

STATE OF
MONTANA

2005-2007
COMPREHENSIVE HIV PREVENTION PLAN

PREPARED BY THE
COMMUNITY PLANNING GROUP FOR HIV PREVENTION
PROJECT COOPERATIVE AGREEMENT, PROGRAM
ANNOUNCEMENT 04012

AUGUST 2004

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HIV Prevention Community Planning Group**

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HIV PREVENTION COMMUNITY PLANNING

ACRONYMS

ADAP	AIDS Drug Assistance Program (Ryan White Title II)
AED	Academy of Educational Development, Washington DC
CBO	Community Based Organization
CDC	The Centers for Disease Control and Prevention, Atlanta, GA
CPG	Community Planning Group
CSA	Community Services Assessment
CTR	Counseling, Testing & Referral Services
DPHHS	MT Department of Public Health and Human Services
EIP	Early Intervention Program (Title II/III)
EPI	Epidemiological Profile of HIV In Montana
FSR	Final Status Report (fiscal) to CDC
GLI	Group Level Intervention (Type of Activity)
GMTF	Gay Men's Task Force
HCV	Hepatitis C Virus
HE/RR	Health Education/Risk Reduction (Intervention Category)
HIV	Human Immunodeficiency Virus
HIV SAFE	HIV Prevention Statewide Activities For Evaluation System
HPS	HIV Prevention Site
HRSA	Health Resources Services Administration; Ryan White Care Act
IDU	Injection Drug User (target population)
IHS	Indian Health Service
ILI	Individual Level Intervention (Type of Activity)
MMWR	Morbidity and Mortality Weekly Report (from CDC)
MSM	Men Who Have Sex With Men (target population)
MTAP	Montana Targeted Prevention Program
NAPWA	National Association of Persons Living with HIV/AIDS
NASTAD	National Association of State & Territorial AIDS Directors
NMAC	National Minority AIDS Council, Washington DC
NPIN	National Prevention Intervention Network
OPI	Office of Public Instruction, State of Montana
PCM	Preventive Case Management (Intervention Category)
PCRS	Partner Counseling and Referral Services
PIR	Parity, Inclusion and Representation (CPG Membership Composition)
PLWA	People Living With AIDS
PSE	Public Sex Environment
RFP	Request for Proposals (For contracted services providers)
SAFE	Statewide Activities For Evaluation System
SPC	Statewide Planning Committee (Ryan White Title II)
STD	Sexually Transmitted Diseases
TA	Technical Assistance
YRBS	Youth Risk Behavior Survey

2005-2007 Montana Comprehensive HIV Prevention Plan

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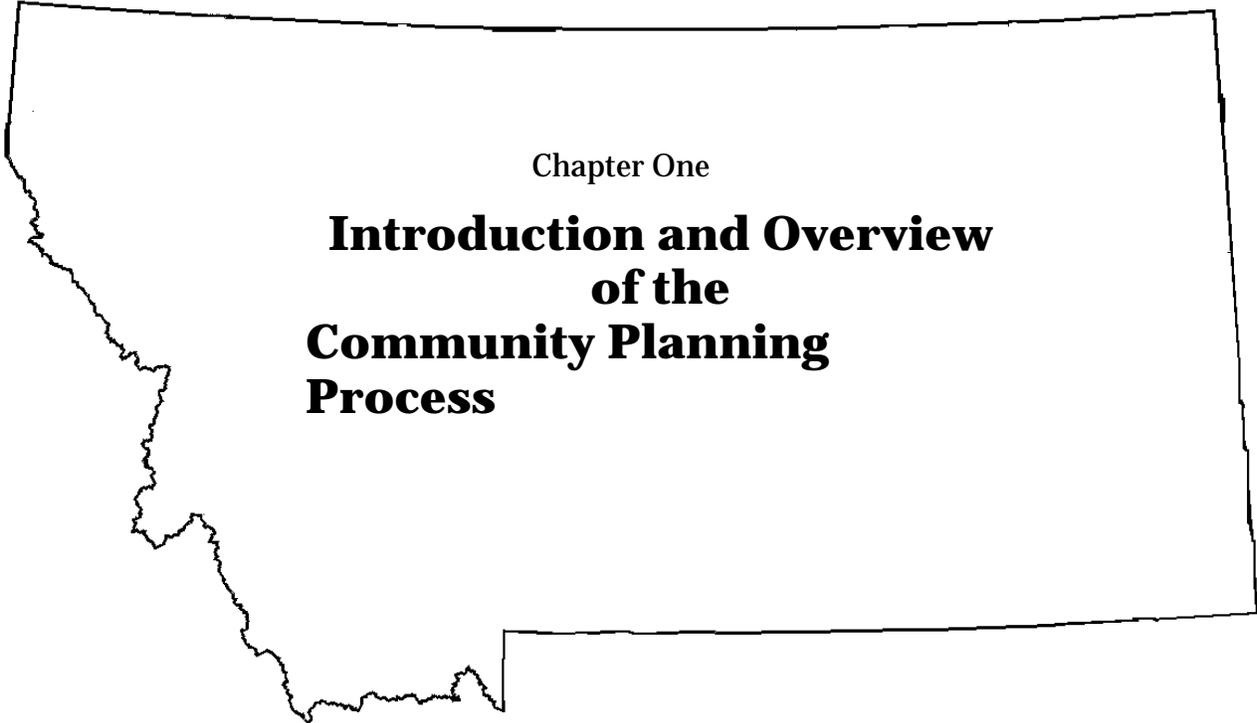
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Chapter One

**Introduction and Overview
of the
Community Planning
Process**

Introduction and Overview of the HIV Prevention Community Planning Process

Sustaining and Improving Performance Regarding the Community Planning Goals:

Montana's HIV prevention community planning process is structured for the purpose of meeting the three goals and eight objectives for HIV Prevention Community Planning as described in the 2003-2008 HIV Prevention Community Planning Guidance. The critical attributes associated with each objective have been integrated into the planning process to ensure that the objectives of community planning are being met. A general description of the processes that have occurred and will occur as a part of community planning is offered below.

Goal One – Community planning supports broad-based community participation in HIV prevention planning.

Objective A: Implement an open recruitment process for CPG membership.

Membership on the CPG is determined primarily through a standing committee consisting of individuals who are members of or representatives of Montana's high risk populations. The Membership Committee solicits nominations for membership on the CPG and is responsible for assuring broad based representation and community participation in the planning process. Specific written criteria for determining membership were developed by the CPG and are based upon representation from the six communities listed below. Additional criteria considered by the membership committee include age, geographic location, expertise/experience, and personal interest in becoming a CPG member (Attachment 1). The membership committee maintains term and attendance records as well as revises membership application forms. Most importantly, this committee periodically reviews membership composition, and identifies and fills vacancies in a timely manner.

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

Montana's current HIV Prevention Community Planning Group (CPG), consists of thirty-six members; thirty positions are filled by individuals chosen to reflect the following affected communities (listed in alphabetical order): High Risk Heterosexual, HIV Positive, HIV Prevention Service Providers, IDU, MSM, and Native American. In addition, six positions are filled by DPHHS staff and CPG chairpersons including: the HIV Prevention Planning Coordinator, the DPHHS Co-Chair, the STD Supervisor, and the past, current and elect Community Co-Chairs. Members representing the communities serve a three-year term, staggered to ensure continuity. At the end of their term, members are able to reapply for another three-year term if they wish. The CPG maintains two procedures to resolve membership conflicts: 1) The Membership Appointment Conflict Resolution Procedure (Attachment 1)

addresses the possibility that the State Director may refuse to approve a particular individual's membership on the CPG and 2) The Internal Membership Conflict Resolution Procedure (Attachment 1) addresses conflicts resulting from Membership Committee action or inaction regarding applications for membership.

Although they do not have specific positions on the CPG, other staff members in the STD/HIV Prevention Section share in the community planning process by providing information, technical assistance and playing supportive roles as appropriate (i.e. the Quality Assurance Specialist, the Ryan White Title II Program Manger, the STD Program Staff Members, and the STD/HIV Health Educator). In addition, the state surveillance coordinator and The University of Montana evaluation contractor play active roles in the community planning process. Other interested members of the public and community partners attend CPG meetings and their input is a valued part of the community planning process.

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

Inclusion and parity in community planning are fostered in the following ways: 1) formal focus groups and interviews with high risk individuals are conducted in the course of assessing the needs of priority populations; 2) information regarding the prevention needs of marginalized groups is gathered informally by CPG members who represent those groups; 3) CPG members with economic needs who attend state meetings are given the opportunity to receive advance payment for expenses incurred while attending the meetings; 4) orientation sessions for new members are held twice a year – current members of the CPG are encouraged to attend orientation as well; 5) all CPG members and interested individuals receive an updated Orientation Manual, a Policies and Procedures Manual (Attachment 1) as well as a copy of the By-Laws (Attachment 1); 6) the decision making process and process for conflict of interest are described in detail in the Policies and Procedures Manual; and 7) meetings are open to the public and all attendees are welcome to provide input into the process.

Goal Two – Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

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

The epidemiologic profile and the Community Services Assessment (including a gap analysis) are critical to Montana's process for identifying HIV prevention needs. The epidemiologic profile is updated annually in an effort to incorporate new information or relevant data sources identified during the previous year. The profile provides information about Montana's high risk populations, describes strengths and limitations of data sources used, explicitly identifies data gaps, and contains a narrative of the data presented (see chapter 2). The surveillance coordinator delivers a comprehensive written report, as well as a power point presentation, to the CPG just prior to the priority setting process. He is available for questions during the priority setting process and delivers brief updates regarding the epidemiologic profile at three of the four state meetings.

A Community Services Assessment was conducted on all four of Montana's priority populations in 2004. The assessment utilized information regarding each population's knowledge, skills, attitudes and norms; access to services; an HIV service provider survey; and current interventions targeted to each population. Information from all sources was then analyzed and used to identify both met and unmet needs. The specific process for conducting the Community Services Assessment in relationship to population and intervention priority setting is discussed below.

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

The following process for determining priority populations was used in 2004 and will, in all likelihood, be used again when a new plan is created in 2008.

A state meeting was organized in February 2004 primarily for the purpose of determining priority populations. At this meeting, members of the CPG were divided into four groups based upon their expertise or association with one of Montana's high risk groups as identified through the epidemiologic profile. Each group represented one of the following high risk populations: HIV Positive Individuals, MSM, IDU, and High Risk Heterosexuals. DPHHS staff supplied each group with documents necessary for determining population priorities. Documents used in the process included the epidemiologic profile, needs assessment reports, Youth Risk Behavior Survey, STI data, a list of current prevention interventions, resource data, and other relevant information. In addition, group members were responsible for bringing to the state meeting any information they could gather either formally or informally regarding their target population. The surveillance coordinator and the evaluation contractor as well as DPHHS staff were available to assist the groups in interpreting the data and formulating a gap analysis.

Groups met in the morning and were provided with guidelines for preparing a presentation for the CPG regarding the prevention needs of their assigned population. After meeting for several hours and carefully considering all available information, the afternoon was devoted to presentations regarding the prevention needs of each high risk group. Questions and comments were entertained after each presentation. When the four presentations and the ensuing discussions were finished the CPG members used the Population Ranking Chart (see Chapter 3) to anonymously rank the populations in terms of their contribution to new HIV infections. Rankings were then totaled, presented to the CPG for approval, and populations were prioritized accordingly.

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

The following process for determining effective interventions was used in 2004 and will, in all likelihood, be used again when a new plan is created in 2008.

For the purpose of researching and recommending effective science based interventions to the CPG, an Effective Interventions Committee was created in 2003 as a standing committee of the CPG. This committee is comprised of individuals representing each of Montana's six communities and includes the community planning coordinator. The committee is charged with conducting research and recommending effective science based interventions for each priority population.

In 2004, the committee devoted itself to collecting information regarding effective interventions for each priority population. Multiple data sources were collected and reviewed including: 1) a statewide survey requesting information from all known HIV/AIDS service providers regarding current interventions and the effectiveness of those interventions (Attachment 2); 2) a document describing all current prevention interventions funded by CDC dollars; 3) CDC's Procedural Guidance for Community Based Organizations; 4) a state funded document containing a comprehensive review of effective interventions for HIV+ individuals; 4) CDC's Compendium of Effective HIV Prevention Interventions; and 5) multiple journal articles and other publications describing effective interventions. Members also brought their personal expertise as representatives of high risk groups to the discussion and decision making process.

In an effort to synthesize all available information, the members of the committee convened at several state meetings, conducted several conference calls, and organized an all day in person meeting to which various experts were invited. Prior to the all day meeting committee members were assigned to one of the priority populations and were charged with reviewing and presenting three to six interventions that would be appropriate for that population. After each intervention was presented to the committee a discussion ensued and the committee members completed a form (Attachment 3) that listed critical factors to consider when adopting HIV prevention interventions. The outcome of the meeting was a list of recommended interventions prioritized by risk population based on their ability to have the greatest impact on decreasing new infections.

Information regarding the recommended interventions was organized into a power point presentation and was presented at the June CPG meeting. Following the presentation, CPG members divided into small groups; each group representing one of the four priority populations. Small group members were given the opportunity to once again review and discuss the interventions and concur with those recommendations or suggest changes. The CPG members then came to consensus to adopt the interventions into the comprehensive plan.

Goal Three – Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

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

The relationship between the plan and the application is demonstrated in two major ways. First, DPHHS staff complete a linkages worksheet that illustrates the number of HIV prevention interventions described in the plan that also appear in the application for funding. Second, members of the CPG are given the opportunity to review both the application and the plan prior

to the August statewide CPG meeting. At the August meeting, the application and plan undergo further review and revision by CPG members prior to their engagement in the process of consensus regarding concurrence or non-concurrence.

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

Montana’s CPG has established several safeguards to ensure the proper expenditure of prevention resources. First, a Budget Committee was established to ensure that resources are expended in a manner consistent with the prevention plan. The committee is comprised of members who work directly with the HIV/STD Prevention Section Supervisor to determine all aspects of funding for the coming year. Second, DPHHS staff complete a worksheet illustrating the number of dollars expended for each intervention. These expenditures are then compared with the prevention needs established during the population and intervention priority setting process based upon the Community Services Assessment.

CPG Demographics

AGE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-24	2	8.3	8.3	8.3
	25-34	5	20.8	20.8	29.2
	35-44	6	25.0	25.0	54.2
	45+	11	45.8	45.8	100.0
	Total	24	100.0	100.0	

GENDER

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	10	41.7	41.7	41.7
	female	14	58.3	58.3	100.0
	Total	24	100.0	100.0	

Sexual Orientation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	heterosexual	12	50.0	52.2	52.2
	gay	10	41.7	43.5	95.7
	lesbian	1	4.2	4.3	100.0
	Total	23	95.8	100.0	
Missing	System	1	4.2		
Total		24	100.0		

Ethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	hispanci/latino	1	4.2	4.8	4.8
	non-hispanic/non-latino	20	83.3	95.2	100.0
	Total	21	87.5	100.0	
Missing	System	3	12.5		
Total		24	100.0		

American Indian or Alaskan Native

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	5	20.8	22.7	22.7
	not checked	17	70.8	77.3	100.0
	Total	22	91.7	100.0	
Missing	System	2	8.3		
Total		24	100.0		

Asian

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	not checked	22	91.7	100.0	100.0
Missing	System	2	8.3		
Total		24	100.0		

Black or African-American

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	not checked	22	91.7	100.0	100.0
Missing	System	2	8.3		
Total		24	100.0		

Native Hawaiian or Pacific Islander

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	not checked	22	91.7	100.0	100.0
Missing	System	2	8.3		
Total		24	100.0		

White

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	16	66.7	72.7	72.7
	not checked	6	25.0	27.3	100.0
	Total	22	91.7	100.0	
Missing	System	2	8.3		
Total		24	100.0		

No response

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	1	4.2	4.5	4.5
	not checked	21	87.5	95.5	100.0
	Total	22	91.7	100.0	
Missing	System	2	8.3		
Total		24	100.0		

Geographic Location

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rural	6	25.0	25.0	25.0
	urban nonmetropolitan	16	66.7	66.7	91.7
	urban metropolitan	1	4.2	4.2	95.8
	other	1	4.2	4.2	100.0
	Total	24	100.0	100.0	

Other Locaton

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		23	95.8	95.8	95.8
	Frontier	1	4.2	4.2	100.0
	Total	24	100.0	100.0	

Area of Expertise Primary

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	community representative	11	45.8	45.8	45.8
	community organization	1	4.2	4.2	50.0
	PLWHA	4	16.7	16.7	66.7
	Intervention specialist/service provider	5	20.8	20.8	87.5
	health planner	3	12.5	12.5	100.0
	Total	24	100.0	100.0	

Area of Expertise Secondary

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	community representative	4	16.7	21.1	21.1
	community organization	6	25.0	31.6	52.6
	PLWHA	1	4.2	5.3	57.9
	Intervention specialist/service provider	5	20.8	26.3	84.2
	evaluation	1	4.2	5.3	89.5
	health planner	2	8.3	10.5	100.0
	Total	19	79.2	100.0	
Missing	System	5	20.8		
Total		24	100.0		

HIV Risk Perspective 1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MSM and are at risk through unsafe sex	12	50.0	52.2	52.2
	MSM unsafe sex and unsafe drug injection practices	1	4.2	4.3	56.5
	Men and women at risk through unsafe injection drug practices	3	12.5	13.0	69.6
	Men and women through unsafe heterosexual sex with infected	4	16.7	17.4	87.0
	Men and women not part of a specific HIV risk population	3	12.5	13.0	100.0
	Total	23	95.8	100.0	
Missing	System	1	4.2		
Total		24	100.0		

HIV Risk Perspective 2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MSM and are at risk through unsafe sex	3	12.5	20.0	20.0
	MSM unsafe sex and unsafe drug injection practices	6	25.0	40.0	60.0
	Men and women at risk through unsafe injection drug practices	4	16.7	26.7	86.7
	Men and women through unsafe heterosexual sex with infected	1	4.2	6.7	93.3
	Men and women not part of a specific HIV risk population	1	4.2	6.7	100.0
	Total	15	62.5	100.0	
Missing	System	9	37.5		
Total		24	100.0		

HIV Serostatus

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	living with HIV/AIDS	6	25.0	25.0	25.0
	not living with HIV/AIDS	17	70.8	70.8	95.8
	unknown	1	4.2	4.2	100.0
	Total	24	100.0	100.0	

Partner, Relative, Friend with HIV

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	16	66.7	66.7	66.7
	no	8	33.3	33.3	100.0
	Total	24	100.0	100.0	

Primary Organization

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	faith community	1	4.2	4.2	4.2
	non-minority cbo	8	33.3	33.3	37.5
	other	1	4.2	4.2	41.7
	health department:HIV/AIDS	9	37.5	37.5	79.2
	health department:STD	1	4.2	4.2	83.3
	mental health	1	4.2	4.2	87.5
	non-agency/community rep.	3	12.5	12.5	100.0
	Total	24	100.0	100.0	

Secondary Organization

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid non-minority cbo	2	8.3	15.4	15.4
other nonprofit	1	4.2	7.7	23.1
other	1	4.2	7.7	30.8
health department:HIV/AIDS	1	4.2	7.7	38.5
health department:STD	4	16.7	30.8	69.2
substance abuse	1	4.2	7.7	76.9
HIV care and social services	2	8.3	15.4	92.3
non-agency/community rep.	1	4.2	7.7	100.0
Total	13	54.2	100.0	
Missing System	11	45.8		
Total	24	100.0		

Other Organization

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	22	91.7	91.7	91.7
Tribal	1	4.2	4.2	95.8
Tribal Health	1	4.2	4.2	100.0
Total	24	100.0	100.0	

HIV Prevention Funding

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid yes	15	62.5	62.5	62.5
no	6	25.0	25.0	87.5
not applicable	3	12.5	12.5	100.0
Total	24	100.0	100.0	

HIV Prevention Funding Secondary

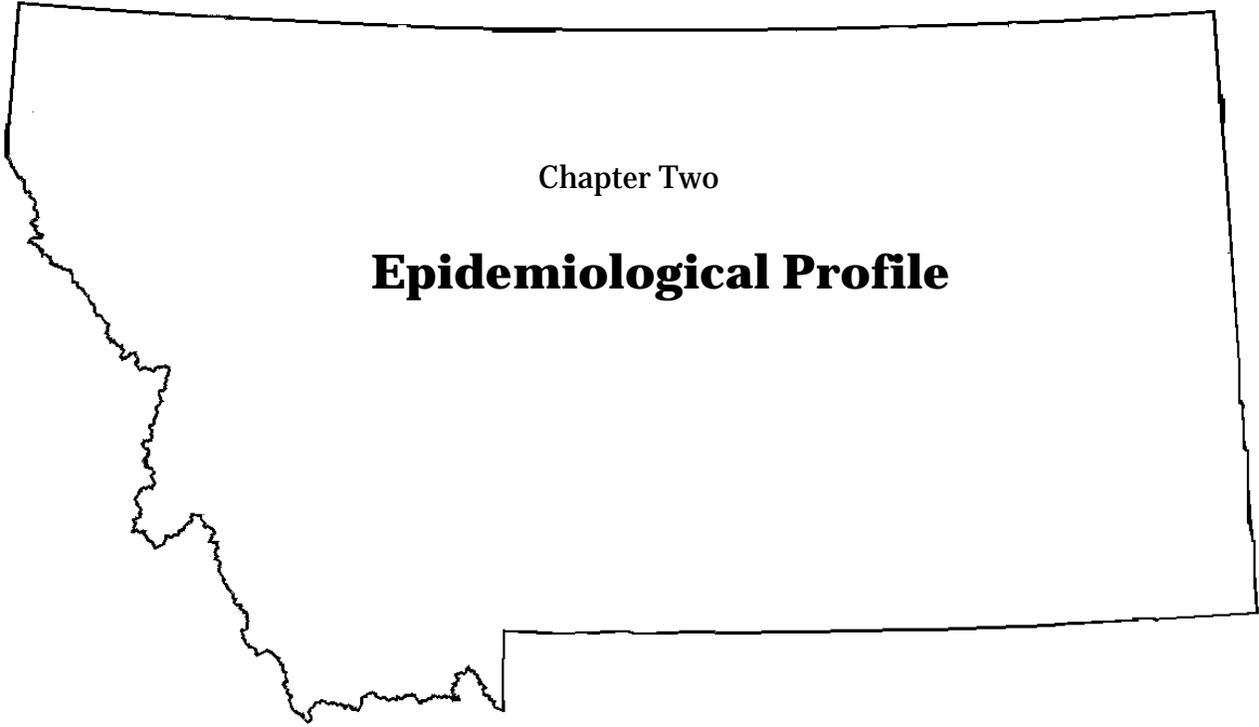
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	6	25.0	27.3	27.3
	no	8	33.3	36.4	63.6
	not applicable	8	33.3	36.4	100.0
	Total	22	91.7	100.0	
Missing	System	2	8.3		
Total		24	100.0		

of CPG Meetings Attended

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	3	12.5	12.5	12.5
	3	9	37.5	37.5	50.0
	4	11	45.8	45.8	95.8
	5	1	4.2	4.2	100.0
	Total	24	100.0	100.0	

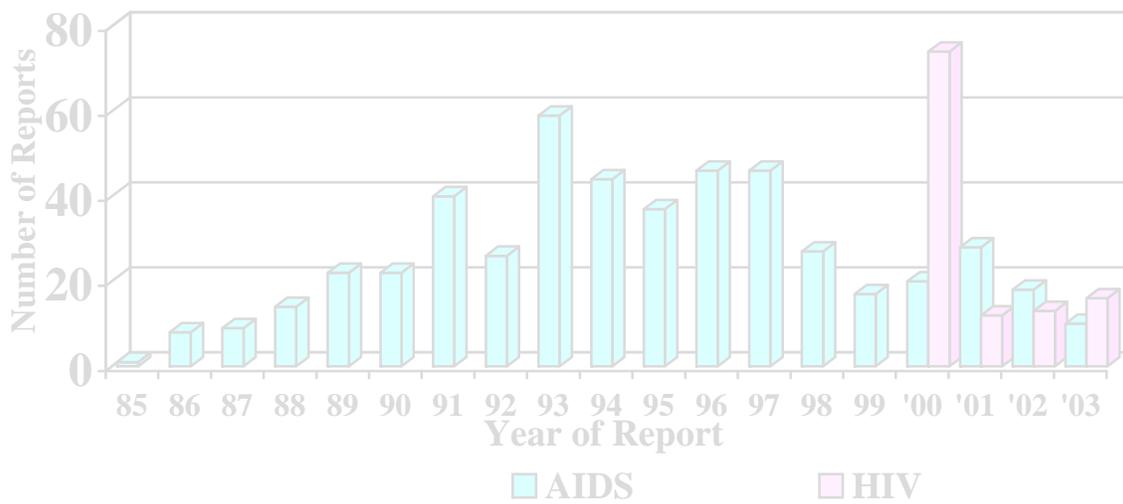
Year of CPG Membership

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1993	1	4.2	4.2	4.2
	1994	1	4.2	4.2	8.3
	1995	3	12.5	12.5	20.8
	1998	1	4.2	4.2	25.0
	1999	1	4.2	4.2	29.2
	2000	1	4.2	4.2	33.3
	2001	1	4.2	4.2	37.5
	2002	2	8.3	8.3	45.8
	2003	6	25.0	25.0	70.8
	2004	7	29.2	29.2	100.0
	Total	24	100.0	100.0	



2003 Epidemiologic Profile for HIV/AIDS Prevention and Care Planning

Figure 1. Reported HIV/AIDS Cases in Montana by Year of Report, 1985-2003.



