council of Community Services | Roanoke, Abingdon, Martinsville and Lynchburg | IDUs, substance abusers | GLI | \$33,320 | VDH - ASO | 12/31/2005 |
| Council of Community Services | Roanoke | IDUs, other substance abusers | Basic and intensive street outreach, OraSure testing | \$10,714 | VDH - OraSure | 12/31/2005 |
| Crossroads CSB | Amelia | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$46,081 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |
| Danville | Danville | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$64,630 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |
| Department of Behavioral Health Care | Portsmouth | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$99,443 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |
| District 19 Community Services Board | Petersburg | IDUs, substance abusers | HIV testing | \$96,752 | DMHMRSAS | |
| Eastern Shore | Nassawadox | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$24,339 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| IDU and Other Substance Abusers (Continued) | | | | | | |
|---|--------------------------------|--|--|-----------|---|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Fairfax CSB | Fairfax | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$48,829 | DMHMRSAS-SAPT HIV Early Intervention-SAMHSA | |
| Fan Free Clinic | Richmond | Adult substance abusers | GLI and hotline | \$34,625 | VDH - ASO | 12/31/2005 |
| Hampton CSB | Hampton | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$222,394 | DMHMRSAS-SAPT HIV Early Intervention-SAMHSA | |
| Hampton Newport News CSB | Hampton/Newport News | African American IDUs and their partners | Basic and intensive street outreach, OraSure testing | \$37,200 | VDH - OraSure | 12/31/2005 |
| Henrico CSB | Henrico | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$33,000 | DMHMRSAS-SAPT HIV Early Intervention-SAMHSA | |
| International Black Women's Congress | Norfolk | African American IDUs women | Safety Counts | \$6,100 | VDH - MAP | 12/31/2007 |
| K.I. Services | Arlington, Alexandria, Fairfax | African American IDUs | Basic and intensive street outreach, group level and OraSure testing | \$25,500 | VDH - MAP | 12/31/2007 |
| Middle Peninsula-Northern Neck CSB | Gloucester | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$13,491 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| IDU and Other Substance Abusers (Continued) | | | | | | |
|---|-------------------------------------|--|--|-----------|---|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Minority Health Consortium | Richmond and Petersburg | African American IDUs | Basic and intensive outreach, Project Respect, OraSure | \$25,000 | VDH - MAP | 12/31/2007 |
| Norfolk CSB | Norfolk | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$253,059 | DMHMRSAS-SAPT HIV Early Intervention-SAMHSA | |
| Northwestern CSB | Front Royal | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$14,918 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |
| Positive Livin' | Northern Virginia | IDUs | GLI | \$44,200 | VDH - ASO | 12/31/2005 |
| Region Ten CSB | Charlottesville | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$76,183 | DMHMRSAS-SAPT HIV Early Intervention-SAMHSA | |
| Richmond Behavioral Health Authority | Richmond | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$270,469 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |
| Tidewater AIDS Community Taskforce | Portsmouth | IDUs and their partners | Intensive street outreach to IDUs and their partners, OraSure and OraQuick testing, partner elicitation | \$56,800 | VDH-OraSure | 12/31/2005 |
| Tidewater AIDS Community Taskforce | Norfolk, Portsmouth, Virginia Beach | IDUs | Basic and intensive outreach, Safety Counts | \$19,200 | VDH - MAP | 12/31/2007 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| IDU and Other Substance Abusers (Continued) | | | | | | |
|--|----------------------|--|--|-----------|---|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Tidewater AIDS Community Taskforce | Norfolk | IDUs | Presentations, GLI, VOICES | \$19,080 | VDH - ASO | 12/31/2005 |
| Tidewater AIDS Community Taskforce | Norfolk | Substance abusers (HIV+ and -) | Refer substance abusers into service and provide case management for HIV+ substance abusers | \$66,209 | Subcontract with Norfolk CSB above | |
| Valley CSB | Staunton | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$44,515 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |
| Virginia Beach Department of Public Health (VBHSD) | Virginia Beach | Substance abusers / persons with mental health disorders | Case management / prevention case management | \$35,000 | Subcontract with VBHSD above | |
| Virginia Beach Human Services Department (DMHMRSAS) | Virginia Beach | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$147,879 | DMHMRSAS-SAPT HIV Early Intervention-SAMHSA | |
| Western Tidewater CSB | Suffolk | Substance abusers / persons with mental health disorders | HIV CTR, follow-up for HIV-infected persons, community education; screening & counseling for Hepatitis A and B | \$100,583 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | |
| Whitman Walker Clinic | Northern Virginia | Latino IDUs | Basic and intensive outreach using Brief Motivational Interviewing and the Transtheoretical Model. | \$36,000 | VDH - MAP | 12/31/2007 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| IDU and Other Substance Abusers (Continued) | | | | | | |
|---|----------------------|-----------------------|--|----------|---------------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Whitman Walker Clinic | Northern Virginia | Latino IDUs | Basic and intensive street outreach, OraSure and OraQuick testing, partner elicitation | \$13,170 | VDH - OraSure | 12/31/2005 |
| Whitman Walker Clinic | Northern Virginia | African American IDUs | Basic and intensive street outreach, OraSure and OraQuick testing, partner elicitation | \$17,560 | VDH - OraSure | 12/31/2005 |

| Men who have sex with Men | | | | | | |
|--------------------------------|--|---|---|----------|----------------------------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| AIDS Response Effort | Winchester | MSM | OraSure testing | \$2,468 | VDH - OraSure | 12/31/2005 |
| AIDS Response Effort | Winchester | Young MSM | Basic street outreach, ILI | \$2,000 | Subcontract to ASG/VDH ASO | 12/31/2005 |
| AIDS/HIV Services Group | Charlottesville, Harrisonburg, Rockingham, Augusta and Prince William counties | MSM, young MSM, African American non-identifying MSM and incarcerated MSM | GLI, Basic street outreach Counseling & Testing, Internet Chat Rooms, ILI, Pres & Lecture, Mpowerment | \$46,000 | VDH - MSM | 12/31/2005 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| Men who have sex with Men (Continued) | | | | | | |
|---------------------------------------|--|--|--|-----------|---------------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| AIDS/HIV Services Group | Charlottesville, Harrisonburg, Staunton, Waynesboro, Augusta, Rockingham, Albemarle, Fluvanna, Louisa, Greene | Young MSM | Basic street outreach, ILI | \$2,000 | VDH - ASO | 12/31/2005 |
| AIDS/HIV Services Group | Charlottesville, Harrisonburg, Staunton, Waynesboro, Augusta, Rockingham, Albemarle, Fluvanna, Louisa and Greene | MSM | Mpowerment, Internet outreach, PCM | \$100,000 | SAMHSA | 9/30/2005 |
| Council of Community Services | Roanoke and surrounding counties | Young MSM, rural MSM, African American MSM | HIV Prevention Projects for Community Based Organizations: Mpowerment, OraSure and OraQuick testing | \$303,114 | CDC 04064 | 9/30/2006 |
| Council of Community Services | Roanoke | MSM and MSM of Color | Basic and intensive street outreach, OraSure testing | \$19,286 | VDH - OraSure | 12/31/2005 |
| Council of Community Services | Roanoke | MSM | GLI, Basic street outreach, Intensive street outreach, Internet Outreach, Mass Media, Social Marketing, Lecture/Pres, Health/Community Fairs | \$23,000 | VDH - MSM | 12/31/2005 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| Men who have sex with Men (Continued) | | | | | | |
|---|--------------------------------|--|---|----------|--------------------------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Council of Community Services | Roanoke | Rural African American MSM | Many Men, Many Voices | \$60,598 | VDH - ASE | 6/30/2007 |
| Fan Free Clinic | Richmond | MSM / MSM of Color | PCM | \$30,800 | VDH -MSM | 12/31/2005 |
| Fan Free Clinic | Richmond | MSM of Color | Community level intervention and hotline | \$6,925 | VDH - ASO | 12/31/2005 |
| Fan Free Clinic | Richmond | MSM, MSM of Color | Basic and intensive street outreach, OraSure and OraQuick testing, partner elicitation | | VDH - OraSure | 12/31/2005 |
| Hampton Newport News CSB | Hampton/Newport News | African American MSM | Basic and intensive street outreach, OraSure testing | \$10,629 | VDH - OraSure | 12/31/2005 |
| Hampton Newport News CSB | Hampton/Newport News | African American MSM | Support group for HIV+ MSM | \$12,000 | VDH - MAP | 12/31/2007 |
| International Black Women's Congress | Norfolk | African American MSM | Many Men, Many Voices | \$40,260 | VDH - MAP | 12/31/2007 |
| K.I .Services, Inc. | Northern Virginia | MSM / men on the down low | Support group | \$0 | MOU with "Us Helping Us" | |
| K.I. Services | Arlington, Alexandria, Fairfax | African American MSM | Basic and intensive street outreach, group level and OraSure testing | \$25,500 | VDH - MAP | 12/31/2007 |
| Minority Health Consortium | Richmond and Petersburg | African American MSM and men on the down low | Basic and intensive street outreach, Brief Group Counseling Popular Opinion Leader, OraSure testing | \$34,000 | VDH - MSM | 12/31/2005 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| Men who have sex with Men (Continued) | | | | | | |
|--|-----------------------------|---------------------------|---|----------------|-------------------|-------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| NOVAM | Arlington, VA | Young MSM | Community Level Intervention, Mass Media: Internet Outreach, Basic street outreach, ILI | \$46,000 | VDH - MSM | 12/31/2005 |
| SERAS | Fairfax County | Latino MSM | Support group | \$0 | Private donations | |
| TACT | Norfolk | MSM | Basic Outreach and Popular Opinion Leader | \$25,600 | VDH - MAP | 12/31/2007 |
| Tidewater AIDS Community Taskforce | Norfolk, VA | Young MSM, MSM | Mass Media, GLI, Basic street outreach, Community Level Intervention | \$45,000 | VDH - MSM | 12/31/2005 |
| Tidewater AIDS Community Taskforce | Portsmouth and Norfolk | MSM | Basic and intensive street outreach, OraSure and OraQuick testing, partner elicitation | \$10,000 | VDH - OraSure | 12/31/2005 |
| Whitman Walker Clinic | Northern Virginia | Latino MSM | Basic and intensive street outreach, OraSure and OraQuick testing, partner elicitation | \$13,170 | VDH - OraSure | 12/31/2005 |
| Whitman Walker Clinic | Northern Virginia | Latino MSM | Basic and intensive outreach using Brief Motivational Interviewing and the Transtheoretical Model | \$40,000 | VDH - MAP | 12/31/2007 |
| Whitman Walker Clinic | Northern Virginia | African American MSM | Basic and intensive street outreach, OraSure and OraQuick testing, partner elicitation | \$13,170 | VDH - OraSure | 12/31/2005 |
| Whitman Walker Clinic | Northern Virginia | White MSM | Basic and intensive street outreach, OraSure and OraQuick testing, partner elicitation | \$17,560 | VDH - OraSure | 12/31/2005 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| High-Risk Heterosexuals | | | | | | |
|--|---|---|--|----------|---------------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| AIDS/HIV Services Group | Charlottesville, Harrisonburg, Staunton, Waynesboro, Augusta, Rockingham, Albemarle, Fluvanna, Louisa and Greene counties | African American women | SISTA, group level interventions | \$65,000 | SAMHSA | 9/30/2005 |
| AIDS/HIV Services Group | Charlottesville, Harrisonburg, Staunton, Waynesboro, Augusta, Rockingham, Albemarle, Fluvanna, Louisa and Greene counties | African American men | GLI | \$35,000 | SAMHSA | 9/30/2005 |
| Council of Community Services | Roanoke, Abingdon, Martinsville and Lynchburg | High risk heterosexuals, African American heterosexuals | GLI | \$8,330 | VDH - ASO | 12/31/2005 |
| Council of Community Services | Roanoke | High risk heterosexuals | Basic and intensive street outreach, OraSure testing | \$6,429 | VDH - OraSure | 12/31/2005 |
| Ethiopian Community Development Council | Arlington, Alexandria and Fairfax | African immigrant heterosexuals | GLI, Basic street outreach, Intensive street outreach, Health communication/mass media | \$25,000 | VDH - MAP | 12/31/2007 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| High-Risk Heterosexuals (Continued) | | | | | | |
|---|-----------------------------|--|--|----------------|---------------------|-------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Faith Community Baptist Church | Richmond | High risk heterosexual African American women | Social Skills training | \$18,000 | VDH - MAP | 12/31/2007 |
| Faith Community Baptist Church | Richmond | High risk heterosexual African American men | Project Respect | \$9,000 | VDH - MAP | 12/31/2007 |
| Fan Free Clinic | Richmond | African American heterosexuals | GLI and hotline | \$27,700 | VDH - ASO | 12/31/2005 |
| Fan Free Clinic | Richmond | Heterosexuals | Hotline | \$6,925 | VDH - ASO | 12/31/2005 |
| Hampton Newport News CSB | Hampton and Newport News | High risk heterosexuals--sex workers | Basic and intensive street outreach, OraSure testing | \$5,314 | VDH - ORA | 12/31/2005 |
| Hampton Newport News CSB | Hampton and Newport News | African American high risk heterosexuals using AOD | Safety Counts | \$20,000 | VDH - MAP | 12/31/2007 |
| International Black Women's Congress | Norfolk | African American high risk heterosexuals | VOICES, SISTA | \$18,300 | VDH - MAP | 12/31/2007 |
| International Black Women's Congress | Norfolk | African American women | SISTA | \$9,000 | CSPS | 12/31/2005 |
| Minority Health Consortium | Richmond and Petersburg | African American high risk heterosexuals | Basic and intensive outreach, VOICES/VOCES and SISTA | \$38,000 | VDH - MAP | 12/31/2007 |
| Pittsylvania Community Action Agency | Danville | African American women | SISTA | \$12,000 | CSPS | 12/31/2005 |
| SERAS | Fairfax County | Latino women | Outreach, referrals | \$5,000 | MAC AIDS Foundation | |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| High-Risk Heterosexuals (Continued) | | | | | | |
|--|--|---|--|----------------|---------------|-------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Tidewater AIDS Community Taskforce | Norfolk | Heterosexual females who exchange sex for money | Community Promise and HIV/STD screenings | \$67,000 | VDH - HRYA | 12/31/2008 |
| Tidewater AIDS Community Taskforce | Portsmouth, Norfolk and Virginia Beach | High risk heterosexuals | Basic and intensive outreach and Safety Counts | \$57,600 | VDH - MAP | 12/31/2007 |
| Tidewater AIDS Community Taskforce | Norfolk | Heterosexuals | Presentations and GLI | \$4,770 | VDH - ASO | 12/31/2005 |
| Tidewater AIDS Community Taskforce | Norfolk and Portsmouth | High risk heterosexuals | Basic and intensive street outreach, OraSure and OraQuick testing, partner elicitation | \$7,000 | VDH - OraSure | 12/31/2005 |
| VCU Center for Cultural Experiences, Education and Prevention | Central Virginia | African American women | SISTA | \$250,000 | SAMHSA | |
| Way of the Cross Community Development Corporation | Louisa and Fluvanna | High risk African American women | SISTA | \$36,000 | VDH - HRYA | 12/31/2008 |
| Whitman Walker Clinic | Northern Virginia | High risk heterosexuals | Basic and intensive street outreach, OraSure and OraQuick testing, partner elicitation | \$13,170 | VDH - OraSure | 12/31/2005 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| Inmates | | | | | | |
|---|--|---|--------------------------------------|----------|-------------------------------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| AIDS Response Effort | Winchester | New Parolees & Substance Abusers | Prevention education | \$14,000 | Northwest Community Services | |
| AIDS Response Effort | Winchester, Clarke, Frederick, Warren, Page | Incarcerated men and women | GLI | \$13,000 | subcontract to ASG/ VDH - ASO | 12/31/2005 |
| AIDS/HIV Services Group | Charlottesville, Harrisonburg, Staunton, Waynesboro, Augusta, Rockingham, Albemarle, Fluvanna, Louisa, Greene | Incarcerated men and women | GLI | \$15,000 | VDH - ASO | 12/31/2005 |
| AIDS/HIV Services Group | Charlottesville, Harrisonburg, Staunton, Waynesboro, Augusta, Rockingham, Albemarle, Fluvanna, Louisa and Greene | Incarcerated men | GLI | \$30,000 | SAMHSA | 9/30/2005 |
| Council of Community Services | Roanoke | Incarcerated | OraSure testing | \$8,571 | VDH - OraSure | 12/31/2005 |
| Fan Free Clinic | Richmond, Chesterfield, State Farm, Goochland, Caroline, Haynesville, and Henrico | Incarcerated men and women | GLI, Each One Teach One | \$55,400 | VDH - ASO | 12/31/2005 |
| Fredericksburg HIV AIDS Support Services | Fredericksburg, Stafford, Orange, Spotsylvania | Incarcerated men and women | GLI | \$15,000 | subcontract to ASG/ VDH - ASO | 12/31/2005 |
| K.I. Services | Alexandria | Incarcerated adolescent male drug users | Outcomes of Intensive AIDS Education | \$12,750 | VDH - MAP | 12/31/2007 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| Inmates (Continued) | | | | | | |
|---|--|---|--|----------|--------------------------------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Life Management | Hopewell Riverside Regional Jail | Inmates | Prevention education | \$800 | Title II Health Care Solutions | |
| Life Management | Hopewell Riverside Regional Jail | Inmates in pre release | Prevention series reentry, Healthy Sexuality | \$3,000 | DOC | |
| Minority Health Consortium | Richmond, Petersburg, Hopewell and Emporia | High risk adults in corrections or probation and parole | VOICES/VOCES, Talking Drum, PCM intervention Enhancing Prevention Skills for People Living with HIV program | \$45,000 | VDH - HRYA | 12/31/2008 |
| Minority Health Consortium | Richmond, Petersburg, Hopewell and Emporia | Men and women in probation and parole | SISTA and Project Respect | \$37,500 | VDH - MAP | 12/31/2007 |
| Tidewater AIDS Community Taskforce | Norfolk and Hampton/Newport News | Incarcerated | Presentations, group level | \$17,940 | VDH - ASO | 12/31/2005 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| Transgender | | | | | | |
|----------------------------|----------------------|--------------------|--|----------|-----------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Fan Free Clinic | Richmond | Transgender | GLI, VOICES/VOCES, offerors and administers hormone therapy, HIV/STD clinical & testing services | \$69,402 | VDH - ASE | 6/30/2007 |
| Fan Free Clinic | Richmond | Transgender | Basic and intensive street outreach, OraSure testing | \$13,200 | VDH - MSM | 12/31/2005 |
| Minority Health Consortium | Richmond, Petersburg | Transgender | Basic and intensive street outreach, Brief Group Counseling, Popular Opinion Leader | \$11,500 | VDH - MSM | 12/31/2005 |
| TACT | Norfolk | Transgender | Popular Opinion Leader | \$25,600 | VDH - MAP | 12/31/2007 |

| At-Risk Youth | | | | | | |
|-------------------------------|---|---|---|----------|----------------------------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| AIDS Response Effort | Winchester | Youth | Community health fairs | \$1,000 | Subcontract to ASG/VDH ASO | 12/31/2005 |
| AIDS/HIV Services Group (ASG) | Charlottesville, Fredericksburg, Spotsylvania, Orange | Youth offenders, homeless, runaways, racial and ethnic minorities | Street Smart: group level intervention and basic and intensive street outreach and counseling and testing | \$50,000 | VDH - HRYA | 12/31/2008 |
| AIDS/HIV Services Group (ASG) | Charlottesville, Harrisonburg, Staunton, Waynesboro, Augusta, Rockingham, Albemarle, Fluvanna, Louisa, Greene | Youth | Group level peer education, community health fairs | \$6,000 | VDH - ASO | 12/31/2005 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| At-Risk Youth (Continued) | | | | | | |
|--|---|---|--|----------|---|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| AIDS/HIV Services Group (ASG) | Charlottesville, Harrisonburg, Staunton, Waynesboro, Augusta, Rockingham, Albemarle, Fluvanna, Louisa, Greene | Youth | Peer education | \$40,000 | SAMHSA | 9/30/2005 |
| Basilica of St. Mary of the Immaculate Conception | Norfolk | African American Youth | Becoming A Responsible Teen and Keeping it Real, youth retreat | \$8,523 | VDH - AAFI | 12/31/2006 |
| ACCESS | Norfolk | Youth | Focus on Kids | \$9,719 | VDH - ASO | |
| Central Virginia Community Services | Lynchburg, Bedford, Appomattox, Campbell and Amherst | Adolescents addicted to alcohol and other drugs | Neways Program: youth group outpatient treatment program | \$92,864 | DMHMRSAS - SAPT HIV Early Intervention - SAMHSA | Ongoing |
| Coalition for HIV Awareness and Prevention | Lynchburg | Youth | Outreach, health fairs, presentations, public information | \$1,000 | VDH - ASO subcontract | 12/31/2005 |
| Council of Community Services | Roanoke, Abingdon, Martinsville and Lynchburg | Youth | GLI | \$17,850 | VDH - ASO | 12/31/2005 |
| Ethiopian Community Development Council | Arlington, Alexandria and Fairfax | African immigrant youth | GLI, Basic street outreach, Intensive street outreach, Health communication/mass media | \$25,000 | VDH - MAP | 12/31/2007 |
| Faith Community Baptist Church | Richmond | African American youth | Becoming A Responsible Teen | \$18,000 | VDH - MAP | 12/31/2007 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| At-Risk Youth (Continued) | | | | | | |
|---|--------------------------|----------------------------------|---|-----------|---|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Hampton Newport News CSB | Hampton and Newport News | African American youth using AOD | Safety Counts | \$36,500 | VDH - MAP | 12/31/2007 |
| International Black Women's Congress | Norfolk | African American youth | Street Smart, Becoming a Responsible Teen | \$23,180 | VDH - MAP | 12/31/2007 |
| Minority Health Consortium | Richmond | African American youth | Talking Drum, Street Smart | \$25,000 | VDH - MAP | 12/31/2007 |
| NOVAM | Northern Virginia | Youth | Youth Speak | \$298,503 | SAMHSA | |
| NOVAM | Arlington | Youth | Youth Speak & Face to Face | \$25,000 | Arlington County | |
| NOVAM | Fairfax County | Youth | Youth Speak | \$43,169 | Fairfax Co. Community Services Funding Pool | |
| NOVAM | Northern Virginia | Youth | Youth Speak | \$30,000 | WA AIDS Partnership | |
| NOVAM | Northern Virginia | Youth | Youth Speak | \$30,000 | Freddie Mac Foundation | |
| NOVAM | Northern Virginia | Youth | Health Education Alternatives for teens: outreach, testing, case management | \$42,488 | Ryan White Title IV | |
| NOVAM | Arlington | Youth | Youth Speak & Face to Face | \$4,000 | Arlington County United Way | |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| At-Risk Youth (Continued) | | | | | | |
|---|--------------------------|--|--|----------|---|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| NOVAM | Falls Church & Fairfax | Youth | Youth Speak & Face to Face | \$6,000 | Fairfax County & Falls Church United Way | |
| NOVAM | Northern Virginia | GLBTQ youth | Orion program - home grown group level intervention | \$52,000 | VDH - HRYA | 12/31/2008 |
| Pittsylvania Community Action Agency | Danville | youth | Be Proud, Be Responsible | \$12,000 | CSPS | 12/31/2005 |
| Positive Livin' | Northern Virginia | African American Youth | GLI | \$23,400 | VDH - ASO | 12/31/2005 |
| Prince William Interfaith Volunteer Caregivers | Prince William County | At risk and HIV-infected youth, youth in detention | Outreach, linkages for HIV counseling and testing | \$16,480 | Subcontract with INOVA | 7/31/2006 |
| Tidewater AIDS Community Taskforce | Norfolk | Youth | GLI, counseling and testing, presentations, street outreach | \$58,830 | VDH - ASO | 12/31/2005 |
| Virginia League for Planned Parenthood | Central VA | Incarcerated youth | Becoming A Responsible Teen | \$43,000 | VDH - HRYA | 12/31/2007 |
| Wholistic Family Agepe Ministries | In and around Alexandria | African American teens 12-18 | Teen Age Pregnancy Prevention (TAPP) program: uses wholistic approach, "developing academics as well as the life skills/decision making skills needed to make positive decisions." | \$52,000 | Freddie Mac Foundation, City of Alexandria Youth Department, DHHS and HUD | |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| At-Risk Youth (Continued) | | | | | | |
|--|----------------------|------------------------|--|----------|------------|------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Wholistic Family Agape Ministries | Alexandria | African American youth | Presentations and public information in faith-based settings | \$0 | Volunteers | NA |
| Wholistic Family Agape Ministries | Alexandria | African American youth | Support for programs listed above | \$75,000 | CDC | |