**Communicable Disease Bureau
Division of Health Policies & Services
Department of Public Health & Human Services**

Revised June 2004

Executive Summary

As of December 31, 2003, a cumulative total of 612 cases of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) had been reported to the Montana Department of Public Health and Human Services (DPHHS) since 1985. In 2003, HIV/AIDS was the eighth most common reportable disease in Montana with a combined total of 29 (10 AIDS, 19 HIV) cases reported. Approximately 347 individuals aware of their infection are known to be living with HIV/AIDS in Montana. An estimated 66% of these individuals have been diagnosed with AIDS. Forty of our 56 counties have reported at least one HIV/AIDS case since 1985. Montana remains a “low incidence” state with respect to HIV/AIDS, reporting fewer cases annually than all other states except Wyoming, and North and South Dakota.

The geographic distribution of Montana’s HIV/AIDS cases closely reflects the state’s overall population distribution. Our eight largest counties account for approximately 80% of all reported HIV/AIDS cases since 1985. Cases reported during the last two years show no significant change. In fact, nearly 90% of all cases identified in the last two years resided in our eight largest counties.

To supplement our AIDS reporting system, formal HIV reporting was implemented in 2000. The implementation of HIV reporting was essential and provides us an opportunity to better monitor more recent trends in HIV transmission. To date, the characteristics of newly reported HIV cases appear similar to those of our AIDS cases with respect to race and age. In addition, modes of HIV transmission and the populations most impacted by HIV/AIDS appear to be relatively stable since our first case was identified in 1985. *In general*, our HIV/AIDS epidemic continues to be primarily among white males aged 20-50 who report same-sex contact and/or injecting drug use.

Although most characteristics of our cases varied little with respect to HIV or AIDS diagnosis, the ratio of women to men did differ when examined by the severity of infection. Men with an AIDS diagnosis outnumber women with the same diagnosis by a ratio of almost 9 men for every one woman with AIDS. However, recent HIV reports reflect a ratio of about 4 men for every woman with HIV. Whether this difference reflects an increase in heterosexual transmission or more frequent opportunities for risk assessment and testing among women is unknown at this time.

Male-to-male sexual contact (MSM) and injecting drug use (IDU) continue to be associated with the majority of reported HIV/AIDS cases. Together, these risks account for approximately 75% of the HIV/AIDS cases occurring in Montana, a percentage that has changed very little over the last decade. Among female HIV/AIDS cases, the predominant exposure category continues to be heterosexual contact, accounting for about 60% of the cases among women. Epidemiologic data continue to show little spread of HIV into the general population not perceived to be at high risk.

HIV/AIDS does not appear to have had a disproportionate impact on Montana’s American Indian population at the present time. American Indians represent approximately 6% of our population and represent 7% of the HIV/AIDS cases reported. Fortunately, we have not experienced the increase in cases among racial/ethnic minority groups experienced by larger

urban areas of our nation. While the number and characteristics of cases among American Indians differs little from those of the general population, other markers of potential HIV risk (teen pregnancies, STD rates) suggest an increased level of risk among American Indians when compared to non-Indian populations.

Youth Risk Behavior Surveys of high school students in Montana indicate teens and young adults continue to present a population at risk. While slightly less sexually active than their U.S. counterparts, many teens who are report not using a condom at last sexual encounter (37%) and one-third reported being under the influence of drugs or alcohol during their last sexual encounter. While not *direct* risks for HIV infection, risky sexual behavior among youth increases the chances of acquiring more common sexually transmitted diseases as well as HIV-infection.

Introduction

This epidemiologic profile provides detailed information about the current HIV/AIDS epidemic in Montana. Epidemiologic profiling of communicable diseases is an essential component in the development of effective prevention and control plans. Such reports serve as a cornerstone for program activities, and provide a measure of success for intervention efforts. A variety of data sources were relied upon to provide a comprehensive overview of Montana's HIV/AIDS epidemic.

Those familiar with earlier versions of the *profile* will note a few changes in the current document. First, we are trying to accommodate recent suggestions by the Centers for Disease Control and Prevention (CDC) and the Health Resources Services Administration (HRSA) to integrate data needed by treatment programs. As a result, the final version of the profile will address treatment related questions of interest to those involved in service delivery programs to HIV/AIDS impacted populations.

The second significant change reflects the reorganization of the state planning group and the move away from regional subgroups. The new profile presents the data in a statewide fashion but continues to point out relevant differences in distribution of cases and resources. Information by region is available from the surveillance program upon request.

Section 1: Core Epidemiologic Questions for Prevention Planning

1. What are the socio-demographic characteristics of the general population in Montana?
2. What is the scope of the HIV/AIDS epidemic in Montana?
3. What are the indicators of risk for HIV/AIDS infection in Montana?

Section 2: Ryan White HIV/AIDS CARE Act Special Questions and Considerations

4. What are the patterns of utilization of HIV services in persons in Montana?
5. What are the number and characteristics of persons who know they are HIV-positive, but who are not receiving primary medical care?

Each of the questions represents a section of the report and includes relevant data and interpretation.

Data Sources & Quality

Data were compiled from a variety of sources to provide the most complete picture possible. When interpreting the data, keep in mind that each of the data sources has strengths and limitations. A brief description of each of the data sources follows.

HIV/AIDS Surveillance Data

Each state established a reporting or *surveillance* system to collect information on newly diagnosed AIDS cases in the mid 1980s. These systems use a standardized case report form to collect limited sociodemographic information, mode of exposure, laboratory and clinical information, vital status (i.e., living or dead), and referrals for treatment or services on individuals meeting the CDC AIDS case definition (see appendix). The information collected by this system is subject to strict confidentiality standards and is used primarily for prevention, planning and evaluation purposes. In 2000, Montana implemented formal HIV reporting to supplement the AIDS surveillance system. The intent was to collect information on individuals without CDC-defined AIDS to better assess current HIV transmission trends.

Like all reporting systems, the HIV/AIDS surveillance system has some limitations and the information must be interpreted cautiously. Both HIV and AIDS data will underestimate the number of infected persons because some infected persons either do not know they are infected, have not sought testing or care, or have not been reported. In addition, persons testing positive at a state sponsored anonymous test site and who have not sought medical care are *not* included in HIV surveillance statistics *until care is sought*. Therefore, HIV infection data can provide only minimum estimates of the number of persons known to be HIV infected. Although more likely to reflect current trends, HIV cases may be reported to the health department at any point along the clinical spectrum of disease. Consequently, HIV infection data do not necessarily represent characteristics of persons who have been recently infected with HIV.

Behavioral Surveys

Youth Risk Behavior Survey (YRBS)

The YRBS is a self-administered questionnaire given every 2 years to a representative sample of students in grades 9 through 12 at the state and local level. Questions are asked about exposure to HIV prevention education materials, sexual activity (age at initiation, number of partners, condom use, past drug or alcohol use), contraceptive use, and pregnancy history. The YRBS is a standardized questionnaire, so comparisons can be made across participating jurisdictions. Jurisdictions may also add questions of local interest. However, because the YRBS project relies upon self-reported information, sensitive behavioral information may be underreported or overreported. Also, because the YRBS questionnaire is administered in school, the data are representative only of adolescents who are enrolled in school and cannot be generalized to all adolescents. For example, students at highest risk, who may be more likely to be absent from school or to drop out of school, may be underrepresented in this survey, especially those in upper grades. The questionnaire does not include questions about homosexual or bisexual behavior.

STD Surveillance

STD Case Reporting

Working closely with local health agencies, the DPHHS STD/HIV Control Program conducts statewide surveillance to determine the number of reported cases of STDs and monitor trends. Other services include partner counseling and, to help reduce the spread of STDs, referral services for examination and treatment. In Montana, chlamydia, gonorrhea, and syphilis are the most common reportable STDs. Because of the relatively short incubation periods between exposure and infection, STDs can serve as a marker of recent unsafe sexual behavior. In addition, certain STDs (e.g., ulcerative STDs) can facilitate the transmission or acquisition of HIV infection. Although STD risk behaviors result from unsafe sexual behavior, they do not necessarily correlate with HIV risk. Finally, the majority of cases are detected through screening of women seeking family planning services. As a result, results will be biased toward women seeking these services and may not be representative of the general population of other women or males.

Vital Statistics Data

Birth and Death Data

The National Center for Health Statistics receives information on births and deaths in the United States through a program of voluntary cooperation with state government agencies (i.e., state departments of health, state offices of vital statistics) called the Vital Statistics Cooperative Program. States use standard forms to collect birth and death data. The birth certificate form includes demographic information on the newborn and the parents, insurance status, prenatal care, prenatal risk factors, maternal morbidity, mode of delivery, pregnancy history, and clinical characteristics of the newborn. Death certificates include demographics, underlying cause of death, and contributions of selected factors to the death (i.e., smoking, accident, or injury) of all deceased persons. Reporting is approximately 100% complete for births and deaths. Therefore, inferences can be made concerning the number of live births in a service area. The data can also be used to determine the effect of deaths related to HIV infection in a service area. The data on birth certificates that are obtained from patient medical records (i.e., smoking history, morbidity) may be incomplete. In addition, deaths resulting from, or whose underlying cause was, HIV infection may be underreported on a death certificate. Clinical information related to HIV or AIDS may be missing.

Population Data

U.S. Bureau of the Census (Census Bureau)

The Census Bureau collects and provides timely information about the people and economy of the United States. The Census Bureau's Web site (<http://www.census.gov>) includes data on demographic characteristics (e.g., age, race, Hispanic ethnicity, sex) of the population, family structure, educational attainment, income level, housing status, and the proportion of persons who live at or below the poverty level. Summaries of the most requested information for states and counties are provided, as well as analytical reports on population changes, age, race, family structure, and apportionment. State- and county-specific data are easily accessible, and links to other Web sites with census information are included.

Profile Strengths And Limitations

When making planning decisions, it is important to consider the overall strengths and limitations of this document. While every attempt is made to provide a complete and accurate description of HIV/AIDS in Montana, we will have gaps. Much of the information is based on HIV/AIDS surveillance data, which can never be as complete or accurate as we'd like. As a result, we will always be "undercounting" cases as we await reports and conduct investigations. It is important to remember that the data in this report have to be interpreted carefully and may not necessarily represent the characteristics of all persons who have been recently infected, nor do they provide a true measure of HIV incidence (i.e. the number of new cases in a given time period). It is important to supplement this information with other available information available at the local or state level to help get the most complete picture of the epidemic in Montana. In most cases, the narrative in each section will point out limitations of the data sources used.

Profile Preparation

This profile was prepared by the DPHHS Surveillance Program in close collaboration with the Ryan White CARE and Prevention Programs. Questions and comments can be directed to the Surveillance Program at (406) 444-0273.

Organization Of The Profile

The epidemiologic profile is organized into 2 main sections, within which the 5 key questions are addressed.

Section 1: Core Epidemiologic Questions for Prevention Planning

This section provides the reader with an understanding of the characteristics of the general population in Montana, the distribution of HIV disease, and a detailed look at persons at risk for HIV infection. The section is organized around 3 key questions:

Question 1: What are the sociodemographic characteristics of the general population in Montana? Orients the reader to the overall demographic and socioeconomic characteristics of the general population of Montana.

Question 2: What is the scope of the HIV/AIDS epidemic in Montana? Examines the effect of the HIV/AIDS epidemic on a number of population groups in Montana to help planners focus prevention and care services.

Question 3: What are the indicators of risk for HIV/AIDS infection in Montana? Provides a detailed look at high-risk populations. Examines direct measures of risk behaviors associated with HIV transmission and indirect measures that may serve as indicators of high-risk behavior.

Section 2: Ryan White HIV/AIDS CARE Act Special Questions and Considerations

This section focuses on questions that pertain to HRSA HIV/AIDS care planning groups. Section 2 describes access to, use of, and standard of care among persons in Montana who are HIV-infected. It is organized around 2 key questions:

Question 1: What are the patterns of utilization of HIV services of persons in Montana? Characterizes the patterns in the use of services by a number of the populations living with HIV/AIDS in Montana.

Question 2: What are the number and characteristics of persons who know they are HIV-positive but who are not receiving primary medical care? Describes current efforts to assist in assessing the unmet need of persons who know they are HIV-positive, but who are not in care.

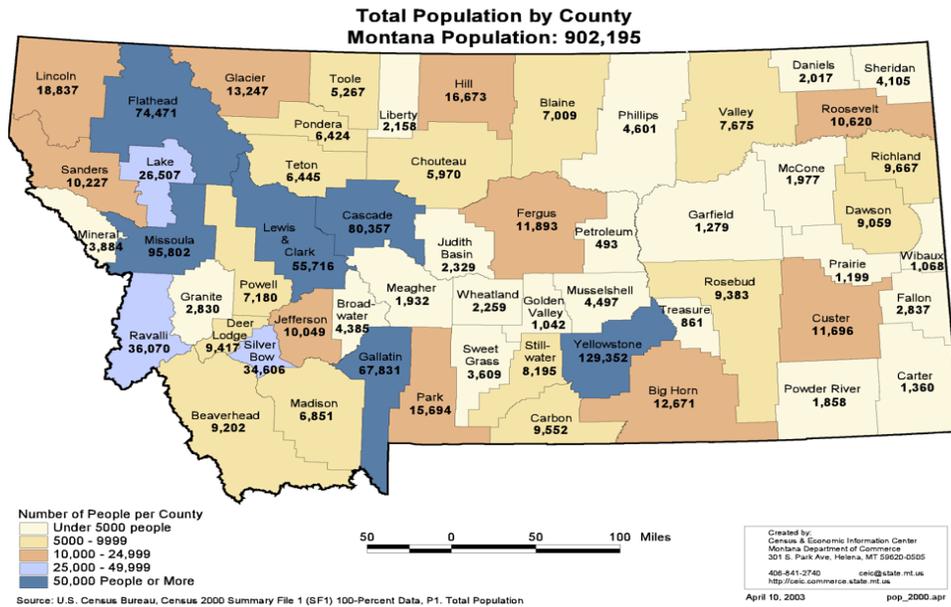
Question 1: What are the sociodemographic characteristics of the population?

This section provides information on the demographic and socioeconomic characteristics of the State of Montana. The information is intended to provide a basic over view of the state and its population. At this time and based on the limited data collected on HIV/AIDS case reports, the distribution of HIV/AIDS in Montana does not appear to be influenced directly by sociodemographic factors.

General Demographics

Population: In the 2000 census, the total population reported for Montana was 902,195 persons spread across an area comprising 145,552 square miles (Figure 1-1). Montana is comprised of 56 counties ranging in population from a low of 493 persons (Petroleum County) upwards to 129,352 persons in our most densely populated county (Yellowstone County). Of these 56 counties, 45 are designated frontier, 8 rural and only 3 as urban/Metropolitan Statistical Areas. The five major population centers, with respective counties, in order of descending population are: Billings (89,847)-Yellowstone County, Missoula (57,053)- Missoula County, Great Falls (56,690)-Cascade County, Butte (33,892)- Silver Bow County, and Bozeman (27,509)-Gallatin County. When the combined city/county populations are included these counties represent 45.2% of the state's population.

Figure 1-1. Montana's Population 2000 Census



Demographic Composition: The racial and ethnic composition of the state was estimated by the 2000 census data, to be 90.6% white, 0.3% black, 6.2% American Indian and Alaska Native, 0.5% Asian, 0.1% Native Hawaiian and Other Pacific Islander, 0.6% some other race, and 1.7% two or more races. Persons of Hispanic or Latino origin were estimated to make up 2.0% of the total population. Table 1-1 reflects the racial/ethnic composition of Montana.

Table 1-1. Racial/Ethnic Composition of Montana's Population, 2000 Census

Race/Ethnicity	MT Population	%	U.S. Population	%
White	817,229	90.6	211,460,626	75.1
Black	2,692	0.3	34,658,190	12.3
Native Amer.	56,068	6.2	2,475,956	0.9
Asian	4,691	0.5	10,242,998	3.6
Hawaiian/PI.	470	0.1	398,835	0.1
Other	5,315	0.6	15,359,073	5.5
Two or more races	15,730	1.7	6,826,228	2.4
Total:	902,195	100	281,421,906	100

Ethnicity: 2% of Montana's Population report being of Hispanic/Latino origin. Source: U.S. Bureau of the Census

Age and Sex: In 2000, the median age of Montana residents was 37.5 years. More than 28% of the population was 19 years of age or younger; 13.5% of the population was 65 or older. The

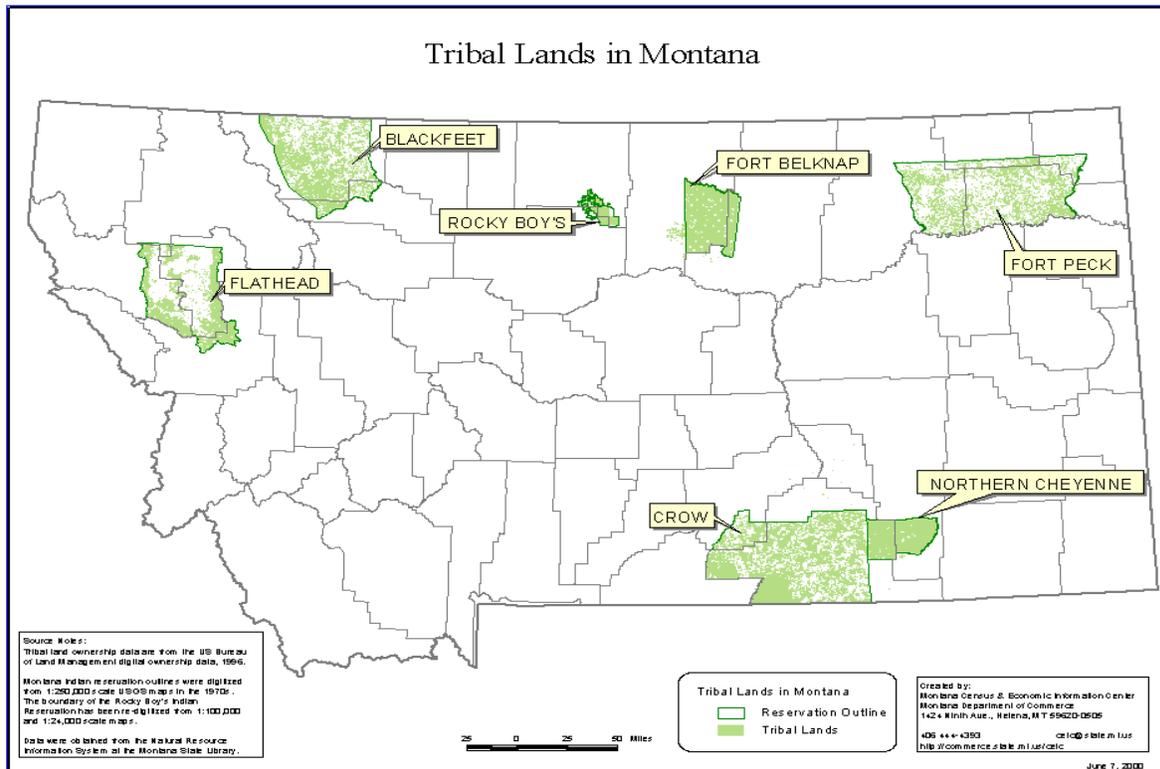
proportion of females in the overall population was 50.2% compared to the males at 49.8%. Montana's population by gender and age is presented in Table 1-2.

Table 1-2. Distribution of the general population in Montana, by age group and sex, 2000 census.

Age Group	MT Males	%	MT Females	%	MT Total	%	U.S. Comparison (%)
0 to 19	132,480	14.7	124,960	13.9	257,440	28.6	28.6
20 to 24	30,345	3.4	28,034	3.1	58,379	6.5	6.7
25 to 34	52,449	5.8	50,830	5.6	103,279	11.4	14.2
35 to 44	69,942	7.7	71,999	8.0	141,941	15.7	16.0
45 to 54	68,522	7.6	66,566	7.4	135,088	15.0	13.4
55 and Up	95,742	10.6	110,326	12.2	206,068	22.9	21.0
Total	449,480	49.8	452,715	50.2	902,195	100	100

Native American Issues: Within Montana's borders resides seven American Indian reservations (Figure 1-2); five of which are within the Bureau of Indian Affairs infrastructure and two (Rocky Boy and Flathead) are independent tribal confederations. Refer to 24 for further detail on issues related to Montana's Native American population and HIV/AIDS.

Figure 1-2. Native American Reservations in Montana



Incarcerated/Institutionalized Populations: In the 2000 census, 4,124 Montanans (0.5% of the population) were incarcerated in state-run correctional facilities (Table 1-3). Of these, 69 (1.7%) were under the age of 18 and 420 (10.2%) were female. A small number of *state* prisoners are supervised at the local level by the county (in jails, in treatment, electronically, etc.). Others incarcerated by county sheriff's offices in jails and the Federal Government in penitentiaries are not included in these totals.

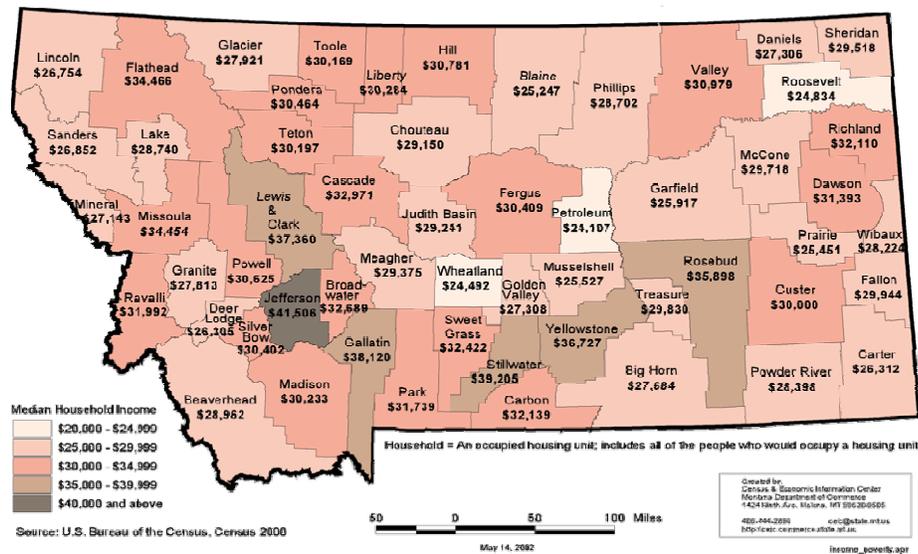
Table 1-3. Age Distribution of Montana's Incarcerated Population.

Age Group	Males (#)	Female (#)	Total (#)
Under 18	60	9	69
18 to 64	3,609	409	4,018
65 years and over	35	2	37
Total	3,704	420	4,124

Socioeconomic Status

Income: The median household income in Montana, according to the 2000 census, was \$33,024 (Figure 1-3) as compared to the U.S. median of \$41,994. Montana's individual income average was only \$17,151 compared to \$21,194 for the U.S. per capita income.

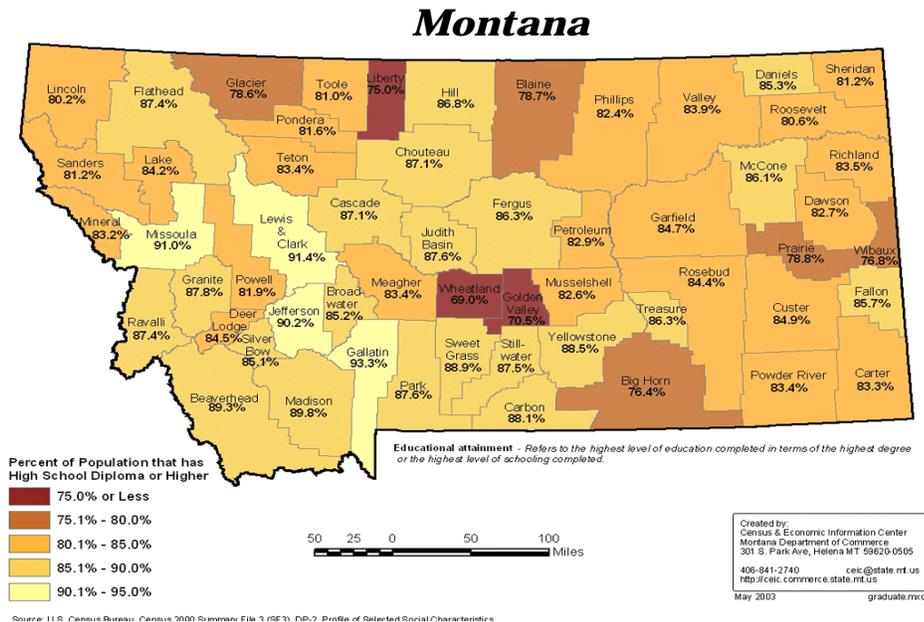
Figure 1-3. Montana Household Income \$33,024.00



Education: In the 2000 census 87.2% (Figure 1-4) of Montana residents, 25 years of age and older, reported educational attainment of a high school diploma or higher; 24.4% reported having

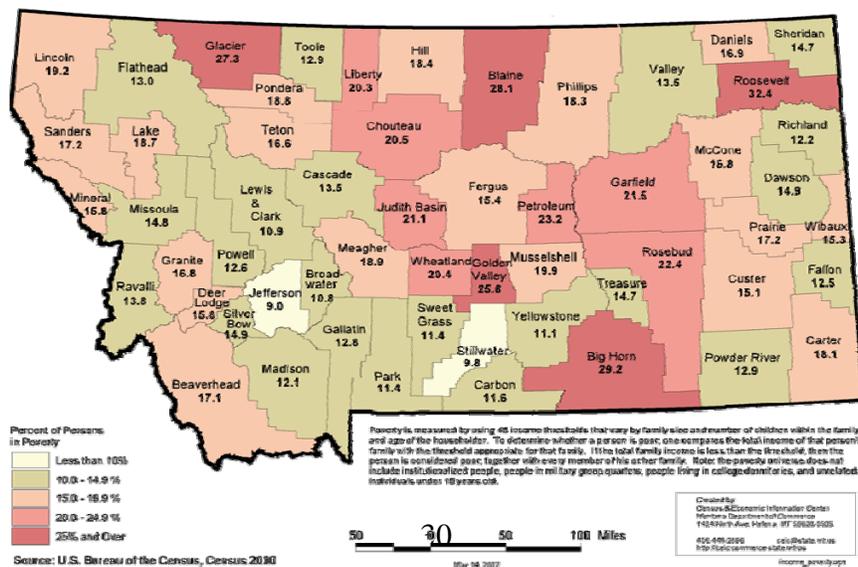
a bachelor's degree or higher. Among our American Indian population the rates were 79.1% and 14.2% respectively. The national census statistics reported 80.4% for a high school diploma and 24.4% for a bachelor's degree or higher.

Figure 1-4. Percent of Montana's population over the age of 25 with a high school diploma or higher



Poverty: Over 128,000 residents (14.6% of the population) for whom poverty status was determined had incomes that fell below the federally defined poverty level, compared with 13% nationally according to the 2000 census (Figure 1-5). Of the total number of families, 16.4% had children under 18 years of age, 33.2% had a female head of household (no male present), and 10.5% of all families had incomes below the poverty level. The unemployment rate in 2000 was 4.1% statewide and 11.6% on the American Indian reservations.

Figure 1-5. Poverty status of Montana residents



Insurance: According to estimates from the Urban Institute and Kaiser Commission on Medicaid and the Uninsured in 2003, 15% of Montana’s population (compared to a 15% national average) are uninsured (Table 1-4). Nationally, 57% of the population are covered by employer-provided health insurance, whereas Montana has only 49% of their residents covered by their employers.

Table 1-4. Montana resident insurance status estimates, 2002

Population Distribution by Insurance Status, state data 2001-2002, U.S. 2002				
	MT #	MT %	US #	US %
Employer	440,950	49	161,727,800	57
Individual	90,560	10	13,365,930	5
Medicaid	93,480	10	33,006,620	12
Medicare	138,830	16	33,404,670	12
Uninsured	129,780	15	43,572,090	15
Total	893,600	100	285,077,110	100

Question 2: What is the scope of the HIV/AIDS epidemic in Montana

AIDS Case Counts and Rates

As of December 31, 2003, a cumulative total of 612 HIV/AIDS cases have been reported to the Montana Department of Public Health and Human Services (DPHHS). This total includes 498 (81%) individuals meeting the Centers for Disease Control and Prevention AIDS case definition and 114 (19%) individuals diagnosed with HIV-infection (non AIDS). Of the 612 cases reported, 438 (72%) were Montana residents¹ at the time of their diagnosis. The remaining 174 (28%) were diagnosed while residing in another state and later returned to or moved to Montana.

In 2003, Montana reported 10 AIDS cases and 19 cases of HIV infection (*non AIDS*), a total of 29 HIV/AIDS cases. Using the CDC’s most recent data for comparison, Montana’s 2003 AIDS case rate is estimated to be 1.4 (1.4 AIDS cases per 100,000 people), compared to 1.9 in 2002 and 1.7 in 2001. This small change in the case rate reflects variability in reporting and our small number of cases rather than any change in disease trends or significant decrease in cases. As reflected in Figure 2-1, our case rate is comparable to states similar in population, but significantly lower than the national average of 15.1 cases per 100,000 (estimated).

¹ To ensure national consistency, the Centers for Disease Control and Prevent (CDC) assigns HIV and AIDS cases to the state of residence at the time of diagnosis. As a result, states like Montana that include all reported cases in our statistics will have totals that vary from the official CDC counts.

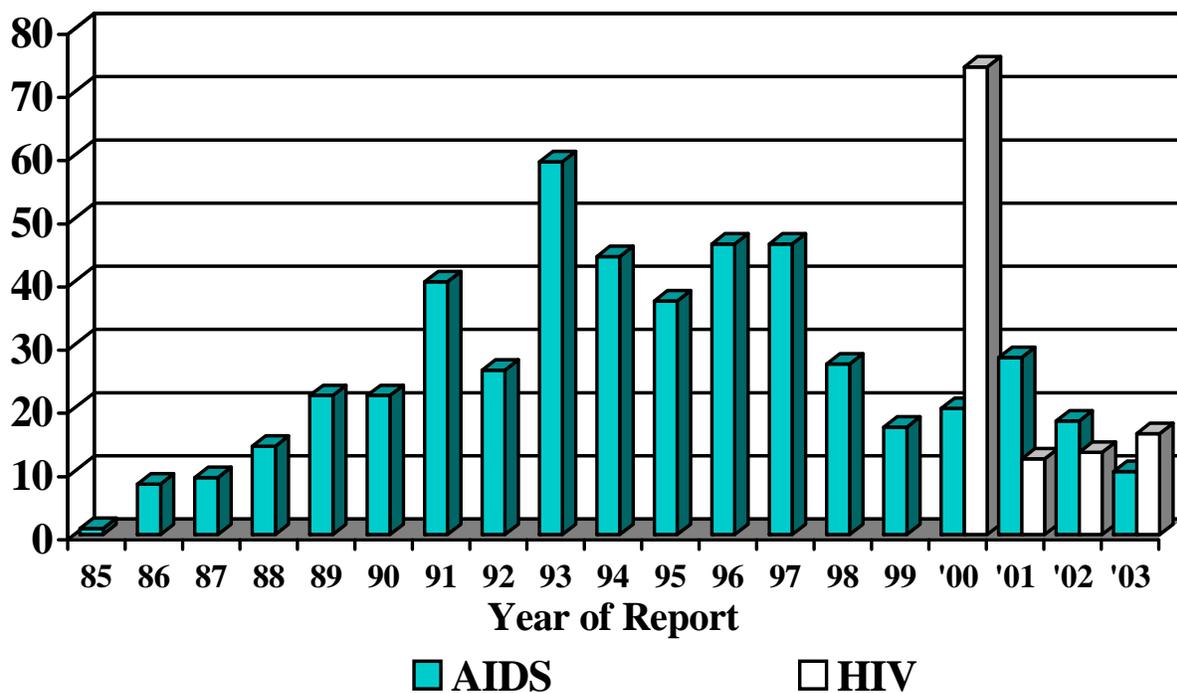
As reflected in Figure 2-2, the distribution of Montana’s HIV/AIDS cases is very similar to the state’s overall population distribution. While 40 of Montana’s 56 counties have reported at least one HIV/AIDS case, our 10 most populous counties contain 78% of all cases reported since 1985 and 87% of cases reported in the last two years.

Reporting Trends

Reported HIV and AIDS cases by year of report are detailed in Figure 2-3. This figure shows the number of cases by **year of report** since surveillance for AIDS was initiated at DPHHS in 1985 and the incorporation of HIV reporting in 2000. While HIV and AIDS surveillance data based on year of diagnosis may provide the most direct measure of incidence (the number of new diagnoses per year), most cases are reported without a significant delay and analysis by year of report is easier to present and interpret. With these factors in mind, all case counts and analyses in this document are based on year of report.

The large “spike” of HIV cases in 2000 reflects the implementation of formal reporting of individuals receiving care for HIV, *regardless of their date or state of diagnosis*. In order to accurately reflect the diagnostic status at time of report the graph does not reflect disease progression that may have occurred after the initial report. In other words, an individual reported as HIV positive but not meeting the AIDS definition will continue to be graphed as an HIV case even if progression to AIDS had occurred.

Figure 2-3. Reported HIV/AIDS Cases in Montana by Year of Report, 1985-2003.



Reporting “artifacts” (factors influencing the reporting of a disease other than the occurrence of the disease itself) have impacted the reporting of HIV/AIDS cases and must be considered when viewing Figure 2-3. The increase of AIDS reports in 1991 and 1993 and HIV reports in 2000 are a direct result of changes in our reporting system. For example, DPHHS devoted additional resources to AIDS reporting in 1991 and in 1993 CDC expanded the AIDS case definition- resulting in an instant AIDS diagnosis for some infected individuals. Over time, HIV reports will level out after pre-existing cases are reported during the next few years, much as AIDS reports stabilized after 1993. *In general, the data presented in Figure 2-3. reflect a steady increase since AIDS became reportable in 1985 until the leveling and decline of reported cases after expanded use of more effective treatments in 1997.*

Description of Cases by Age, Sex and Race

The age at time of HIV and AIDS diagnosis is shown in Table 2-1. Whether HIV, AIDS, or combined data are examined, individuals aged 20 to 39 consistently account for approximately 70% to 80% of all cases. *It is important to keep in mind that because of the extended incubation period of AIDS, individual cases reported to DPHHS were likely to have been infected several years previously. At this time, preliminary HIV data do not show any unexpected trends with respect to age.* Comparison of resident and non-resident cases reflects no significant differences with respect to age.

Table 2-1. Age at HIV/AIDS Diagnosis, Montana, 1985-2003.

Age at HIV or AIDS Diagnosis	HIV No. (%)	AIDS No. (%)
Under 5	2 (2)	4 (1)
5-12	0 (0)	0 (0)
13-19	6 (5)	3 (1)
20-29	43 (38)	101 (20)
30-39	47 (41)	235 (47)
40-49	12 (11)	103 (21)
Over 49	4 (4)	52 (10)
Total:	114 (100)	498 (100)

The distribution of Montana's reported Adult HIV/AIDS cases by gender is shown in Table 2-2. Males continue to account for the majority of all HIV/AIDS cases. Overall, the male to female ratio of HIV/AIDS cases is approximately 7.3:1 (7.3 men with HIV/AIDS for every woman with the condition). *When examined separately, HIV (non-AIDS) data reflect a male to female ration of 4.3:1, significantly different than our AIDS (8.5:1) or combined HIV/AIDS ratio of 7.3:1 stated above.*

It cannot be determined at this time if the smaller difference in the ratio of males to female with HIV is the result of an increased burden of infection among women or more frequent access to risk assessment and testing. We will continue to closely monitor the ratio of men to women as more cases are reported to detect changes in HIV transmission.

Table 2-2. Gender of Adult HIV/AIDS Cases, Montana, 1985-2003.

Gender & Ratio of Males to Females	HIV No. (%)	AIDS No. (%)	Total HIV/AIDS No. (%)
Males	91 (81)	442 (89)	533 (88)
Female	21 (19)	52 (11)	73 (12)
Ratio M:W	4.3:1	8.5:1	7.3:1
Totals:	112 (100)	494 (100)	606 (100)

While approximately one-third of our total HIV and AIDS cases were initially diagnosed in another state, 20 of our 21 women with HIV were Montana residents. As a result, women diagnosed with HIV may have been more likely to acquire infection locally than males with HIV/AIDS or females with AIDS.

Analysis of cases by gender and by year of report does not show any unique trend over time. Although nationally, urban areas with large minority populations continue to report increasing numbers of cases among women, our cases are still relatively evenly distributed over time. Additional information on women with HIV/AIDS in Montana can be found on pages 22 of the profile.

The impact of HIV/AIDS on racial/ethnic groups in Montana is shown in Table 2-3. *The overall distribution of AIDS cases among racial/ethnic groups in Montana generally reflects each group's distribution among the total state population (see Table 1-1.). Montana has not experienced the large increase in cases among racial/ethnic minority groups seen in larger urban areas of our nation.*

Table 2-3. Race/Ethnicity of HIV/AIDS Cases, 1985-2003.

Race/Ethnicity	HIV No. (%)	AIDS No. (%)	Total HIV/AIDS No. (%)
Hispanic- All Races	4 (4)	13 (3)	17 (3)
Non Hispanics- American Indian	6 (5)	35 (7)	41 (7)
Black/African American	5 (4)	14 (3)	19 (3)
Native Hawaiian/Pacific Is.	0 (0)	1 (0)	1 (0)
White	97 (85)	432 (87)	529 (86)
Unknown	2 (2)	3 (1)	5 (1)
Totals:	114 (100)	498 (100)	612 (100)

Reported Exposure Categories of Montana HIV/AIDS Cases

The reported exposure categories (risk factors) of HIV and AIDS cases are detailed by gender in Tables 2-4 and 2-5. As indicated in Table 2-4, men who had sex with men is the predominant exposure category reported, accounting for nearly 60% of the cases in men, regardless of whether HIV, AIDS or combined data are examined. Similarly, regardless of stage of infection, men who reported injecting drug use (including a combination of male-to-male sexual contact

and injecting drug use) accounted for approximately one-quarter of male cases. *Together, male-to-male sexual contact and injecting drug use have consistently accounted for 85% of the infections among males in Montana, regardless of diagnostic status and race/ethnicity.*

Table 2-4. Exposure Categories of Adult/Adolescent HIV/AIDS Cases among Males, Montana, 1985-2003.

Exposure Category	HIV No. (%)	AIDS No. (%)	Total HIV/AIDS No. (%)
Men who have sex with Men (MSM)	51 (56)	264 (60)	315 (59)
Injecting Drug Use (IDU)	13 (14)	54 (12)	67 (13)
MSM & IDU	16 (18)	52 (12)	68 (13)
Hemophilia/Coagulation Disorder	0 (0)	9 (2)	9 (2)
Heterosexual Contact	5 (5)	18 (4)	23 (4)
Receipt of Blood/Tissue Products	0 (0)	6 (1)	6 (1)
Risk not Reported/Other ¹	6 (7)	39 (9)	45 (8)
Totals:	91 (100)	442 (100)	533 (100)

¹ Refers to persons who either died during follow-up, were lost to follow-up, or decline to be interviewed.

Among female HIV/AIDS cases, shown in Table 2-5, the predominant exposure category was contact with an HIV-infected or at-risk individual (heterosexual contact), representing approximately 60% of all cases regardless of stage of illness. Although documenting heterosexual transmission was not possible in some cases, investigation of reports included in the “risk not reported” category indicates other likely heterosexual cases among females, increasing this total to an estimated 75%. Exposure categories among women with HIV or AIDS do not appear to differ significantly with respect to race/ethnicity.

Table 2-5. Exposure Categories of Montana Adult/Adolescent Female AIDS Cases, by Region, 1985-2003.

Exposure Category	HIV No. (%)	AIDS No. (%)	Total HIV/AIDS No. (%)
Injecting Drug Use (IDU)	4 (19)	10 (19)	14 (19)
Hemophilia/Coagulation Disorder	0 (0)	0 (0)	0 (0)
Heterosexual Contact	14 (67)	29 (56)	43 (59)
Receipt of Blood/Tissue Products	0 (0)	4 (8)	4 (5)
Risk not Reported/Other ¹	3 (14)	9 (17)	12 (16)
Totals:	21 (100)	52 (100)	73 (100)

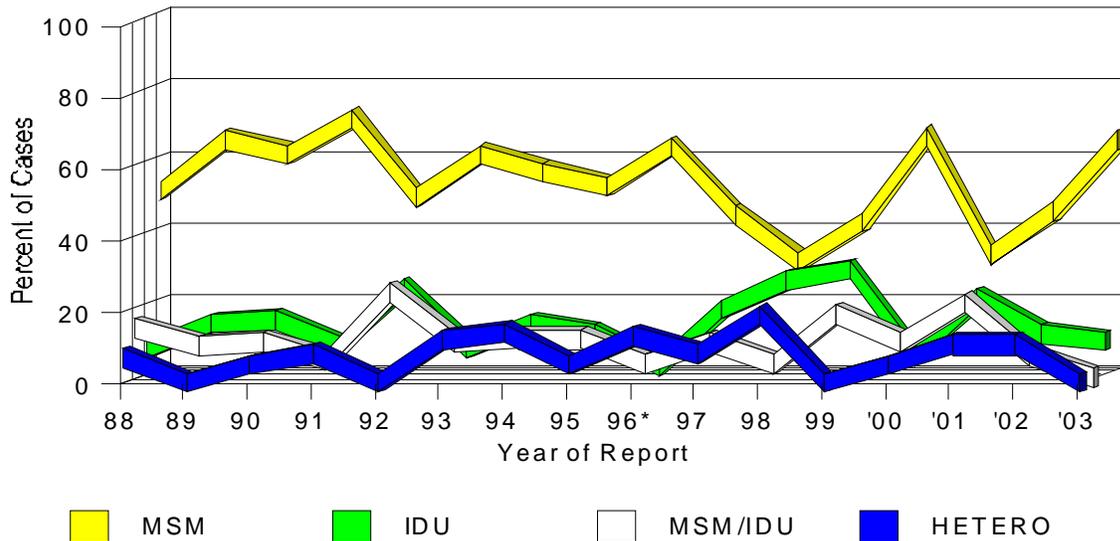
¹ Refers to persons who either died during follow-up, were lost to follow-up, or decline to be interviewed.

The percent distribution of Montana Adult AIDS cases by exposure category and by year of report is shown in Figure 2-4. Data collected before 1988 is not included due to the limited number of cases reported.

Data after 1997 were heavily influenced by a the decline in the number of AIDS cases, a greater percentage of cases reported without risk, and a greater percentage of cases diagnosed with AIDS at the time of initial HIV diagnosis. As a result, the data are more subject to fluctuations when percentages are presented and this complicates interpretation of transmission trends.

Overall, modes of transmission among AIDS cases appear to have remained relatively stable. HIV reports are not included in Figure 2-4 at this time.

Figure 2-4. Percent Distribution of AIDS Cases by Exposure Category, Montana, 1988-2003.



Individuals Living with HIV/AIDS

As of December 31, 2003, 347 of the 612 HIV/AIDS cases reported in Montana were known to be living with HIV/AIDS. Of the 347 living with HIV/AIDS, 233 (67%) met the AIDS case definition of severe illness and the remaining 114 (33%) were HIV-positive (non-AIDS). The 233 AIDS cases include 172 (74%) individuals considered Montana cases, the remaining 59 (26%) were diagnosed in another state and moved to or returned to Montana. Individuals reported as HIV (non-AIDS) cases reflected a similar percentage of in-state diagnoses with 82 (72%) of the 114 considered residents of Montana at the time of diagnosis. The above numbers are based on residence at the time of report.

For practicality purposes, individuals *are not* removed from our statistics when leaving the state. In addition, individuals with HIV infection who are unaware of their status or those with HIV or AIDS that have not been reported cannot be counted. Table 2.6 on the following page provides a brief overview of individuals living with HIV/AIDS in Montana. *Analysis of race, risk, gender and exposure history of living cases does not differ significantly from the cumulative HIV/AIDS data presented in the remainder of the profile.*

Table 2.6. Overview of Individuals Living with HIV/AIDS, Montana, December 2003.

People Living with HIV/AIDS in Montana¹ As of December 31, 2003 Includes all cases reported to the Montana Department of Public Health & Human Services since 1985.			
Reported HIV/AIDS Cases	Adult/Adolescent Cases (%)	Pediatric (<13) Cases (%)	Total Cases (%)
Total:	345 (99)	2 (1)	347 (100)

Exposure Category- Adults and Adolescents	Males (%)	Females (%)	Total (%)
Men who have sex with men	167 (57)	0 (0)	167 (48)
Injecting Drug Use (IDU)	35 (12)	9 (18)	44 (13)
Men who have sex w/ men & IDU	46 (16)	0 (0)	46 (13)
Hemophilia/Coagulation Disorder	4 (1)	0 (0)	4 (1)
Heterosexual Contact	14 (5)	31 (62)	45 (13)
Transfusion with Blood or Blood Products	1 (0)	0 (0)	1 (0)
None of the Above/Under Investigation	28 (9)	10 (20)	38 (11)
Total:	295 (100)	50 (100)	345 (100)

Exposure Category- Pediatric Cases (<13)	Males (%)	Females (%)	Total (%)
Mother with/at risk for HIV infection	1 (100)	1 (100)	2 (100)
Total:	1 (100)	1 (100)	2 (100)

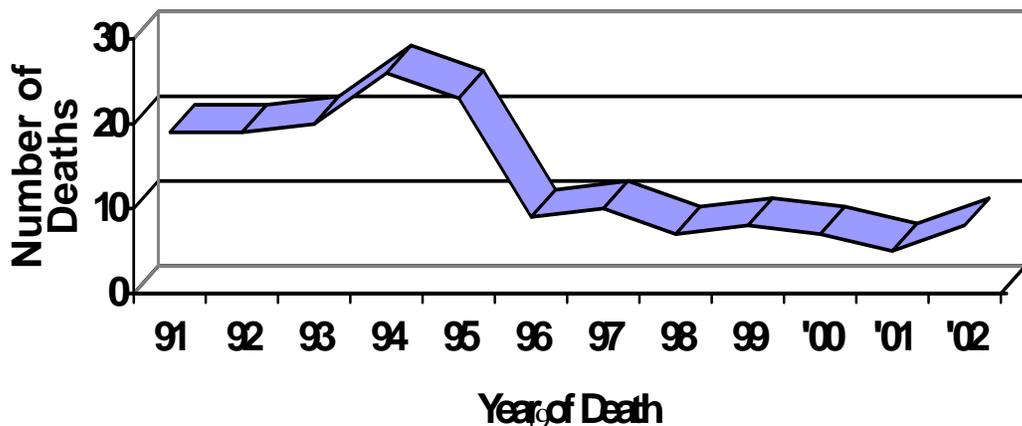
Age at Time of Diagnosis	Cases (%)	Race/Ethnicity	Adult/Adolescent Cases (%)	Pediatric<13 Cases (%)	Total Cases (%)
Under 5	2 (1)	Hispanic-Races	All 9 (3)	1 (50)	10 (3)
5-12	0 (0)	Non-Hispanic Amer Indian/Ak Native	20 (6)	0 (0)	20 (6)
13-19	7 (2)	Black/African American	12 (3)	1 (50)	13 (4)
20-29	96 (28)	White	299 (87)	1 (50)	299 (86)
30-39	164 (47)	Unknown	5 (1)	0 (0)	5 (1)
40-49	57 (16)	Total:	345 (100)	2 (100)	347 (100)
Over 49	21 (6)	¹ Cases include 233 AIDS cases & 114 HIV (non-AIDS) cases. Resident and non-resident cases are included in the totals above. Please Refer to the narrative for additional information.			
Unknown	0 (0)				
Total:	347 (100)				

HIV/AIDS Related Mortality

As of December 31, 2003, 265 (43%) of the 612 reported HIV/AIDS were reported to be deceased and all were among individuals meeting the CDC AIDS case definition. As reflected in Figure 2.5, HIV/AIDS related deaths in have stabilized with 5-8 per year since 1997. In general, deaths have declined with the availability and success of new therapies.

In 1996, HIV was the ninth leading cause of death among Montanans aged 25 to 44. In 1997, HIV was the seventh leading cause of death (9 deaths) among the same age group. HIV was not among the top ten leading causes of death for any age-group in Montana since 1997.

Figure 2.5. HIV-Related Deaths, Montana, 1991-2002.