| Homeless | | | | | | |
|--------------------------------------|----------------------|--------------------|---------------|----------|-----------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Council of Community Services | Roanoke | Homeless | GLI | \$13,090 | VDH - ASO | 12/31/2005 |
| Positive Livin' | Northern Virginia | Homeless | GLI | \$41,600 | VDH - ASO | 12/31/2005 |

| Mentally Challenged | | | | | | |
|---|----------------------|---------------------|------------------------|---------|-----------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Tidewater AIDS Community Taskforce | Norfolk | Mentally Challenged | Presentations/lectures | \$1,590 | VDH - ASO | 12/31/2005 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| Non-Specific Populations | | | | | | |
|--|--|--|---|----------|---------------------------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| AIDS/HIV Services Group | Charlottesville, Harrisonburg, Staunton, Waynesboro, Augusta, Rockingham, Albemarle, Fluvanna, Louisa and Greene | At-risk populations | Counseling and testing | \$20,000 | SAMHSA | 9/30/2005 |
| AIDS/HIV Services Group | Charlottesville, Harrisonburg, Staunton, Waynesboro, Augusta, Rockingham, Albemarle, Fluvanna, Louisa and Greene | At-risk populations | Social marketing | \$9,000 | SAMHSA | 9/30/2005 |
| Alexandria Health District | Alexandria | At-risk populations | Anonymous Testing | \$18,000 | VDH - General funds | NA |
| Appalachian Assistance Coalition | Marion and 15 surrounding counties | General population and at-risk populations | HIV 101 presentations, skills building, one-on-one counseling | \$7,500 | Collin Higgins Foundation | 12/31/2005 |
| Arlington Department of Health and Human Services | Arlington | At-risk populations | Anonymous Testing | \$18,000 | VDH - General funds | NA |
| Central Shenandoah Health District | Harrisonburg | At-risk populations | Anonymous HIV testing | \$18,000 | VDH - General funds | NA |
| Coalition for HIV Awareness and Prevention | Lynchburg | General population | Outreach, health fairs, presentations, public information | \$1,000 | VDH - ASO subcontract | 12/31/2005 |
| Council of Community Services | Southwest Virginia | General population | Mass media, hotline, social marketing, health fairs | \$23,800 | VDH - ASO | 12/31/2005 |
| Crater Health District | Petersburg | At-risk populations | Anonymous Testing | \$9,300 | VDH - ATS | NA |
| Crater Health District | Petersburg | At-risk populations | ATS billboards | \$8,700 | VDH - ATS | NA |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| Non-Specific Populations (Continued) | | | | | | |
|---|--|---------------------|--|-----------|-----------------------------|------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Fairfax Health District | Fairfax City and County. Falls Church | At-risk populations | Anonymous Testing | \$18,000 | VDH - General funds | NA |
| International Black Women's Congress | Norfolk | At-risk populations | STD 101 presentations | \$49,000 | CSPS | 12/31/2005 |
| Mount Rogers Health District | Abingdon and Wytheville | At-risk populations | Anonymous Testing | \$18,000 | VDH - General funds | NA |
| New River Health District | Christiansburg | At-risk populations | Anonymous Testing | \$16,500 | VDH - General funds | NA |
| Norfolk Health District | Hampton, Norfolk, Portsmouth, Virginia Beach | At-risk populations | Anonymous Testing | \$51,000 | VDH - General funds | NA |
| Rappahannock Health District | Fredericksburg | At-risk populations | Anonymous HIV testing | \$18,000 | VDH - General funds | NA |
| Roanoke Health District | Roanoke | At-risk populations | Anonymous Testing | \$16,500 | VDH - General funds | NA |
| Southside Health District | South Boston | At-risk populations | Anonymous HIV testing | \$7,434 | VDH - General funds | NA |
| Thomas Jefferson Health District | Charlottesville | At-risk populations | Anonymous HIV testing | \$18,000 | VDH - General funds | NA |
| Tidewater AIDS Community Taskforce | Norfolk | At-risk populations | Basic street outreach, presentations, health fairs and testing to promote syphilis elimination | \$34,000 | VDH - CSPS | 12/31/2005 |
| VCU HIV/AIDS Center | Richmond | At-risk populations | Anonymous HIV testing | \$30,000 | VDH - CDC | 12/31/2005 |
| Virginia Department of Health | Statewide | At-risk populations | Hotline services: information and referral, crisis counseling | \$150,000 | VDH - CDC and general funds | 12/31/2005 |

2005 Resource Inventory

Note: The following represents agencies being funded when the gap analysis process was being conducted.

| Non-Specific Populations (Continued) | | | | | | |
|---|-----------------------------|---------------------------|---|----------------|---------------------------------|-------------|
| Agency | Location of Services | Population Details | Interventions | Funding | Source | Ends |
| Virginia Department of Health | Statewide | At-risk populations | Media campaign for HIV Testing Day | \$45,000 | VDH - CDC carry over dollars | 12/31/2005 |
| West Piedmont Health District | Martinsville | At-risk populations | Anonymous Testing | \$18,000 | VDH - General funds | NA |
| Williamsburg AIDS Network | Williamsburg | At-risk populations | Distribution of Home Access HIV test kits | \$0 | Pharmaceutical company donation | NA |

Assessing the Status of Need and Ranking Unmet Needs

Identified needs from the various sources were compiled for each target population. The HCPC again broke into small groups to review the identified needs of the target populations. In this review process, the groups used a version of the 2005 Resource Inventory that omitted programs with funding sources that would be eliminated in 2006. They were tasked to use this second version of the Resource Inventory to aid in deciding the status of each need and determining whether they were existing/emerging needs or continuing needs. Some needs had been identified prior to review by the HCPC as ones that could not be funded through the HIV Prevention Cooperative Agreement.

Each HCPC member then individually prioritized those needs identified as being an existing/emerging need. Each member was given 42 “votes” in the form of dots to be used amongst all target populations. Members were instructed to distribute their dots among 42 different needs or place numerous dots on a particular need based on their perception of its importance. The needs were then compiled by status of need and priority for review by the HCPC. The top unmet needs are listed below as determined by the HCPC. All existing/emerging and continuing needs that were identified are listed in Appendix II.

Ranked Unmet Needs

People Living with HIV

- ◆ Care and prevention services for those newly diagnosed
- ◆ Programs in rural areas
- ◆ Assistance/coaching around disclosure with sex partners

The CDC estimates that 25 percent of HIV-infected individuals are unaware of their HIV status. People living with HIV, who continue to engage in risky behaviors, not only risk infecting their partners, but also risk acquiring additional infections that may affect their health. Furthermore, those with mental health or substance abuse issues are more likely to continue engaging in risky behaviors.

There is a significant focus on prevention efforts to be directed toward people living with HIV, especially those newly diagnosed, which includes linking prevention and care services. This effort is focused on both preventing the spread of HIV to others as well as on protecting individuals from possible re-infection with HIV or other infections that can affect their health. This will also involve programs providing people with skills to make healthier sexual decisions, which include disclosure of their HIV status to sex partners. There is also a need for programs in rural areas that focus on people living with HIV. Various factors, such as stigma, a large geographic area and a lack of resources, in rural areas prevent individuals from getting tested as well as seeking or accessing care.

Injection Drug Users (IDUs) and Other Substance Abusers

- ◆ Harm/Risk reduction programs
- ◆ Training for pharmacists

HIV infection rates have declined among IDUs; however, they still comprise 17 percent of AIDS cases and 10 percent of HIV cases. Blacks, primarily male, make up 75 percent of IDU cases. The use of methamphetamine, crack and cocaine also contribute to HIV risk behaviors.

The HCPC found a need for HIV prevention programs that include a harm/risk reduction model. A subset of harm reduction includes programs providing wound care accompanied by prevention messages, which was also prioritized as a top unmet need by the HCPC. One step in reducing the risk of HIV among injection drug users is the availability of clean needles or syringes. However, statute § 54.1-3466 of the Code of Virginia states that *“it shall be a misdemeanor for any person to possess or distribute controlled paraphernalia which shall mean a hypodermic syringe, needle or other instrument ... which reasonably indicate an intention to use such controlled paraphernalia for purposes of illegally administering any controlled drug...”*. Therefore, training of pharmacists on harm/risk reduction, in regards to injection drug use, would place pharmacists in a position to commit a misdemeanor by law.

Blacks

- ◆ Programs to link newcomers into the public health system
- ◆ Outreach testing with rapid testing kits

African Americans are disproportionately affected by HIV/AIDS. Seventy-seven percent of all HIV positive women are Black. Of all HIV positive men, 60 percent are Black. Thirty-one percent of HIV positive Black women are contacts to IDU's, which is four times the rate of White women. There is a strong need for programs targeting African American women as well as African immigrants. For this reason, this population is referred to as Blacks, rather than African Americans.

Linking newcomers, mainly African immigrants, into the public health system is critical in providing both prevention and care services. This may include prevention education and counseling and testing for African refugees and new immigrant heterosexual females and youth. Utilizing faith based organizations may aid in reaching this population as well. Programs that link newcomers with buddy or peer-to-peer programs and programs providing education and raising awareness of HIV risks was also ranked by the HCPC as a top unmet need.

Asian / Pacific Islanders

- ◆ Culturally specific curricula for Asian populations
- ◆ Culturally sensitive prevention models for Asian / Pacific Islanders

- ◆ Interventions that are gender specific

Unfortunately, there is very little data reflecting the risk of HIV infection among Asian/Pacific Islanders in Virginia. It is a diverse population and includes many different cultures, making targeted prevention efforts difficult. Prevention barriers include avoidance of discussing sexual behavior and/or drug use as well as a lack of cultural support for such behaviors. To address these cultural issues, educational programs and materials must be both culturally specific and sensitive to Asian / Pacific Islander communities. Many of these cultures also have a strong separation of gender roles, creating a need for prevention interventions to be gender specific.

Latinos

- ◆ Need for bilingual educators
- ◆ Improved educational materials
- ◆ Targeted prevention messages
- ◆ Culturally specific curricula
- ◆ Activities targeting Latino men
- ◆ Outreach testing
- ◆ Activities to remove barriers to undocumented individuals
- ◆ Counseling and testing in non-clinical settings
- ◆ Faith-based initiatives

Latinos now represent a larger percentage of the Virginia population than in the past. There has been a 50 percent increase in HIV infections among Latinos. Latinos in the U.S. are comprised of diverse ethnicities and cultures. Immigrations issues, language barriers and cultural norms make reaching this population for prevention services that much more difficult.

Language barriers create the greatest need for the Latino population. The HCPC identified the need for more bilingual health educators as the greatest need to reach this population. There is a need for education to be culturally specific; more educational materials translated into Spanish; and a need for educational materials at a low-literacy level. There is also a need for more prevention messages targeting the Latino population, mainly through such venues as television/radio stations; organizations providing services to migrant workers; health clinics serving the Latino population and Latino businesses.

Awareness of HIV/AIDS risk needs to be raised among Latino men specifically in breaking myths and stigmas surrounding HIV/AIDS and homosexuality. There is also a need to target Latino men to increase their knowledge of safe-sex practices as well as the risks associated with not only multiple partners but also having both male and female partners. The HCPC also found a need for more outreach testing with rapid HIV testing and counseling and testing in non-clinical settings. Many Latinos encounter significant barriers to access health services, especially those that are undocumented. The HCPC identified a need to remove these barriers.

Also, to aid in reaching Latinos who may not be reached through other venues, more faith based initiatives are needed in Latino communities.

High Risk Heterosexuals

- ◆ Programs specifically targeting men
- ◆ Programs addressing intergenerational dating
- ◆ Interventions for African-American women
- ◆ Peer to peer programs
- ◆ Social marketing

A population category of high-risk heterosexuals encompasses a broad spectrum of sub-populations. It can include African-American men and women; those who have had multiple (five or more) partners in the past six months; those who have engaged in sexual behaviors with anonymous partners; or those who have had a past STD diagnosis. It can also include sex partners of IDU's or female partners of MSM. An increased proportion of HIV positive women are among Black women. Black females represent the largest proportion of heterosexual transmission, followed by Black males, White females and White males.

There is a need for programs and prevention messages targeting men, especially those men who are having sex with other men, but do not self-identify as being homosexual. The HCPC also identified intergenerational dating - dating between an older male/female and a much younger partner – as an issue to be addressed in prevention/education programs. Also, there is a need for interventions that target African-American women, including programs to empower women, that address taking care of the 'self' and not relying on religious beliefs as protection from HIV/AIDS. The HCPC also identified a need for more peer-to-peer programs and social marketing strategies to aid in reaching those that are not being reached by traditional prevention messages.

High-Risk Youth

- ◆ Comprehensive sexual health education
- ◆ Access to condoms
- ◆ Peer programs at STD clinics
- ◆ Programs targeting trading sex for money / drugs

Between 2000 and 2003, there has been an increase in HIV infections among youth, the largest proportion of which was among MSM youth. There are also high rates of chlamydia among youth, indicating sexual activity without using a condom.

Sexual education is a prime avenue to reach high-risk youth. There is, however, a need for more comprehensive sex education that stresses abstinence while still offering accurate information on risks associated with unprotected sex and the skills necessary to make healthy

sexual decisions. There is a need for youth to have greater access to condoms. The HCPC also found a need for peer programs at STD clinic as a method of reaching high-risk youth as well as programs that target youth trading sex for money or drugs.

Incarcerated

- ◆ Re-entry education programs
- ◆ Counseling and Testing
- ◆ Risk/harm reduction education
- ◆ Increased number of programs for incarcerated populations

National data show high rates of HIV infection among incarcerated women. Incarcerated men and women also have high rates of substance abuse, mental health issues and poor decision making and coping skills, all of which pose great risks to, not only themselves, but their partners upon release.

Many individuals are released from jail/prison into the community with few or no resources, including HIV care and prevention services. The HCPC prioritized a need for more educational programs for those released from jail/prison. More programs are needed for the incarcerated population, including case management, counseling and testing and risk/harm reduction programs, in order to reduce the spread of infection in this population. HIV testing in the prisons should include rapid testing as well as testing for inmates with less than 90 days of release from jail/prison. These programs will not only aid in preventing the spread of disease while individuals are incarcerated, but also give them the skills needed to make healthy decisions upon release.

Men who have sex with men (MSM)

- ◆ Holistic health needs
- ◆ Prevention messages/education for non-identifying MSM
- ◆ Programs targeting sex workers
- ◆ Programs targeting situational bisexuality
- ◆ Programs targeting older men (age 35+)
- ◆ Rapid testing
- ◆ Role models
- ◆ Bilingual MSM health educators

Sexual activity between men remains the greatest risk for HIV infection in Virginia. MSM comprise of 34 percent of new HIV cases and 36 percent of new AIDS cases. There is also an increased use of methamphetamine and other drugs among MSM, which may lead to risky sexual behaviors.

There are many factors, other than HIV prevention, that are of more importance for many MSM. For this reason, the HCPC supported a need for programs that focus on the holistic needs of MSM in order to address their HIV prevention needs. Similar to needs identified by the HCPC for heterosexuals, there is also a need for prevention messages and educational material that target MSM that do not self-identify as being homosexual. There is also a need for programs targeting sex workers. The HCPC also identified a need for programs targeting situational bisexuality, referring to engaging in incidental homosexual activity while in a single-sex environment for a prolonged period of time, such as correctional facilities or other single-sex institutions. Many MSM (over the age of 35) assume that HIV affects younger MSM and that they are no longer at risk, creating a need for programs targeting this subset of the population. There is also a need for programs to begin utilizing rapid HIV testing and to provide MSM role models. The HCPC also identified a need for more bilingual, specifically Latino, MSM health educators.

Although not ranked for MSM, the HCPC also ranked needs separately for Latino and Black MSM, some of which were collapsed under MSM needs. The HCPC identified a need to increase educational efforts targeting Latino MSM on dispelling beliefs of machismo, on safer sex alternatives to anal sex and on self-control of sexual urges. The HCPC identified a need to increase programs targeting Black MSM that address the stigmas of homosexuality. There is also a need to identify resources, such as support groups, that are specific for and culturally sensitive toward both Latino and Black MSM.

Transgender

- ◆ Improved access to prevention and care services
- ◆ Local programs operating on a harm reduction model
- ◆ Medical service delivery training for medical providers in transgender care services
- ◆ Programs targeting trading sex for money or drugs
- ◆ Adaptation of Diffusion of Effective Behavioral Interventions (DEBIs)

There is very limited data on risks for HIV/AIDS among transgenders in Virginia and nationally. It is known, however, that there may be high-risk behaviors among the transgender population, such as trading sex for money or drugs and needle sharing to inject drugs, hormones, or silicone.

Social stigmatization toward the transgender population creates a barrier to services. There is a need for improved access to HIV prevention and care services as well as local programs that utilize a harm reduction model. Many do not seek HIV prevention and care services, not only due to fear created by this stigma, but also the insensitivity of providers that may have been experienced in the past. Thus, as a linkage with care services, there is a need for medical service delivery training for medical providers in transgender care. There is also a need for programs that target transgenders trading sex for money or drugs. Programs that take

adaptations of the DEBIs, such as SISTA for male-to-female (MTF) transgenders and VOICES for female-to male (FTM) and MTF transgenders, are also needed.

Older adults (Adults 50+)

- ◆ General education and awareness programs

There has been an increase in HIV and AIDS rates among adults over 50 years of age. Older adults are often overlooked in planning for HIV prevention programs and education, making them less knowledgeable about HIV and how to protect themselves. Since many older adults do not consider themselves as being at risk, the HCPC felt that general education and awareness programs are appropriate for this population.

Sex Workers

- ◆ Prevention case management
- ◆ Street and community outreach
- ◆ Access to testing on demand
- ◆ Condom negotiation skills
- ◆ Individual level intervention

There is limited data on risk of HIV infection among sex workers in Virginia. However, high risk behaviors include drug use and engaging in unprotected sex, especially among those who may be exchanging sex for money, drugs, shelter or protection. Prevention concerns are often overlooked by sex workers for various reasons. To aid in reaching sex workers, the HCPC identified prevention case management as well as street and community outreach as top priority needs of this population. There is a need for testing on demand. Sex workers often, for financial and other reasons, do not demand condom use, creating a need for programs that focus on condom negotiation skills. Programs are also needed that offer individual level intervention to sex workers.

Mentally Challenged

- ◆ Programs that provide skills in avoiding sexual coercion or enticement for mentally challenged clients
- ◆ Low-literacy brochures
- ◆ Sexuality training for group home staff

With limited data, the mentally challenged are another population that is often overlooked in planning for HIV prevention services. There is a need for programs targeting this population that focus on teaching skills to avoid sexual coercion or enticement. There is also need for low-literacy educational materials. Also, because many in this population live in group homes, staff at these facilities needs sexuality training to better aid their residents.

Furthermore, many do not consider the mentally challenged as sexual active beings and, therefore, do not receive HIV education messages.

Homeless

- ◆ Cultural competency training
- ◆ Rapid testing
- ◆ Street and community outreach
- ◆ Substance abuse education and referrals to treatment

There is a probability of high risk behaviors among the homeless, such as their vulnerability to assault or coercion; the exchange of sex for money, shelter, etc.; and substance abuse and mental illness cofactors. However, data depicting this is limited. Because of the transient lifestyles of the homeless population, there is a need for rapid HIV testing and street and community outreach. People who are homeless often come with a variety of health and social issues. Therefore, cultural competency training is needed for medical, social service, shelter and transitional housing staff. There is also a high prevalence of drug and alcohol use among the homeless populations, creating a need for programs that offer substance abuse education and referrals to treatment.

In 2006, the HCPC began the process of prioritizing target populations identified during the community services assessment. When this process was last completed in 2001, target populations were prioritized using a formula that included HIV seroprevalence, a relative risk factor score derived from the San Francisco Community Planning Group, population size, three year HIV incidence and a relative need factor score. The formula used in 2001 to prioritize populations is as follows.

$$\text{Risk} = 0.6(\text{HIV seroprevalence}) + 0.4(\text{relative risk factor})$$

$$\text{Need} = 0.2(\% \text{ of population}) + 0.4(\% \text{ of 3 year HIV incidence}) + 0.4(\text{relative need factor})$$

$$\text{Score} = 0.7(\text{Risk}) + 0.3(\text{Need})$$

2001 Priority Populations:

- Persons living with HIV/AIDS
- Racial/Ethnic Minorities
- Injection Drug Users
- Men who have sex with men
- Heterosexuals
- Inmates
- Youth

2001 Populations of Special Interest (not prioritized):

- Transgender persons
- Homeless
- Persons who sell or trade sex
- Mentally ill / mentally retarded

To begin the process in 2006, the HCPC discussed the process used in 2001. Compared to 2001, the current epidemiological data available and the Resource Inventory completed in 2005 were stronger and more reliable to use for the 2006 process. Therefore, the formula used in 2001 could be modified or other priority setting models could be used with the data now available.

The HCPC broke into small groups to discuss and brainstorm the options of potential methods that could be used to prioritize populations. They were asked to discuss whether the 2001 process should be used, whether modifications should be made to the 2001 process or whether a new process should be developed. The HCPC considered whether the population represented a behavioral, demographic or situational risk factor. For example, the Black population is a demographic at risk, but merely being Black is not what places individuals at risk for HIV infection. Blacks are a population with a higher prevalence of HIV, so a risk behavior practiced in the Black population is more likely to lead to HIV infection within this population than in a lower prevalence population practicing that risk behavior. Groups were also asked to consider other factors such as the number and percent of cases; rates per 100,000; population

size; available resources; whether rates have increased, decreased, or remained the same in recent years; and any other factors that should be considered. Suggestions from the three groups were compiled, which included a formula developed by one group (see option 2 below).

The HCPC was, then, presented with various data sets that could be used during the prioritization process, which included both national and statewide data for the target populations identified during the community services assessment. National data included seroprevalence rates and the percentage of people estimated to be living with HIV/AIDS in the U.S. Statewide data included population estimates, reported cases of HIV/AIDS from 2001 to 2005, and incidence rates per 100,000 from 2001 to 2005. Population sizes made available to the HCPC for some populations were not exact, but rather estimates based on current literature review. Data was also made available on available resources based on the 2005 Resource Inventory and VDH funded programs.

The HCPC was given three possible formulas to consider for prioritizing populations, which are as follows.

Option 1: A modified version of formula used in 2001

$$\begin{aligned} \text{Score} = & [0.3 \text{ (3-year HIV prevalence/100,000)}] & + \\ & [0.3 \text{ (3-year HIV incidence/100,000)}] & + \\ & [0.2 \text{ (\% of population)}] & + \\ & [0.2 \text{ (proportion of resources)}] \end{aligned}$$

Option 2: Formula developed by group during the brainstorming process.

$$\begin{aligned} \text{Score} = & [\text{Risk (Unduplicated Living HIV+)}] & \mathbf{X} \\ & [\% \text{ Incidence/Prevalence by Transmission}] & \mathbf{X} \\ & [5 \text{ Year Trend (} \uparrow, \downarrow, \leftrightarrow \text{)}] & \mathbf{X} \\ & [\text{Weighted Co-Factors (i.e. mental health, substance abuse, homeless, etc.)}] \end{aligned}$$

Option 3: Adapted from *Setting HIV Prevention Priorities: A Guide for Community Planning Groups* developed by AED Center on AIDS & Community Health with funding from CDC. For each target population:

| | Indicator Weight | Scale Rating | Score |
|--|------------------|--------------|-------|
| % HIV/AIDS Cases | | | |
| Incidence | | | |
| Population Size | | | |
| Population Impact | | | |
| Change $\uparrow \downarrow \leftrightarrow$ | | | |
| Available Resources | | | |
| Risk | | | |
| Overall Score | | | |

The three options were discussed and it was decided to use a modified version of option three. This model was discussed further to determine which indicators to include and to determine appropriate weights for each indicator. The Epidemiology Profile Coordinator and Community Planner developed an appropriate scale to ensure equal distribution for each indicator. The following worksheet was used for each target population to determine prioritization of target populations.

| Indicator | Indicator Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
|---|---|-------|------------------|---|--------------|-------|
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | | |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | | |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | | |
| Population Size | Estimated size of the 2005 target population in Virginia | | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | | |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | | |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | | |
| Risk | The nature and relative risk of behaviors that occur in the target population | | 4 | 1: Demographic 3: Situational 5: Behavioral | | |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | | |
| | | | | | Score | |

The HCPC broke into three groups to determine scale ratings for *Resources Available to Meet Population Needs* and *Social Indicators*. An average of the three groups' ratings was used for the scale ratings of these indicators. The completed worksheets for all target populations can be found in Appendix III.

People living with HIV/AIDS were not prioritized because of CDC requirements of the CDC for community planning that specify people with HIV as the number one priority population. Therefore, a score was not calculated for this population as they are the number one priority population. The final scores for the other target populations were discussed and approved by the HCPC. Upon discussion, the HCPC voted to prioritize the top ten target populations, with the bottom four being populations of special interest. Final ranking of target populations, based on using the above worksheet, are as follows:

2006 Priority Populations

| <u>Priority Target Population</u> | <u>Score</u> | <u>Rank</u> |
|--|---------------------|--------------------|
| People Living with HIV/AIDS | --- | 1 |
| Blacks | 114.83 | 2 |
| Men who have sex with men | 107.17 | 3 |
| High risk heterosexuals | 93.50 | 4 |
| Transgenders | 86.83 | 5 |
| Injection drug users | 80.17 | 6 |
| Homeless | 62.17 | 7 |
| Incarcerated | 61.83 | 8 |
| Youth | 61.83 | 8 |
| Latinos | 61.00 | 9 |

Note: Final scores for the incarcerated and youth populations were the same, giving both populations the 8th ranking order.

Populations of Special Interest

| | | |
|--------------------------|-------|----|
| Mentally Challenged | 60.67 | 10 |
| Sex Workers | 58.50 | 11 |
| Older adults | 53.33 | 12 |
| Asian / Pacific Islander | 51.83 | 13 |

Priority Populations

The terminology used for some priority populations were changed from the 2003 Comprehensive Plan to better target HIV prevention efforts. Racial and ethnic minorities were separated because HIV/AIDS rates and needs were different among racial/ethnic groups. This created three populations: Blacks, Hispanics, and Asian/Pacific Islanders. Also, the term Black is being used so that it is inclusive of African Americans, African immigrants, and those of Caribbean descent.

Each priority population includes individuals that pose a higher risk for acquiring the HIV infection than others. As in 2001, the HCPC decided to include sub-populations for each priority target population. The HCPC also recognizes that some individuals will fall into more than one population category, creating overlap in populations and sub-populations. This overlap, however, will help assure that individuals receive the appropriate prevention services to fit their needs. Targeting the sub-populations will allow to better meet the prevention needs of the priority population.

To identify sub-populations, the HCPC reviewed sub-populations from the 2003 Comprehensive HIV Prevention Plan along with those that were identified during the community services assessment. All sub-populations were reviewed and discussed by the HCPC as a group and some sub-populations were added while others were removed. Below are descriptions of the priority populations with the respective sub-populations. Sub-populations are not in any particular ranking order.

People Living with HIV/AIDS

There is a national focus on primary prevention efforts for people living with HIV/AIDS. Reasons why individuals may continue to engage in high risk behaviors after becoming HIV infected may be social (such as being lost to care or follow up), personal (such as addiction to sex or drugs or the lack of information about transmission or support for remaining vigilant about transmission), or cultural (such as the reluctance to know one's HIV status or disclose their status due to cultural shame or blame). There are many factors that may result in individuals being lost to care and follow-up, including fear, anger and the inability or unwillingness to accept their diagnosis. Mental illness or having a low educational level may also lead to individuals not understanding their diagnosis. These factors may lead to individuals continuing or increasing their risky behaviors. The continuation of risky behaviors places people living with HIV/AIDS at an additional risk for sexually transmitted diseases (STDs), acquiring a different or resistant strain of HIV, and may place others at risk for HIV infection.

Sub-populations for people living with HIV/AIDS include those continuing to engage in high risk behaviors. However, it is important to note that risk increases for each priority population when individuals are HIV infected.

- Sub-populations include:
- ◆ Men who have sex with men
 - ◆ Persons engaging in unprotected sex
 - ◆ Persons with recent STD diagnosis (within past 12 months)
 - ◆ Sex workers
 - ◆ Substance abusers
 - ◆ Women with unplanned pregnancies

Blacks

Blacks include African Americans, African immigrants and those of Caribbean descent. HIV disproportionately affects the Black community, with AIDS being the leading cause of death among African Americans between the ages of 25 and 34. In 2004, the CDC estimated that 50 percent of those diagnosed with HIV/AIDS were African American. In 2005, there were 508 reported cases of HIV (61%) and 388 reported cases of AIDS (62%) among Blacks in Virginia. An individual's race is not what places them at risk for HIV, but rather the behaviors they may engage in. Between 2001 and 2005, the primary modes of transmission among Blacks in Virginia were through heterosexual contact, injection drug use, and among men who have sex with men.

Although they only represent 10 percent of Virginia's population, Black women accounted for 21 percent of the new HIV cases reported in 2005. The HIV rate among Black women in Virginia is approximately four times that of their White counterparts.¹ In 2005, there were 411 reported cases of AIDS or HIV (not AIDS) among women in Virginia. Of these cases, 77 percent of the reported HIV cases and 77 percent of the reported AIDS cases were Black.

Considering representation in the population and available community resources, HIV/AIDS impacts African American MSM disproportionately. Stigma and discrimination surrounding HIV and homosexuality in the African American community are powerful influences on whether, how, where, and when African-American MSM seek services. African American MSM may not self-identify as being gay or bisexual and continue sexual relationships with women as well as men. Cultural factors, such as having and taking care of one's family or the importance of having children, may also contribute to African American MSM having sex with both men and women. Recent studies have cited African American men having sex with both men and women as being one of the primary reasons for increases in HIV infection among African American women.²

Based on an analysis of a national study, African Americans were more likely to have some substance abuse problem and were less likely than Whites to seek substance abuse treatment.³ Injection drug use in particular has had the largest impact on HIV in the African American community. African American IDUs have a higher prevalence of HIV/AIDS than White IDUs.

African American gatekeepers and opinion leaders, such as faith leaders and other community leaders, play a key role in reaching African Americans that are not being reached through other prevention efforts. Faith institutions serve as a spiritual, moral and cultural

¹ *The Impact of HIV/AIDS Among Black Women in Virginia*, Virginia Department of Health, Division of Disease Prevention. August 2006.

² Millett G, et al. *Focusing "down low": bisexual black men, HIV risk and heterosexual transmission*. **Journal of the National Medical Association**. July 2005: Vol. 97 (7 Suppl), 52S-59S.

³ Wells K, et al. *Ethnic Disparities in Unmet Need for Alcoholism, Drug Abuse, and Mental Health*. **American Journal of Psychiatry**. December 2001: Vol. 158 (12), 2027-2032.

center of many African American communities. Individuals tend to be more open when prevention messages come from those who have high respect in the community. This respect allows faith leaders and other gatekeepers or opinion leaders to influence the community norms about HIV, especially in allowing the adoption of risk reduction behaviors, testing and entrance into care.

African immigrants are a growing population in Virginia. This population has several barriers to access HIV prevention services, such as language and cultural barriers, documentation issues, the lack of access to health care services and the lack of awareness of HIV risk and transmission. A recent survey conducted among African immigrants in Houston, Texas revealed that 36.3 percent had never used a condom; 79.5 percent reported as having a low self-perceived risk for contracting HIV; and 16.3 percent of women and 29.9 percent of men showed a lack of awareness of transmission risks.⁴

Sub-populations include:

- ◆ African American gatekeepers
- ◆ African American men who have sex with men
- ◆ African American substance abusers
- ◆ African American youth engaging in high risk behaviors
- ◆ African immigrants
- ◆ Black women

Men who have sex with men

Men who have sex with men (MSM) includes men who self-identify as being gay or bisexual as well as those who do not self-identify but still engage in sexual activity with other men. The CDC estimated that, in 2004, MSM accounted for 70 percent of the male adults that received an HIV/AIDS diagnosis that year. Although, the number of HIV/AIDS cases has declined in Virginia, MSM still accounted for nearly 36 percent of the reported HIV/AIDS cases in 2005. This category continues to represent the greatest behavioral risk factor in HIV transmission. In this Comprehensive Plan, MSM have been moved to a higher priority than in the 2003 plan.

This population is made up of a variety of men from different cultures and ethnicities, different lifestyles, life experiences and social and economic conditions. Each of these differences is associated with different risks for HIV infection. All these different groups, however, experience some level of discrimination and stigma arising from lack of knowledge about homosexuality or from the hatred of homosexuality and homosexual persons (homophobia). Whatever the source of the discrimination and stigma, these forces often lead to lower or threatened self-esteem, which may, in turn, lead to engaging in high risk behaviors. Cultural, social, economic and political forces that create this stigma associated with homosexuality affects men's access to prevention services, especially among African American and Latino men as well as men living in rural areas. These communities may especially

⁴ Rosenthal L. *Assessing the HIV/AIDS Health Services Needs of African Immigrants in Houston*. **AIDS Education and Prevention**. December 2003: Vol. 15 (6); 570-580.

experience homophobia without any helpful sources of information or support. Among the many adverse impacts of discrimination, stigma and homophobia are reluctance or failure to disclose sexual activities to female partners or to health care providers. This may also lead to failure to seek care when questions or problems arise about HIV or other sexually transmitted infections as well as mental health issues or concerns, such as domestic violence, depression, substance abuse, sexual addictions and other problems.

Substance abuse, including alcohol abuse and the use of drugs, such as methamphetamine, continues to play a role in the MSM communities. Alcohol or other drug use may lead to engaging in risky sexual behaviors and injection of drugs may place men at an additional risk for HIV infection and other STIs. Recent reports have shown an increased use of methamphetamine and other party drugs among MSM, which can decrease social inhibitions and enhance sexual experiences and possibly lead to risky sexual behavior. Various studies have consistently shown that methamphetamine use is associated with unprotected anal sex among MSM.⁵

Men who may have had sex with men while incarcerated should also be targeted for HIV prevention services. Recent reports have suggested that the increase of HIV diagnosis among females, especially Black women, may be due to heterosexual contact with men who have been incarcerated. Recent reports also suggest that men who have a history of childhood sexual abuse may engage in high risk and/or aggressive sexual behavior. Although transgender persons are a separate population and not a subpopulation of MSM, it may be important to consider male-to-female (MTF) transgenders that have male sex partners as a subset of the MSM population. MTFs may not consider themselves as being MSM; however, some MSM may have transgender sex partners and systems of health care providing services to this population may provide care based on MSM needs. Sub-populations for MSM include those discussed as well as those engaging in other high risk behaviors.

- Sub-populations include:
- ◆ Black men
 - ◆ Incarcerated men
 - ◆ Latino men
 - ◆ Men living in rural areas
 - ◆ Men who do not self identify as gay or bisexual
 - ◆ Men engaging in sexual behaviors with anonymous partners
 - ◆ Men with a history of childhood sexual assault
 - ◆ MSM gatekeepers
 - ◆ Sex workers
 - ◆ Substance abusers
 - ◆ Youth engaging in high risk behaviors

⁵ Mansergh G, et al. *CDC Consultation on Methamphetamine Use and Sexual Risk Behavior for HIV/STD Infection: Summary and Suggestions*. **Public Health Reports**. March-April 2006: Vol. 121; 127-132.

High risk heterosexuals

High risk heterosexuals include men and women who engage in risky behaviors that place them at risk for HIV infection. Heterosexual contact accounted for nearly 19 percent of HIV/AIDS cases in Virginia in 2005. Recent reports depict an increase in infection among heterosexual Black women, due partly to heterosexual contact with MSM who do not self-identify as being gay, bisexual, or having had sex with men and do not disclose their sexual activities with their female partners.⁶ Studies have also shown that those who have a history of childhood sexual abuse may engage in high risk and/or aggressive sexual behavior.

Sub-populations include:

- ◆ Black men
- ◆ Black women
- ◆ Female partners of men who have sex with men
- ◆ Latino women
- ◆ Persons engaging in sexual behaviors with anonymous partners
- ◆ Persons with a history of childhood sexual assault
- ◆ Persons with multiple sex partners (3 or more in past year)
- ◆ Persons with recent STD diagnosis (within past 12 months)
- ◆ Sex partners of IDUs
- ◆ Substance Abusers

Transgenderers

In 2003, transgender persons were categorized as a population of special interest. The HCPC research subcommittee decided to make transgender persons their next population of interest and collaborated with Virginia Commonwealth University, Community Health Research Initiative to conduct the Virginia Transgender Health Initiative Survey (T.H.I.S.). Of the 350 survey participants, 10.5 percent self-reported as being HIV infected, all of which were male-to-female (MTF) transgenderers. Eighty-six percent of survey participants self-reported as being HIV negative and nearly four percent were not aware of their HIV status. These data allowed the HCPC to estimate HIV/AIDS prevalence for Virginia to use during the prioritization process. Results from T.H.I.S. provided the data to justify making transgender persons a priority population.

Of the survey participants, nearly 37% reported having had unprotected sex since their last HIV test. Over 50 percent of MTFs and 51.4 percent of FTMs reported never using a condom with primary partners. In terms of accessing health care services, 62.1 percent reported having regular doctors. Seventy-one percent of participants were “out” to their doctors and 51 percent felt their providers were knowledgeable about transgender issues.

⁶ Millett G, et al. *Focusing “down low”: bisexual black men, HIV risk and heterosexual transmission.* **Journal of the National Medical Association.** July 2005: Vol. 97 (7 Suppl), 52S-59S.

Survival sex, which is more common among MTFs, and sharing needles to inject hormones and silicone are common issues that place transgenders at risk for HIV infection. Social stigma, discrimination and victimization are common among transgender persons, all of which can lead to low self-images, the lack of social and medical services and increased risky behaviors. The lack of cultural sensitivity among providers discourages many transgenders from seeking medical or prevention services. All of these factors place transgender persons at a greater risk for engaging high-risk sexual or drug-related behaviors. Reaching this population may be difficult due to mistrust in providers; therefore, gatekeepers that are trusted in transgender community should be targeted to provide prevention messages to this population.

Sub-populations include:

- ◆ MTF transgenders
- ◆ Persons that share needles to inject drugs, hormones, or silicone
- ◆ Substance abusers
- ◆ Sex workers
- ◆ Transgender gatekeepers

Injection drug users (IDUs)

IDUs include those individuals injecting such drugs as methamphetamines, heroin, cocaine, etc. Between 2001 and 2005, reported cases of HIV/AIDS among IDUs in Virginia have decreased 56.1 percent. Therefore, the IDU population has moved down in priority ranking from the 2003 Comprehensive Plan. Through the end of 2005, 14 percent of reported HIV cases and 16.7 percent of reported AIDS cases in Virginia were reported with an IDU risk factor. A reported risk factor of "Sex partner of IDU" accounted for 4 percent of reported HIV cases and 4.8 percent of reported AIDS cases. The nature of injecting drugs, through sharing needles or works as well as the methods used in drug preparation, place users at heightened risk for HIV infection and make this population hard to reach. The injection of some drugs, such as methamphetamine, can decrease social inhibitions and enhance sexual experiences and can lead to risky sexual behavior.

The prevalence of injection drug use has impacted Black men disproportionately, compared to White and Hispanic males. New injectors should also be targeted because previous HIV prevention messages targeting IDUs may not have reached them and may provide the greatest opportunity to prevent both hepatitis and HIV transmission. They are likely to have been introduced to injection drug use by older or more experienced users; therefore, they may be at risk of sharing needles or works with individuals who may already be HIV infected. IDUs in aftercare and recovery should also be targeted to assure that prevention messages and interventions are offered as they return to the communities in which they previously engaged in drug use. Also, a substantial proportion of people who engage in sex work and/or exchange sex for money or drugs have a drug or alcohol addiction (also known as substance use disorder). Targeting HIV prevention services to IDUs also presents an opportunity to provide prevention services for Hepatitis B and C, which have become epidemic among this population.

- Sub-populations include:
- ◆ Black men
 - ◆ IDU in aftercare and recovery
 - ◆ New injectors (injecting 1 year or less)
 - ◆ Sex workers

Homeless

In 2005, it was estimated that over 43,000 persons in Virginia were homeless, including those either permanently, temporarily or periodically without a residence or shelter. The homeless population has shown a high prevalence of mental illness, substance abuse, and sex work, placing them at higher risk for contracting HIV. A recent study showed that 88% of homeless single men and 68% of homeless single women had a mental illness or substance abuse issues.⁷ The presence of mental illness and/or substance abuse issues impairs individual judgment to make healthy sexual or drug-related decisions. The transient lifestyle of the homeless makes it difficult to reach this population with HIV prevention messages and interventions. Population may also be more vulnerable to exploitation, sexual assault, etc. No sub-populations were identified for this population.

Incarcerated

Incarcerated individuals include men and women currently incarcerated or those that are enrolled in probation or parole systems. The CDC estimates that HIV infection among the incarcerated population is five times higher than that of the general population. These individuals are at a greater risk because the activities that lead to incarceration, such as drug-related issues, are the same activities that place them at risk for HIV infection. Also, sexual and drug-related behaviors during incarceration place them at risk. Among the challenges of this population is the lack of reliable data available from which a valid assessment of risk can be made.

A recent study in the Georgia prison system found that, between 1988 and 2005, 88 men had a negative HIV test at entry into the prison system and a HIV seroconversion during incarceration. The primary transmission risk found was among men who had had sex with another man.⁸ Another study found that 51 percent of men engaged in unprotected sex on the first day of re-entry into the community from prison and 86 percent had engaged in unprotected sex within the first week of re-entry into the community from prison.⁹ Therefore, it is imperative that HIV interventions target those recently released from jail or prison. Youth

⁷ Carol S., et al; *Are Rates of Psychiatric Disorders in the Homeless Population Changing?* **American Journal of Public Health.** Vol. 94 (1); January 2004: 103-108.

⁸ *HIV Transmission Among Male Inmates in a State Prison System – Georgia, 1992-2005.* **Morbidity and Mortality Weekly Report.** Vol. 15 (15); April 21, 2006.

⁹ *Project START: HIV/STD/hepatitis prevention for young men being released from prison.* July 2004. [Online: <http://www.cdc.gov/hiv/topics/research/projectSTART/resources/publications/pdf/Project%20Description.PDF>].

offenders must also be targeted as they may not have received HIV education or interventions while in the school system.