Issues Related to Specific Populations

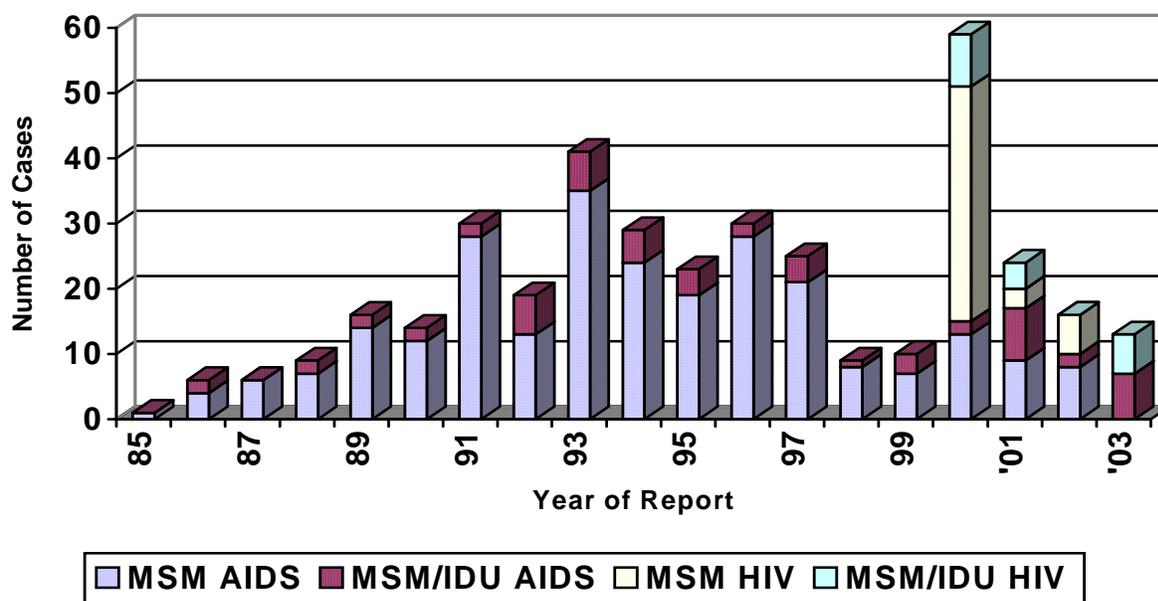
This section is intended to address issues of interest concerning specific populations. Detailed information cases relating to Men who have Sex with Men (MSM), Injecting Drug Use (IDU), heterosexual cases and American Indians is presented.

Men who have Sex with Men (MSM)

Men who have sex with men (MSM) account for approximately 63% or 383 of the 612 cumulative HIV/AIDS cases reported since 1985. This total includes 315 reporting MSM and 68 reporting dual risk factors of MSM and injecting drug use (IDU). MSM and MSM/IDUs have consistently accounted for the majority our cases, and the percentage of cases has not changed significantly over time.

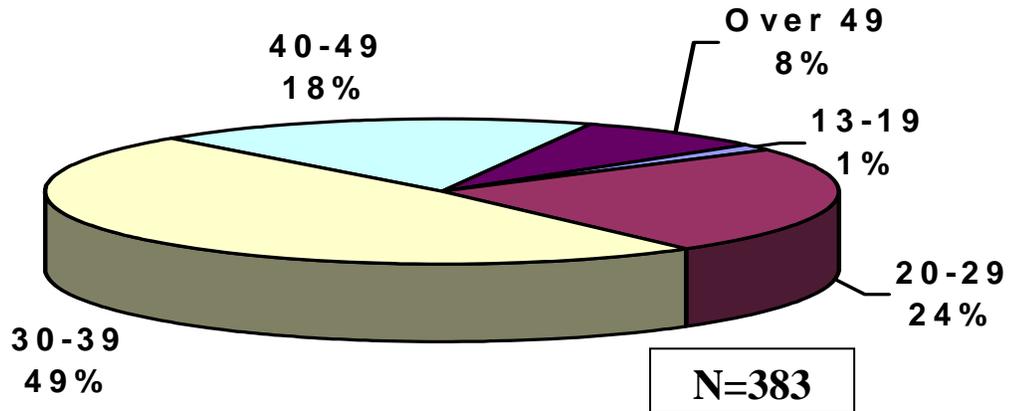
Figure 2-6. reflects MSM and MSM/IDU related cases by year of report to DPHHS. The overall decline in reported AIDS cases during 1998 and 1999 was dramatic among MSM-related AIDS cases. *The success of new therapies is believed to be the biggest factor in this decline.* As indicated earlier in this report, the surge in cases in 2000 is the result of the implementation of HIV reporting- not an increase in disease burden. For more discussion on this reporting “artifact” see page 12 of this report and the section on data quality in the introduction.

Figure 2-6. Montana MSM and MSM-IDU Related HIV/AIDS Case Reports, 1985 - 2003.



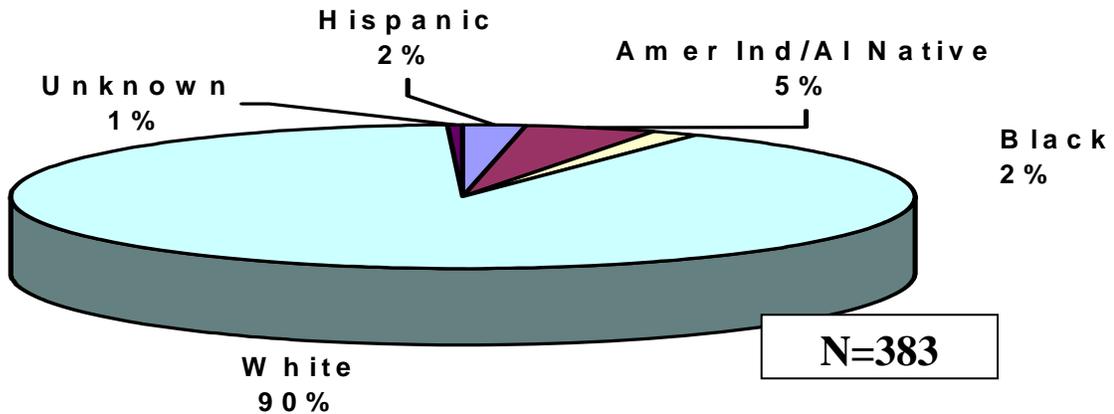
Figures 2-7 and 2-8 provide a selected demographic summary of MSM related HIV/AIDS cases. With respect to non-MSM cases, MSM related cases do not differ significantly with respect to age, race or geography. Rather, MSM cases still tend to define the AIDS statistics collected by DPHHS.

Figure 2.7. Age Distribution of Montana MSM-Related HIV/AIDS Cases, 1985-2003.



As detailed in Figure 2-7, over 70% of the 383 cases among MSM and MSM/IDUs were between the ages 20-39 when diagnosed with HIV or AIDS. The distribution of cases among this age group is virtually identical to the distribution of the non MSM-related cases. The racial distribution, Figure 2-8, is similar, with 91% of MSM and MSM/IDU cases among whites.

Figure 2-8. Race Distribution of Montana MSM-Related HIV/AIDS Cases, 1985-2003.



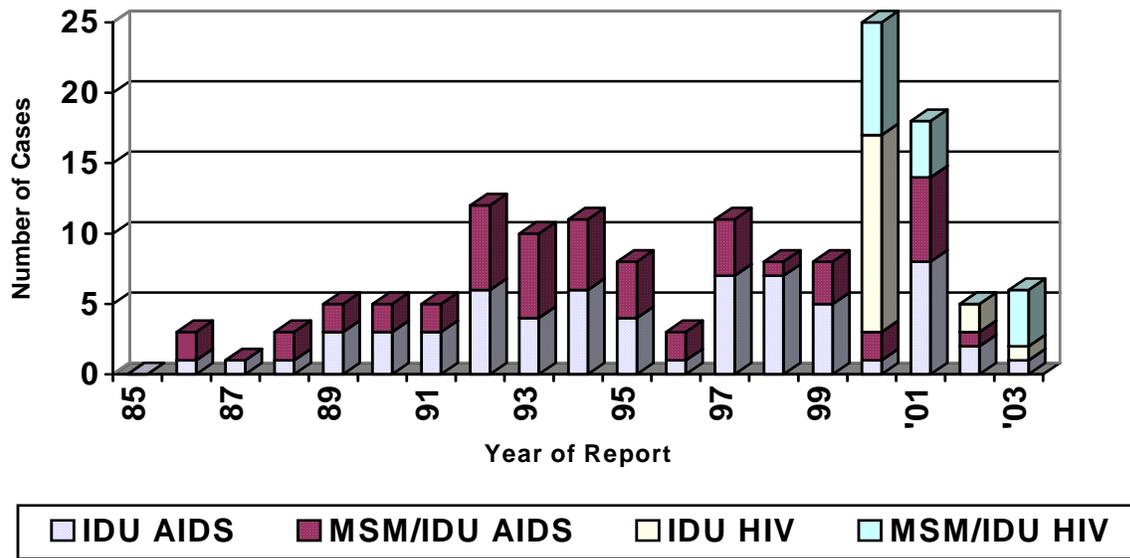
A comparison of MSM-related HIV cases to MSM-related AIDS cases reflects no unexpected trends or patterns. As expected, HIV (non AIDS) individuals are slightly younger. Race also reflected no significant difference.

Injecting Drug Use (IDU)

Of the 612 cases of HIV/AIDS cases reported as of December 31, 2003, 149 (24%) report a direct link with injecting drug use (IDU). This total includes 13% (81 of 612 cases) reporting IDU as well as 11% (68 of 612 cases) reporting dual risk factors of MSM and IDU. In addition, 30 of 66 (45%) of heterosexual HIV/AIDS cases are linked to a partner who injected drugs. When this “indirect” link is considered, 29% of all reported cases are linked to IDU. This brief section provides specific data on individuals reporting an IDU-related exposure.

Figure 2-9 reflects cases directly linked with IDU by year of report (including individuals reporting a combination of MSM/IDU exposures). With the exception of 2000 and 2001 during which HIV reporting was formally implemented, IDU-related cases are more or less evenly distributed over the last ten years. Unlike MSM-related cases, the number of IDU-related cases reported did not decline as dramatically in recent years. Although relatively few IDU-related cases were reported, lack of a decline in IDU-related cases may be partially attributed to accessing care and/or a failure to acknowledge the risk of infection.

Figure 2-9. Montana IDU and MSM-IDU Related HIV/AIDS Case Reports, 1985 - 2003.



The increase in case reports in 2000 and 2001 reflected in Figure 2-9 is the result of the implementation of HIV reporting- not an increase in disease burden. For more discussion on this reporting “artifact” see page 12 of this report and the section on data quality in the introduction.

Figures 2-10 and 2-11 provide a selected demographic summary of IDU-related cases. In general, individuals with HIV/AIDS reporting IDU as a risk were similar in age, gender and race to cases not reporting IDU. When compared by status of diagnosis (HIV or AIDS) no significant differences with respect to gender, age or racial characteristics. In short, preliminary HIV data do not show any emerging trends among IDU cases at this time.

Figure 2-10. Age Distribution of IDU-Related HIV/AIDS Cases, Montana, 1985-2003.

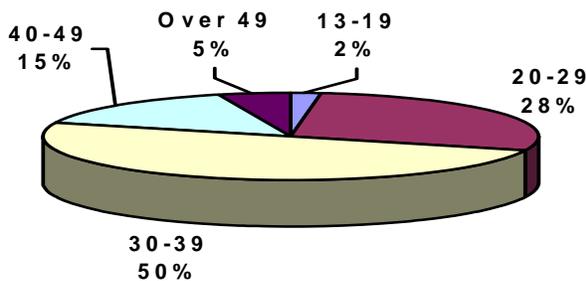
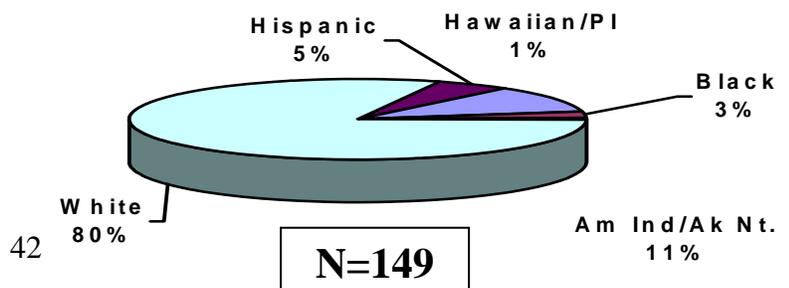


Figure 2-11. Race Distribution of IDU-Related HIV/AIDS Cases, Montana, 1985-2003.



Heterosexual AIDS Cases and Women

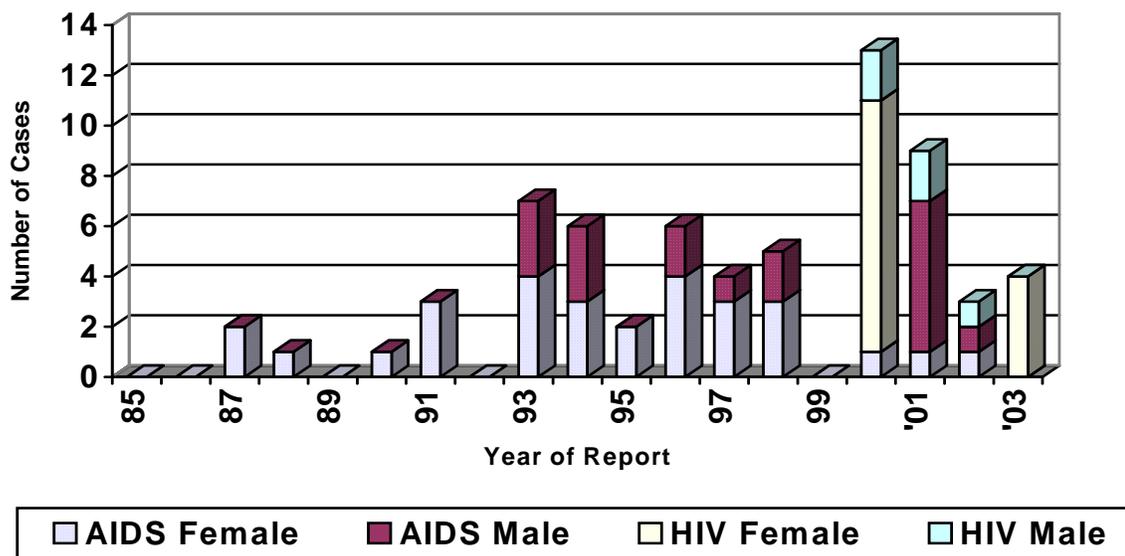
Although the greatest number of HIV/AIDS cases reported in Montana and the U.S. are associated with male-to-male sexual contact, a significant rate of increase has been experienced among heterosexuals in the U.S. Nationally, the increase in heterosexual transmission continues to be primarily among minority populations in large urban areas. Given Montana's rural nature and relatively homogeneous population, similar increases among our heterosexual population are unlikely. However, such transmission does occur and as the number of people living with HIV increases in Montana, heterosexual cases will be reported more frequently.

In order to be considered a heterosexual AIDS case, the individual must report contact with someone known to be infected or at risk for HIV infection. Such contact would include having sex with an IDU, or a woman having sex with a bisexual man. At times it is not possible to document such a risk and individuals may be classified as "None of the above/Other." This often results in a slight under-reporting of heterosexual cases and over-reporting of "None of the above/Other" cases.

As of December 31, 2003, heterosexually acquired cases account for 66 (11%) of the 606 adult HIV/AIDS cases. *However, when examined by gender, this percentage differs significantly. While 23 of 533 (4%) of adult male HIV/AIDS cases are attributed to heterosexual contact, 43 of 73 (59%) of adult female cases are the result of heterosexual contact.*

The distribution of heterosexual HIV/AIDS cases by year of report is detailed in Figure 2-12. Given the difficulties with interpreting small numbers and considering the impact of HIV reporting in 2000 and 2001, heterosexual cases appear to be fairly distributed among reporting years.

Figure 2-12. Montana Heterosexual HIV/AIDS Case Reports by Sex, 1985 - 2003.



Figures 2-13 and 2-14 provide a selected demographic summary of heterosexual HIV/AIDS cases by age and race. Analysis of heterosexual cases with respect to HIV or AIDS status does

not show any differences with respect to race. As expected, the age of individuals diagnosed with HIV tends to be younger than those with AIDS. Analysis by race/ethnicity is limited by the small numbers of cases involved. For example, American Indians and Blacks account for approximately 19% of the heterosexual cases reported. However, the actual *number* of cases reflects 7 American Indians and 5 African Americans reported since 1985.

Figure 2-13. Age Distribution of Montana Heterosexual Cases, 1985-2003.

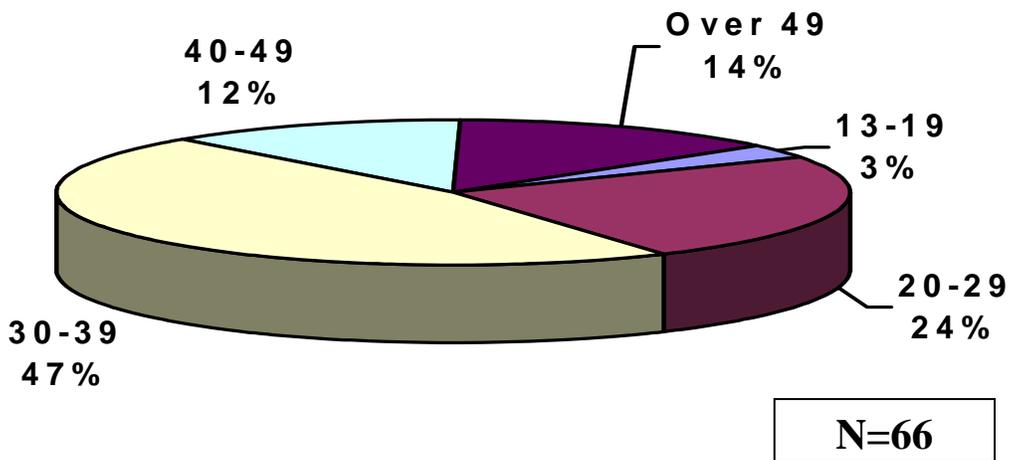
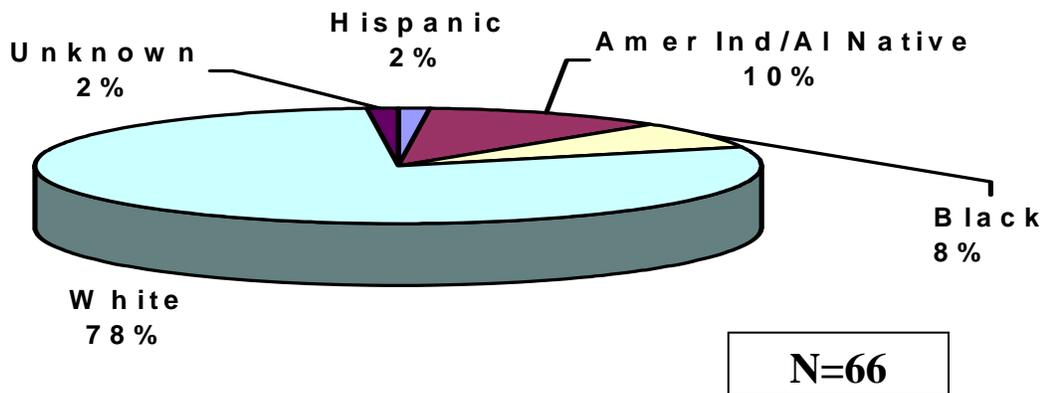


Figure 2-14. Race Distribution of Montana Heterosexual Cases, 1985-2003.



The Impact of HIV on Montana’s American Indians

Nationally, minority populations have been disproportionately impacted by the HIV epidemic. The CDC suggests that minorities are at an increased risk because of less access to HIV-prevention services, higher rates of sexually transmitted diseases, and culturally inappropriate HIV-prevention activities. Fortunately, American Indians in Montana, have not followed this national trend and appear to be impacted by HIV/AIDS to the same degree as non-Indian populations. As a result, the percentage of reported HIV/AIDS cases among American Indians is roughly the same as the percentage of American Indians in our general population. In part,

effective HIV-prevention initiatives by tribal educators, IHS, Urban Indian Clinics and the current low incidence of infection is responsible for the prevention of the spread of HIV among American Indians.

The figures presented are from Census 2000.

Population Distribution and Characteristics

The official figures from Census 2000 indicate that American Indians account for approximately 56,068 or 6.2%, of Montana's 902,195 residents. The location of Montana's seven tribal lands and the distribution of American Indians by tribal lands are presented in Figure 2-14 and Table 2-7.

Figure 2-14. Tribal Lands in Montana.

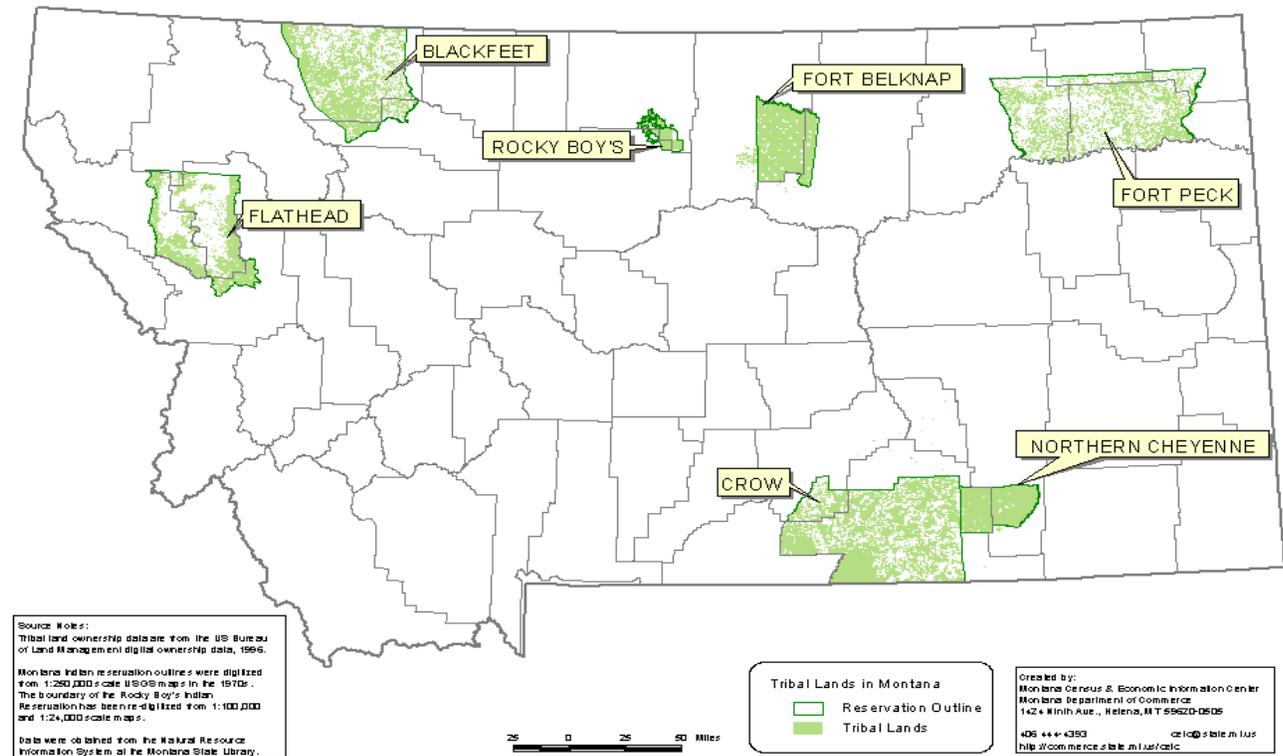


Table 2-7. American Indian Population by Reservation, 2000 Census

Place/Reservation	Total Pop.	Total One Race	White	Black	Amer. Indian	Asian	Hawaiian or PI	Other	Two or more Races	Hispanic /Latino Origin
All Montana	902,195	886,465	817,229	2,692	56,068	4,691	470	5,315	15,730	18,081
Blackfeet Reservation and Off-Reservation Trust Land**	10,100	9,901	1,359	8	8,507	4	3	20	199	137
Crow Reservation and Off-Reservation Trust Land	6,894	6,757	1,551	1	5,165	7	0	33	137	191
Flathead Reservation	26,172	25,086	17,814	24	6,999	76	10	163	1,086	711
Fort Belknap Reservation and Off-Reservation Trust Land	2,959	2,936	136	4	2,790	1	2	3	23	31
Fort Peck Reservation and Off-Reservation Trust Land	10,321	10,086	3,622	4	6,391	44	5	30	235	123
Northern Cheyenne Reservation and Off-Reservation	4,470	4,390	350	1	4,029	2	0	8	80	105
Rocky Boy's Reservation and Off-Reservation Trust Land	2,676	2,653	69	1	2,578	2	1	2	23	40
Turtle Mountain Reservation and Off-Reservation Trust Land, MT--ND--SD (part)***	24	24	24	0	0	0	0	0	0	0
Selected Totals for Reservations:	63,616	61,833	24,925	43	36,459	136	21	259	1,783	1,338

*Notes: Persons of Hispanic origin may be of any race

** Off-reservation trust lands, along with reservation lands, constitute the territory over which American Indian tribes have primary governmental authority. Trust land is property associated with a specific American Indian reservation or tribe, held in trust by the federal government. Trust lands recognized in data tabulations are always "off-reservation", that is, they comprise all tribal and individual trust lands located outside of a reservation boundary. For more detailed information see Appendix A in the Public Law 94-171 Technical Documentation.

*** The Montana portion of the Turtle Mountain Reservation and Off-Reservation Trust Land is Trust Land spread over 13 counties. Only three counties have population in the them: Roosevelt (12), Sheridan (10), Daniels (2). The other counties are Blaine, Carter, Chouteau, Fergus, Hill, Liberty, McCone, Phillips, Richland, and Valley.

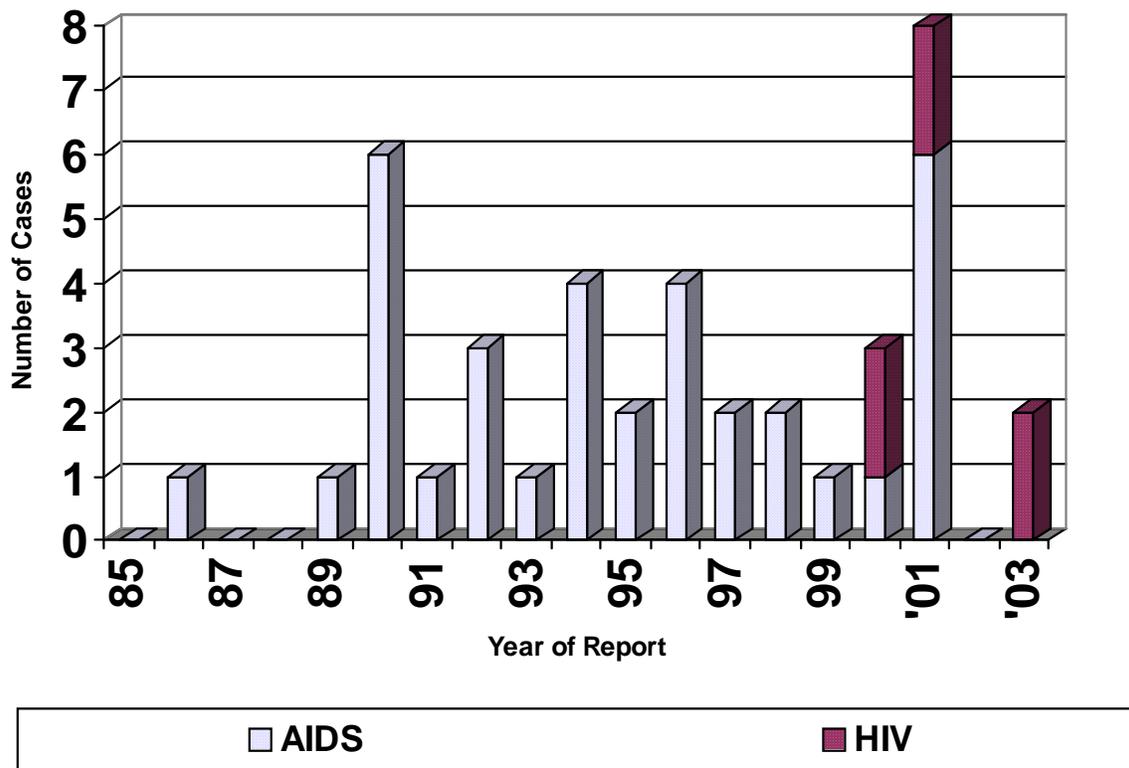
Adapted by DPHHS from: Census and Economic Information Center, Montana Department of Commerce (406) 444-2896 4/16/01

Source: U.S. Census Bureau Released March 21, 2001

HIV/AIDS Case Demographics and Distribution of American Indians

American Indian HIV/AIDS cases reported since 1985 are presented by year of report in Figure 2-15. In general, the distribution over time of American Indian cases corresponds with other non American Indian cases. Cases have been consistently reported since 1990, experienced a decline in the late 90's and the spiked in 2000 and 2001 in response to the implementation of HIV reporting. *Given the relatively few reports each year, no reliable trends or patterns are apparent, regardless of whether HIV, AIDS or combined data are examined.*

Figure 2-15. Montana American Indian HIV/AIDS Case Reports, 1985 - 2003.



American Indians account for 7% of all reported HIV/AIDS cases, a percentage roughly the same as the percentage of American Indians among Montana's general population. As presented in Table 2-8, *approximately 85% of all males, regardless of race, were infected through homosexual contact and/or injecting drug use. However, American Indian males were more likely than non American Indian cases to report IDU.* Other characteristics such as age or stage of illness indicate no significant differences with respect to race among males in Montana.

Table 2.8. Exposure Categories of Adult American Indian Males & Males of Other Races, Montana HIV/AIDS Cases, 1985 - 2003.

Exposure Category- Adult Males	American Indian No. (%)	All Other Races No. (%)
Men who have sex with men	10 (36)	305 (60)
Injecting Drug Use	6 (21)	61 (12)
Men who have sex w/men & inject drugs	8 (29)	60 (12)
Hemophilia/coagulation disorder	0 (0)	9 (2)
Heterosexual contact	1 (4)	22 (4)
Receipt of blood or tissues	0 (0)	6 (1)
Risk not reported/Other	3 (11)	42 (8)
TOTALS:	28 (100)	505 (100)

While based on limited data, American Indian females appear to be disproportionately impacted by HIV/AIDS, accounting for 16% of all HIV/AIDS cases among women and 27% of all cases among American Indians in Montana.

A comparison of American Indian adult females to other races by risk behavior is detailed in Table 2.9. Approximately 75% of all females, regardless of race, were infected either through IDU or heterosexual contact. The data indicate no significant difference with regards to mode of exposure and race among females in Montana.

Table 2.9. Exposure Categories of Adult American Indian Females & Females of Other Races, Montana HIV/AIDS Cases, 1985 - 2003.

Exposure Category- Adult Females	American Indian No. (%)	All Other Races No. (%)
Injecting Drug Use	2 (18)	12 (19)
Hemophilia/coagulation disorder	0 (0)	0 (0)
Heterosexual contact	6 (55)	37 (60)
Receipt of blood or tissues	1 (9)	3 (5)
Risk not reported/Other	2 (18)	10 (16)
TOTALS:	11 (100)	62 (100)

Table 2-10. compares the age at time of HIV/AIDS diagnosis for American Indians to that of other races. Again, interpretation of the data is limited by relatively small numbers in some categories. However, approximately 70% of all cases, regardless of race, are in the age group 20-39.

Table 2-10. Age Distribution of HIV/AIDS Indian Cases & Other Races, Montana 1985-2003.

Age at time of HIV/AIDS Diagnosis	American Indians No. (%)	All Others No. (%)
Under 5	2 (5)	4 (1)
5-12	0 (0)	0 (0)
13-19	2 (5)	7 (1)
20-29	13 (32)	131 (23)
30-39	15 (37)	267 (47)
40-49	6 (15)	109 (19)
Over 49	3 (7)	53 (9)
TOTALS:	41 (100)	571 (100)

Table 2-11 indicates residence at the time of HIV/AIDS diagnosis of American Indians relative to reservation. As indicated, *American Indians diagnosed with HIV/AIDS were more likely to report their residence as non-reservation.*

Table 2-11. Distribution of HIV/AIDS American Indian Cases by Reservation, Montana 1985-2000.

Residence in Respect to Reservation	Number of Cases & % of Total
Off Reservation	28 (68%)
On Reservation	13 (32%)
TOTALS:	41 (100%)

Additional information on Montana’s American Indian population is available on pages 7 and 37, and *in the Profile of the Montana Native American* which can be obtained from the Governor’s Office of Indian Affairs. The report is a collection of data tables on American Indian subjects ranging from Crime & Justice to Gaming statistics. The Indians Affairs office can be reached at 444-3702.

Other Sources of Data Related to HIV/AIDS in Montana

Comment: Much of the information contained in this area is “historical” in nature and has not been collected or revised recently. The information is presented to provide examples and results of past efforts to assess HIV/AIDS in Montana. A few items were revised or updated as appropriate.

HIV Seroprevalence Survey in Childbearing Women

The HIV Seroprevalence Survey in Childbearing Women, conducted from 1988 through 1996, indirectly measured HIV infection in women delivering live-born infants. The survey was conducted by testing leftover blood used for routine metabolic screening of newborns. During pregnancy, HIV antibody is passed from an infected mother to her infant; therefore HIV antibody in the infant's blood indicates HIV infection of the mother. In general, all infants born to an HIV-infected mother will have a positive HIV-antibody test, but not all infants become infected. Before recent treatment advances, approximately 15% to 30% of infants born to HIV-infected mothers become infected with HIV. If administered during pregnancy and delivery, current therapies can reduce the transmission of HIV to approximately 8%.

Nationally, most women are infected through injecting drug use or through heterosexual contact. Data collected through this survey was used to indicate the impact of HIV in women, leading to the development of prevention strategies. Such strategies are often unique because women can be reached at different locations than men (e.g., reproductive and antenatal health clinics), and are at a greater risk of HIV infection through heterosexual activity.

The results of tests in Montana (Table 2-13.) show that from 1989 through 1995, a total of 76,161 specimens were tested. Of these tests, eight, or 0.01% (1 in 10,000) tested positive. *Based on these findings, childbearing women did not appear to be at a significant risk for HIV-infection in Montana. However, women having children may not be representative of all women in the state and community planning members are encouraged to look at other relevant factors. The blinded study has been discontinued in U.S. and samples are no longer collected or tested for HIV antibodies.*

Table 2-12. National HIV Survey of Childbearing Women, Test Results, Montana, 1989-1995.

YEAR	SPECIMENS TESTED	# POSITIVE	% POSITIVE
1989	10,828	0	0.00
1990	10,811	3	0.03
1991	11,698	0	0.00
1992	11,053	1	0.01
1993	10,769	1	0.01
1994	10,223	2	0.02
1995	10,779	1	0.01
TOTAL	76,161	8	0.01

Perinatal HIV Infections in Montana

The National Survey of Childbearing Women provides data on the HIV seroprevalence of newborn infants in Montana. Because maternal antibodies cross the placenta, a positive test reflects HIV infection in the mother but not necessarily in the infant. However, based on estimates of the number of HIV-infected mothers and on estimates of perinatal transmission rates, the number of HIV-infected infants born each year can be estimated.

Table 2-13. shows that the estimated perinatal HIV infection rate in Montana is one case every 3 to 5.5 years. Actual surveillance data show that Montana has sustained 3 neonatal AIDS cases since 1985. While perinatal transmission of HIV occurs in Montana, it is not a factor in the epidemiology of HIV/AIDS in this state.

Table 2-13. HIV Seroprevalence Among Childbearing Women (CBW) and Estimated Annual Number of Perinatal Infections in Montana

<u>Mean Number Live Births/Yr.</u>	<u>% HIV (+) Among CBW</u>	<u>Expected No. HIV (+) Mothers</u>	<u>Estimated No. Perinatal Infections</u> ¹
11,500	0.01	1	1 per 3.0 - 5.5 years

¹ Based on 18-33% transmission rates, with proper treatment, rates of transmission are reduced by 2/3.

Update: As of December 31, 2003, a total of six pediatric cases of HIV/AIDS have been reported and two are living with HIV/AIDS. Three of the six are considered Montana resident cases, the others were diagnosed in other states and moved top Montana. In all instances, mother infected or at risk of for HIV infection was the infant’s mode of exposure.

Blinded Survey of Individuals Entering the Montana Chemical Dependency Center

During 1996, the Montana Chemical Dependency Center (MCDC) and DPHHS cooperated in conducting a blinded survey of individuals entering drug treatment. The survey design allowed DPHHS to remove identifiers from specimens and test blood routinely drawn for other purposes for HIV antibodies. Because this was a blinded survey, results could not be linked with individuals testing and obtaining informed consent was not necessary. Although identities of those tested are unknown, limited demographic information was collected so that results of the survey could be analyzed by race, sex, drug use habits and other factors. The intent of the survey was to determine the frequency, or prevalence, of HIV in what is perceived to be a high-risk population.

A total of 1,011 samples were collected during the study period. Of these, 945 (93%) have test results including 3 positives and 942 negatives. The individuals testing positive reported a history of injecting drug use, two were male, one white and one American Indian. The other’s sex and race was not completed. All were between 25 and 35 years of age and regions of residence included Eastern Montana, South Central Montana, and Northwestern Montana.

The rate of infection, .3% or 1 in 300, is too low to provide for meaningful analysis of those testing positive. However, it does reflect a relatively low rate of infection among one sampling of individuals perceived to be at high risk of infection. Whether this rate can be generalized to other drug-using populations is questionable. Many of those most at risk do not seek treatment or may receive treatment at other facilities. Table 2-14 provides an overview of the information collected on the 1,011 individuals in this survey.

Table 2-14. Selected Characteristics of Clients, MCDC Blinded HIV Study- 1996

Sex:	71% Male	29% Female	
Race:	76% White	19% American Indian	5% Other
Age:	90% Between 18 to 44		
History of IDU:	29% Yes	71% No	
Frequency of IDU:	53% Heavy	33% Occasional	12% Just Tried

Estimates of HIV Prevalence in Montana

As a result of the impact of new therapies on the AIDS epidemic, past methods used to estimate HIV prevalence are no longer appropriate. Previous methods had relied on characteristics of the AIDS epidemic, such as average time between HIV infection, an AIDS diagnosis and death; time frames no longer known. However, in low incidence areas like Montana, the methods described below may still provide a minimum estimate of HIV prevalence as recent as 1995.

Two simple methods for estimating the number of persons currently infected have been described by CDC: 1) use of state-specific data from the National HIV Survey of Childbearing Women (SCBW), and 2) extrapolation from national estimates of HIV prevalence. Crude estimates of HIV prevalence (number of persons living with HIV) among adults and adolescents (persons older than 12 years) were calculated for Montana based on each method. *The results are summarized in Table 2-15 and show that estimates of the current prevalence of HIV infection in Montana range from 300 to 700 persons.*

These methods are intended for the estimation of the number of infected persons in states with a high incidence of AIDS: the smaller the number of AIDS cases or HIV infection used in the calculations, the less reliable the estimates. Also, these figures will be influenced by effective prevention measures, new pharmaceuticals slowing the progression of HIV infections, and the movement of infected individuals from higher prevalence states to Montana.

Update: Based on past estimates and recent reporting trends, it seems reasonable to believe that approximately 500 people were infected with HIV in Montana in 1995 and as of December 2003 a reasonable estimate would be 500 to 600.

Table 2-15. Estimated of HIV Prevalence in Montana, 1995

Estimate based on SCBW:	270
Estimate based on National HIV Prevalence:	460-680

Question 3: What are the indicators or risk for HIV/AIDS in Montana?

The persons most likely to become infected with HIV are those who engage in high-risk behaviors *and* who live in communities where HIV prevalence is high. To help community planning groups understand the differing risks for HIV infection in Montana, this section examines characteristics of populations that may practice high-risk behaviors.

Information regarding specific behaviors increasing exposure to HIV is limited in Montana. Many CDC supported surveys assessing specific sexual practices, use of injecting drugs and other relevant behaviors of the general public and/or individuals living with HIV/AIDS are not administered in Montana. Much of the available information focuses on youth and their direct and indirect risks for HIV infection. These sources include data on sexually transmitted diseases and the Office of Public Instruction's (OPI) Youth Risk Behavior Survey (YRBS).

We encourage you to examine additional information collected, at the local level or by DPHHS contractors, to help supplement the information provided in this section of the report.

Surveillance of Bacterial Sexually Transmitted Diseases

Persons with bacterial sexually transmitted diseases (STD's) represent a sexually active population with recent unprotected intercourse with other persons who have STD's, some of whom may also be infected with HIV. Chlamydia, gonorrhea and syphilis are examples of our most common reportable STD's. While several other STDs such as herpes and human papillomavirus (HPV) circulate, they are generally not reportable conditions and no data are available for Montana.

The extent to which STD rates correlate with HIV risk depends on the prevalence of HIV infection among individuals practicing unsafe sex and the local patterns of STD transmission. Because STD rates are a reliable indicator of high-risk behavior (i.e., unprotected sexual intercourse), groups with high rates of STD's are potentially at increased risk for the introduction and spread of HIV.

Chlamydia

Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. In 2002, 834,555 chlamydial infections were reported to CDC from 50 states and the District of Columbia. Under-reporting is substantial because most people with chlamydia are not aware of their infections and do not seek testing. Also, testing is not often done if patients are treated for their symptoms. An estimated 2.8 million Americans are infected with chlamydia each year. Women are frequently re-infected if their sex partners are not treated. To help prevent the serious consequences of chlamydia, screening at least annually for chlamydia is recommended for all sexually active women age 25 years and younger.

As a result of targeted screening, women account for approximately 80% of the cases reported nationally. Men are less likely to be tested and the number of infections in men is under-

reported. When examined by age, national chlamydia data reflect 80% of the women reported are aged 15-24 (46% of all cases are in teens aged 15 to 19).

The high rates of chlamydial infection can serve as a surrogate marker for other STD risks, including HIV. While case rates in recent years have generally increased, the implementation of more sensitive testing methods and potential changes in screening practices during that period make it difficult to interpret the significance of the increase.

Table 3-1 reflects chlamydia case rates in Montana during 1999-2003. The data show that Montana's rates per 100,000 are generally much lower than those of the nation.

Table 3-1. Chlamydia Case Rates per 100,000 in the U.S. and Montana, 1999-2003.

YEAR	Laboratory-Confirmed Chlamydia Case Rates ¹	
	NATION	MONTANA
1999	253	179
2000	252	163
2001	278	213
2002	296	274
2003	NA	278

¹Chlamydia cases per 100,000 population.

As reflected by Table 3-2, the vast majority of chlamydia cases, approximately 75%, are among individuals aged 15-24, the primary target of screening efforts.

Table 3-2. Distribution of Chlamydia Cases in Montana by Age, Montana 2003.

AGE	TOTAL CASE NUMBER (%)
0-14	39 (1.5)
15-19	981 (38.9)
20-24	938 (37.2)
25-29	306 (12.1)
30-34	116 (4.6)
35+ or Unknown	140 (5.6)
TOTAL ¹ :	2520 (100)

¹ Excludes cases for which age was unavailable.

The distribution of chlamydia cases by race/ethnicity is detailed in detailed in Table 3-3. While American Indians consistently account for a significant percentage of chlamydia cases in each region, aggressive screening campaigns by tribal health departments and the Indian Health Service (IHS) strongly influence these data.

Table 3-3. Distribution of Chlamydia Cases in Montana by Race, 2003

RACE/ETHNICITY	TOTAL CASE NUMBER (%)
White	969 (36.8)
Black	51 (1.9)
Hispanic	56 (2.1)
Asian	22 (0.8)
American Indian	774 (29.4)
Other/Unknown	763 (29.0)
TOTAL:	2635 (100)

In summary, Chlamydia data are influenced by Montana's screening systems targeting young women and American Indians. However, the data do reflect many individuals are not protecting themselves from acquiring a sexually transmitted disease and the highest risk is among teens and young adults of all races. Although influenced by screening programs, American Indian teens and young adults appear to have a greater risk for acquiring chlamydia than their non-Indian counterparts.

Gonorrhea and Syphilis

Since those at greatest risk of heterosexual transmission of HIV are likely to be those who are acquiring other STD's, increasing rates of syphilis and gonorrhea may provide an early warning of the heterosexual spread of HIV infection. As indicated by Table 3-4 recent syphilis rates have remained constant in Montana. Gonorrhea rates have increased until recently leveling off and may be partly attributed to increased screening of partners of diagnosed cases. Syphilis and gonorrhea rates in Montana are far below the national average.

Table 3-4. Syphilis and Gonorrhea Case Rates, U.S. and Montana by Year, 1999-2003¹

YEAR	Laboratory-Confirmed Syphilis Case Rates/100,000		Laboratory-Confirmed Gonorrhea Case Rates/100,000	
	NATION	MONTANA	NATION	MONTANA
1999	2	1	132	6
2000	2	0	129	7
2001	2	0	128	11
2002	2	0	125	14
2003	NA	0	NA	13

¹Case rate = number of cases of disease/per 100,000.

Since gonorrhea and syphilis rates are highest in areas that have high urban minority populations where sex is exchanged for money and drugs, Montana's low rate likely reflects the frontier nature of the state, rapid public health responses, and intense epidemiological investigations that help keep these disease from spreading.

HIV/AIDS Behavioral Risks Among Montana Youth

The U.S. Centers for Disease Control has established a nationwide epidemiologic surveillance system, called the Youth Risk Behavior Surveillance System (YRBS). The system monitors the prevalence of behaviors that influence health, and place youth at risk for significant health and social problems which occur during adolescence. *The survey is conducted every-other year and was last conducted in 2003.*

Survey questions on the YRBS related to youth sexual behaviors included:

1. Have you ever had sexual intercourse?
2. How old were you when you had intercourse for the first time?
3. During your life, with how many people have you had sexual intercourse?
4. During the past three months, with how many people did you have sexual intercourse?
5. Did you drink alcohol or use drugs before you had sexual intercourse the last time?
6. The last time you had sexual intercourse, did you or your partner use a condom?

The information in this section contains highlights from the recent YRBS. More detailed reports and state to US comparisons can be found at the OPI website (<http://www.opi.state.mt.us/yrbs/>).

Sexual Behaviors & HIV/AIDS Education

YRBS survey findings are typically used to measure the extent to which adolescents engage in health-risk behaviors. The data primarily provide information on youth in school and do not represent out-of-school youth who may have higher levels of risky behavior. *Unlike the data presented for high-school students, information presented for junior high students (9,428 surveyed) and American Indian students (1,047 surveyed from reservations and 392 from urban schools in 2003) is not from a random survey. As a result, it may not be valid to generalize the results of junior high and American Indian students to all students in these groups. In the data presented for 7th and 8th grade and American Indian students, it is only valid to attribute the results to the students actually surveyed.*

Data presented in Table 3-5. show that Montana high-school students are slightly less sexually active than their national counterparts. Recent surveys indicate over one-half of 9th-12th grade students (56 percent) report *not* having had sexual intercourse. Slightly over three-fourths (80 percent) of 7th and 8th grade students surveyed reported not having had sexual intercourse. Both urban and rural American Indian students surveyed were more likely to have reported risky sexual behaviors than non-American Indian students.

Table 3-5. Sexual Behaviors of Junior & Senior High School Students in Montana YRBS, 1999 - 2003.

Selected Sexual Behaviors & HIV/AIDS Education	Percentage of Students Reporting Behavior					
	Grades 7-8 ¹		Grades 9-12		Amer Indians ¹	
	Montana 99-01-03		Montana 99-01-03	U.S. 2003	Reservations 99-01-03	Urban 99-01-03
	21-19-20	43-44-44	47%	64-61-66	57-57-52	
Ever had sexual intercourse	21-19-20	43-44-44	47%	64-61-66	57-57-52	
Had sexual intercourse with four or more people during their life	5 - 5- 6	12-14-14	14%	26-21-28	21-26-16	
Used or whose partner used a condom during last sexual intercourse	62-66-66	60-61-63	60%	51-65-37	59-55-34	
No HIV/AIDS education	16-19-21	9 - 7- 9	12%	13-15-15	12-16-16	

Source: Montana Youth Risk Behavior Surveys Grades 7-8; and Montana Youth Risk Behavior Surveys Grades 9-12.

¹ Data from 7th and 8th grade and American Indian students not from a random sample.

Non-American Indian youth surveyed were much less likely to use a condom than their non-Indian counterparts. Only 9% of Montana Senior High School students report not having had HIV/AIDS education, whereas 21% of Montana Junior High School students report not having had HIV/AIDS education. Both urban and reservation American Indian students were also less likely to report having had received HIV/AIDS education than their counterparts.

High Risk Sexual Behaviors

Table 3-6 presents data on the high-risk sexual behaviors of Montana youth who *have had* sexual intercourse. In general, the percentage of students reporting high-risk behaviors has remained stable over the last two surveys. Male students were more likely to have multiple sex partners than female students and more likely to use a condom the last time they had sex

Table 3-6. High-Risk Sexual Behaviors Among Students Who Have Had Sexual Intercourse, Non-American Indians, Montana YRBS, 2001 and 2003.