- Sub-populations include:
- ◆ Recently released (within 6 months)
 - ◆ Partners of those recently re-entering the community
 - ◆ Substance abusers
 - ◆ Youth offenders

Youth

The youth population includes all those between the ages of 13 and 24. The CDC estimates that 13 percent of HIV/AIDS cases diagnosed in 2004 were among the youth population. In 2005, youth accounted for nearly 16 percent of HIV/AIDS cases in Virginia. Black youth are disproportionately affected by HIV/AIDS. Provision of comprehensive human sexuality and HIV/STD education can be challenging especially for those youth in school settings due to requirements of parental approval and the autonomy of school districts in determining the content of Family Life curricula.

Adolescence is a time for growth and change as well as a time for exploration, which may include sexual activity or substance abuse. Unprotected sex places youth at risk for contracting HIV, other STDs and unintended pregnancies. This population may not be concerned about becoming infected with HIV. Young MSM may not receive HIV prevention messages targeting MSM in fear of being outed and may engage in anonymous sex or have relationships with older men. Those who have not disclosed their sexual orientation are also less likely to seek HIV testing. Also, homeless or runaway youth may be placing themselves at risk for HIV by exchanging sex for money, drugs, shelter, clothing or food. The HIV prevalence among homeless youth is estimated to be two to ten times higher than among other youth in the U.S.¹⁰

- Sub-populations include:
- ◆ Black youth
 - ◆ Incarcerated youth
 - ◆ Young men who have sex with men
 - ◆ Persons with a history of childhood sexual assault
 - ◆ Persons with a recent STD diagnosis (within 12 months)
 - ◆ Pregnant teens
 - ◆ Runaway or homeless youth
 - ◆ Substance abusers
 - ◆ Youth with multiple sex partners (3 or more in past year)
 - ◆ Youth who engage in survival sex

¹⁰ *Homeless Youth (Fact Sheet #13)*. **National Coalition for the Homeless**. June 2006: [Found online: <http://www.nationalhomeless.org/publications/facts/youth.pdf>].

Latinos

The Latino population continues to be affected by the HIV epidemic, accounting for over nine percent of HIV diagnosis in Virginia in 2005. Discrimination, economic disparities, and language barriers act as obstacles for this population when accessing health services. The primary mode of transmission among Latino men was through sexual activity with other men. There is also a high prevalence of substance abuse among Latino men. The concept of familismo is that of commitment to family, which for Latino MSM may cause conflict in disclosing their sexual activities with families and/or with female sexual partners. Also, machismo gives men an idea that sex proves masculinity, leading men to have multiple partners and allowing them to make the decisions on sexual practices. This reduces women's ability to make healthy sexual decisions. As in the Black community, Latino gatekeepers, such as faith leaders and other community leaders, play a key role in affecting community norms surrounding HIV and allow access in reaching Latinos that are not being reached through other prevention efforts.

In addition, Virginia has one of the fastest growing Latino populations in the country. Latinos represented 4.7 percent of Virginia's population in 2000; whereas, in 2005 they represented six percent. This estimate, however, only includes those with documented immigration status. It is estimated that there are between 250,000 and 300,000 undocumented individuals living in Virginia. Nationally, 81 percent of undocumented individuals are from Latin America.¹¹ Furthermore, this population may have a transient lifestyle, especially among those undocumented or among migrant workers. This may have a negative impact and lead to underreporting of HIV risk and infection. This continuing growth in the Latino population contributes to the need for additional resources targeting this population.

- Sub-populations include:
- ◆ Latino gatekeepers
 - ◆ Latino immigrants
 - ◆ Latino men
 - ◆ Latino women
 - ◆ Men who have sex with men
 - ◆ Persons with a recent STD diagnosis (within 12 months)
 - ◆ Seasonal and migrant farm workers
 - ◆ Substance abusers
 - ◆ Sex workers
 - ◆ Transgender Persons

¹¹ Pew Hispanic Center, 2005. [www.pewhispanic.org]

The following populations fell below the scores for populations in the top ten ranking; however, these populations have considerable risk factors for HIV and should be included when possible in the development of HIV prevention programs and interventions. In some cases, these populations may also fall within and overlap the priority populations previously listed. Limited data on some populations of special interest may have prevented them from being ranked higher and inclusion of these populations in HIV prevention efforts is certainly justified.

Mentally Challenged

Those that are mentally challenged or have some mental illness may not be capable of understanding the risks of HIV transmission and often lack the negotiation skills needed to make healthy sexual decisions that protect them from HIV infection. This population may be vulnerable to coercion and exploitation. When the mental illness is not being treated properly, these individuals have a high prevalence of incarceration, substance abuse and homelessness. There is also a low prevalence of condom use among this population. Mentally challenged people who choose to engage in consensual sex may not have been provided with any reproductive health or sex education or have been given limited access to such information because providers/family members may fail to recognize their adult sexual desires.

Sex Workers

This population includes men and women who sell or trade sex for money, drugs or some benefit, such as housing or food. These individuals are vulnerable to HIV infection and often engage in risky sexual behaviors because they do not feel they can negotiate safer sexual behaviors. Due to the illegal nature of sex work and any history of violence, they may not trust those providing services, such as HIV prevention services, making them difficult to reach. This population has been incorporated into many of the priority target populations.

Older adults

This population includes those individuals 50 years of age and older. It is often viewed that individuals in this age category are not engaging in sexual or drug-related behaviors; therefore, HIV prevention messages do not target this population. Furthermore, older adults do not view themselves as being at risk for HIV infection, making them less likely to use condoms or seek HIV testing. Being divorced or widowed may place older adults back into a dating environment in which they are not used to negotiating or discussing safer sex. Because older women are no longer worried about pregnancy risks, they may not be concerned about protection for STDs and HIV. Furthermore, older adults with HIV are often diagnosed later in the disease process because physicians may fail to suspect HIV when symptoms arise.

Asian / Pacific Islanders (API)

Although the number of HIV/AIDS cases among APIs remains low, from 2001 through 2005, APIs had the largest percentage increase in HIV/AIDS cases than any other ethnic minority in the U.S.¹² Virginia has the ninth highest number of API residents in the U.S. The API community consists of over 40 distinct ethnicities and over 100 languages or dialects. Sixty-three percent of APIs in the United States are foreign born and over four million have a limited English proficiency. These cultures also view sexual behaviors as private issues and avoid discussion surrounding sex, especially homosexuality. These cultural and linguistic barriers make the API community difficult to reach with HIV prevention messages.

¹² Tepporn, Ed. *The Impact of HIV/AIDS*. Asian/Pacific Islander American Health Forum. June 7, 2006: [PowerPoint presentation]

In 2007, the Virginia HCPC began the process of selecting HIV prevention interventions for each priority population. In 2003, six factors, listed below, were used to prioritize interventions. Each factor was assigned a weight and a scale of zero to five was used to aid in the scoring process. A list of interventions was determined based on the Taxonomy of HIV Interventions.

Six Factors used in 2003 to Prioritize HIV Interventions:

- ◆ Does the intervention target a specific behavior that will change as a result of the intervention?
- ◆ Are there indicators of outcome effectiveness?
- ◆ Does the intervention meet the norms, values, and consumer preferences of the community?
- ◆ Is there a theoretical basis?
- ◆ Is the intervention cost effective?
- ◆ Does the intervention address a high priority need?

In 2007, this process differed in that prioritization of interventions was no longer required. To begin, a list of interventions was compiled by priority population, which included interventions from the Taxonomy as well as *Diffusion of Effective Behavioral Interventions* (DEBIs), those from the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*, Best-Evidence Interventions and other known HIV interventions. Committee members were also given a list of possible criteria that could be used to select interventions. The committee broke into three groups to determine which criteria, either from the list provided to them or any additional criteria, to use in this process. The recommendations from the three groups were compiled and a list of six criteria was approved by the full committee, two of which would be a mandatory requirement for each intervention. It was also decided that if an intervention met four of the six criteria, then it would be selected as a recommended intervention.

Six Criteria used in 2007 to Select HIV Interventions:

- ✧ The intervention targets a specific behavior / population.
 - ✧ The intervention is based on behavioral and/or social science theory and has proven effectiveness.
 - ◆ The intervention is acceptable to the target population, including accessibility to and input from the target population.
 - ◆ The intervention is cost-effective.
 - ◆ There are sufficient resources available to carry out the intervention.
 - ◆ The intervention is adaptable for other populations or settings (i.e. rural vs. urban).
- ✧ *The first 2 criteria are mandatory for an intervention to be selected.*

Once the criteria were decided, the process of selecting interventions began. The committee broke into four groups based on priority population. All groups evaluated homeless

populations together to ensure standardization of the process across groups. Groups one and two assessed interventions for people living with HIV, men who have sex with men, high risk heterosexuals, transgenders and Latinos. Groups three and four assessed interventions for Blacks, injection drug users, the incarcerated and youth. Each group was given the list of interventions, by priority population, with the criteria for selection as well as information on each of the interventions, information on cost-effectiveness of various types of interventions and information on which interventions were currently being conducted through funding from the Virginia Department of Health. Each group used this information to decide whether the interventions met the criteria for selection.

The selected interventions were then compiled and were compared for those that differed between groups. Groups one and two reconvened to decide on whether to keep or remove interventions that differed among them. Groups three and four did the same. The groups also assessed the final list of interventions, considering such factors as whether the intervention is currently or has in the past been funded through the Virginia Department of Health and whether training is available for the intervention, either through the Virginia Department of Health or through national technical assistance. Groups also decided what, if any, interventions should be kept as alternate interventions if resources and/or training become available. Due to concerns of insufficient resources to provide all of the interventions selected for each priority population, a conference call was also conducted with HCPC members to review the final menu of recommended interventions. At this time, some interventions were removed or placed on the alternate list of interventions.

Table 1 lists the interventions recommended by the Virginia HCPC for each priority population. Table 2 lists the alternate interventions selected for each priority population if resources and/or training become available. Descriptions of each intervention follow each table.

Table 1: Menu of HIV Interventions for Priority Populations

Descriptions of the interventions follow.

| | PLWAs | Blacks* | MSM | Heterosexuals | Transgenders | IDUs | Homeless | Youth | Incarcerated | Latinos |
|--|-------|---------|-----|---------------|--------------|------|----------|-------|--------------|---------|
| Counseling, Testing and Referral Services | | | | | | | | | | |
| Partner Counseling and Referral Services | | | | | | | | | | |
| Comprehensive Risk Counseling and Services | | | | | | | | | | |
| Outreach | | | | | | | | | | |
| Community PROMISE | | | | | | | | | | |
| Healthy Relationships | | | | | | | | | | |
| Intensive AIDS Education in Jail | | | | | | | | | | |
| Many Men, Many Voices | | | | | | | | | | |
| MPowerment | | | | | | | | | | |
| Popular Opinion Leader | | | | | | | | | | |
| Real AIDS Prevention Project (RAPP) | | | | | | | | | | |
| Safety Counts | | | | | | | | | | |
| Sisters Informing Sisters on Topics about AIDS (SISTA) | | | | | | | | | | |
| Social Skills Training | | | | | | | | | | |
| Street Smart | | | | | | | | | | |
| Together Learning Choices | | | | | | | | | | |
| VOICES/VOCES | | | | | | | | | | |

* For all interventions recommended for Blacks, consideration should be made for gender-based groups when being conducted with the African immigrant population. Mixed gender groups may be effective if interventions are being conducted with African youth.

Counseling, Testing and Referral Services (CTR)

HIV counseling and testing provides information about HIV transmission and prevention, the meaning of test results, and HIV prevention counseling to reduce individual's risk for transmitting or acquiring HIV. The referral process assesses and prioritizes the individual's needs for prevention, care and/or supportive services. CTR is recommended for all priority populations. Refer to the Taxonomy and Standards for HIV Prevention Interventions for more details on the CTR model.

Partner Counseling and Referral Services (PCRS)

PCRS provides services to HIV-infected individuals, their partners and affected communities that includes informing current and past partners and encouraging HIV counseling and testing. PCRS allows sex and/or injection drug use partners who test positive access to early medical evaluation, treatment and prevention services, including risk reduction services. PCRS is recommended for all priority populations.

Comprehensive Risk Counseling and Services (CRCS)

CRCS, formerly known as prevention case management (PCM), is intensive, client-centered counseling, which promotes the adoption and maintenance of HIV risk-reduction behaviors. CRCS assists HIV-positive and HIV-negative individuals to reduce risk behaviors and to address the psychosocial and medical needs that contribute to HIV risk behavior or poor health outcomes. CRCS is recommended for all priority populations. Refer to the Taxonomy and Standards for HIV Prevention Interventions for more details on the CRCS model.

Outreach

Outreach allows providers to reach high-risk individuals to increase their knowledge of HIV, prevention strategies and relevant community resources. Outreach can be affective in linking individuals to care and supportive services and enrolling individuals into other HIV prevention interventions. Outreach is recommended for Blacks, men who have sex with men, heterosexuals, transgenders, injection drug users, homeless, youth and Latinos. Refer to the Taxonomy and Standards for HIV Prevention Interventions for more details.

Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies)

Community PROMISE is based on the Stages of Change theory and is a community-level DEBI that relies on role model stories and peer advocates from the community. Role model stories are written based on interviews of the priority population and are distributed by peer advocates within their social networks. Community PROMISE can easily be adapted for various subpopulations and can be formatted to reflect cultural differences. The HCPC recommends Community PROMISE for the Blacks, men who have sex with men, heterosexuals, transgenders, injection drug users, youth and Latinos. For more information, please refer to www.effectiveinterventions.org.

Healthy Relationships

Healthy Relationships is a DEBI based on the Social Cognitive Theory and incorporates five small-group sessions for men and women living with HIV/AIDS. This intervention focuses on developing decision-making and problem-solving skills, allowing individuals to make informed and safe decisions about disclosure and behavior. Healthy Relationships is highly adaptable for subpopulations of persons living with HIV/AIDS and can be adaptable for various settings, including clinical and community-based settings. The HCPC recommends Healthy Relationships for people living with HIV/AIDS. For more information, please refer to www.effectiveinterventions.org.

Intensive AIDS Education in Jail

Intensive AIDS Education in Jail, found in the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*, is based on a problem-solving therapy model. It consists of four 60-minute small group sessions to reduce HIV drug- and sex-related behaviors among adolescent drug users. The HCPC recommends Intensive AIDS Education in Jail for the incarcerated population. For more information, please refer to the *Compendium* at www.cdc.gov/hiv/resources/reports/hiv_compendium/pdf/HIVcompendium.pdf.

Many Men, Many Voices (3MV)

3MV is a group-level DEBI of six or seven sessions, which targets gay men of color and men on the 'down low' with or without female partners. This intervention addresses such issues as behavioral factors specific to gay men of color with a goal of fostering a positive self-image, increasing knowledge of STD/HIV risks and increasing skills in risk reduction and partner communication. 3MV may be modified for other populations that may not identify as being 'of color,' such as Asian/Pacific Islanders and Latinos. The HCPC recommends 3MV for men who have sex with men. For more information, please refer to www.effectiveinterventions.org.

MPOWERment

MPOWERment is a community level DEBI that targets young gay and bisexual men between 18 and 29 years of age. Young gay men and volunteers design and carry out this intervention, which consists of four integrated activities: formal outreach, M-groups, informal outreach and an ongoing publicity campaign. The HCPC recommends MPOWERment for men who have sex with men. For more information, please refer to www.effectiveinterventions.org.

Popular Opinion Leader (POL)

POL is a community-level DEBI that trains opinion leaders to encourage safer sexual norms and behaviors within their social networks through risk reduction conversations. POL can be easily adapted for various target populations and settings. The HCPC recommends POL for people living with HIV/AIDS, Blacks, men who have sex with men, heterosexuals, transgenders, injection drug users, and Latinos. For more information, please refer to www.effectiveinterventions.org.

Real AIDS Prevention Project (RAPP)

RAPP is a community-level DEBI targeting sexually active women and their male partners to reduce their risks for HIV infection. The objectives of this intervention include increasing consistent condom use, change community norms surrounding safer sex practices and involve the community in the process. This intervention can be adapted for different cultures; however, the adapted intervention must be culturally competent. The HCPC recommends RAPP for the heterosexual population. For more information, please refer to www.effectiveinterventions.org.

Safety Counts

Safety Counts, a DEBI, is a cognitive-behavioral intervention that targets those currently using drugs, including both injection and non-injection drug users, and those that are not in drug treatment programs. This intervention consists of seven sessions, in both group and individual settings, and aims to reduce high-risk drug use and sexual behaviors. Adaptations to Safety Counts for other populations or subpopulations may be difficult. The HCPC recommends Safety Counts for injection drug users. For more information, please refer to www.effectiveinterventions.org.

Sisters Informing Sisters about AIDS (SISTA)

SISTA is a peer-led DEBI that targets heterosexually active African American women. It focuses on social skills training and aims to reduce HIV sexual risk behavior. This intervention includes five two-hour sessions, which are gender specific and culturally relevant. Sessions are delivered by peer facilitators in a community-based setting. SISTA may be adapted for other populations; however, it may involve new activities and discussions not part of the SISTA curricula that are culturally relevant to the new population of women. The HCPC recommends SISTA for the Black and heterosexual populations. For more information, please refer to www.effectiveinterventions.org.

Social Skills Training

Social Skills Training, found in the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*, is a social skills training based on the Social Cognitive Theory and theories of gender and power. This intervention consists of five two-hour sessions, led by peer educators, which focus on gender and ethnic pride, personal responsibility for sexual decision making, sexual assertiveness and communication, condom use and cognitive coping skills. The HCPC recommends Social Skills Training for Blacks. For more information, please refer to the *Compendium* at www.cdc.gov/hiv/resources/reports/hiv_compendium/pdf/HIVcompendium.pdf.

Street Smart

Street Smart is a DEBI that targets runaway and homeless youth between the ages of eleven and 18. It is a skills building program based on the social learning theory and aims to aid young people in reducing unprotected sex acts, number of sex partners, and substance use. This intervention is conducted over a six- to eight-week period with ten to twelve youth through eight group sessions, one individual counseling session and one visit to a

community-based organization that provides healthcare. Street Smart can be adapted and used in other venues and among other racial or ethnic groups. The HCPC recommends Street Smart for the youth population; however, because this intervention is effective in established areas, it may not be as effective in rural settings. For more information, please refer to www.effectiveinterventions.org.

Together Learning Choices

Together Learning Choices is a group-level DEBI that targets young people between 13 and 29 years of age living with HIV. This intervention assists young people to identify ways to increase their use of health care services, decrease risky sexual behaviors and drug and alcohol use and improve their quality of life. The HCPC recommends Together Learning Choices for the youth population. For more information, please refer to www.effectiveinterventions.org.

Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES)

VOICES/VOCES is a DEBI that targets African American and Latino adult men and women and consists of one 45-minute session. Through this intervention, HIV risk behavior and condom use education is delivered through videos, facilitated group discussion, and a poster depicting various condom brands in both English and Spanish. VOICES/VOCES can be adapted for other populations at high risk for HIV infection. The HCPC recommends VOICES/VOCES for the Black, heterosexual, transgender and Latino populations. For more information, please refer to www.effectiveinterventions.org.

Table 2: Alternate Menu of HIV Interventions for Priority Populations

The following HIV interventions will be recommended if resources and/or training become available.

Descriptions of the interventions follow.

| | PLWAs | Blacks | MSM | Heterosexuals | Transgenderers | IDUs | Homeless | Youth | Incarcerated | Latinos |
|--|-------|--------|-----|---------------|----------------|------|----------|-------|--------------|---------|
| AIDS Community Demonstration Project | | | | | | | | | | |
| Be Proud! Be Responsible! | | | | | | | | | | |
| Becoming a Responsible Teen (BART) | | | | | | | | | | |
| Breaking the Silence | | | | | | | | | | |
| Coaching for Wellness | | | | | | | | | | |
| Communal Effectance – AIDS Prevention | | | | | | | | | | |
| Health Improvement Project | | | | | | | | | | |
| Hermanos de Luna y Sol | | | | | | | | | | |
| Hot, Healthy, and Keeping It Up! | | | | | | | | | | |
| Keeping It Real | | | | | | | | | | |
| Project SAFE | | | | | | | | | | |
| Sex, Drugs, and Latex | | | | | | | | | | |
| Talking Drum | | | | | | | | | | |
| Unmasking Sexual Con Games | | | | | | | | | | |
| Women Involved in Life Learning from Others (WiLLOW) | | | | | | | | | | |

AIDS Community Demonstration Project

The AIDS Community Demonstration Project, found in the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*, is a community-level intervention that is based on the Transtheoretical Model of Behavior Change. This intervention involves the use of role model stories from members of the target population with a goal of modifying attitudes and beliefs about HIV prevention services and increase condom use with main and non-main partners and/or increase disinfection of injection equipment. The HCPC recommends the AIDS Community Demonstration Project for transgenders and injection drug users if resources and/or training for the intervention become available. For more information, please refer to the *Compendium* at www.cdc.gov/hiv/resources/reports/hiv_compendium/pdf/HIVcompendium.pdf.

Be Proud! Be Responsible!

Be Proud! Be Responsible!, found in the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*, is a small group intervention consisting of one five-hour session aimed to reduce HIV risk behaviors and increase condom use. The intervention includes information about risks associated with injection drug use and specific sexual activities. The HCPC recommends Be Proud! Be Responsible! for youth if resources and/or training for the intervention become available. For more information, please refer to the *Compendium* at www.cdc.gov/hiv/resources/reports/hiv_compendium/pdf/HIVcompendium.pdf.

Becoming a Responsible Teen (BART)

BART can be found in the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* and is based on social learning theory and focuses on participants' informational needs, motivational influences and behavior. This intervention aims to increase condom use and decrease the frequency of unprotected intercourse. The HCPC recommends BART for youth if resources and/or training for the intervention become available. For more information, please refer to the *Compendium* at www.cdc.gov/hiv/resources/reports/hiv_compendium/pdf/HIVcompendium.pdf.

Breaking the Silence

Breaking the Silence is a faith-based intervention that was developed for African American clergy, Christian educators and ministry leaders to increase their comfort level in addressing issues related to sex and sexuality with teens. This intervention compliments "Keeping It Real," which targets African American youth, and was developed for implementation within a church setting. The HCPC recommends Breaking the Silence for Blacks if resources and/or training for the intervention become available.

Coaching for Wellness

Coaching for Wellness is a group level intervention in which participants focus on health maintenance and coping with HIV, social support and decreased risk behavior. This intervention involves skill development sessions that include risk reduction components, behavioral self-management, assertion skills training, relationship skills and social support

development. The HCPC recommends Coaching for Wellness for people living with HIV/AIDS if resources and/or training for the intervention become available.