High-Risk Sexual Behavior	Percentage of Students Reporting Behavior											
	Junior High Students						Senior High Students					
	2001			2003			2001			2003		
	% ¹	& ²	All	%	&	All	%	&	All	%	&	All
	Multiple Sex Partners	60	55	58	61	55	59	65	63	64	69	62
Used Alcohol or drugs before sex	36	39	37	32	38	34	37	32	34	34	35	35
Did Not use a Condom	33	37	34	31	38	34	30	47	39	33	41	37

¹Male ²Female

Source: Montana Youth Risk Behavior Surveys.

In general, American Indian students were more likely than their peers to report having multiple partners, using drugs or alcohol before sex, or not using a condom. No consistent differences between American Indian students *in urban schools* and their reservation counterparts are apparent.

Table 3-7. High-Risk Sexual Behaviors Among Students Who Have Had Sexual Intercourse, American Indians, Montana YRBS, 2001 and 2003.

High-Risk Sexual Behavior American Indian Students ³	Percentage of Students Reporting Behavior											
	Reservation AI Students						Urban AI Students					
	2001			2003			2001			2003		
	% ¹	& ²	All	%	&	All	%	&	All	%	&	All
Multiple Sex Partners	76	68	72	77	66	72	80	74	77	72	70	71
Used Alcohol or drugs before sex	37	38	38	38	34	36	43	36	40	31	25	28
Did Not use a Condom	30	40	35	34	41	37	45	46	46	27	44	36

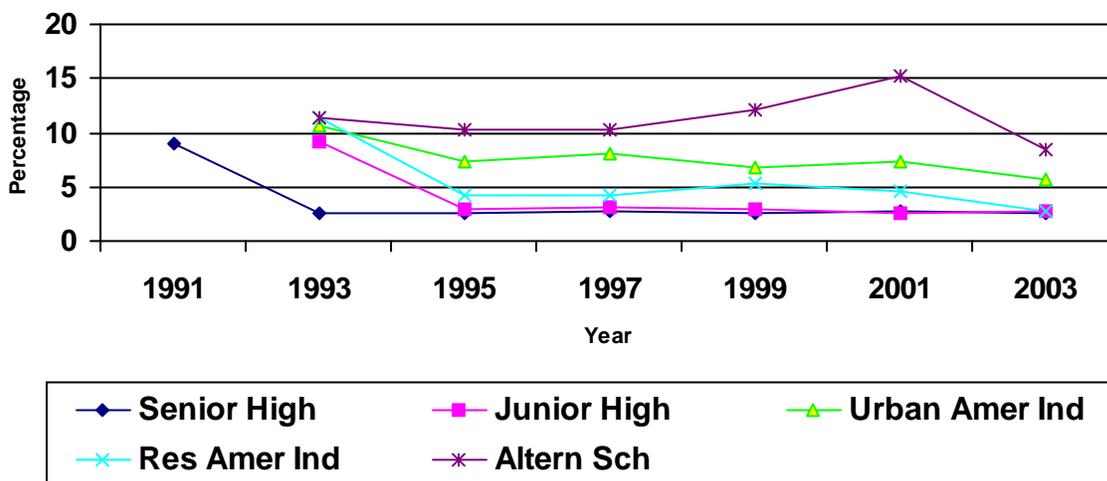
¹Male ²Female

³ includes only American Indian students on Montana reservations, not a random survey.

Source: Montana Youth Risk Behavior Surveys.

Injecting drug use (IDU) is linked, directly and indirectly, to approximately 29% of Montana's HIV/AIDS cases. Figure 3-1 reflects that needle use for injecting drugs is a relatively uncommon practice with over 90% of students reporting no use. Students in alternative schools were an exception, consistently reporting a higher level of needle use. Unlike the high school survey of grades 9-12, the survey result for American Indians, 7th and 8th grade students and alternative schools are not random. As a result, results reflect the behavior of only those surveyed and may not reflect the all students of these groups.

Figure 3-1. Percentage of Students, by Setting, Reporting Injecting Drug Use at Least Once During Lifetime, Montana YRBS 1991-2003.



to initiate sexual activity and having less sex when they do; and 2) a significant increase in contraceptive use for those who are sexually active.

RYAN WHITE HIV/AIDS CARE ACT SPECIAL QUESTIONS AND CONSIDERATIONS

Question 1: What are the patterns of utilization of HIV services of persons in Montana?

Question 2: What are the number and characteristics of persons are HIV-positive but who are not receiving primary care?

Note: This section of the Profile is under development and will be distributed when complete.

Appendices

A. Centers for Disease Control & Prevention HIV/AIDS Surveillance Case Definition

Appendix

Revised Surveillance Case Definition for HIV Infection*

This revised definition of HIV infection, which applies to any HIV (e.g., HIV-1 or HIV-2), is intended for public health surveillance only. It incorporates the reporting criteria for HIV infection and AIDS into a single case definition. The revised criteria for HIV infection update the definition of HIV infection implemented in 1993 (18); the revised HIV criteria apply to AIDS-defining conditions for adults (18) and children (17,19), which require laboratory evidence of HIV. This definition is **not** presented as a guide to clinical diagnosis or for other uses (17,18).

I. In adults, adolescents, or children aged ≥ 18 months[†], a reportable case of HIV infection must meet at least one of the following criteria:

Laboratory Criteria

- Positive result on a screening test for HIV antibody (e.g., repeatedly reactive enzyme immunoassay), followed by a positive result on a confirmatory (sensitive and more specific) test for HIV antibody (e.g., Western blot or immunofluorescence antibody test)

or

- Positive result or report of a detectable quantity on any of the following HIV virologic (nonantibody) tests:
 - HIV nucleic acid (DNA or RNA) detection (e.g., DNA polymerase chain reaction [PCR] or plasma HIV-1 RNA)[§]
 - HIV p24 antigen test, including neutralization assay
 - HIV isolation (viral culture)

OR

*Draft revised surveillance criteria for HIV infection were approved and recommended by the membership of the Council of State and Territorial Epidemiologists (CSTE) at the 1998 annual meeting (11). Draft versions of these criteria were previously reviewed by state HIV/AIDS surveillance staffs, CDC, CSTE, and laboratory experts. In addition, the pediatric criteria were reviewed by an expert panel of consultants. [External Pediatric Consultants: C. Hanson, M. Kaiser, S. Paul, G. Scott, and P. Thomas. CDC staff: J. Bertolli, K. Dominguez, M. Kalish, M.L. Lindegren, M. Rogers, C. Schable, R.J. Simonds, and J. Ward]

[†]Children aged ≥ 18 months but < 13 years are categorized as "not infected with HIV" if they meet the criteria in III.

[§]In adults, adolescents, and children infected by other than perinatal exposure, plasma viral RNA nucleic acid tests should **NOT** be used in lieu of licensed HIV screening tests (e.g., repeatedly reactive enzyme immunoassay). In addition, a negative (i.e., undetectable) plasma HIV-1 RNA test result does not rule out the diagnosis of HIV infection.

Clinical or Other Criteria (if the above laboratory criteria are not met)

- Diagnosis of HIV infection, based on the laboratory criteria above, that is documented in a medical record by a physician

or

- Conditions that meet criteria included in the case definition for AIDS (17–19)

II. In a child aged <18 months, a reportable case of HIV infection must meet at least one of the following criteria:

Laboratory Criteria

Definitive

- Positive results on two separate specimens (excluding cord blood) using one or more of the following HIV virologic (nonantibody) tests:
 - HIV nucleic acid (DNA or RNA) detection
 - HIV p24 antigen test, including neutralization assay, in a child ≥ 1 month of age
 - HIV isolation (viral culture)

or

Presumptive

A child who does not meet the criteria for definitive HIV infection but who has:

- Positive results on only one specimen (excluding cord blood) using the above HIV virologic tests and no subsequent negative HIV virologic or negative HIV antibody tests

OR

Clinical or Other Criteria (if the above definitive or presumptive laboratory criteria are not met)

- Diagnosis of HIV infection, based on the laboratory criteria above, that is documented in a medical record by a physician

or

- Conditions that meet criteria included in the 1987 pediatric surveillance case definition for AIDS (17,19)

III. A child aged <18 months born to an HIV-infected mother will be categorized for surveillance purposes as "not infected with HIV" if the child does not meet the criteria for HIV infection but meets the following criteria:

Laboratory Criteria

Definitive

- At least two negative HIV antibody tests from separate specimens obtained at ≥ 6 months of age

or

- At least two negative HIV virologic tests* from separate specimens, both of which were performed at ≥ 1 month of age and one of which was performed at ≥ 4 months of age

AND

No other laboratory or clinical evidence of HIV infection (i.e., has not had any positive virologic tests, if performed, and has not had an AIDS-defining condition)

or

Presumptive

A child who does not meet the above criteria for definitive "not infected" status but who has:

- One negative EIA HIV antibody test performed at ≥ 6 months of age and NO positive HIV virologic tests, if performed

or

- One negative HIV virologic test* performed at ≥ 4 months of age and NO positive HIV virologic tests, if performed

or

- One positive HIV virologic test with at least two subsequent negative virologic tests*, at least one of which is at ≥ 4 months of age; or negative HIV antibody test results, at least one of which is at ≥ 6 months of age

AND

No other laboratory or clinical evidence of HIV infection (i.e., has not had any positive virologic tests, if performed, and has not had an AIDS-defining condition).

OR

Clinical or Other Criteria (if the above definitive or presumptive laboratory criteria are not met)

- Determined by a physician to be "not infected", and a physician has noted the results of the preceding HIV diagnostic tests in the medical record

AND

NO other laboratory or clinical evidence of HIV infection (i.e., has not had any positive virologic tests, if performed, and has not had an AIDS-defining condition)

IV. A child aged <18 months born to an HIV-infected mother will be categorized as having perinatal exposure to HIV infection if the child does not meet the criteria for HIV infection (II) or the criteria for "not infected with HIV" (III).

*HIV nucleic acid (DNA or RNA) detection tests are the virologic methods of choice to exclude infection in children aged <18 months. Although HIV culture can be used for this purpose, it is more complex and expensive to perform and is less well standardized than nucleic acid detection tests. The use of p24 antigen testing to exclude infection in children aged <18 months is not recommended because of its lack of sensitivity.

Conditions that meet the Current Criteria for AIDS

Acquired immunodeficiency syndrome (AIDS) surveillance case definition includes all human immunodeficiency virus (HIV)-infected adolescents and adults aged greater than or equal to 13 years who have either:

less than 200 CD4positive T-lymphocytes/uL; b) a CD4positive T-lymphocyte percentage of total lymphocytes of less than 14%; or

any of the following clinical conditions:

Candidiasis of bronchi, trachea, or lungs

Candidiasis, esophageal

Cervical cancer, invasive

Coccidioidomycosis, disseminated or extrapulmonary

Cryptococcosis, extrapulmonary

Cryptosporidiosis, chronic intestinal (greater than 1 month's duration)

Cytomegalovirus disease (other than liver, spleen, or nodes)

Cytomegalovirus retinitis (with loss of vision)

Encephalopathy, HIV-related

Herpes simplex: chronic ulcer(s) (greater than 1 month's duration); or bronchitis, pneumonitis, or esophagitis

Histoplasmosis, disseminated or extrapulmonary

Isosporiasis, chronic intestinal (greater than 1 month's duration)

Kaposi's sarcoma

Lymphoma, Burkitt's (or equivalent term)

Lymphoma, immunoblastic (or equivalent term)

Lymphoma, primary, of brain

Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary

Mycobacterium tuberculosis, any site (pulmonary or extrapulmonary)

Mycobacterium, other species or unidentified species, disseminated or extrapulmonary

Pneumocystis carinii pneumonia

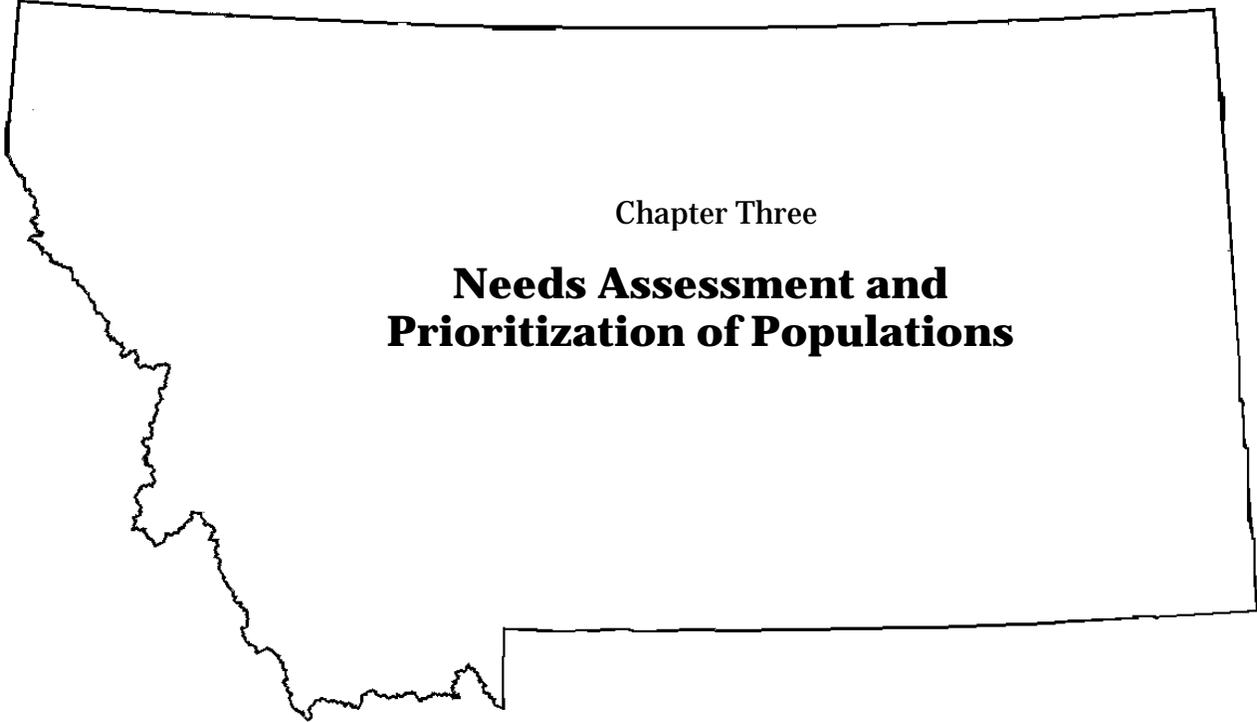
Pneumonia, recurrent

Progressive multifocal leukoencephalopathy

Salmonella septicemia, recurrent

Toxoplasmosis of brain

Wasting syndrome due to HIV



Chapter Three

**Needs Assessment and
Prioritization of Populations**

In the past five years, in the state of Montana many needs assessments have been completed that the CPG has been able to utilize for population prioritization.

1. 2003 Housing Survey Result for Montana, North Dakota, and South Dakota
Social and health service providers in Montana, North Dakota, and South Dakota distributed the housing survey to people living with HIV and AIDS by mail and in person. The primary purpose of the survey was to determine the housing needs and preferences of people living with HIV/AIDS throughout the three states. Individuals were asked questions pertaining to personal demographics, income and benefits, living situation, history of homelessness, and housing preferences.
2. 2001 Montana Behavior Risk Factor Surveillance System (BRFSS)
The BRFSS is designed to collect information on health risk behaviors of Montana residents age 18 and over and to monitor prevalence of these behaviors. The risk behaviors surveyed are major contributors to illness, disability, and premature death. This survey is administered every other year.
3. Annual Counseling and Testing Referral Site Reports
All test results from the DPHHS Public Health Laboratory are recorded. Epidemiological data and demographic data for people being counseled and tested through CTR sites are reviewed.
3. Annual Sexually Transmitted Disease Statistics
Data provided by the DPHHS STD section. Includes an annual description of the epidemiology of sexually transmitted diseases in Montana.
4. 2004 HIV/AIDS in Montana
DPHHS report on the epidemiology of HIV/AIDS in Montana is updated quarterly. See Chapter 2 – Epidemiological Profile.
5. 2001 Montana Youth Risk Behavior Survey (YRBS)
Administered by the Montana Office of Public Instruction, the CDC sponsored survey of public school students in grades 7-12, is a self-reporting assessment to help monitor the prevalence of behaviors that put youth at risk for the most serious health and social problems that can occur during adolescence and into adulthood including drug use, sexual activity, etc. This survey is also conducted and data compiled for American Indian students on Reservations. This survey is administered every other year.
6. 2000 Gay/Bisexual Men's Health Survey Results
A survey of 192 gay and bisexual men conducted by FDH & Associates. Surveys were conducted in Billings at a local gay bar, Butte at an adult bookstore, Missoula at a local gay bar, at the annual Montana Two Spirit Gathering and at the annual Montana Pride Celebration held in Helena.
7. 2001 HIV-Positive Individual's Needs Assessment

Conducted by The University of Montana, Department of Health and Human Performance Needs Assessment Project Team. The purpose of this project was to collect information about the needs of people living with HIV/AIDS in Montana, including both those receiving and those not receiving HIV related services.

8. 2002 MSM Needs Assessment

Conducted by The University of Montana, Department of Health and Human Performance Needs Assessment Project Team. The purpose of the needs assessment was to collect information about the HIV prevention needs of MSM living in Montana, including an exploration of the demographic and contextual factors which contribute to HIV infection.

9. 2002 State of Montana, DPHHS, Addictive and Mental Disorders Division – Alcohol and Drug Information System.

Demographic data regarding the number of individuals admitted to drug treatment programs who indicated intravenous drug use.

10. 2003 Outcome Evaluation of Gay Men’s Health Retreats

Outcome results suggest that Gay Men’s Health Retreats affect participant’s sense of social support, attitudes, and sexual behavior to some degree. Participants also showed a reduction in behaviors associated with HIV transmission, including lower rates of UAI and use of substances during or in anticipation of sex.

11. 2003 National College Health Assessment – Montana State University Bozeman. The NCHA contains approximately 300 questions that assess health status and health problems, risk and protective behaviors, access to health information, impediments to academic performance, and perceived norms across a variety of content areas including sexual health.

12. 2004 HIV Prevention Service Provider Survey

Conducted by the CPG Effective Interventions Workgroup, The University of Montana, Department of Health and Human Performance and DPHHS. The purpose of the Provider Survey was to assess the scope of HIV prevention services currently being provided in the State of Montana, determine effectiveness of these interventions, and assess provider capacity and capacity building needs.

13. 2003 Montana Targeted Prevention (MTAP) MSM and IDU Survey

Conducted by the MTAP, MSM, and IDU outreach workers. The results of these surveys indicate that the targeted populations are being reached through MTAP and behaviors may be changing due to the education and prevention messages delivered by MTAP outreach workers. The results of this survey give us an idea of the effectiveness of our outreach workers, help us determine baseline numbers, and give us a snapshot of the target populations MTAP works with.

14. 2003 Provider Resource Directory

Developed by Butte AIDS Support Services and HIV Prevention. The directory includes HIV/AIDS prevention services, care and support services, housing information, and emergency assistance available in Montana.

15. 2003 HIV-Positive Resource Directory of Interventions

Francis Gary and Claudia Montagne, MPH. Prevention with Positives: A review of the Literature and a Resource Directory of Interventions for HIV-Positive Individuals.

16. 2004 A Study of Women's Experiences of Living With HIV/AIDS in Rural Areas

Dissertation by Joyce Mphande. The purpose of this study was to explore the experience of living with HIV/AIDS from the perspective of the women living with HIV/AIDS in rural areas.

17. 2004 Gay Friendly Provider Survey

A survey of gay and bisexual men conducted by FDH & Associates. The purpose of the survey is to compile a list of gay and gay-friendly medical and health providers who practice in Montana. Providers listed by respondents are then sent a follow-up survey informing them that they have been identified as a gay-friendly provider and if they would consent to being listed for the directory. The survey also includes questions about healthcare and ways to improve services.

18. Outcome Evaluation of an IDU Outreach Intervention

Conducted by the University of Montana. The population that was evaluated in this study was injection drug users (IDUs) currently enrolled in chemical dependency programs in Montana. This population consisted of men and women over the age of 18, who attend Connections Inc's. HIV and Hepatitis C educational outreach program, *Taking it to the Population*.

19. 2003 State Assessment of CTR Services

University of Montana conducted an assessment of HIV Counseling and Testing Services statewide.

At the June CPG meeting, members set a timeline for implementation of priority populations needs assessments. The decision is as follows:

- CY 2005 IDU population
 - Treatment centers
 - Pre-release centers
 - Jails
 - Detentions centers
 - Outreach efforts
 - County and tribal entities

- CY 2006 HIV-Positive Population

- Ryan White programs
- Care providers

- CY 2007 MSM
 - Outreach efforts
 - Bars
 - Public sex environments
 - Bookstores

UNMET NEEDS

Unmet needs cannot be identified at this time. The DPHHS is currently requesting proposals for the interventions outlined within this plan. The CPG will evaluate any unmet needs once contracts are signed for CY 2005 interventions.

The CPG members recognized an unmet need at the June 2004 meeting. In planning the needs assessment timeline, the High Risk Heterosexual population will require a needs assessment conducted in the next three year planning cycle.

PRIORITIZATION OF POPULATIONS

In preparing for the prioritization process, representatives from each proposed target population met in small groups at the March 2004 CPG meeting. Group members reviewed all available data related to incidence and prevalence, risk behavior, STD rates, and anecdotal or expert information regarding the population they represent. The importance of considering both quantitative and qualitative factors was stressed.

Priority population community representatives compiled all of the data relevant to their population and prepared a presentation for CPG members. Each of the presentations included information related to incidence and prevalence, indicators of risk behavior, existing interventions and resources currently targeting the population, and barriers to reaching the population. Following the presentations related to each priority population, CPG members considered all factors presented and rated each population utilizing the “Ranking Priority Populations” form. The scores for each of the factors were tallied and the following target populations were determined by consensus of the CPG.

PRIORITY POPULATIONS ADOPTED BY THE STATEWIDE CPG

PRIORITY I: HIV-Positive Individuals (HIV+)

Definition: Individuals who are infected with the Human Immunodeficiency Virus (HIV).

PRIORITY II: Men Who Have Unprotected Sex With Men (MSM)

Definition: Men who participate in unprotected oral and anal sex with other men in high-risk situations. These include but are not limited to Men Who Have Sex With Men (MSM) who are adults (over age 24); are young (age 16-24); are in communities of color; are incarcerated; who are sex workers (exchange sex for resources, survival); who have sex with HIV+ partners.

PRIORITY III: Injecting Drug Users (IDU)

Definition: Individuals who inject drugs and share the equipment with others.

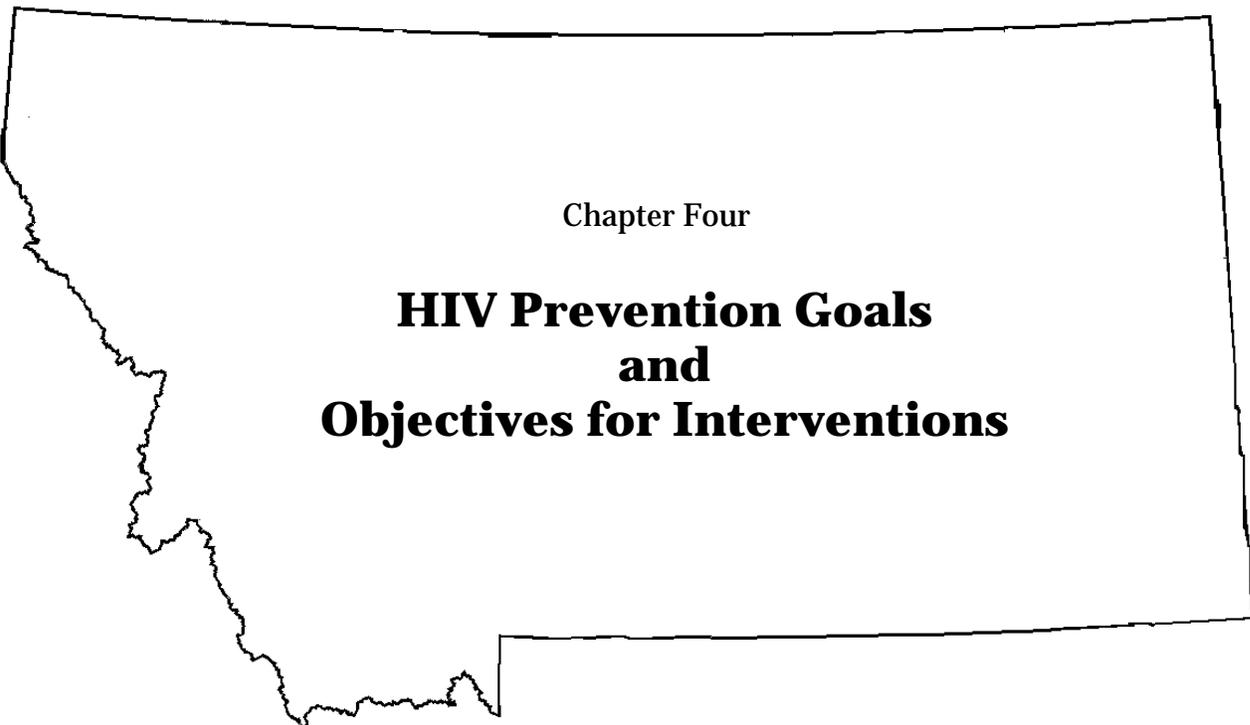
PRIORITY IV: High Risk Heterosexuals (HRH)

Definition: Individuals who participate in unprotected oral, vaginal, and anal sex in high-risk situations. These include, but are not limited to, HIV+ partners, females with sexually transmitted diseases (STD); females who have sex with MSM; females who are sex workers (exchange sex for resources, survival or drugs); male and female substance abusers; male and female sexual partners of IDUs; or youth* in high-risk situations.

- CDC Definition: “Youth in high-risk situations are aged 10-24. These youth include, but are not limited to, youth who have run away or are homeless; are not in school and are unemployed; seek treatment for substance abuse, especially for injecting drugs and using crack cocaine; are juvenile offenders; are medically indigent; require mental health services; are in foster homes; are migrants; are gay and lesbians; have had sexually transmitted diseases, especially genital ulcer disease; have been psychologically, physically, or sexually abused; are pregnant; seek counseling and testing for HIV infection; exhibit signs or symptoms of AIDS or HIV infection without alternative diagnosis; barter or sell sex; are in alternative or continuation schools; are in gangs.” Montana also considers youth engaging in unprotected sex with multiple partners in this priority population.

RANKING PRIORITY POPULATIONS
MONTANA'S MARCH 2004 HIV PREVENTION MEETING

<u>FACTORS</u>	<u>RATING INFORMATION</u>	<u>SCALES</u>	<u>SCORES</u>
CATEGORY I : HIV/ AIDS SURVEILLANCE	This category provides information about the extent of the HIV/AIDS epidemic among the target populations.	Each point corresponds to a given # of cases in target population.	Circle the number that best represents the degree of infection in each target population.
HIV/AIDS INCIDENCE	How many persons within the target population have been diagnosed with AIDS in the past year?	1: less than 5 2: between 5 & 10 3: more than 10	MSM: 1 2 3 IDU: 1 2 3 HETERO: 1 2 3 _____: 1 2 3
HIV/AIDS PREVELANCE	What is the estimated total number of persons living with HIV in the target populations?	1: less than 100 2: between 100 & 300 3: more than 300	MSM: 1 2 3 IDU: 1 2 3 HETERO: 1 2 3 _____: 1 2 3
CATEGORY II: DOCUMENTATION OF HIV RISK BEHAVIORS	This category provides information about behaviors that may lead to HIV transmission.	Each point correlates to the degree of risky behaviors present in the population.	Circle the number that best represents the degree of risky behaviors in each target population.
<u>RISKINESS OF POPULATION BEHAVIORS</u>	This factor consists of the relative risk of behaviors. High risk behaviors are listed in decreasing order in the next column.	1: unprotected oral or vaginal sex with a potentially infected partner. 2: unprotected anal sex with a potentially infected partner. 3: sharing of potentially contaminated needles and works.	MSM: 1 2 3 IDU: 1 2 3 HETERO: 1 2 3 _____: 1 2 3
CATEGORY III: SOCIO- DEMOGRAPHIC DATA	This factor examines complex issues that may effect provision of HIV prevention programs.	Each point relates to the level of difficulty in providing HIV prevention programs.	Circle the number that best represents the degree of difficulty in reaching target population.
<u>DIFFICULTY MEETING NEEDS OF POPULATION</u>	This factor relates to the complexity of need and whether or not the population has been reached by current programs, and whether service providers have the capacity, etc.	1: little difficulty meeting needs. 2: moderate difficulty meeting needs. 3: substantial difficulty meeting needs.	MSM: 1 2 3 IDU: 1 2 3 HETERO: 1 2 3 _____: 1 2 3



Chapter Four

**HIV Prevention Goals
and
Objectives for Interventions**

HIV PREVENTION INTERVENTIONS

An HIV prevention intervention is an organized activity designed to influence knowledge, attitudes, beliefs or behavior related to the prevention of HIV/AIDS. Interventions can vary widely in scope from a single educational material, such as a mailing on AIDS information, to multifaceted comprehensive programs, such as client-centered counseling and testing activities.

The CPG Effective Interventions standing committee began collecting information regarding HIV Prevention interventions in 2003. A representative from each community compiled research related to interventions specific to working with the priority population they represent. The information gathered was varied and included HIV prevention service provider survey results. The importance of considering both quantitative and qualitative factors was stressed.

Committee members reviewed and organized the information gathered, and prepared a presentation for the remaining committee members, highlighting the interventions specific to the priority population they represent. Effective Interventions committee members reached consensus regarding selected interventions utilizing Form B. Some of the questions considered in reviewing each of the proposed interventions include:

- Is the intervention legal?
- Does the intervention meet the needs of one of the priority populations?
- Did the priority population have input in the development of the intervention?
- Is the intervention acceptable to the community's norms and values?
- Is there research that demonstrates the effectiveness of this type of intervention?
- Is the intervention realistic?
- Are there sufficient resources to carry out the intervention?

The Effective Interventions Committee members presented the selected interventions at the June 2004 CPG meeting. Small groups representing each priority population reviewed the interventions and made recommendations to the whole group. The members came to consensus to adopt all of the recommended interventions into the Comprehensive Plan.

Once an intervention is adopted, its actual impact will depend on how it is implemented. It is important to achieve a balance between adapting the intervention to suit local needs and maintaining the core elements and key characteristics that made the original intervention successful. Replication of proven effective program models is not always feasible or appropriate in rural communities. Several intervention models chosen were selected from the CDC Procedural Guidance for Selected Strategies and Interventions for Community Based Organizations. Most of these selected interventions were developed in urban areas and will need to be modified and adapted to meet the needs of rural populations.

The information in this section is intended to be used as a guide for implementing HIV prevention interventions. Agencies will select from these interventions, tailor the capacity requirements and key characteristics to suit their needs while trying to maintain the core elements.

HIV-Positive Individuals: Individuals who are infected with the Human Immunodeficiency Virus (HIV).

HIV-Positive Prevention Objectives: Reduce high-risk sexual behaviors in HIV+ Individuals by increasing knowledge and understanding of HIV prevention and transmission, safer sex practices, and knowledge and access to condom use.

- Increase the HIV+ Individual's knowledge and understanding of HIV prevention and transmission, focusing on secondary prevention issues.
- Collaborate, coordinate and develop linkages with other agencies, organization, and service groups or providers to strengthen risk reduction knowledge, skills, and activities.
- Provide general support for safe behaviors; dispel myths about transmission and support efforts for risk reduction.
- To ensure HIV+ individuals are linked to appropriate care and treatment services as well as to encourage linkages, testing, and risk reduction skills and services to partners of HIV+ individuals. (Information on how to obtain prevention, care and treatment services including CRRPCRS and STD screening and treatment).

TARGET POPULATION: HIV-Positive Individuals

PROGRAM MODEL: HEALTHY RELATIONSHIPS

(Complete program details can be requested from DPHHS or visit http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf)

INTERVENTION GOALS: To reduce sexual or drug using risk behaviors or maintain protective behaviors, increase coping, decision-making, and condom negotiation skills.

INTERVENTION TYPE: Group Level Intervention (GLI)

PROGRAM OVERVIEW: Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills. Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure and behavior. The sessions create a context where people can interact, examine their risks, develop skills to reduce their risks, and receive feedback from others. Healthy Relationships is intended to create a positive, engaging, and creative atmosphere that can be integrated into existing support groups or can be introduced as a new program.

CORE ELEMENTS are those components that are a critical feature of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Peer led with a facilitator guiding the group.
- 2) Defining stress and reinforcing coping skills across three life areas: disclosing to family and friends, disclosing to sexual partners, and building healthier and safer relationships.
- 3) Using modeling, role-play, and feedback to teach and practice skills related to coping with stress.
- 4) Teaching decision-making skills about disclosure of HIV status.
- 5) Providing personal feedback reports to motivate change of risky behaviors and continuance of protective behaviors.
- 6) Using movie clips to set up scenarios about disclosure and risk reduction to stimulate discussions and role-plays.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Participants meet in small groups, similar in style to support groups. New members cannot join once the series of sessions has begun.

- Participants sit in a circle, face-to-face.
- Participants meet for at least five, 120-minute sessions.
- Groups contain members of the same gender and sexual orientation.
- At least one group facilitator is an experienced and skilled counselor, preferably a mental health professional. This facilitator may or may not be HIV-positive.
- The peer facilitator should be HIV-positive.
- One facilitator is male and the other female.
- At least one facilitator matches the ethnicity of the majority of the participants.
- Both facilitators need the personal characteristics and group skills of effective facilitators.

EVALUATION AND MONITORING:

- Collect and report client-level data. (optional)
- Collect and report data on the percent of HIV infected persons who report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with seronegative partners or with partners of unknown status.
- Collect and report standardized process and outcome monitoring data consistent with CDC requirements.
- Use of the CDC developed Program Evaluation Monitoring System (PEMS) to report data electronically.
- Collect and report data consistent with CDC's requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:
 - **H.1** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), group level interventions (GLI), and Prevention Case Management (PCM).

RESEARCH RESULTS:

- Participants reported greater self-efficacy for suggesting condom use with new partners.
- Participants reported intentions to consider the pros and cons of HIV status disclosure to partners.
- Participants reported intentions to engage in safer sex with partners who did not know their HIV status.
- Participants were significantly more likely to have followed through on their earlier intentions at the three-month and six-month follow-up.
- Participants reported less unprotected intercourse, more protected intercourse, and fewer sexual contacts at the six-month follow-up.
- Participants reported less sexual intercourse and less unprotected intercourse with non-HIV-positive partners at the three-month and six-month follow-up.
- Participants were significantly more likely to refuse to engage in unsafe sex at the six-month follow-up.

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http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf

TARGET POPULATION: HIV-Positive Individuals

PROGRAM MODEL: PREVENTION CASE MANAGEMENT (PCM) FOR PERSONS LIVING WITH HIV AND HIGH RISK NEGATIVE INDIVIDUALS

(Complete program details can be requested from DPHHS or visit http://www.cdc.gov/hiv/partners/AHP/CBOPcedures_15Dec03_FinalDraft.pdf)

INTERVENTION GOALS: Promote the adoption of HIV risk-reduction behaviors by clients with multiple, complex case management and risk-reduction needs.

INTERVENTION TYPE: Prevention Case Management (PCM)

PROGRAM OVERVIEW: PCM provides client-centered, multiple-session HIV risk-reduction counseling to help individuals initiate and maintain behavior change to prevent the transmission of HIV while addressing competing needs which may make HIV prevention a lower priority. This HIV prevention activity addresses the relationship between HIV risk and other issues such as substance abuse, mental health, social and cultural factors, and physical health.

CORE ELEMENTS are those components that are a critical feature of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) PCM is a hybrid of HIV risk-reduction counseling and traditional case management.
- 2) PCM is based on the premise that some people may not be able to prioritize HIV prevention when they face problems perceived to be more important and immediate.
- 3) PCM is intended for people living with HIV (PLWH) with multiple, complex case management and risk-reduction needs who are having, or are likely to have difficulty initiating or sustaining practices that reduce or prevent HIV transmission.
- 4) Individuals who are committed to participating in ongoing risk-reduction counseling should be targeted with PCM.
- 5) Organizations must hire case managers with the appropriate training and skills to complete the PCM activities within their job description.
- 6) Clear procedure and protocol manuals for the PCM program must be developed to ensure effective delivery of PCM services and minimum standards of care. Yellowstone AIDS Project (YAP) developed a PCM program manual that may be utilized. Contact YAP 406-245-2029.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Develop a client identification and engagement strategy.
- Screen and assess clients to identify those who are at highest risk and are appropriate for PCM.
- Develop a written, client-centered prevention plan.
- Provide multiple HIV risk-reduction counseling sessions.
- Provide active coordination of services with follow-up. Agency protocols should address co-managing clients with Ryan White case managers to avoid duplication of services.
- Monitor and reassess clients' needs, risks, and progress.
- Establish protocols to classify clients as “active,” “inactive,” or “discharged,” and outline the minimum active effort required to retain clients.
- Discharge clients from PCM upon attainment and maintenance of risk reduction goals.

EVALUATION AND MONITORING:

- Collect and report client-level data.
- Collect and report standardized process and outcome monitoring data consistent with CDC requirements.
- Use of the CDC developed PEMS (Program Evaluation Monitoring System) to report data electronically.
- Collect and report data consistent with CDC's requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:
 - **H.1** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), group level interventions (GLI) and Prevention Case Management (PCM).
 - **I.1** Proportion of HIV infected persons that completed the intended number of sessions for Prevention Case Management.
 - **I.2** Percent of HIV infected persons who, after a specified period of participation in Prevention Case Management, report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with seronegative partners or with partners of unknown status.

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TARGET POPULATION: HIV-Positive Individuals

PROGRAM MODEL: PARTNERSHIP FOR HEALTH

Pacific AIDS Education and Training Center, USC Keck School of Medicine, 1441 Eastlake Ave., Suite 3412, LA, CA. 90089-9175 Maggie Hawkins Phone: (323) 865-0343

INTERVENTION GOALS: To reduce new infections and re-infections of HIV among HIV positive individuals and their sex partners, improve patient/provider communication about safer sex and disclosure and have patient/provider discussions about HIV prevention become a standard of care.

INTERVENTION TYPE: Capacity Building

PROGRAM OVERVIEW: The Partnership for Health is designed to train health care providers and staff in HIV outpatient clinics to talk more effectively with patients about protecting themselves, protecting their sex partners and disclosing their HIV status to sex partners.

Montana has two trainers located at Yellowstone City/County Health Department who may be utilized to facilitate the training for health care providers and staff.

The program details are as follows:

- Adopt prevention as a standard part of clinical practice.
- Conduct a brief assessment (risk screening) of behavioral and clinical factors associated with transmission of HIV and other STDs.
- Identify patients at greatest risk for transmission of HIV who should receive more in depth risk assessment and HIV risk-reduction counseling, other risk-reduction interventions, or referral for other services.
- Deliver brief (3-5 minute) prevention messages focused on self and/or partner prevention and HIV status disclosure to every patient at every clinic visit.
- Screen for and treat STDs, as appropriate.
- Discuss reproductive health options with female patients of childbearing age.
- Hang waiting and exam room posters and hand out patient brochures that present education and prevention messages and reinforce messages delivered by the clinician.

CORE ELEMENTS are those components that are a critical feature of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Four hour training for clinical staff conducted by person trained in program details.
- 2) Training for all clinic staff should include information on the use of open-ended questions, demonstrating empathy and remaining non-judgmental.

- 3) Counseling sessions can last longer than 5 minutes and follow-up reminders may last less than 3-5 minutes depending on the needs of the patient. It is important to repeat the message over time.
- 4) Providers need to deliver prevention messages at all clinic visits; however, these messages may be eliminated if pressing medical needs take priority.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Screening methods include probing for behaviors associated with transmission of HIV and other STDs, eliciting patient reports of symptoms and other STDs, and laboratory testing for other STDs.
- Clinics should make condoms available in a way that patients can feel comfortable taking them as needed.

EVALUATION AND MONITORING:

- Collect and report standardized process and outcome monitoring data consistent with CDC requirements
- Use of the CDC developed Program Evaluation Monitoring System (PEMS) to report data electronically.
- Collect and report data consistent with CDC requirements to ensure data quality and security, and client confidentiality
- Collect and report data on the following indicators:
 - **G.1** Proportion of providers who have received at least one health department supported capacity building assistance episode, specifically in the form of trainings/workshops in the design, implementation or evaluation of science-based HIV prevention interventions.

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TARGET POPULATION: HIV Positive Individuals

PROGRAM MODEL: RETREATS

INTERVENTION GOALS: To reduce the frequency of unprotected intercourse and increase the use of condoms among HIV positive individuals at risk for HIV and STD's; reduce the sense of isolation experienced by HIV positive individuals living in rural areas and achieve a sense of community; increase knowledge of sexual health and HIV/STDs; have social interaction with peers to increase social support; increase likelihood that participants will act on referrals provided. Individuals that have never attended a retreat will be given priority.

INTERVENTION TYPE: Group Level Intervention (GLI)

PROGRAM OVERVIEW: Weekend retreats for HIV positive individuals will encompass group level and individual level interventions on a variety of topics. Facilitators and presenters will educate participants about sexual health and HIV / STDs. Participants will learn the importance of developing a sense of community as a way to help educate their peers about taking personal responsibility for individual health. This intervention is based on various theories and prevention research such as: Diffusion of Innovation Theory, Sexual Health Model for HIV Prevention, Stages of Behavior Change.

CORE ELEMENTS are those components that are critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) HIV prevention transmission issues must encompass 50% of curriculum
- 2) Educate participants about HIV risk, transmission, prevention and ways to reduce other risks associated with HIV such as drug and alcohol use among HIV positive individuals.
- 3) Build skills on using condoms correctly and consistently.
- 4) Incorporate team building activities and free time as a way to increase social support.
- 5) Educate participants on various topics dealing with general health and wellness as it relates specifically to HIV positive individuals as a way to encompass HIV / STD prevention within a holistic model of health.
- 6) Include large group presentations, small group discussions, team building exercises, role playing and skills building activities as integral aspects of the retreat so that participants experience a variety of learning styles.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Topics may include but are not limited to depression, sexuality, HIV/STD prevention, drug and alcohol use, homophobia, and self-esteem.
- Length of retreats may vary, although it is recommended that retreats take place over a weekend or weekday setting that is at least two days in length.
- Peer trained facilitators are encouraged.
- Held at facilities that allow for people with disabilities to participate.
- Advanced registration is required.
- Track completion of referrals to monitor effectiveness of referral strategy
- Recommended that retreats are drug, alcohol and sex free so that the focus is on the individual and the learning experiences within a safe setting that is conducive to personal growth.
- Engage participants about community health in an effort to shift community norms to ones that value health and personal responsibility, including responsibility for the health of the community.

EVALUATION AND MONITORING:

- Collect and report client-level data. (optional)
- Collect and report standardized process and outcome monitoring data consistent with CDC requirements
 - Process evaluation tools
 - Minutes of planning committee conference calls or meetings
 - Promotional materials and press clippings for the retreat
 - Aggregate demographic information for participants
 - Retreat evaluations by participants
 - Outcome monitoring tools
 - Pre and post test knowledge assessments
 - Health risk surveys
 - Retreat evaluations by participants
- Collect and report data on the percent of HIV infected persons who report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with seronegative partners or with partners of unknown status.
- Use of the CDC developed Program Evaluation Monitoring System (PEMS) to report data electronically.
- Collect and report data consistent with CDC requirements to ensure data quality and security, and client confidentiality
- Collect and report data on the following indicators:
 - **H.1** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), group level interventions (GLI), and Prevention Case Management (PCM).

RESEARCH RESULTS:

- Participants showed that retreats were effective in helping men eroticize condom usage.
 - Participants showed increase in positive sense of self and adoption of safer sex behaviors.
-

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Sondag K. A., Dybdal L., Campbell R., Mulla N. (July 2002). Determining the HIV prevention needs of MSM in Montana. Paper presented at the State Planning Group, Helena, MT.

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Men Who Have Unprotected Sex With Men (MSM): Men who participate in unprotected oral and anal sex with other men in high-risk situations. These include but are not limited to Men Who Have Sex With Men (MSM) who are adults (over age 24); are young (age 16-24); are in communities of color; are incarcerated; who are sex workers (exchange sex for resources, survival); who have sex with HIV+ partners.

MSM PREVENTION OBJECTIVES: Reduce high-risk sexual behaviors in men having sex with men (MSM).

- Increase condom use; facilitate access to low or no cost condoms and educational materials in places convenient - to gay and bisexual men; support education about, and access to, condoms for sexually active youth.
- Increase sense of self-esteem.
- Increase knowledge and understanding of risk behaviors.
- Decrease sense of isolation.
- Decrease percentage of MSM reporting problems with depression.
- Increase percentage of MSM who report increase in communication skills around sex and HIV status.
- Decrease percentage of MSM reporting unprotected sex while under the influence of drugs and/or alcohol.
- Increase number of men who know their HIV status.
- Decrease unprotected anal sex between HIV+ MSM and MSM with unknown HIV status.
- Decrease number of men reporting unprotected anal intercourse.
- Increase the capacity of the prevention contractors to conduct peer outreach and education.
- Continue public information services to individuals from high-risk behavior categories.
- Provide opportunities for prevention case management (client centered HIV prevention activities) to promote the adoption and maintenance of HIV risk reduction behaviors.
- Provide peer outreach and individualized risk reduction education in settings where gay and bisexual men socialize.
- Provide general support for safe behaviors, dispel myths about transmission, and support efforts for personal risk reduction.

TARGET POPULATION: Men Who Have Sex With Men (MSM)

PROGRAM MODEL: RAPID/ORAL FLUID TESTING IN NON-CLINICAL SETTINGS

(Complete program details can be requested from DPHHS or visit

http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf)

INTERVENTION GOALS: To increase knowledge of serostatus among target population.

INTERVENTION TYPE: Counseling, Testing and Referral (CTR)

PROGRAM OVERVIEW: Testing programs in non-clinical venues are more likely to reach members of some racial and ethnic minorities and persons at increased risk for HIV.

CORE ELEMENTS are those components that are the critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Assess the community to determine
 - a. in which populations HIV is likely to be under-diagnosed (because risk is underestimated, and/or because traditional counseling, testing, and referral services are not used)
 - b. where persons at risk and/or underdiagnosed can be reached.
- 2) The agency must have a written agreement with the state Health Department and/or a laboratory to ensure compliance with the Clinical Laboratory Improvement Amendments (CLIA) (for rapid testing) and state and local regulations and policies.
- 3) A clear supervisory structure should be delineated to ensure responsibility for training and guidance, oversight for testing procedures, and coordination.
- 4) Train or ensure training of non-clinical providers to perform rapid/oral fluid HIV testing including the following essential elements:
 - a. Perform the test, including procedures performed before, during, and after testing
 - b. Integrate rapid/oral fluid testing into the overall counseling and testing program
 - c. Develop and implement a quality assurance (QA) program
 - d. Collect and transport specimens for confirmatory testing
 - e. Ensure specimen integrity
 - f. Document and deliver confirmatory testing results to persons whose rapid test results had been preliminary positive
 - g. Comply with universal and biohazard safety precautions
 - h. Ensure confidentiality and data security
 - i. Ensure compliance with relevant state or local regulations
- 5) In conjunction with the state policy or local health department and community mental health providers, establish or utilize existing guidelines and define sobriety standards for counselors to use to determine when clients are not competent to provide consent.

- 6) Confirmatory testing of preliminary positive tests must be assured for rapid testing.
- 7) Clients with a confirmed HIV-positive diagnosis must be provided with or referred for medical evaluation, partner counseling and referral services, and other appropriate prevention services.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Arrange appropriate referral agreements (for medical and social services) and develop strategies for follow-up.
- Define process for confirmatory testing to occur with Health Department including:
 - Obtain detailed locating information on clients whose test results are preliminary positive so that they can be contacted and encouraged to come in for care if they fail to return for their follow-up appointment. The Health Department and the testing program should specify who is responsible for follow-up if clients fail to return for confirmatory test results.
- Assemble the testing supplies for easy storage and transportation to each testing site. Individually packaged rapid test kits include all the supplies and materials necessary to facilitate single client testing in non-clinical settings.

EVALUATION AND MONITORING:

- Collect and report client level data.
- Collect and report standardized process and outcome data consistent with CDC's Requirements.
- Use the CDC developed PEMS (Program Evaluation Monitoring System) to report data electronically.
- Collect and report data consistent with CDC's requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:
 - **B.1** Percent of newly identified, confirmed HIV-positive test results among all tests reported by HIV counseling, testing, and referral sites.
 - **B.2** Percent of newly identified, confirmed HIV-positive test results returned to clients.