Communal Effectance – AIDS Prevention

Communal Effectance – AIDS Prevention is a Best Evidence Intervention that consists of small group sessions that emphasize negotiation skills training and that women’s sexual behavior affects both themselves and the people around them. The intervention includes information on HIV/AIDS prevention, high-risk behaviors and condom use with the goal of reducing HIV transmission risk behaviors and STDs. The HCPC recommends Communal Effectance – AIDS Prevention for heterosexuals if resources and/or training for the intervention become available. For more information, please refer to www.cdc.gov/hiv/topics/research/prs/best-evidence-intervention.htm.

Health Improvement Project (HIP)

HIP, a Best Evidence Intervention, is a small group, skills training intervention that aims to increase HIV-related knowledge, interpersonal skills and condom use and to reduce risky sexual behaviors among persons with mental illness. The HCPC recommends HIP for heterosexuals if resources and/or training for the intervention become available. For more information, please refer to www.cdc.gov/hiv/topics/research/prs/best-evidence-intervention.htm.

Hermanos de Luna y Sol

Hermanos de Luna y Sol was developed as a culturally-appropriate HIV risk-reduction intervention targeting immigrant and Spanish-speaking gay and bisexual men. This intervention aims to promote awareness of the social and cultural norms that impact participants’ social and sexual lives. The HCPC recommends Hermanos de Luna y Sol for the Latino population if resources and/or training for the intervention become available. For more information, please refer to www.caps.ucsf.edu/projects/HLS.

Hot, Healthy, and Keeping It Up!

Hot, Healthy, and Keeping It Up! is a group level intervention based on the Health Belief Model, the Theory of Reasoned Action and the Social Learning Theory. This group-level intervention targets gay and bisexual men through culturally appropriate behavioral skills-based training and aims to provide support for making healthy sexual decisions. The HCPC recommends Hot, Healthy, and Keeping It Up! for men who have sex with men if resources and/or training for the intervention become available.

Keeping It Real

Keeping It Real is a faith-based intervention that targets African American youth and was developed for African American clergy, ministry leaders, youth ministers and adults to address issues of teen pregnancy prevention, HIV/AIDS and other reproductive issues. This intervention provides youth the resources needed to make healthy and responsible decisions. Keeping It Real compliments Breaking the Silence and was developed for

implementation within a church setting. The HCPC recommends Keeping It Real for the youth population if resources and/or training for the intervention become available.

Project SAFE

Project SAFE, a Best Evidence Intervention, is based on a small group, motivational and skill building model that aims to reduce high-risk sexual behaviors and STDs among minority women. This intervention emphasizes recognizing risk, increasing commitment to change behavior and facilitating protective skills. It includes such strategies as abstinence, monogamy, correct condom use and reducing the number of sex partners. The HCPC recommends Project SAFE for the Latino population if resources and/or training for the intervention become available. For more information, please refer to www.cdc.gov/hiv/topics/research/prs/best-evidence-intervention.htm.

Sex, Drugs, and Latex

Sex, Drugs, and Latex is a group-level intervention that targets men who have sex with men between the ages of 15 and 46. This four-hour workshop includes HIV 101, drugs and HIV/STD discussion, risk reduction, condom use, condom and sexual negotiation skills building, small group discussions and disclosure skills. HIV counseling and testing is offered at the end of the workshop. The HCPC recommends Sex, Drugs, and Latex for men who have sex with men if resources and/or training for the intervention become available.

The Talking Drum

The Talking Drum was developed under the American Red Cross African American HIV/AIDS Program to provide factually accurate, nonjudgmental and culturally appropriate HIV/AIDS prevention sessions that promote self-protective behaviors. Sessions assist participants in building HIV prevention skills, including decision-making, problem solving, negotiation and refusal skills. The HCPC recommends the Talking Drum for the Black population if resources and/or training for the intervention become available.

Unmasking Sexual Con Games

Unmasking Sexual Con Games is a multiple session intervention designed to assist youth identify and deal with sexual harassment and abuse, identify coercion strategies that may be used by members of the opposite sex, and identify and set personal boundaries for healthy relationships. This intervention can be conducted in a variety of settings, including middle schools, high schools, churches, detention centers, shelters and residential group homes. The HCPC recommends Unmasking Sexual Con Games for youth if resources and/or training for the intervention become available.

Women Involved in Life Learning from Other Women (WiLLOW)

WiLLOW, a Best Evidence Intervention, is a small group, skills-building intervention targeting women living with HIV. The intervention focuses on reducing HIV and STD risk behaviors and enhancing HIV-preventive psychosocial and structural factors. WiLLOW emphasizes gender pride and informs women how to identify and maintain supportive people in their social networks. The HCPC recommends WiLLOW for people living with

HIV/AIDS and heterosexuals if resources and/or training for the intervention become available. www.cdc.gov/hiv/topics/research/prs/best-evidence-intervention.htm.

The Taxonomy and Standards for HIV Prevention Interventions from the 2003 Comprehensive HIV Prevention Plan were revised with input from the Standards and Practices Subcommittee of the Virginia HCPC and adopted by the Virginia HCPC in July 2007.

Taxonomy of Virginia HIV Prevention Interventions

The purpose of this section is to outline and define categories of HIV prevention interventions. Agencies should refer to the Standards for HIV Prevention Interventions for further requirements related to the following interventions.

Counseling, Testing, Partner Counseling and Referral Services

- **Screening:** A process by which all individuals in a population or specific site are routinely offered HIV testing. The individual receives information about HIV tests and the meaning of the test results and is provided testing to detect the presence of antibodies. Screening does not generally include risk reduction or prevention counseling unless an individual client is identified as having an increased risk for HIV.
- **Counseling and Testing:** A process through which an individual receives information about HIV transmission and prevention, information about HIV tests and the meaning of the tests results, HIV prevention counseling to reduce their risk for transmitting or acquiring HIV, and is provided testing to detect the presence of HIV antibodies.
- **Referral:** A process by which immediate client needs for prevention, care and supportive services are assessed and prioritized and clients are provided with information and assistance in identifying and accessing specific services (such as, setting up appointments and providing transportation).
- **Partner Counseling and Referral Services (PCRS):** A range of services available to HIV-infected persons, their partners and affected communities that involves informing current and past partners that a person who is HIV-infected has identified them as a sex or injection drug partner and advising them to have HIV counseling and testing. Notified partners, who may have suspected their risk, can then choose whether to be tested for HIV, enabling those who test positive to receive early medical evaluation, treatment and prevention services, including risk-reduction counseling.

Comprehensive Risk Counseling and Services (CRCS)

- **CRCS:** A client-centered HIV prevention counseling activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. CRCS provides intensive, on-going, individualized prevention counseling, support and services. This HIV prevention

activity addresses the relationship between HIV risk and other issues, such as substance use disorders, STD treatment, mental health and social and cultural factors.

Health Communication / Public Information (HC/PI)

- **HC/PI:** The delivery of planned HIV/AIDS prevention messages through one or more channels to encourage safe behavior, personal risk-reduction efforts, the use of HIV prevention services and changing community norms. Channels of delivery include:
 - **Electronic media:** Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcast, infomercials, etc., which reach a large-scale (e.g., city, region or statewide) audience.
 - **Print media:** These formats also reach a large-scale or nationwide audience and include any printed material, such as newspapers, magazines, pamphlets and "environmental media" such as billboards and transportation signage.
 - **Mass media:** Use of the media to reach the public or targeted populations. (Includes television, radio, print and the Internet.) The use of print, radio, television or the Internet to advertise an event or agency should not be considered a mass media campaign.
 - **Hotlines:** Telephone service (local or toll free) offering up-to-date information and referral to local services, e.g., counseling/testing and support services
 - **Clearinghouses:** Interactive electronic outreach systems using telephones, mail and the Internet/Worldwide Web to provide responsive information service to the general public as well as high-risk populations.
 - **Community/health fairs:** An effective way to provide valuable health information and/or screening services to the general public and/or high risk individuals in a convenient "one-stop shop" format.
 - **Presentation/lectures:** These are information-only activities conducted in group settings; often called "one-shot" education interventions.

Health Education / Risk Reduction (HE/RR)

- **HE/RR:** A set of prevention activities provided to individuals or groups to assist clients in making plans for individual behavior change, promote and reinforce safer behaviors and provide interpersonal skills training in negotiating and sustaining appropriate behavior

change. Activities range from individual HIV prevention counseling to group interventions to broad, community-based interventions.

- **Individual Level Interventions (ILI):** Health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings, e.g., substance abuse treatment settings, in support of behaviors and practices that prevent transmission of HIV. Help clients make plans to obtain these services.
- **Group Level Interventions (GLI):** Health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. Uses peer and non-peer models involving a wide range of skills, information, education and support.
- **Community Level Interventions (CLI):** Programs designed to reach a defined community (geographic or an identified subgroup) to increase community support of the behaviors known to reduce the risk for HIV infection and transmission by working with the social norms or shared beliefs and values held by members of the community. CLI aim to reduce risky behaviors by changing attitudes, norms and practices through community mobilization and organization and community-wide events.
 - ♦ **Social Marketing:** Social marketing is an example of a community level intervention that is a research-driven and consumer-centered process used to change individuals' behavior. Social marketing differs from other health education strategies in that it is based upon commercial marketing techniques. Social products, such as condom use, are viewed as commercial products and promoted using the same principles applied in the commercial sector.

Outreach

- **Outreach:** Interventions generally conducted by health educators, face-to-face in neighborhoods or other areas where high-risk individuals typically congregate. Outreach may include risk-reduction counseling, referral to HIV testing and the distribution of condoms or educational materials. A major purpose of outreach activities is to encourage those at high-risk to learn their HIV status and to provide information and assistance in accessing HIV testing services. *Note: The distribution of materials by itself is not considered outreach but rather an activity associated with HC/PI intervention(s).*

- **Basic Street/Community Outreach:** Brief contacts in which outreach specialists engage in conversations in order to provide educational information, literature and resources, such as condoms, bleach kits, referrals, etc. This type of outreach is important for establishing rapport within a community and building trust with individuals. It can be used as a method for bringing clients into other services such as intensive street outreach, counseling and testing, comprehensive risk counseling services, home health parties and education groups. Basic outreach cannot be expected to change behaviors in and of itself.
- **Intensive Street/Community Outreach:** Ongoing encounters in which outreach specialists spend extended periods of time with clients to assess risks, make plans with clients for behavior change and provide referrals. Outreach specialists may also facilitate clients' entrance into services and should verify follow-through on referrals when possible. Both process and outcome monitoring should be used in assessing this type of outreach. (The conditions of Basic Outreach must be met.)

Activities within the above categories of outreach may include the following:

- **Active Street Outreach:** Outreach specialists moving from place to place within a defined geographic area, screening and engaging prospective clients for the purposes of delivering information, materials and/or referrals. Active outreach is usually location specific, occurring within a few blocks radius or within a specific neighborhood.
- **Fixed Site Outreach:** Outreach activities that are conducted at a specific place within a given location (e.g., setting up a table on a corner or working out of a mobile van or storefront). During fixed site outreach, outreach specialists may invite individuals they have engaged in the street to come to the site or place for more in-depth assessment discussions and/or service delivery, based upon client needs or interests.
- **Drop Off Site Outreach:** Outreach activities that provide risk reduction supplies to volunteer distributors who may then distribute these items to high risk individuals (e.g., brochures left at a checkout counter or bleach kits distributed at a "shooting gallery").
- **Contact:** Face-to-face interaction during which educational materials and/or information is exchanged between an outreach specialist and a client (or a small group of clients).
- **Encounter:** Face-to-face interaction that goes beyond the contact to include focused assessments, specific service delivery in response to the client's identified need(s) and a planned opportunity for follow-up.

For all interventions, each agency must have a grievance policy in place for receiving and addressing complaints.

- Clients must be aware of the grievance policy.
- Clients should be given contact information for grievance questions and/or submissions.

1. Community Level Interventions (CLI)

1.0 Definition

Programs designed to reach a defined community (geographic or an identified subgroup) to increase community support of the behaviors known to reduce the risk for HIV infection and transmission.

1.1 Goal

To reduce HIV-risk behaviors by changing attitudes, norms and practices through community mobilization and organization and community-wide events.

1.2 Standards

This section addresses the overarching standards for CLI.

- Key components of CLI should:
 - ◆ Target attitudes, norms and practices placing a community at increased risk for HIV infection and/or transmission.
 - ◆ Be provided in a community-centered, non-judgmental and linguistically appropriate approach.
 - ◆ Be in an accessible safe space conducive to confidential and personal discussion, when appropriate.
 - ◆ Consist of a CDC-recommended or VDH-approved curriculum or model that defines goals and objectives for the intervention.
 - ◆ Include culturally and linguistically appropriate curriculum and/or educational materials.
 - ◆ Evaluate the effectiveness of the intervention through participants' feedback and/or knowledge assessment.
- CLI facilitators should adhere to agency confidentiality policies.
- If necessary, each agency should develop a written safety protocol.

2. Comprehensive Risk Counseling and Services (CRCS)

2.0 Definition

CRCS, formerly known as prevention case management (PCM), is intensive, individualized client-centered counseling for adopting and maintaining HIV risk-reduction knowledge and behaviors.

2.1 Goal

To assist both HIV-positive and HIV-negative persons who are at high risk for HIV transmission or acquisition to reduce risk behaviors and to address the psychosocial and medical needs that contribute to HIV risk behavior or poor health outcomes.

2.2 Standards

2.2.1 Core Elements

This section addresses standards for the seven core elements of CRCS.

- 1) Develop and implement a strategy to recruit and engage high risk clients.
 - ◆ Protocols for client engagement and related follow-up should be developed by each agency, such as requiring a minimum number of follow-up contacts within a specified time period.

- 2) Screen clients to identify those who are at highest risk and appropriate for CRCS, enroll them in CRCS and assess enrolled clients to determine specific risks and psychosocial needs.
 - ◆ CRCS program staff should develop screening procedures to identify persons at highest risk for acquiring or transmitting HIV and who are appropriate for CRCS.
 - ◆ All persons screened for CRCS, including those who are not considered to be appropriate clients for CRCS, should be offered counseling by the CRCS counselors (or other staff) and referrals relevant to their needs.
 - ◆ Thorough and comprehensive assessment instrument(s) should be obtained or developed to assess HIV, STD, chemical dependency and substance abuse risks along with related medical and psychosocial needs.
 - ◆ All CRCS clients should participate in a thorough client-centered assessment of their HIV, STD, chemical dependency and substance abuse risks and their medical and psychosocial needs.
 - ◆ CRCS counselors must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must guarantee the client's rights to privacy and confidentiality and should provide contact information for questions or grievances.

- 3) Develop an individualized prevention plan with goals and measurable objectives.
 - ◆ For each CRCS client, a written prevention plan must be developed, with client participation, which specifically defines measurable HIV risk-reduction behavioral goals, objectives, and strategies for change.
 - ◆ For persons living with HIV and receiving anti-retroviral or other drug therapies, the prevention plan should address issues of adherence.
 - ◆ The prevention plan should address efforts to ensure that a CRCS client is medically evaluated for STDs at regular intervals regardless of symptom status.
 - ◆ For clients with chemical dependency and substance abuse problems, the prevention plan should address referral to appropriate drug and/or alcohol treatment.
 - ◆ Clients should sign-off on the mutually negotiated prevention plan to ensure their participation and commitment.
 - ◆ Client files that include individual prevention plan must be maintained in a locked file cabinet to ensure confidentiality.

- 4) Provide ongoing, multi-session intensive HIV risk and behavior change counseling.
 - ◆ Multiple-session, one-on-one, HIV risk-reduction counseling aimed at meeting identified behavioral objectives must be provided to all CRCS clients. Sessions should be flexible to address the needs of the clients.
 - ◆ Training and quality assurance for staff must be provided to ensure effective identification of HIV risk behaviors and appropriate application of risk-reduction strategies.
 - ◆ Clients who are not aware of their HIV antibody status should receive information regarding the potential benefits of knowing their HIV serostatus.
 - ◆ Clients should be provided education about the increased risk of HIV transmission associated with other STDs and about the prevention of STDs.
 - ◆ CRCS program staff should develop a protocol for assisting HIV seropositive clients in confidentially notifying partners and referring them to CRCS and/or counseling and testing services.
 - ◆ For persons receiving treatment for opportunistic infections and/or anti-retroviral therapy(ies), counseling to support adherence to treatments/therapies should be provided.

- 5) Coordinate client support with other case management programs and provide referrals as needed.
 - ◆ Formal and informal agreements, such as memoranda of understanding, should be established with relevant service providers to ensure availability and access to key service referrals.
 - ◆ A standardized written referral process for the CRCS program should be established.

- ◆ Explicit protocols for structuring relationships and communication between case managers or counselors in different organizations should be established to avoid duplication of services, for example, how to transfer or co-manage CRCS clients with Ryan White CARE Act case management.
 - ◆ Communication with other providers about an individual client is dependent upon the obtainment of written, informed consent from the client.
 - ◆ A referral tracking system should be maintained.
 - ◆ Annual assessment of relevant community providers with current referral and access information must be maintained.
 - ◆ A mechanism to provide clients with emergency psychological or medical services should be established.
- 6) Conduct on-going monitoring and reassessment of client progress and needs.
- ◆ CRCS counselors must meet on a regular basis with clients to monitor their changing needs and their progress in meeting HIV behavioral risk-reduction objectives. Individual meetings with a client must be reflected in the client’s confidential progress notes.
 - ◆ A protocol should be established defining minimum, active efforts to retain clients. That protocol should specify when clients are to be made “inactive.”
- 7) Discharge clients when they attain and can maintain behavior change goals.
- ◆ Agencies should establish protocols to classify clients as “active,” “inactive” or “discharged.”
 - ◆ Clients should be aware of the agency’s policies for becoming “inactive” or discharged.
 - ◆ Agencies should outline the minimum active effort required to retain clients.
 - ◆ CRCS programs should be willing to readmit clients who need new or additional risk reduction support.

2.2.2 Coordination of CRCS with Ryan White CARE Act Case Management

- A protocol for structuring relationships with Ryan White CARE Act case management providers should be established and should detail how to transfer and/or share clients.
- CRCS should not duplicate Ryan White CARE Act case management for persons living with HIV, but CRCS may be integrated into these services.

2.2.3 Quality Assurance

- Quality assurance is essential to make certain that delivery of quality CRCS services are consistent and to ensure that interventions are delivered in accordance with the following standards:

- ◆ Clear procedures and protocol for the CRCS program should be developed to ensure effective delivery of CRCS services and minimum standards of care.
- ◆ Written quality assurance protocols should be developed.
- ◆ Client CRCS records must contain a copy of the voluntary informed consent document, acknowledgement of rights and responsibilities and grievance procedure and the prevention plan showing the client's signature.

2.2.4 Standards for Ethical and Legal Issues

- **Confidentiality.** Organizations must have well established policies and procedures for handling and maintaining HIV-related confidential information that comply with state and federal laws. These policies and procedures must ensure that strict confidentiality is maintained for all persons who are screened, assessed and/or participate in CRCS.
- **Voluntary and Informed Consent.** A client's participation in CRCS must always be voluntary and with the client's informed consent. Documentation of voluntary informed consent should be maintained in the client's file. In addition, a client's informed consent is required before a prevention case manager may contact another provider serving that same client.
- **Harm Reduction.** CRCS staff should utilize principles of harm reduction. Harm reduction is a set of practical strategies that reduce negative consequences of risk behaviors, incorporating a spectrum of strategies from reducing risks to abstinence. Harm reduction strategies meet clients "where they're at," addressing conditions of use along with the use itself.
- **Cultural Competence.** Organizations must make every effort to uphold a high standard for cultural competence, that is, programs and services provided in a style and format respectful of the cultural norms, values and traditions that are endorsed by community leaders and accepted by the target population.
- **Professional Ethics.** The practice of CRCS should be guided through relevant law and by standards provided through contemporary codes of ethics that govern most human service fields such as social work, counseling and clinical psychology.
- **Discharge Planning.** Organizations must make efforts to ensure that clients have received appropriate referrals and are adequately receiving needed services at the time of discharge (graduation).
- **Duty to Warn.** Organizations must be familiar with federal, state and local laws related to duty to warn or duty to protect third parties.

3. Group Level Interventions (GLI)

3.0 Definition

Health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. Uses peer and non-peer models involving a wide range of skills, information, education and support.

3.1 Goal

To assist clients as part of a group setting in identifying, adopting and maintaining behaviors that reduce their risk for transmission and/or acquisition of HIV.

3.2 Standards

This section addresses the overarching standards for GLI.

- Key components of GLI should:
 - ◆ Be provided in a group to target a specific behavior(s) that places clients at increased risk for HIV infection and/or transmission.
 - ◆ Consist of participants with at least one common characteristic that identifies them as members of a group.
 - ◆ Be provided in a group-centered, non-judgmental and linguistically appropriate approach.
 - ◆ Be in an accessible safe space conducive to confidential and personal discussion that is accessible and acceptable to the clients.
 - ◆ Include a behavioral risk assessment, when appropriate.
 - ◆ Include an HIV prevention skills building component.
 - ◆ Consist of a CDC-recommended or VDH-approved curriculum or model that defines goals and objectives for the intervention.
 - ◆ Include culturally and linguistically appropriate curriculum and educational materials.
 - ◆ Evaluate the effectiveness of the intervention through participants' feedback and/or knowledge assessment.

- Guidance regarding the intervention process should be established prior to the start of the intervention.
 - ◆ GLI providers should adhere to agency confidentiality policies.
 - ◆ GLI providers should address client rights and responsibilities.
 - ◆ Rules for participation should be made clear in writing or by verbal description and receive the affirmation of the client.

- The facilitator should share some characteristics with group participants. This may include, but is not limited to, the following: race, ethnicity, sexual orientation, primary language, gender, HIV status, HIV risk behavior, etc.
 - ◆ Some approved curriculum may specify the required characteristics of group facilitators, which should be adhered to.

4. HIV/AIDS 101

4.0 Definition

Educational session(s) provided by HIV educators on basic information about HIV, HIV transmission, risk behaviors associated with contracting HIV, interventions for prevention and risk reduction, HIV testing, symptoms of HIV and AIDS and appropriate responses to HIV/AIDS in communities and organizations.

4.1 Goal

To increase participants' knowledge of HIV/AIDS and its transmission, prevention and risk reduction strategies, appropriate community responses and local resources.

4.2 Standards

This section addresses the basic information to cover, at minimum, in HIV/AIDS 101 sessions.

- Common terms and acronyms should be defined and understood by participants, including, but not limited to, the following:
 - ◆ HIV (Human Immunodeficiency Virus)
 - ◆ AIDS (Acquired Immunodeficiency Syndrome)
 - ◆ Antibodies
 - ◆ HIV antibody tests and testing methods
 - ◆ HIV transmission
 - ◆ Risk reduction
 - ◆ Perinatal transmission
 - ◆ Immune system
 - ◆ Opportunistic infections

- **What are HIV and AIDS?** The following topics should be discussed, at minimum.
 - ◆ The distinction between HIV and AIDS.
 - ◆ Origin and history of HIV/AIDS in the U.S.
 - ◆ How the virus attacks the body and immune system.
 - ◆ Explanation of the spectrum of the disease and its progression from HIV to AIDS.
 - ◆ Opportunistic infections.

- **HIV Transmission.** The following topics should be discussed, at minimum.
 - ◆ HIV transmission
 - Identify body fluids that transmit HIV: blood, semen, vaginal fluids, breast milk.
 - Address myths and misconceptions regarding body fluids that do not transmit HIV: saliva, sweat, urine.
 - ◆ Risk factors and behaviors that place an individual at risk for contracting or transmitting HIV.
 - Unprotected vaginal, oral and anal sex
 - Sharing needles/syringes, other drug paraphernalia and other equipment that may pierce the skin

- Perinatal transmission
 - Receipt of infected blood, blood products, tissues or organs (very rare in the U.S.)
- ◆ Address myths and misconceptions regarding the transmission of HIV: casual contact, mosquitoes, urban legends (i.e., needles in phone booths, gas pump handles, etc.)
- **HIV Prevention.** The following prevention and/or risk reduction strategies should be discussed, at minimum.
 - ◆ Abstinence from sex, alcohol and drug use
 - ◆ Monogamous sexual relationship between two uninfected people
 - ◆ Sex that does not involve exchange of body fluids
 - ◆ Not sharing needles/syringes and other drug paraphernalia or other equipment that pierces the skin
 - ◆ Cleaning needles/syringes and other drug paraphernalia
 - ◆ Using condoms, dental dams and/or other barriers consistently and correctly. Sessions may include demonstrations on the proper use of barrier methods and discussions on safer-sex and harm reduction methods, when appropriate.
 - ◆ Not sharing sex toys
 - ◆ Cleaning sex toys
 - ◆ Knowing your HIV status
 - ◆ “Every Baby Can Be HIV Free” – the importance of perinatal testing
- **Understanding your status.** The following should be discussed, at minimum, so that participants understand the different methods of testing and what results mean.
 - ◆ Review methods of HIV testing: traditional (blood draw), oral HIV testing and rapid HIV testing, including confirmatory positive test results.
 - ◆ Define and discuss anonymous testing and confidential testing.
 - ◆ Discuss when individuals should get tested after possible exposure.
 - ◆ Understanding negative and/or positive test results.
- Provide resources available to participants for additional information. Resources may include, but not limited to:
 - ◆ VDH Division of Disease Prevention and CDC HIV/STD hotlines
 - ◆ Available VDH literature
 - ◆ Statewide HIV/AIDS Resource and Referral Listings (includes local health departments, community based organizations, AIDS service organizations, testing sites, etc.)
 - ◆ Local resources for confidential and anonymous testing: local health department, AIDS services organizations, etc.
 - ◆ Local resources, such as social services, housing services, drug treatment services, community health clinics, etc.
 - ◆ Reputable websites appropriate to the audience. Websites should be reviewed for content and accuracy. If unsure about the reliability of a website, one should

call the Division of Disease Prevention Hotline (1-800-533-4148). Websites may include, but are not limited to:

- National organizations providing HIV information and/or services
- Federal and/or state agencies
- Private and/or nonprofit organizations providing HIV information and/or services
- Research institutes
- Professional associations (i.e., American Medical Association)

5. HIV Counseling and Testing

5.0 Definition

HIV counseling and testing provides information regarding the acquisition and transmission of HIV and the meaning of HIV test results.

5.1 Goal

To provide client-centered HIV counseling and testing to assist individuals in becoming aware of their HIV status and, when appropriate, help clients identify risk behaviors for HIV and assist them in committing to a plan to reduce risk behaviors.

5.2 Standards

This section addresses the overarching standards for HIV counseling and testing.

- All staff providing counseling and testing services should use a non-judgmental client-centered approach. This approach meets the client at their place of need and is guided by the client's level of self-motivation.
- Staff/agencies conducting HIV testing should adhere to Federal, State, and Local regulations and statutes, to include:
 - ◆ the Centers for Disease Control and Prevention's Revised Guidelines for HIV Counseling, Testing and Referral issued November 9, 2001;
 - ◆ the Revised Guidance for Partner Counseling and Referral Services;
 - ◆ the Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings issued September 22, 2006, in accordance with Virginia's interpretation and guidance; and
 - ◆ any additional guidance or standards prescribed by VDH or revisions and/or updates to any of the above.
- In accordance to the Code of Virginia § 32.1-37.2, informed consent should be obtained from the client prior to testing.
- As outlined in the Code of Virginia § 32.1-37.2 B, all test results, whether the client tested negative or positive, must be provided in person.

- HIV prevention should address cultural competency issues as they affect HIV counseling and testing. Culturally competent prevention services respond to the context of the client’s cultural beliefs, behaviors, language needs presented by the client and their communities.
 - ◆ Counseling and testing educational materials should be culturally and linguistically appropriate to the targeted client population.
 - ◆ All staff providing counseling and testing should receive cultural competency training, as appropriate.
- HIV counseling and testing courses should involve trainers with current knowledge and experience in HIV counseling and testing practices.
- Client privacy and confidentiality must be a priority. Each agency should develop, implement and maintain policies and procedures to ensure client confidentiality during counseling and testing referral services.
- Persons who test negative or positive should be assessed to identify and prioritize their immediate needs and to link the client to appropriate services, such as care, prevention, and/or support services.
- The Program Assessment and Review (PAAR) with health districts should adhere to CDC and VDH standards. The review process conducted by the state health department should verify that skills audits of health counselors have taken place, as recommended by the STD/HIV Operations Manual.

6. Individual Level Interventions (ILI)

6.0 Definition

Health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings, e.g., substance abuse treatment settings, in support of behaviors and practices that prevent transmission of HIV. Help clients make plans to obtain these services.

6.1 Goal

To assist clients on an individual level in identifying, adopting and maintaining behaviors that reduce their risk for transmission and/or acquisition of HIV.

6.2 Standards

This section addresses the overarching standards for ILI.

- Key components of ILI should:
 - ◆ Be provided to one individual at a time in a client-centered and non-judgmental approach.
 - ◆ Be in a safe space conducive to private and personal discussion.

- ◆ Include a behavioral risk assessment.
 - ◆ Include an HIV prevention skills building component.
 - ◆ Target specific behavior(s) that places the client at increased risk for HIV infection and/or transmission.
 - ◆ Assist the client in identifying safer goal behavior(s).
 - ◆ Assist the client in developing a culturally and linguistically appropriate action plan to achieve identified goals.
 - ◆ Provide linkages or referrals to appropriate services.
 - ◆ Provide appropriate educational materials.
 - ◆ Evaluate the effectiveness of the intervention through client feedback and/or knowledge assessment.
- Guidance regarding the intervention process should be established prior to the start of the intervention.
 - ◆ ILL providers should adhere to agency confidentiality policies.
 - ◆ ILL providers should address client rights and responsibilities.
 - ◆ Rules for participation should be made clear in writing and by verbal description and receive the affirmation of the client.

7. Outreach

7.0 Definition

Outreach interventions are generally conducted face-to-face with individuals in the clients' neighborhoods or other areas where clients typically congregate. Usually includes distribution of condoms, bleach, sexual responsibility kits and educational materials.

Outreach differs from Individual Level Interventions (ILL) in that it is a relatively brief intervention and an individual risk reduction plan is not developed.

7.1 Goal

To increase knowledge/awareness of HIV/AIDS and STDs, prevention strategies and relevant community resources.

7.2 Categories of Outreach

This section defines categories of street outreach.

- **Basic Street/Community Outreach:** Brief contacts in which outreach specialists engage in conversations in order to provide educational information, literature and resources, such as condoms, bleach kits, referrals, etc.
 - ◆ This type of outreach is important for establishing rapport within a community and building trust with individuals.
 - ◆ It can be used as a method for bringing clients into other services such as intensive street outreach, counseling and testing, comprehensive risk counseling services, home health parties and education groups.
 - ◆ Basic outreach cannot be expected to change behaviors in and of itself.

- **Intensive Street/Community Outreach:** Ongoing encounters in which outreach specialists spend extended periods of time with clients, assess risks, make plans with clients for behavior change and provide referrals.
 - ♦ Outreach specialists may also facilitate clients' entrance into services and should verify follow-through on referrals when possible.
 - ♦ Both process and outcome monitoring should be used in assessing this type of outreach. (The conditions of Basic Outreach must be met.)
- **Collaborative Street Outreach:** A collaborative effort between community-based organizations and/or other health care providers in order to saturate a specific geographic area with educational information (e.g., a major syphilis outbreak has occurred in a residential area; the health department will be providing on-site testing; outreach specialists would then be pivotal in disseminating information and directions about the testing).
 - ♦ Collaborative outreach is a strategy that may combine basic and intensive outreach and should not be considered an intervention on its own.

Activities within the above categories of outreach may include the following:

- **Active Street Outreach:** Outreach specialists moving from place to place within a defined geographic area, screening and engaging prospective clients for the purposes of delivering information, materials and/or referrals. Active outreach is usually location-specific, occurring within a few blocks radius or within a specific neighborhood.
- **Fixed Site Outreach:** Outreach activities that are conducted at a specific place within a given location (e.g., setting up a table on a corner or working out of a mobile van or storefront).
 - ♦ During fixed site outreach, outreach specialists may invite individuals they have engaged in the street to come to the site or place for more in-depth assessment discussions and/or service delivery, based upon client needs or interests.
- **Drop Off Site Outreach:** Outreach activities that provide risk reduction supplies to volunteer distributors who may then distribute these items to high risk individuals (e.g., brochures left at a checkout counter or bleach kits distributed at a "shooting gallery").
- **Contact:** Face-to-face interaction during which educational materials and/or information is exchanged between an outreach specialist and a client (or a small group of clients).
- **Encounter:** Face-to-face interaction that goes beyond the contact to include focused assessments, specific service delivery in response to the client's identified need(s) and a planned opportunity for follow-up.

7.3 Standards

This section outlines standards for conducting the above outreach activities.

7.3.1 Core Strategies

- Outreach activities should be conducted in accordance with the Core Strategies for Street and Community Outreach Training Manual.
 - ◆ Be provided to one individual at a time;
 - ◆ Include risk and risk reduction information;
 - ◆ Be provided in settings and during times appropriate to the target population;
 - ◆ Be accompanied by risk reduction methods and education materials (e.g., condoms, brochures);
 - ◆ Present scientifically accurate and current information;
 - ◆ Provide information to facilitate access to prevention, medical and support services; and
 - ◆ Include culturally and linguistically appropriate education materials.

7.3.2 Safety Protocol

- Each agency should develop a written protocol to address outreach activities, including but not limited to:
 - ◆ Methods used to determine the outreach location, times of day and the day of the week that are most productive for reaching the target population;
 - ◆ Safety of outreach workers.
 - Outreach should be conducted in pairs.
 - Supervisors should be informed about the areas to be targeted.
 - Outreach specialists should carry personal and agency identification and/or clothing that identifies them as an outreach specialist or agency staff person.
 - Before beginning outreach activities, staff should familiarize themselves with local law enforcement so that police understand their role in the community. If possible, involvement with the police department through a liaison or training should be established.
 - Outreach specialists should never buy from or sell anything to street contacts.
 - Agencies should establish a “no weapons” policy while staff are conducting outreach.
 - Agencies should establish a communication, tracking and/or emergency plan for street outreach specialists.

8. Prevention Provider Qualifications

The following outlines the minimum qualifications and training required by staff providing the following HIV prevention interventions.

8.1 HIV Counseling and Testing

- All staff providing HIV counseling and testing services should complete all appropriate training to ensure that they are able to provide high quality prevention services, including:
 - ♦ the three-day CDC prevention counseling courses, “The Facts” and “The Fundamentals”;
 - ♦ the “Partner Counseling and Referral Services” course; and
 - ♦ appropriate trainings relevant to test technology.

8.2 Health Educators and Group / Individual / Community Level Interventions (GLI, ILI, CLI)

- Staff conducting GLI and/or CLI should be competent in group facilitation and/or complete appropriate trainings, as feasible.
- Staff providing ILI should complete appropriate trainings in HIV prevention counseling as stated above in Section 7.1.
- HIV educators providing HIV counseling and testing should adhere to the appropriate trainings and standards. (Refer to Section 7.1)
- HIV educators should have the appropriate formal education and/or practical knowledge and experience to perform expected duties, including but not limited to the following.
 - ♦ Understanding the basics of behavioral science theory.
 - ♦ Facilitation skills, including different methods of delivering education, such as in workshops and discussion groups in various settings, reviewing and summarizing journal articles and other publications, Internet forums (chat rooms, blogs, discussion groups, websites), public meetings, collaborative planning groups, etc.
 - ♦ Conducting a sexual history, drug use history and other risk assessments, and helping clients develop a risk reduction plan.
 - ♦ Referring participants to clinical care, drug treatment and other community services.
- HIV educators should receive a minimum of four hours of training on a quarterly basis in one or more of the areas listed below. Employers should document training(s) in employment records.
 - ♦ HIV/AIDS: prevention and clinical issues
 - ♦ Sexually transmitted diseases: prevention and clinical issues
 - ♦ Tuberculosis: prevention and clinical issues
 - ♦ Viral hepatitis: prevention and clinical issues
 - ♦ Current laws, regulations and policies related to HIV/AIDS and STDs

- ◆ Behavioral science theories
 - ◆ Human sexuality
 - ◆ Reproductive health and contraception
 - ◆ Substance abuse, chemical dependency and related interventions and referrals
 - ◆ Mental health issues and related interventions and referrals
 - ◆ Racial and ethnic diversity and overcoming racism
 - ◆ Cultural diversity and competency
 - ◆ Sexual and gender diversity and overcoming homophobia and transphobia
- HIV educators' dress, demeanor and communication skills should be appropriate to the situation and program participants.
 - HIV educators should always maintain a professional demeanor and should not engage in illegal, unethical or inappropriate relationships with program participants, on or off duty. These may include sexual relationships, alcohol or other drug use, financial relationships or conflicts of interest.

8.3 Comprehensive Risk Counseling and Services (CRCS)

- **Suggested minimum qualifications for staff conducting the following core elements:**
Client recruitment and engagement, screening and coordination of services:
 - ◆ Knowledge of target population;
 - ◆ Cultural and linguistic competency;
 - ◆ Knowledge of HIV/AIDS and other STDs;
 - ◆ Knowledge of available community services; and
 - ◆ Effective communication skills.
- **Suggested minimum qualifications for staff conducting the following core elements:**
Assessment, development of prevention plan, HIV risk reduction counseling, monitoring and reassessment, ongoing support and relapse prevention, graduation and discharge planning:
 - ◆ Bachelor's degree or extensive experience in a human services-related field, such as social work, psychology, nursing, counseling, or health education;
 - ◆ Skills in CRCS techniques;
 - ◆ Skills in counseling;
 - ◆ Ability to develop and maintain written documentation (case notes);
 - ◆ Skills in crisis intervention;
 - ◆ Knowledge of HIV risk behaviors, human sexuality, substance abuse, STDs, the target population and HIV behavior change principles and strategies; and
 - ◆ Cultural and linguistic competency.
- **CRCS Supervisors Qualifications and Responsibilities**
 - ◆ Academic training and/or experience to adequately develop an overall CRCS program:
 - Program goals and objectives;

- Protocols;
- Quality assurances; and
- Evaluation measures.
- ◆ Management skills and experience overseeing CRCS staff.
- ◆ Provide an orientation to the CRCS program for new staff and ongoing supervision to ensure that the CRCS intervention is clearly understood.
- ◆ Ongoing training and development to build staff skills.
- ◆ Staff must be provided written job descriptions and opportunities for regular constructive feedback.
- ◆ All staff must be knowledgeable of confidentiality laws and agency confidentiality policies and procedures. CRCS staff should have signed confidentiality agreements on file with their employer.

8.4 Outreach

- Outreach specialists should complete the Street Outreach Specialist Certification provided by the Virginia Department of Health, as available.
- Outreach specialists should possess:
 - ◆ Scientifically accurate and current information related to HIV/AIDS;
 - ◆ Knowledge of relevant community resources, including accessibility;
 - ◆ Ability to present information in a culturally and linguistically appropriate manner;
 - ◆ Skills in counseling, substance use/abuse issues and building rapport with clients.
 - ◆ Outreach specialists should receive training in the following areas:
 - HIV/AIDS;
 - STDs;
 - Viral Hepatitis;
 - Substance abuse;
 - Mental health issues;
 - Counseling skills;
 - Availability of local resources;
 - Human sexuality;
 - Homophobia; and
 - Behavioral science.
- Outreach specialists should not engage in sexual relationships with contacts/clients.
- Outreach specialists with a history of substance abuse should have a minimum of two years of sobriety prior to conducting outreach activities.
 - ◆ Agencies should establish support mechanisms for outreach specialists in recovery.
 - ◆ A staff person or other professional resource should be identified for support and referral into relapse prevention, 12 Step or other program(s).

The Research Subcommittee remains an integral part of the Virginia HCPC. The following research initiatives were completed or conducted from 2004 through 2007 by the Community Health Research Initiative (CHRI), formerly part of the Survey and Evaluation Research Laboratory, at Virginia Commonwealth University (VCU) on behalf of the Virginia HCPC. Findings from the studies resulted in recommendations that were used by the HCPC and VDH in planning HIV prevention services.

HIV/AIDS Among Latino Men in Rural Virginia

The purpose of this study was to assess the social and cultural factors and behaviors, such as poverty, access to health care services, language and cultural barriers and isolation that increase the risk for HIV infection among Latino men in rural areas in Virginia. This study also assessed the HIV/AIDS medical and social services available for Latinos in the study areas. The study had two components: (1) to examine cultural and social contextual factors that put Latino men in rural areas at risk for HIV infection, via survey administration, and (2) to explore the HIV/AIDS prevention needs and services directed to Latinos in the area, via key-informant interviews.

The report for this study was published in January 2004 and can be found at:

http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/documents/word/latino_rural.final.jb.11.03.06-1.doc.

African American Women and HIV/AIDS Risk Behaviors

This study was conducted among African American women between 18 and 49 years of age with an unknown HIV status in health districts within Central Virginia. Women with an unknown status were those who had never been tested for HIV or those who had had a negative test result at some point in their lives. The study examined gender and socio-cultural factors associated with the risk of HIV infection.

The research highlight for this study, published in January 2004, examines HIV risk behaviors of African American women and can be found at:

<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/HCPC/documents/research%20highlights%20jan%2004article14.pdf>.

Intensive Street Outreach with Injection Drug Users

In 2002 and 2003, an outcome study of intensive street outreach was conducted. The Street Outreach Study (SOS) assessed the effectiveness of training outreach specialists in delivering theory-based behavioral interventions to injection drug users. The SOS evaluated the outcomes of delivering such interventions on the street.

The research highlight for this study was published in December 2005 and can be found at:
http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/HCPC/documents/SO%20Research%20Highlight1_17_06.pdf.

Transgender Health Initiative

The 2003 Comprehensive HIV Prevention Plan categorized transgender persons as a population of special interest. The HCPC recognized a high risk among this population for HIV infection, but had little to no data to prioritize transgender persons for HIV prevention services. In response, the research subcommittee decided to begin a research initiative that focused on the transgender population in Virginia.

This three-year study was conducted in two phases. In the first phase of the study, seven focus groups were conducted throughout the state in March and April 2004. The purpose of the focus groups was to assess the factors placing transgender persons at risk for HIV infection and experiences in accessing medical care. Results from the focus group were used to develop the Transgender Health Initiative Survey (THIS), the second phase of the study. The THIS assessed the health needs and concerns for the transgender community in Virginia, including health status, the ability to access health care, violence, substance abuse, housing, employment and HIV/AIDS.

Transgender Health Access in Virginia: Focus Group Report was published in December 2005 and can be found at:

<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/HCPC/documents/TG%20Focus%20Group%20Report%20final%201.3.pdf>.

Health, Health Related Needs and Lifecourse Experiences of Transgender Virginians was published in January 2007 and can be found at:

<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/documents/pdf/THISFINALREPORTVol1.pdf>.

Recommendations from the Virginia HCPC for HIV Prevention Services

- ◆ The HCPC continues to recommend funding for needle exchange programs, as needle sharing continues to be a significant risk behavior for HIV transmission.
- ◆ As there continues to be a national focus on testing pregnant women for HIV infection, the HCPC recommends the adoption of opt-out HIV testing among pregnant women as routine prenatal care to further reduce perinatal HIV infections. Current Virginia law states that *as a routine component of prenatal care, every practitioner...shall advise every pregnant woman who is his patient of the value of testing for HIV infection and shall request of each such pregnant women consent to such testing. Any pregnant woman shall have the right to refuse consent to testing for HIV infection and any recommended treatment.* (§ 54.1-2403.01) In a convenience study conducted by the Virginia Department of Health, patient records of women who had delivered at seven hospitals throughout the state were reviewed. Of the 397 cases reviewed, 91 percent of women had documentation in their medical record of being offered a HIV test. Eight percent of women tested for HIV infection had documentation of refusing a HIV test during prenatal care.
- ◆ The HCPC recommends that agencies funded through the Virginia Department of Health be required to conduct cultural competency trainings with staff that provide HIV prevention services.
- ◆ Trainings for HIV prevention interventions should be available in Spanish for providers reaching the Latino population.
- ◆ The HCPC recommends collaborations around HIV and methamphetamine use, specifically in rural areas of the state (Northwest and Southwest regions), where use is widespread among all populations.
- ◆ The HCPC recommends the integration of STD prevention messages and STD and Viral Hepatitis testing within HIV prevention services.

Recommendations from the Virginia HCPC for HIV Prevention Services Targeting Rural Populations

'Rural' in Virginia is defined as being a locality *not* in one of the eight established Metropolitan Statistical Areas (MSAs), which are the Washington, Charlottesville, Danville, Johnson City, Lynchburg, Norfolk, Richmond and Roanoke MSAs. Data through 2005 indicates that approximately 10 percent of reported HIV/AIDS cases in Virginia have been in rural localities, the majority of which are reported from rural parts of the Central Virginia Health Region and among African Americans. From 2004-2005, reported cases of HIV and AIDS have increased in the rural parts of the Central and Northwest Health Regions. Males have more reported cases than females, with the highest number of reported cases being among men who have sex with men. Among HIV infected females in rural Virginia, the greatest risk factor was through heterosexual contact.¹³

Recent funding losses have led to the discontinuation of regional funding for the AIDS Service Organizations (ASOs) grant program, which will predominantly affect rural Virginia. In response, in the fall of 2005, the HCPC created a rural workgroup, consisting of nine HCPC members and the HCPC planner, to assess the impact of these funding losses in rural localities of Virginia and to make recommendations of how to address the impact. The rural workgroup met four times to review rural Virginia statistics (i.e., poverty, education, employment rates, etc.), HIV statistics, current HIV prevention programs highlighting those that would be discontinued due to funding losses and rural HIV prevention programs that have been successful in other parts of the country.

There was a consensus among the workgroup that HIV/AIDS data may not truly be representative of rural areas. First, some rural counties are categorized within the established MSAs and, therefore, not included in rural data. To overcome this, the workgroup suggested looking at different definitions of 'rural' for purposes of possible funding. The workgroup decided that 'rural' should include those localities designated as being rural based on the current definition used by VDH as well as those that have a population less than 50,000¹⁴ and are medically underserved¹⁵. As previously stated, rural areas of Virginia account for approximately 10 percent (through the end of 2005) of HIV/AIDS cases, based on the current VDH definition. However, with the definition designated by the rural workgroup, nearly 16 percent of the HIV/AIDS cases are in rural areas of the state.¹

Secondly, data may not be representative due to such factors as stigma associated with HIV or the lack of resources, creating low rates of HIV testing in rural areas. There is also a lack of HIV education and outreach services in rural areas, leading to a denial of individual risk among those that are at-risk as well as low HIV testing rates. Furthermore, some rural counties may have higher HIV infection rates due to the presence of prisons in that locality.

¹³ Virginia Department of Health, Division of Disease Prevention

¹⁴ U.S. Census, July 2005

¹⁵ Virginia Department of Health, Center for Primary Care and Rural Health

Recommendations

- ◆ In many cases, providing HIV prevention in rural areas means having to battle the stigma and misconceptions surrounding HIV. To combat this, key community gatekeepers, such as faith leaders in the African American and Latino communities, must be identified. Often times, communities tend to be more open when the messages come from those who have high respect in the community. The key is to identify those gatekeepers that are willing to deliver HIV prevention messages to their communities and utilize their willingness to network with other gatekeepers.
- ◆ For rural regions of Virginia, prevention efforts should be increased that include working with known HIV-positive individuals', counseling and testing, and partner counseling and referral services (PCRS). Although general HIV awareness and education is needed in rural areas, efforts aimed at getting people to know their HIV status and working with HIV-positive individuals will be more effective.
- ◆ Rural communities often do not consider HIV a problem for them, but rather an urban problem – due mainly to a lack of understanding of HIV and their own personal risk. There needs to be more aggressive educational efforts to promote HIV awareness and prevention. Educational efforts and prevention messages should be targeted to specific populations that are at high risk. Targeted populations in rural areas should include MSM, minority populations, and heterosexual women. There should also be efforts to raise awareness on available HIV prevention services.
- ◆ HIV prevention programs that currently exist in rural Virginia are, in many cases, unable to meet the needs of their communities, due partly to covering a large geographic area and other programmatic issues. The loss of regional ASO funding and any future funding losses will only further prevent current programs from being effective in providing services.
- ◆ Local health departments play a key role in rural areas. Health departments should be utilized to assist and work with local HIV prevention programs. Furthermore, staff from existing HIV prevention programs should work with the staff of new HIV prevention programs trying to become established in the community – similar to a train the trainer type format.
- ◆ Information should be shared with services that may currently or potentially be interested in sharing HIV messages, such as community hospitals, the American Red Cross and other similar agencies.
- ◆ Collaborations are essential in addressing the HIV prevention needs and issues of rural communities. This entails creating a community prevention network of key agencies and organizations working together towards the same goal. This would reduce duplication of services, save resources, and improve referral services.

- ◆ Partnerships should be between both public and private agencies. VDH should develop Memorandums of Agreement (MOAs) with local health departments and/or other rural agencies to subcontract with other agencies providing HIV prevention services in their region. VDH should also create collaborations with other rural centers in Virginia, such as the Rural Health Care Research Center at the University of Virginia. Collaborations should also include linking prevention efforts through care providers within the Ryan White Consortia.
- ◆ Rural providers and health departments need to provide more HIV education to better care and manage their HIV+ patients as well as incorporate regular HIV testing as a standard of care for at-risk patients. Existing networks for reaching providers in underserved rural areas include the system of Virginia Area Health Education Centers (AHEC) (<http://www.ahec.vcu.edu>) and the Virginia Association of Free Clinics (<http://www.vafreeclinics.org>). These existing resources should be explored to learn more about their capacity for reaching underserved rural communities and the possibilities of sharing available resources.
- ◆ Local health departments should be utilized. Although it is not required, many health counselors from local health departments routinely visit physician's offices to provide education on recommended STD treatment guidelines, MMWR information, rules and regulations, etc. These visits can also serve as opportunities to promote HIV testing as a routine part of care as well as to raise awareness of available HIV prevention services in the area.
- ◆ Agencies that are receiving HIV prevention funds through VDH and are providing services in rural areas should be required to specify activities targeted towards rural parts of their service area. For example, they should specify how outreach efforts are being conducted in rural areas, how education is being disseminated or how and what outreach efforts for counseling and testing are being conducted.
- ◆ Currently, very few rural agencies submit grant applications to VDH for available prevention funding. Information packets, containing HIV data, information and resources, should be developed and distributed to agencies/organizations to enable them to become more involved and apply for HIV prevention Requests for Proposals. These packets should be distributed to rural providers, local health departments, community hospitals, community colleges, student health centers, mental health CBOs, social services, etc.

The following organizational survey was utilized during the community services assessment to assess the needs of populations served by community-based organizations.

Please answer the following questions regarding current services and unmet needs for primary HIV prevention. HIV prevention services may include counseling, testing and referral services; partner counseling and referral services; health education/risk reduction services, such as outreach, group, individual and community level interventions; prevention case management; social marketing; public information, etc. and prevention with persons living with HIV.

This survey should be completed by front-line staff who provide direct prevention services.

1. What populations do you work with *(list of the targeted populations included)*? What population do you represent (if any)? *(list of targeted populations included)*
2. Do you solicit input from your clients in the development of your prevention program? If so, how do your services reflect their input?
3. What prevention interventions have **you** found to be the most effective?
4. How do **you** measure the success/effectiveness of your interventions? **(list up to three)**
5. What challenges are **you** facing in providing prevention services to your clients in the current environment of funding cutbacks?
6. For each target population that you serve, what HIV prevention needs do your clients have that are not currently being met?
7. How do you ensure that clients are provided services in a culturally competent and linguistically appropriate manner? For example: Do you have someone available to provide translation for clients who do not speak English?
8. How do you share your grievance and/or confidentiality policies?
9. What populations are most in need of HIV prevention/education services that are not being served by your agency? (list)
10. What prevention services would you provide to these populations if funding were available?
11. Within the next year, what type of training would you like to receive?
12. How do staffing shortages and/or turnover (if any) affect your agency's service delivery?

13. Have you ever had to implement a waiting list for preventions services? If so, why?
14. If VDH funding were to cease, what other resources would your clients have? Does your agency have a funding back-up plan?
15. What populations do you feel are most in need of Education and Outreach services that are not being served by your agency?
16. What Prevention Educational and Outreach services would you provide if additional funding becomes available for each target population your agency serves?

People Living with HIVExisting or Emerging Needs

- ◆ Care and prevention services for those newly diagnosed
- ◆ Programs in rural areas
- ◆ Assistance / coaching around disclosure with sex partners
- ◆ Referrals and funding for low-income housing
- ◆ Ways to meet other HIV-positive people (i.e. “safe zones” for HIV-positive persons in rural areas, but also offering other ways to meet)

Continuing Needs

- ◆ Partner counseling and referral services
- ◆ Peer mentoring
- ◆ Activities stressing importance of condom use even if HIV status same (i.e. both HIV-positive)
- ◆ Condom negotiation skills
- ◆ Prevention case management
- ◆ Public awareness campaigns to provide accurate information about HIV/AIDS
- ◆ Counseling and testing

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Lessen stigmatization in society of HIV and people living with it
- ◆ “Safe zones” for HIV positive persons in rural areas
- ◆ Access to emergency food
- ◆ Access to housing
- ◆ Access to mental health services
- ◆ Access to transportation
- ◆ Closer access to HIV care for blood draws and doctors
- ◆ Comprehensive HIV treatment and care for individuals without insurance
- ◆ Substance abuse treatment specifically for HIV infected persons

Injection Drug Users and Other Substance UsersExisting or Emerging Needs

- ◆ Harm reduction programs (including wound care accompanied by prevention messages)
- ◆ Training for pharmacists on awareness of harm reduction and advantages of clean needles

Continuing Needs

- ◆ Condom negotiation skills
- ◆ Counseling and testing

- ◆ Partner counseling and referral services
- ◆ Comprehensive risk counseling services for Black IDU men
- ◆ Public awareness campaigns to provide accurate information about HIV/AIDS
- ◆ Testing and prevention services for rural IDU

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Access to clean needles and syringes
- ◆ Access to treatment for non-IDU substance abusers
- ◆ Alcohol treatment
- ◆ “Pee for Pay” programs for methamphetamine users
- ◆ Residential treatment settings

Blacks

Existing or Emerging Needs

- ◆ Programs to link "newcomers" into public health system (i.e. prevention/education for African refugees and new immigrant heterosexual females and youth; faith-based organizations; counseling and testing; care and prevention services)
- ◆ Outreach testing with rapid testing kits
- ◆ Link newcomers up with buddy programs, peer to peer programs, and education / awareness programs

Continuing Needs

- ◆ Activities to increase awareness of risk factors and risky behaviors, and the importance of getting tested
- ◆ Assure confidential programs
- ◆ Condom negotiation skills
- ◆ Counseling and testing
- ◆ Education on an ongoing basis
- ◆ Establish communication through role play exercises
- ◆ Faith-based programs (non-traditional and traditional)
- ◆ Inclusive street outreach
- ◆ Language interpreter services
- ◆ Partner counseling and referral services
- ◆ Peer to peer programs in clinical settings
- ◆ Personal perspectives from other HIV-positive persons
- ◆ Prevention programs targeting rural areas
- ◆ Program focusing on substance abuse and treatment
- ◆ Programs emphasizing communication with partners about safe-sex practices, sexual history, and STD and HIV testing, including methodology to begin communication
- ◆ Programs for those incarcerated
- ◆ Programs targeting “down low” men
- ◆ Public awareness campaign to provide accurate information about HIV/AIDS

- ◆ Resources and referral to access to local services

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Age appropriate programs for children dealing with positive parenting
- ◆ Education and situational analysis
- ◆ Have Narcotics Anonymous meetings at AIDS services organizations
- ◆ Access, affordability, and variety of microbicides
- ◆ More conferences and seminars on HIV with personal perspectives from HIV-positive individuals
- ◆ More health fairs with educator learning
- ◆ Support groups

Asian/Pacific Islanders

Existing or Emerging Needs

- ◆ Culturally specific curricula for Asian populations
- ◆ Culturally sensitive prevention models for Asians and Pacific Islanders
- ◆ Interventions that are gender specific
- ◆ Condom negotiation skills
- ◆ Counseling and testing
- ◆ Interpretation services
- ◆ Linkages to public health services
- ◆ Public awareness campaigns to provide accurate information about HIV/AIDS

Continuing Needs

- ◆ Partner counseling and referral services

Latinos

Existing or Emerging Needs

- ◆ Need for bilingual educators
- ◆ Improve educational materials (educational and low-literacy materials in Spanish)
- ◆ Prevention messages through Latino television and radio stations, migrant organizations, health clinics serving the Latino population, and Latino business
- ◆ Culturally specific curricula
- ◆ Activities to increase awareness of HIV/AIDS among Latino men, especially in breaking stigmas and myths that surround HIV/AIDS and homosexuality
- ◆ Outreach testing with rapid testing kits
- ◆ Activities to remove barriers to undocumented individuals
- ◆ Activities targeting Latino men to increase awareness of safe-sex practices and risks associated with having multiple partners, as well as both male and female partners
- ◆ Counseling and testing in non-clinical settings

- ◆ Faith-based initiatives
- ◆ Prevention case management
- ◆ Public awareness campaigns to provide accurate information about HIV/AIDS
- ◆ Gay Latino Community of Virginia trainings and workshops
- ◆ Intensive street outreach
- ◆ More activities targeting Latino men
- ◆ Resources and referrals to access local services
- ◆ Bilingual referral list for HIV services in Virginia for Latino gays and Latino inmates
- ◆ General education in the Latino community about HIV prevention and STDs
- ◆ Latino workshops on HIV/STDs
- ◆ Activities addressing risk involved with alcohol and drugs
- ◆ Condom negotiation skills
- ◆ Oral presentations and pictures in health education materials
- ◆ Focus groups with Latino MSM

Continuing Needs

- ◆ HIV and STD testing and counseling
- ◆ Partner counseling and referral services

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Education and situational analysis
- ◆ Food and housing assistance

High-risk Heterosexuals

Existing or Emerging Needs

- ◆ Programs specifically targeting men
- ◆ Program addressing intergenerational dating
- ◆ Interventions for African American women that address taking care of “self” and not relying on religious beliefs as protection from HIV, including classes to empower women
- ◆ Peer to peer programs
- ◆ Social marketing

Continuing Needs

- ◆ Activities to increase awareness of risk factors and risky behaviors, and importance of getting tested
- ◆ Activities addressing risks involved with alcohol and/or drug use before and/or during sex
- ◆ Addition of cultural relevance to curriculum
- ◆ Advertise HIV prevention messages on city transit buses and/or t-shirts
- ◆ Age appropriate education
- ◆ Basic and truthful regional information
- ◆ Condom negotiation skills

- ◆ Counseling and testing
- ◆ Diversity education
- ◆ Faith-based programs, including more HIV seminars offered to faith based communities
- ◆ Incentives to participants for rapid and oral testing
- ◆ More down-to-earth messages
- ◆ More involvement of church leaders with prevention efforts
- ◆ Partner counseling and referral services
- ◆ Partner education
- ◆ Peer group discussions
- ◆ Presentations with more visual pictures of untreated STDs
- ◆ Programs emphasizing communication with partners about safe-sex practices, sexual history, and STD and HIV testing, including methodology to begin communication
- ◆ Programs targeting those trading sex for money and/or drugs
- ◆ Public awareness campaigns to provide accurate information about HIV/AIDS
- ◆ SISTA (WILLOW for older women)

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Self esteem classes

High-risk Youth

Existing or Emerging Needs

- ◆ Comprehensive sexual health education
- ◆ Access to condoms
- ◆ Having a peer at STD clinics to talk to teens at the end of their appointments
- ◆ Programs targeting those trading sex for money and/or drugs
- ◆ Counseling for youth who were perinatally infected and are becoming sexually active
- ◆ HIV-positive MSM and/or women to serve as role models for youth
- ◆ More STD information at primary care physician visits

Continuing Needs

- ◆ Activities to increase awareness of HIV and STD risk factors, risky behaviors, and safe-sex practices
- ◆ Age appropriate education
- ◆ Alcohol and drug education
- ◆ Collaboration with other agencies and programs
- ◆ Condom negotiation skills
- ◆ Counseling and testing
- ◆ Intensive outreach
- ◆ More peer educators
- ◆ More STD information at family planning clinics

- ◆ More STD information at free clinics
- ◆ Need for trustworthy adults to talk to who will maintain their confidentiality
- ◆ One on one discussions with teens
- ◆ Partner counseling and referral services
- ◆ Peer led prevention groups
- ◆ Personalize risk and susceptibility
- ◆ Comprehensive risk counseling services for HIV-positive youth
- ◆ Prevention messages through mass media
- ◆ Programs discussing HIV vulnerability among youth
- ◆ Programs using willing persons living with HIV or STDs to speak to students
- ◆ Public awareness campaigns to provide accurate information about HIV/AIDS
- ◆ Social marketing campaigns
- ◆ STD screening in family planning clinics
- ◆ Training for peer mentoring
- ◆ Training for staff and agencies working with HIV-positive youth

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Condom availability in conjunction with education and schools
- ◆ More discussion in school about options and choices, rather than abstinence only
- ◆ Sex education beginning in middle school
- ◆ Shelters

Incarcerated

Existing or Emerging Needs

- ◆ Re-entry education programs
- ◆ Counseling and testing, including the availability of rapid testing and testing for inmates with less than 90 days before release
- ◆ Risk/harm reduction education
- ◆ Increased number of programs for those incarcerated, including comprehensive risk counseling services
- ◆ Condom negotiation skills
- ◆ Public awareness campaigns to provide accurate information about HIV/AIDS
- ◆ More health educators

Continuing Needs

- ◆ HIV testing for both inmates and re-entry populations
- ◆ Linkages into care services for HIV-infected inmates
- ◆ Partner counseling and referral services
- ◆ Substance abuse education and treatment

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Access to condoms and needles

Men who have Sex with Men

Existing or Emerging Needs

- ◆ Holistic health needs
- ◆ Prevention messages and education for non-identifying MSM
- ◆ Programs targeting sex workers
- ◆ Programs targeting situational bisexuality
- ◆ Programs targeting older men (age 35+) to raise awareness that they are still at risk.
- ◆ Rapid testing
- ◆ Role models
- ◆ Bilingual MSM health educators

Continuing Needs

- ◆ Address new and emerging risks such as methamphetamine use, meeting partners on the internet, and syphilis
- ◆ Condom negotiation skills
- ◆ Substance abuse education for young MSM
- ◆ Availability of condoms at clubs, bars, sex venues, etc. to encourage men to carry condoms in possible sexual situations
- ◆ Counseling and testing
- ◆ Emphasis on drug and alcohol use in terms of judgment and inability of making healthy sexual decisions
- ◆ Increase education and knowledge of risks
- ◆ Individualized risk reduction plans
- ◆ Partner counseling and referral services
- ◆ Partner education
- ◆ Programs emphasizing communication with partners about safe-sex practices and sexual history
- ◆ STD screening
- ◆ Support groups

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Food assistance
- ◆ Hepatitis A and B vaccinations
- ◆ Programs to help build self esteem and self worth
- ◆ Safe housing

Latino Men who have Sex with Men

Existing or Emerging Needs

- ◆ Increase education on dispelling beliefs of machista, on safe-sex alternatives to anal sex, and on self-control of sexual urges
- ◆ Programs targeting Latino MSM trading sex for money and/or drugs

- ◆ Bilingual MSM health educators
- ◆ Translation and interpretation services
- ◆ Target young, less-educated men
- ◆ Identify resources, such as support groups, specifically for Latino MSM

Continuing Needs

- ◆ Counseling and testing
- ◆ Condom negotiation skills
- ◆ Increase awareness of importance of condom use as well as resources on where to get condoms
- ◆ Increase awareness of risks associated with having multiple partners and both male and female partners
- ◆ Partner counseling and referral services
- ◆ Public awareness campaigns to provide accurate information about HIV/AIDS
- ◆ Substance abuse prevention and treatment education

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Housing and food assistance

Black Men who have Sex with Men

Existing or Emerging Needs

- ◆ Programs addressing stigmas associated with homosexuality and identifying resources, such as support groups, specifically for Black MSM
- ◆ Programs targeting Black MSM that are trading sex for money and/or drugs
- ◆ Development of education materials that are gender neutral about partners
- ◆ Faith-based programs
- ◆ Culturally sensitive and safe support groups for Black MSM
- ◆ Include more Black MSM in planning and implementation of prevention activities

Continuing Needs

- ◆ Condom negotiation skills
- ◆ Counseling and testing
- ◆ Partner counseling and referral services

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Access to transportation
- ◆ Job training

Transgenderers

Existing or Emerging Needs

- ◆ Improved access to prevention and care services

- ◆ Local transgender care and prevention programs operating on a harm reduction model
- ◆ Medical service delivery training for medical providers in transgender care services, as part of linkages to care
- ◆ Programs targeting those trading sex for money and/or drugs
- ◆ Adaptation of DEBIs such as SISTA for male-to-female transgenders and VOICES/VOCES for female-to-male and male-to-female transgenders
- ◆ Partner education
- ◆ Identify resources and services available for transgenders (i.e. doctors and dentists who are transgender-friendly)
- ◆ Training for providers
- ◆ Bilingual health educators
- ◆ Culturally appropriate curricula
- ◆ Programs targeting those with low educational level
- ◆ Programs with a focus on those starting the transition process
- ◆ Referrals for job training
- ◆ Workshops on silicone usage and others
- ◆ Educational materials in Spanish
- ◆ Family education
- ◆ Improvement of HIV testing that addresses confidentiality concerns
- ◆ Public awareness campaigns to provide accurate information about HIV/AIDS

Continuing Needs

- ◆ Access to condoms
- ◆ Basic and Intensive street outreach
- ◆ Condom negotiation skills
- ◆ Counseling and testing
- ◆ Development of transgender-specific HIV/AIDS prevention materials
- ◆ Educational programs for transgender people about transgender care
- ◆ Expansion of outreach and condom distribution to transgender subpopulations, especially Latina, transgender youth and female-to-male groups
- ◆ Implementation of transgender-specific prevention workshops
- ◆ Individualized risk reduction plans
- ◆ Partner counseling and referral services
- ◆ Rapid testing
- ◆ Substance abuse education, prevention, and treatment
- ◆ Support groups specifically for transgenders

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Better access to shelters
- ◆ Programs teaching self defense
- ◆ Safe housing

Older adults

Existing or Emerging Needs

- ◆ General education and awareness programs targeting older populations
- ◆ Counseling and testing
- ◆ Culturally sensitive support groups for HIV-positive older adults
- ◆ Education for health care providers on potential risks for older adults
- ◆ Outreach to residential homes
- ◆ Safer sex and condom negotiation skills
- ◆ Sex education and STD and HIV education
- ◆ Public awareness campaigns to provide accurate information about HIV/AIDS
- ◆ Senior peer to peer educators
- ◆ Education for anyone who provides services for older adults (i.e. support services, etc.)
- ◆ Prevention education classes at senior centers, Bingo Halls
- ◆ Accessing community services and resources
- ◆ Gender specific support groups for HIV-positive older adults

Continuing Needs

- ◆ Partner counseling and referral services

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Substance abuse treatment

Sex Workers

Existing or Emerging Needs

- ◆ Comprehensive risk counseling services
- ◆ Street and community outreach
- ◆ Access to testing on demand
- ◆ Condom negotiation skills
- ◆ Individual level intervention
- ◆ Access to condoms
- ◆ Counseling and testing
- ◆ Domestic violence education and prevention
- ◆ STD and basic health education
- ◆ Child abuse education
- ◆ Referrals for job training and housing assistance and transfer education
- ◆ Education for male victims of rape
- ◆ Public awareness campaigns to provide accurate information about HIV/AIDS

Continuing Needs

- ◆ Partner counseling and referral services

- ◆ STD screening

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Self defense training
- ◆ Substance abuse treatment

Mentally Challenged

Existing or Emerging Needs

- ◆ Programs that provide skills in avoiding sexual coercion or enticement for mentally retarded clients
- ◆ Low-literacy brochures
- ◆ Sexuality training for group home staff
- ◆ Peer mentoring
- ◆ Programs that target prevention, education, and the delivery of quality mental health services to people living with and/or affected by HIV/AIDS
- ◆ Assistance / coaching around disclosure with sex partners
- ◆ Public awareness campaigns to provide accurate information about HIV/AIDS
- ◆ Condom negotiation skills
- ◆ Interpretation services
- ◆ Referrals for housing

Continuing Needs

- ◆ Counseling and testing
- ◆ Partner counseling and referral services

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Substance abuse treatment specifically for HIV-infected persons

Homeless

Existing or Emerging Needs

- ◆ Cultural competency training for medical, social service, shelter, and transitional housing staff
- ◆ Rapid testing
- ◆ Street and community outreach
- ◆ Substance abuse education and referral to treatment
- ◆ Domestic violence and abuse prevention education
- ◆ HIV and STD prevention training for shelter staff
- ◆ Public awareness campaigns to provide accurate information about HIV/AIDS
- ◆ Referrals to housing
- ◆ Condom negotiation skills
- ◆ Counseling and testing

- ◆ Community case management
- ◆ Training for mental health providers

Continuing Needs

- ◆ Partner counseling and referral services

Needs that Cannot be Funded through HIV Prevention Funds

- ◆ Access to food and food referrals
- ◆ Job skills training
- ◆ Self defense training

The following models were used for each target population in the prioritization process:

| BLACKS | | | | | | |
|--|---|------------------------|------------------|---|-------------------|---------------|
| | Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | 755 ¹ | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | 4 | 20 |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | 423 ¹ | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | 5 | 20 |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | 402 ¹ | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | 5 | 25 |
| Population Size | Estimated size of the 2005 target population in Virginia | 1,391,168 ² | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | 4 | 8 |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | 64.75% ³ | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | 5 | 15 |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | --- | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | 1.67 ⁴ | 3.33 |
| Risk | The nature and relative risk of behaviors that occur in the target population | --- | 4 | 1: Demographic 3: Situational 5: Behavioral | 1 | 4 |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | --- | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | 4.33 ⁴ | 19.50 |
| | | | | | Score | 114.83 |

¹ Data from the HIV/AIDS Reporting System (HARS).

² U.S. Census (2004)

³ Hazard Distribution = 5-year average HIV/AIDS Prevalence / 5-year Average Total Number HIV/AIDS cases (1,166 avg. reported cases)

⁴ CPG broke into 3 groups to score indicators (Resources Available & Social Indicators). Scale rating based on score average determined by 3 groups.

MEN WHO HAVE SEX WITH MEN

| | Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
|--|---|----------------------|------------------|---|-------------------|---------------|
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | 393 ¹ | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | 3 | 15 |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | 218 ¹ | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | 4 | 16 |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | 202 ¹ | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | 3 | 15 |
| Population Size | Estimated size of the 2005 target population in Virginia | 107,237 ² | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | 1 | 2 |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | 33.7% ³ | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | 4 | 12 |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | --- | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | 2.33 ⁴ | 4.67 |
| Risk | The nature and relative risk of behaviors that occur in the target population | --- | 4 | 1: Demographic 3: Situational 5: Behavioral | 5 | 20 |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | --- | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | 5 ⁴ | 22.50 |
| Score | | | | | | 107.17 |

¹ Data from the HIV/AIDS Reporting System (HARS).

² Smith, Tom W.; American Sexual Behavior: Trends, Socio-Demographic Differences, and Risk Behavior. National Opinion Research Center, University of Chicago: April 2003 (Note: Estimated MSM Population = 3% of VA male population based on 2005 Census estimate)

³ Hazard Distribution = 5-year average HIV/AIDS Prevalence / 5-year Average Total Number HIV/AIDS cases (1,166 avg. reported cases)

⁴ CPG broke into 3 groups to score indicators (Resources Available & Social Indicators). Scale rating based on score average determined by 3 groups.

HIGH-RISK HETEROSEXUALS

| | Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
|--|---|------------------------|------------------|---|-------------------|-------|
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | 272 ¹ | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | 3 | 15 |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | 136 ¹ | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | 3 | 12 |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | 157 ¹ | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | 3 | 15 |
| Population Size | Estimated size of the 2005 target population in Virginia | 4,021,333 ² | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | 5 | 10 |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | 23.3% ³ | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | 3 | 9 |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | --- | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | 1 ⁴ | 2 |
| Risk | The nature and relative risk of behaviors that occur in the target population | --- | 4 | 1: Demographic 3: Situational 5: Behavioral | 5 | 20 |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | --- | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | 2.33 ⁴ | 10.50 |

| | |
|--------------|--------------|
| Score | 93.50 |
|--------------|--------------|

¹ Data from the HIV/AIDS Reporting System (HARS).

² Smith, Tom W.; American Sexual Behavior: Trends, Socio-Demographic Differences, and Risk Behavior. National Opinion Research Center, University of Chicago: April 2003; Note: Estimated Heterosexual Population=(total VA population ages 25-65)-(estimate of lesbian+gay male population)

³ Hazard Distribution = 5-year average HIV/AIDS Prevalence / 5-year Average Total Number HIV/AIDS cases (1,166 avg. reported cases)

⁴ CPG broke into 3 groups to score indicators (Resources Available & Social Indicators). Scale rating based on score average determined by 3 groups.

TRANSGENDER

| TRANSGENDER | | | | | | |
|--|---|---------------------|------------------|---|-------------------|-------|
| | Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | 3,928 ¹ | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | 5 | 25 |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | 0 ² | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | 1 | 4 |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | 0 ² | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | 1 | 5 |
| Population Size | Estimated size of the 2005 target population in Virginia | 37,407 ³ | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | 1 | 2 |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | 337% ⁴ | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | 5 | 15 |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | --- | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | 4.67 ⁵ | 9.33 |
| Risk | The nature and relative risk of behaviors that occur in the target population | --- | 4 | 1: Demographic 3: Situational 5: Behavioral | 1 | 4 |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | --- | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | 5 ⁵ | 22.50 |

¹ HIV Prevalence estimated based on self-reported results from the Virginia Transgender Health Initiative Survey.

² Data not collected as part of routine surveillance at Virginia Department of Health.

³ Virginia Transgender Task Force and using available literature. (Note: Estimated Transgender population = 0.5% of VA population)

⁴ Hazard Distribution = 5-year average HIV/AIDS Prevalence / 5-year Average Total Number HIV/AIDS cases (1,166 avg. reported cases)

⁵ CPG broke into 3 groups to score indicators (Resources Available & Social Indicators). Scale rating based on score average determined by 3 groups.

| | |
|--------------|--------------|
| Score | 86.83 |
|--------------|--------------|

INJECTION DRUG USERS

| INJECTION DRUG USERS | | | | | | |
|--|---|---------------------|------------------|---|-------------------|-------|
| | Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | 99 ¹ | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | 2 | 10 |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | 36 ¹ | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | 2 | 8 |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | 78 ¹ | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | 2 | 10 |
| Population Size | Estimated size of the 2005 target population in Virginia | 14,963 ² | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | 1 | 2 |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | 8.5% ³ | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | 1 | 3 |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | --- | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | 2.33 ⁴ | 4.67 |
| Risk | The nature and relative risk of behaviors that occur in the target population | --- | 4 | 1: Demographic 3: Situational 5: Behavioral | 5 | 20 |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | --- | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | 5 ⁴ | 22.50 |

¹ Data from the HIV/AIDS Reporting System (HARS).

² Population estimated based on results of the National Household Survey on Drug Abuse: Injection Drug Use Update: 2002-2003

³ Hazard Distribution = 5-year average HIV/AIDS Prevalence / 5-year Average Total Number HIV/AIDS cases (1,166 avg. reported cases)

⁴ CPG broke into 3 groups to score indicators (Resources Available & Social Indicators). Scale rating based on score average determined by 3 groups.

| | | |
|--|--------------|--------------|
| | Score | 80.17 |
|--|--------------|--------------|

HOMELESS

| | Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
|--|---|---------------------|------------------|---|-------------------|-------|
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | 0 ¹ | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | 1 | 5 |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | 0 ¹ | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | 1 | 4 |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | 0 ¹ | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | 1 | 5 |
| Population Size | Estimated size of the 2005 target population in Virginia | 43,182 ² | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | 1 | 2 |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | 0% ³ | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | 1 | 3 |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | --- | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | 4.33 ⁴ | 8.67 |
| Risk | The nature and relative risk of behaviors that occur in the target population | --- | 4 | 1: Demographic 3: Situational 5: Behavioral | 3 | 12 |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | --- | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | 5 ⁴ | 22.50 |

¹ Data not collected as part of routine surveillance at Virginia Department of Health.

² Department of Housing & Community Development (http://www.dhcd.virginia.gov/Forms/ConsPlan/ConPlan2003_2007.pdf)

³ Hazard Distribution = 5-year average HIV/AIDS Prevalence / 5-year Average Total Number HIV/AIDS cases (1,166 avg. reported cases)

⁴ CPG broke into 3 groups to score indicators (Resources Available & Social Indicators). Scale rating based on score average determined by 3 groups.

| | |
|--------------|--------------|
| Score | 62.17 |
|--------------|--------------|

YOUTH (AGE 13-24)

| | Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
|--|---|------------------------|------------------|---|-------------------|---------------|
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | 146 ¹ | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | 2 | 10 |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | 118 ¹ | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | 3 | 12 |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | 31 ¹ | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | 1 | 5 |
| Population Size | Estimated size of the 2005 target population in Virginia | 1,159,267 ² | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | 4 | 8 |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | 12.5% ³ | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | 2 | 6 |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | --- | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | 1.67 ⁴ | 3.33 |
| Risk | The nature and relative risk of behaviors that occur in the target population | --- | 4 | 1: Demographic 3: Situational 5: Behavioral | 1 | 4 |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | --- | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | 3 ⁴ | 13.50 |
| | | | | | Score | 61.833 |

¹ Data from the HIV/AIDS Reporting System (HARS).

² U.S. Census (2004)

³ Hazard Distribution = 5-year average HIV/AIDS Prevalence / 5-year Average Total Number HIV/AIDS cases (1,166 avg. reported cases)

⁴ CPG broke into 3 groups to score indicators (Resources Available & Social Indicators). Scale rating based on score average determined by 3 groups.

INCARCERATED

| | Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
|--|---|---------------------|------------------|---|-------------------|---------------|
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | 42 ¹ | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | 1 | 5 |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | 28 ¹ | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | 2 | 8 |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | 13 ¹ | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | 1 | 5 |
| Population Size | Estimated size of the 2005 target population in Virginia | 68,994 ² | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | 1 | 2 |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | 3.6% ³ | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | 1 | 3 |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | --- | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | 3.67 ⁴ | 7.33 |
| Risk | The nature and relative risk of behaviors that occur in the target population | --- | 4 | 1: Demographic 3: Situational 5: Behavioral | 3 | 12 |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | --- | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | 4.33 ⁴ | 19.50 |
| | | | | | Score | 61.833 |

¹ Data from the HIV/AIDS Reporting System (HARS).

² Virginia Department of Corrections (March 2006); Note: 2000 estimate based on FY 2000; Current estimate as of March 2006; Note: *Incarcerated = Inmates + Parole & Probation*

³ Hazard Distribution = 5-year average HIV/AIDS Prevalence / 5-year Average Total Number HIV/AIDS cases (1,166 avg. reported cases)

⁴ CPG broke into 3 groups to score indicators (Resources Available & Social Indicators). Scale rating based on score average determined by 3 groups.

| LATINOS | | | | | | |
|--|---|----------------------|------------------|---|------------------|-----------|
| | Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | 89 ¹ | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | 2 | 10 |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | 48 ¹ | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | 2 | 8 |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | 46 ¹ | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | 1 | 5 |
| Population Size | Estimated size of the 2005 target population in Virginia | 418,130 ² | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | 2 | 4 |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | 7.6% ³ | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | 1 | 3 |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | --- | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | 3 ⁴ | 6 |
| Risk | The nature and relative risk of behaviors that occur in the target population | --- | 4 | 1: Demographic 3: Situational 5: Behavioral | 1 | 4 |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | --- | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | 4.7 ⁴ | 21 |
| | | | | | Score | 61 |

¹ Data from the HIV/AIDS Reporting System (HARS).

² U.S. Census (2004)

³ Hazard Distribution = 5-year average HIV/AIDS Prevalence / 5-year Average Total Number HIV/AIDS cases (1,166 avg. reported cases)

⁴ CPG broke into 3 groups to score indicators (Resources Available & Social Indicators). Scale rating based on score average determined by 3 groups.

MENTALLY CHALLENGED

| | Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
|--|---|---------------------|------------------|---|-------------------|--------------|
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | 0 ¹ | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | 1 | 5 |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | 0 ¹ | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | 1 | 4 |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | 0 ¹ | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | 1 | 5 |
| Population Size | Estimated size of the 2005 target population in Virginia | 29,246 ² | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | 1 | 2 |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | 0% ³ | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | 1 | 3 |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | --- | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | 4.33 ⁴ | 8.67 |
| Risk | The nature and relative risk of behaviors that occur in the target population | --- | 4 | 1: Demographic 3: Situational 5: Behavioral | 3 | 12 |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | --- | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | 4.67 ⁴ | 21 |
| | | | | | Score | 60.67 |

¹ Data not collected as part of routine surveillance at Virginia Department of Health.

² Department of Mental Health, Mental Retardation, and Substance Abuse Services (2003)

³ Hazard Distribution = 5-year average HIV/AIDS Prevalence / 5-year Average Total Number HIV/AIDS cases (1,166 avg. reported cases)

⁴ CPG broke into 3 groups to score indicators (Resources Available & Social Indicators). Scale rating based on score average determined by 3 groups.

SEX WORKERS

| SEX WORKERS | | | | | | |
|--|---|------------------|------------------|---|-------------------|--------------|
| | Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | 0 ¹ | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | 1 | 5 |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | 0 ¹ | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | 1 | 4 |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | 0 ¹ | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | 1 | 5 |
| Population Size | Estimated size of the 2005 target population in Virginia | 781 ² | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | 1 | 2 |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | 0% ³ | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | 1 | 3 |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | --- | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | 4 ⁴ | 8 |
| Risk | The nature and relative risk of behaviors that occur in the target population | --- | 4 | 1: Demographic 3: Situational 5: Behavioral | 3 | 12 |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | --- | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | 4.33 ⁴ | 19.50 |
| | | | | | Score | 58.50 |

¹ Data not collected as part of routine surveillance at Virginia Department of Health.

² Virginia State Police Note: Estimate based on number of offenses/arrests for prostitution.

³ Hazard Distribution = 5-year average HIV/AIDS Prevalence / 5-year Average Total Number HIV/AIDS cases (1,166 avg. reported cases)

⁴ CPG broke into 3 groups to score indicators (Resources Available & Social Indicators). Scale rating based on score average determined by 3 groups.

OLDER ADULTS (AGE 50 & OVER)

| | Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
|--|---|----------------------|------------------|---|-------------------|--------------|
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | 13 ¹ | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | 1 | 5 |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | 7 ¹ | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | 1 | 4 |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | 12 ¹ | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | 1 | 5 |
| Population Size | Estimated size of the 2005 target population in Virginia | 801,903 ² | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | 3 | 6 |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | 1.1% ³ | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | 1 | 3 |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | --- | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | 2.67 ⁴ | 5.33 |
| Risk | The nature and relative risk of behaviors that occur in the target population | --- | 4 | 1: Demographic 3: Situational 5: Behavioral | 1 | 4 |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | --- | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | 4.67 ⁴ | 21 |
| | | | | | Score | 53.33 |

¹ Data from the HIV/AIDS Reporting System (HARS).

² U.S. Census (2004)

³ Hazard Distribution = 5-year average HIV/AIDS Prevalence / 5-year Average Total Number HIV/AIDS cases (1,166 avg. reported cases)

⁴ CPG broke into 3 groups to score indicators (Resources Available & Social Indicators). Scale rating based on score average determined by 3 groups.

ASIAN / PACIFIC ISLANDER

| | Definition | Value | Indicator Weight | Scale | Scale Rating | Score |
|--|---|----------------------|------------------|---|--------------|--------------|
| HIV/AIDS Prevalence (diagnosed, 5 year average) | The average number of people living with diagnosed HIV (including people with AIDS) from 2001-2005 | 13 ¹ | 5 | 1: 0-50 2: 51-250 3: 251-500 4: 500-1,000 5: >1,000 | 1 | 5 |
| HIV Incidence (diagnosed, 5 year average) | The average number of HIV cases diagnosed from 2001-2005 | 6 ¹ | 4 | 1: 0-25 2: 26-51 3: 51-200 4: 201-300 5: >300 | 1 | 4 |
| AIDS Incidence (diagnosed, 5 year average) | The average number of AIDS cases diagnosed from 2001-2005 | 7 ¹ | 5 | 1: 0-50 2: 51-150 3: 151-250 4: 251-350 5: >350 | 1 | 5 |
| Population Size | Estimated size of the 2005 target population in Virginia | 326,563 ² | 2 | 1: 0-250,000 2: 250,001-500,000 3: 500,001-1,000,000 4: 1,000,001-2,000,000 5: >2,000,000 | 2 | 4 |
| Hazard Distribution | Percentage of target population representing people living with diagnosed HIV and AIDS from 2001-2005 | 1.1% ³ | 3 | 1: 0%-10% 2: 11%-20% 3: 21%-30% 4: 31%-40% 5: >40% | 1 | 3 |
| Resources Available to Meet Population Needs | Ability to meet needs of target population based on VDH funded resources. | --- | 2 | 1: Resources Available 3: Partially Available 5: Resources Not Available | | 7.33 |
| Risk | The nature and relative risk of behaviors that occur in the target population | --- | 4 | 1: Demographic 3: Situational 5: Behavioral | | 4 |
| Social Indicators | Barriers to reaching target population (i.e. immigration issues, lack of data, access to health care, etc.) | --- | 4.5 | 1: Few / No barriers 3: Moderate barriers 5: Substantial barriers | | 19.50 |
| | | | | | Score | 51.83 |

¹ Data from the HIV/AIDS Reporting System (HARS).

² U.S. Census (2004)

³ Hazard Distribution = 5-year average HIV/AIDS Prevalence / 5-year Average Total Number HIV/AIDS cases (1,166 avg. reported cases)

⁴ CPG broke into 3 groups to score indicators (Resources Available & Social Indicators). Scale rating based on score average determined by 3 groups.

| | |
|-----------------|---|
| AAFI | African American Faith Initiative |
| ACCESS | AIDS Care Center for Education and Support Services |
| AED | Academy for Educational Development |
| AHEC | Area Health Education Centers |
| AIDS | Acquired Immunodeficiency Syndrome |
| AOD | Alcohol and Other Drugs |
| ASE | AIDS Services and Education |
| ASO | AIDS Service Organization |
| ATS | Anonymous Testing Sites |
| BSO | Basic Street Outreach |
| CDC | Centers for Disease Control and Prevention |
| CLI | Community Level Intervention |
| CRCS | Comprehensive Risk Counseling Services |
| CSB | Community Service Board |
| CSPS | Comprehensive STD Prevention Systems |
| CTR | Counseling, Testing, and Referral |
| DEBI | Diffusion of Effective Behavioral Interventions |
| DHHS | Department of Health and Human Services |
| DMHMRSAS | Department of Mental Health, Mental Retardation, and Substance Abuse Services |
| DOC | Department of Corrections |
| FTM | Female-to-Male Transgender |
| GLBTQ | Gay, Lesbian, Bisexual, Transgender, Queer |
| GLI | Group Level Intervention |
| HCPC | HIV Community Planning Committee |
| HC/PI | Health Communication / Public Information |
| HE/RR | Health Education / Risk Reduction |
| HIV | Human Immunodeficiency Virus |
| HRYA | High Risk Youth and Adults |
| HUD | Housing and Urban Development |

| | |
|---------------|---|
| IDU | Injection Drug User |
| ILI | Individual Level Intervention |
| ISO | Intensive Street Outreach |
| MAP | Minority AIDS Projects |
| MH | Mental Health |
| MMWR | Morbidity and Mortality Weekly Report |
| MSA | Metropolitan Statistical Area |
| MSM | Men who have sex with men |
| MTF | Male-to-Female Transgender |
| NOVAM | Northern Virginia AIDS Ministry |
| P4P | Prevention for Positives |
| PACOCV | Peer Advocates Coalition of Central Virginia |
| PCM | Prevention Case Management |
| PCRS | Partner Counseling and Referral Services |
| PLWHA | People Living with HIV / AIDS |
| SA | Substance Abuse |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SAPT | Substance Abuse Prevention and Treatment |
| SERAS | Sistema Educativo para Realidad Acerca del SIDA |
| SERL | Survey and Evaluation Research Laboratory |
| SISTA | Sisters Informing Sisters about AIDS |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infections |
| TACT | Tidewater AIDS Community Taskforce |
| VCU | Virginia Commonwealth University |
| VDH | Virginia Department of Health |
| VOICES | Video Opportunities for Innovative Condom Education and Safer Sex |