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CDC Model Performance Evaluation Program for Rapid HIV Testing:
<http://www.phppo.cdc/mpep/enrollment.asp>

CDC Revised Guidelines for HIV Counseling, Testing, and Referral.
<http://www.cdc.gov/mmwr/PDF/rr/rr5019.pdf>

CDC Technical Assistance Guidelines for CDC's HIV Prevention Program Performance Indicators. <http://www.cdc.gov/hiv/dhap>

CLIA application and requirements: www.cms.hhs.gov/clia

NASTAD Primer on implementing rapid HIV testing:
<http://www.nastad.org/PDF/RAPIDIPRIMER.PDF>

Occupational Safety and Health Administration: www.osha.gov

Product information, OraQuick Rapid HIV-1 Antibody Test: <http://www.orasure.com/products/>

Quality Assurance Guidelines for Testing Using the OraQuick Rapid HIV-1 Antibody Test:
http://www.cdc.gov/hiv/rapid_testing/materials/QA_Guidelines_OraQuick.pdf

Rapid HIV Testing: www.cdc.gov/hiv/rapid_testing

U.S. Department of Health and Human Services, OPHS Office of Minority Health. (2001).
National Standards for Culturally and Linguistically Appropriate Services in Health Care.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention.
(Dec 2003). Draft CDC Procedural Guidance for Selected Strategies and Interventions.
http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf

TARGET POPULATION: Men Who Have Sex With Men (MSM)

PROGRAM MODEL: OUTREACH based on Recruitment model from CDC
(Complete program details can be requested from DPHHS or visit
http://www.cdc.gov/hiv/partners/AHP/CBOPcedures_15Dec03_FinalDraft.pdf)

INTERVENTION GOALS: To reach at risk MSM populations to help them take advantage of HIV prevention intervention, programs, and services.

INTERVENTION TYPE: Outreach

PROGRAM OVERVIEW: Outreach is a common means of meeting potential high-risk clients in their own environment to deliver HIV prevention messages and services and to bring them into additional prevention services. These activities may take place in specific venues where high-risk individuals congregate and/or in places where high risk behaviors take place or can be conducted at virtual sites including the Internet or telephone hotlines. Finally, outreach can take place as the result of contacts established through the use of social networking techniques that demonstrate connections between high-risk persons. Agencies can work with current clients to reach partners or friends who may also be at high risk.

Within- and between-agency referrals are other common ways for organizations to bring clients to services. Often an agency will use its existing programs or interventions to refer clients to other services within the agency. A benefit of this strategy is that it takes advantage of the trust that is already developed by clients who have previously been engaged with an agency. When a referral is made to another service within that agency, the client may be more likely to accept and access the referral.

CORE ELEMENTS are those components that are a critical feature of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Use of information from multiple sources to describe common characteristics of the target population, which can be used for targeting outreach activities.
- 2) Develop and deliver appropriate health messages for the setting (either to be delivered by an outreach worker or by a referral source).
- 3) Recruit for specific services (e.g., counseling, testing, and referral services, PCM, other prevention interventions). Outreach must be linked to counseling, testing, and referral services for clients of unknown status, and to care and prevention services for people living with HIV (PLWH).
- 4) Track completion of referral to monitor the effectiveness of the referral strategy.
- 5) Revise strategies or venues, as appropriate.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an

intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

On-site Outreach

- Develop criteria that will trigger a referral from providers of other services within the agency.
- Providers of services within the organization should assess all consumers to determine appropriateness for prevention services delivered within the organization and make appropriate referrals to those services.
- Develop targeted and appropriate messages to be delivered by individual members of an agency or by mass messaging strategies (e.g., on posters hung throughout the agency).

Off-site Peer Outreach

- Go to venues where potential clients congregate at the times when they are present.
- Conduct outreach in teams to improve the safety of outreach workers.
- Screen clients to determine their needs for specific prevention services (e.g., counseling, testing, and referral (CTR); prevention case management (PCM); or other prevention interventions).
- Develop and deliver tailored and appropriate health and prevention promotion messages.
- Provide tailored and appropriate materials that describe programs and services to potential clients.
- When possible, use peers as outreach workers.

Outreach through Referral Networks

- Establish linkages with those service providers that members of the target population are most likely to access and provide training to these providers related to prevention services.
- Develop formal agreements with appropriate service providers for ongoing screening and bidirectional referrals.
- Provide tailored and appropriate materials to referral agents that advertise programs and services.
- Provide tailored and appropriate materials that describe programs and services to potential clients.

EVALUATION AND MONITORING:

- Collect and report client-level data. (optional)
- Collect and report standardized process and outcome monitoring data consistent with CDC requirements.
- Use of the CDC developed PEMS (Program Evaluation Monitoring System) to report data electronically.
- Collect and report data consistent with CDC's requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:

- **H.3** The mean number of outreach contacts required to get one person to access any of the following services: Counseling & Testing, Sexually Transmitted Disease Screening & Testing, ILI, GLI or PCM.

NIDA Outreach Manual. To obtain copies, contact: The National Clearinghouse for Alcohol and Drug Information. PO Box 2345, Rockville, MD 20847 (1-800-729-6686) or visit <http://www.drugabuse.gov>.

Disseminating Effective Behavioral Interventions <http://www.effectiveinterventions.org>.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (1994). Planning and conducting street outreach process evaluation.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (Nov 2003). Draft CDC Technical Assistance Guidelines for CBO HIV Prevention Program Performance Indicators.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (Dec 2003). Draft CDC Procedural Guidance for Selected Strategies and Interventions. http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (1998). What we have learned from the AIDS evaluation of street outreach projects. (1-888-232-3228, press 2, 5, 1, and 1 as prompted and request “What we have learned” from AESOP).

U.S. Department of Health and Human Services, OPHS Office of Minority Health. (2001). National Standards for Culturally and Linguistically Appropriate Services in Health Care.

TARGET POPULATION: Men Who Have Sex With Men

PROGRAM MODEL: RETREATS

INTERVENTION GOALS: To reduce the frequency of unprotected anal intercourse and increase the use of condoms among MSM at risk for HIV and STD's; reduce the sense of isolation experienced by many MSM living in rural areas and achieve a sense of community; increase knowledge of sexual health and HIV/STDs; have social interaction with peers to increase social support; increase likelihood that participants will act on referrals provided. Individuals that have never attended a retreat will be given priority.

INTERVENTION TYPE: Group Level Intervention (GLI)

PROGRAM OVERVIEW: Weekend retreats for gay/bisexual men will encompass group level and individual level interventions on a variety of topics. Facilitators and presenters will educate participants about sexual health and HIV / STDs. Participants will learn the importance of developing a sense of community as a way to help educate their peers about taking personal responsibility for individual health. This intervention is based on various theories and prevention research such as: Diffusion of Innovation Theory, Sexual Health Model for HIV Prevention, Stages of Behavior Change.

CORE ELEMENTS are those components that are critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) HIV prevention transmission issues must encompass 50% of curriculum
- 2) Educate participants about HIV risk, transmission, prevention and ways to reduce other risks associated with HIV such as drug and alcohol use among gay and bisexual men.
- 3) Build skills on using condoms correctly and consistently.
- 4) Incorporate team building activities and free time as a way to increase social support.
- 5) Educate participants on various topics dealing with general health and wellness as it relates specifically to gay and bisexual men as a way to encompass HIV / STD prevention within a holistic model of health.
- 6) Include large group presentations, small group discussions, team building exercises, role-playing and skills building activities as integral aspects of the retreat so that participants experience a variety of learning styles.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Topics may include but are not limited to depression, sexuality, HIV/STD prevention, drug and alcohol use, homophobia, and self-esteem.
- Length of retreats may vary, although it is recommended that retreats take place over a weekend or weekday setting that is at least two days in length.
- Peer trained facilitators are encouraged.
- Held at facilities that allow for people with disabilities to participate.
- Advanced registration is required.
- Track completion of referrals to monitor effectiveness of referral strategy
- Recommended that retreats are drug, alcohol and sex free so that the focus is on the individual and the learning experiences within a safe setting that is conducive to personal growth.
- Engage participants about community health in an effort to shift community norms to ones that value health and personal responsibility, including responsibility for the health of the community.

EVALUATION AND MONITORING:

- Collect and report client-level data. (optional)
- Collect and report standardized process and outcome monitoring data consistent with CDC requirements
 - Process evaluation tools
 - Minutes of planning committee conference calls or meetings
 - Promotional materials and press clippings for the retreat
 - Aggregate demographic information for participants
 - Retreat evaluations by participants
 - Outcome monitoring tools
 - Pre and post test knowledge assessments
 - Health risk surveys
 - Retreat evaluations by participants
- Collect and report data on the percent of participants who report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with partners of known or unknown status.
- Use of the CDC developed Program Evaluation Monitoring System (PEMS) to report data electronically.
- Collect and report data consistent with CDC requirements to ensure data quality and security, and client confidentiality
- Collect and report data on the following indicators:
 - **H.1** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), group level interventions (GLI), and Prevention Case Management (PCM).

RESEARCH RESULTS:

- Participants showed that retreats were effective in helping men eroticize condom usage.

- Participants showed increase in positive sense of self and adoption of safer sex behaviors.
-

Sondag K. A., Carneiro R.B., Herrera D. (May 2003). *Community Level HIV Prevention Intervention: The Effects of Gay Men's Health Retreats*.

Sondag K. A., Dybdal L., Campbell R., Mulla N. (July 2002). Determining the HIV prevention needs of MSM in Montana. Paper presented at the State Planning Group, Helena, MT.

Rosser B. R. S. (2002, February). *Evaluation of HIV Prevention for Men Who Have Sex with Men in Thirteen States of the USA*. Paper presented at the State Planning Group, Helena, MT.

Rosser B. R. S., Coleman E., Ohmans P. (1993). Safer sex maintenance and reduction of unsafe sex among homosexually active men: a new therapeutic approach. *Health Education Research*, 8, 19-34.

Rosser B. R. S., Bockting W. O., Rugg D. L., Robinson B. E., Ross M. W., Bauer G. R., et al. (in press). A randomized controlled intervention trial of a sexual health approach to long-term HIV risk reduction for men who have sex with men: I. Effects of the intervention on unsafe sexual behavior.

TARGET POPULATION: Men Who Have Sex With Men

PROGRAM MODEL: based on MANY MEN, MANY VOICES
(Complete program details can be requested from DPHHS or visit
http://www.cdc.gov/hiv/partners/AHP/CBOPcedures_15Dec03_FinalDraft.pdf)

INTERVENTION GOALS: To reduce the frequency of unprotected anal intercourse and increase the use of condoms among MSM.

INTERVENTION TYPE: Group Level Intervention (GLI)

PROGRAM OVERVIEW: Many Men, Many Voices (3MV) is a six- or seven-session, group level STD/HIV prevention intervention for MSM. The intervention addresses behavioral influencing factors specific to gay men of color, including cultural/social norms, sexual relationship dynamics, and the social influences of racism and homophobia. These behavioral influencing factors can be modified to fit our local populations which may include the rural culture of our state.

3MV is designed to be facilitated by a peer in groups of 6-12 clients. The 2-3 hour sessions aim to foster positive self image; educate participants about their STD/HIV risks; and teach risk reduction and partner communication skills. The sessions are highly experiential, incorporating group exercises, behavioral skills practice, group discussions, and role play.

The intervention can also be adapted to 12 sessions of 75-90 minutes each or condensed into a weekend retreat, covering the 18-21 hours of intervention curriculum.

CORE ELEMENTS are those components that are the critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Educate clients about HIV risk and sensitize to personal risk.
- 2) Develop risk reduction strategies.
- 3) Train in behavioral skills.
- 4) Train in sexual assertiveness.
- 5) Provide social support and relapse prevention.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Foster positive identity development for MSM by exploring the rural culture , addressing social and cultural norms within ethnic communities, exploring positive and negative peer influences, setting self-standards and clarifying values
- Discuss sexual roles and risks, addressing knowledge of HIV transmission risk and exploring beliefs about those risks
- Address perceived personal risk and personal susceptibility for HIV infection as well as the perceived benefits and outcomes of remaining HIV negative
- Increase skills and self-efficacy for protective behaviors and intentions to engage in those behaviors
- Explore sexual relationship dynamics including power dynamics
- Address the importance of peer support and social influence on maintaining healthy behaviors

EVALUATION AND MONITORING:

- Collect and report client-level data. (optional)
- Collect and report standardized process and outcome monitoring data consistent with CDC requirements.
- Collect and report data on the percent of participants who report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with partners of known or unknown status.
- Use of the CDC developed Program Evaluation Monitoring System (PEMS) to report data electronically.
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:
 - **H.1** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), group level interventions (GLI), and Prevention Case Management (PCM).

RESEARCH RESULTS:

- Participants reduced their frequency of unprotected anal intercourse and increased their use of condoms significantly more than men who did not participate in the intervention.

Kelly JA, St. Lawrence JS, Hood HV, Brasfield TL. (1989). Behavioral intervention to reduce AIDS risk activities. *Journal of Consulting and Clinical Psychology*, 57(1), pp. 60-67.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (Dec 2003). Draft CDC Procedural Guidance for Selected Strategies and Interventions. http://www.cdc.gov/hiv/partners/AHP/CBOPcedures_15Dec03_FinalDraft.pdf

TARGET POPULATION: Men Who Have Sex With Men

PROGRAM MODEL: GAY MEN’S TASK FORCE (GMTF)

INTERVENTION GOALS: To build capacity among MSM peer leaders on (1) conducting HIV/STD prevention and outreach and (2) planning and evaluating effective interventions for MSM. The Task Force will also serve in an advisory capacity related to HIV prevention planning in the State of Montana.

INTERVENTION TYPE: Structural Intervention

PROGRAM OVERVIEW: The Montana Gay Men’s Task Force will be a statewide group of openly gay men (8-12 members) that will meet four times a year. The task force will advocate for HIV interventions targeted for MSM. Members will be leaders in their community and work closely with community based organizations and HIV prevention sites. Members will promote interventions and events planned by the GMTF in their own communities. Meetings will be held throughout the state to ensure adequate representation and facilitate participation of members in various regions.

CORE ELEMENTS are those components that are critical features of an intervention’s intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Quarterly meetings held at different communities throughout Montana.
- 2) Community leaders who represent MSM population from various regions of the state.
- 3) Review, develop and evaluate MSM interventions occurring in local communities and / or statewide.
- 4) Plan and assist in implementing statewide interventions for MSM.
- 5) Build capacity among members through trainings and learning opportunities about MSM risks for HIV / STDs and prevention strategies.
- 6) Administrative support to coordinate the meetings and facilitate communication among members.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Build social support among members through team building exercises and group meals.
- Members bring ethnic, socioeconomic, geographic, age, and HIV status diversity to the group.
- Members support and encourage each other and their peers about safer sex and

community health.

- Members are knowledgeable about HIV prevention, local MSM communities, MSM risks related to HIV / STDs, public health, and community services for MSM.
- Members promote statewide and local interventions for MSM.

EVALUATION AND MONITORING:

- Collect and report standardized process monitoring data consistent with CDC requirements.
 - Agendas and pre-meeting reading materials packet.
 - Meeting minutes.
 - Evaluations.
- Use of the CDC developed Program Evaluation Monitoring System (PEMS) to report data electronically.
- Collect and report data consistent with CDC's requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:
 - **G.1** Proportion of providers who have received at least one health department supported capacity building assistance episode, specifically in the form of trainings/workshops in the design, implementation or evaluation of science-based HIV prevention interventions.

RESEARCH RESULTS:

- The Montana GMTF has been active since December 1992 and continues to be one of the most important resources for planning and evaluating effective HIV interventions for MSM in Montana. GMTF members have proven to be effective leaders for HIV prevention and outreach in their own communities as well as statewide. Over the past several years, Gay Men's Task Forces have been developed in Washington, Georgia, California and other states.

Fishbone, M. (1997). Predicting, understanding, and changing socially relevant behaviors – lessons learned. In C. McGarty and A. Halam (Eds.), *The Message of School Psychology* (pp. 77-91). Oxford, England: Blackwell Publishers.

Williamson L. M., Hart G. J., Flowers P., Frankis J. S., Der G. J. (2001). The gay men's task force: the impact of peer education on the sexual health behavior of homosexual men in Glasgow. *Sexually Transmitted Infections*, 77, 427-432.

TARGET POPULATION: Men Who Have Sex With Men

PROGRAM MODEL: based on MPOWERMENT

(Complete program details can be requested from DPHHS or visit

http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf)

INTERVENTION GOALS: To reduce rates of unprotected anal intercourse among young gay/bisexual men.

INTERVENTION TYPE: Community Level Intervention (CLI)

PROGRAM OVERVIEW: The Mpowerment Project was developed by and for young MSM ages 18-29. The intervention is run by a core group of 10-15 young MSM from the community and paid staff. The young MSM, along with other volunteers, design and carry out all project activities. Ideally, the project has its own physical space where most social events and meetings are held and which serves as a drop-in center where young men can meet and socialize during specified hours. The program relies on a set of four integrated activities:

- **Formal Outreach:** Teams of young MSM go to locations frequented by young MSM to discuss and promote safer sex, deliver appealing informational literature on HIV risk reduction, and distribute condoms. Additionally, the team creates their own social events to attract young MSM to promote safer sex.
- **M-groups:** These peer-led, 2-3 hour meetings of 8-10 young MSM discuss factors contributing to unsafe sex among the men. Through skills-building exercises, the men practice safer sex negotiation and correct condom use skills. Participants receive free condoms and lubricant and are trained to conduct informal outreach.
- **Informal Outreach:** Informal outreach consists of young men discussing safer sex with their friends.
- **Ongoing Publicity Campaign:** The campaign attracts men to the project by word of mouth and through articles and advertisements in gay newspapers.

CORE ELEMENTS are those components that are the critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Maintain a Core Group of 12-20 young MSM to design and carry out project activities.
- 2) Recruit volunteers to assist in the delivery of services and to make important decisions about the program
- 3) Use project coordinators to oversee project activities
- 4) Establish a project space where many of the project activities can be held
- 5) Conduct formal outreach including educational activities and social events
- 6) Conduct informal outreach to influence behavior change
- 7) Convene peer-led, one-time discussion groups (M-groups)

8) Conduct a publicity campaign about the project within the community

Optional Element

1) Convene a community advisory board

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

Core group:

- Makes important decisions
- Bases decisions on the project's guiding principles
- Membership has racial/ethnic/socioeconomic diversity
- Membership may change over time as new men join and men who have been in Core Group leave
- Supports and encourages each other and other friends about safer sex
- Meetings are fun, social, productive, and scheduled regularly
- Engages in reflective analysis of all parts of the project, its own role in the project, and issues facing young MSM.

Volunteers:

- Represent diverse racial/ethnic/socioeconomic backgrounds
- Make important decisions
- Learn new skills and conduct meaningful/interesting work
- Support and encourage each other and other friends about safer sex
- Encounter a warm, appreciative, social, and welcoming atmosphere

Coordinators:

- Understand HIV prevention and community building
- Are knowledgeable about the local young MSM community
- Demonstrate leadership skills
- Oversee all Project activities
- Promote diverse racial/ethnic/socioeconomic involvement
- Support the Core Group and volunteers to develop and implement activities
- Begin the safer sex diffusion process
- Engage in reflective analysis of all parts of the project, their own role in the project, and issues facing young MSM

Project space:

- Is safe and comfortable
- Is in an accessible, and appealing location.

- Displays safer sex posters and literature are displayed.
- Makes condoms and lubricants available.
- Makes referral information available
- Rapid testing may be offered in this space if privacy and confidentiality is ensured.

Formal Outreach:

- Promotes safer sex, HIV antibody testing, HIV status disclosure
- Sponsors appealing events and engaging performances
- Helps build community
- Provides social opportunities
- Creates opportunities for positive peer influence
- Recruits for M-groups and other project activities
- Empowers project volunteers
- Are scheduled regularly

Informal Outreach:

- Diffuses a norm of safer sex and testing for HIV
- Uses peer influence to change behavior
- Is achieved through non-judgmental and supportive peer interactions
- Is reinforced through other project activities

M-groups:

- Facilitated by well-trained and skilled project staff and/or volunteers
- Address young MSM important issues
- Create social opportunities
- Teach safer sex education
- Teach and motivate informal outreach
- Teach sexual negotiation skills
- Encourage project involvement and volunteerism
- Are scheduled regularly

Publicity campaign

- Creates attractive informative materials
- Reminds young MSM of the importance of safer sex, encourages HIV testing, and seeking medical care if HIV positive.
- Reaches all young gay/bisexual men in the community
- Targets young MSM not the general community.

Community Advisory Board (optional element)

- Includes 5 – 10 individuals, who are typically older than 30, who are knowledgeable about target population, public health in state and community, prior HIV prevention efforts, or other community institutions that reach target population
- Serves as a resource to Core Group
- Does not have day-to-day decision-making power

EVALUATION AND MONITORING:

- Collect and report client-level data. (optional)
- Collect and report standardized process and outcome monitoring data consistent with CDC requirements.
- Collect and report data on the percent of participants who report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with partners of known or unknown status.
- Use of CDC developed Program Monitoring Evaluation System (PEMS) to report data electronically.
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:
 - **H.1** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), groups level interventions (GLI), and Prevention Case Management (PCM).

Project may also want to evaluate and monitor intervention activities using process evaluation methods developed specifically for the intervention:

- These include process evaluation methods designed specifically for M-groups, Formal outreach, Core Group, and publicity.
- These process evaluation forms are designed to be used by the Coordinators and Core Group for reflecting upon success of the project and for redesigning groups and publicity over time

RESEARCH RESULTS:

- Participants significantly decreased their rates of unprotected anal intercourse.
-

Hays, RB, Kegeles, SM, Rebchook, GM. The Mpowerment Project: community-building with young gay and bisexual men to prevent HIV. *American Journal of Community Psychology*, 2003; 31, 301-312.

Kegeles SM, Hays RB, Coates T.J. (1996). The Mpowerment Project: A community-level HIV prevention intervention for young gay men. *American Journal of Public Health*, 86(8), 1129-1136.

Kegeles SM, Hays RB, Pollack LM, Coates T.J. (1999). Mobilizing young gay/bisexual men for HIV prevention: A two-community study, *AIDS*, 13(13), 1753-1762.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (Dec 2003). Draft CDC Procedural Guidance for Selected Strategies and Interventions. http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf

Injecting Drug Users (IDU): Individuals who inject drugs and share the equipment with others.

IDU PREVENTION OBJECTIVES: Reduce drug use behaviors that increase the risk of transmission of disease.

- Develop and/or maintain IDU outreach to actively using individuals to provide risk reduction information on using sterile equipment, not sharing, cleaning works, and safer sexual activity.
- Train professionals who deal with IDUs to conduct HIV prevention services.
- Increase condom use.
- Decrease use of shared injection equipment.
- Increase sense of self-esteem.
- Decrease sense of isolation.
- Increase number of IDU that know their HIV and Hepatitis C status.
- Decrease number of IDU reporting unprotected sex and/or sharing injection equipment.
- Provide peer outreach, individualized risk reduction education, and access to risk reduction materials in settings convenient to individuals who exchange sex for money, drugs, materials, and shelter; such as homeless shelters, rooming houses, halfway houses, street areas, and other areas.
- Provide general support for safe behaviors, dispel myths about transmission, and support efforts for personal risk reduction.

TARGET POPULATION: Injecting Drug Users

PROGRAM MODEL: RAPID/ORAL FLUID TESTING IN NON-CLINICAL SETTINGS

(Complete program details can be requested from DPHHS or visit

http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf)

INTERVENTION GOALS: To increase knowledge of serostatus among target population.

INTERVENTION TYPE: Counseling, Testing, and Referral Services (CTR)

PROGRAM OVERVIEW: Testing programs in non-clinical venues are more likely to reach members of some racial and ethnic minorities and persons at increased risk for HIV.

CORE ELEMENTS are those components that are the critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Assess the community to determine
 - a. in which populations HIV is likely to be under-diagnosed (because risk is underestimated, and/or because traditional counseling, testing, and referral services are not used)
 - b. where persons at risk and/or underdiagnosed can be reached.
- 2) The agency must have a written agreement with the state Health Department and/or a laboratory to ensure compliance with the Clinical Laboratory Improvement Amendments (CLIA) (for rapid testing) and state and local regulations and policies.
- 3) A clear supervisory structure should be delineated to ensure responsibility for training and guidance, oversight for testing procedures, and coordination.
- 4) Train or ensure training of non-clinical providers to perform rapid/oral fluid HIV testing including the following essential elements:
 - a. Perform the test, including procedures performed before, during, and after testing
 - b. Integrate rapid/oral fluid testing into the overall counseling and testing program
 - c. Develop and implement a quality assurance (QA) program
 - d. Collect and transport specimens for confirmatory testing
 - e. Ensure specimen integrity
 - f. Document and deliver confirmatory testing results to persons whose rapid test results had been preliminary positive
 - g. Comply with universal and biohazard safety precautions
 - h. Ensure confidentiality and data security
 - i. Ensure compliance with relevant state or local regulations
- 5) In conjunction with the state policy or local health department and community mental health providers, establish or utilize existing guidelines and define sobriety standards for counselors to use to determine when clients are not competent to provide consent.

- 6) Confirmatory testing of preliminary positive tests must be assured for rapid testing.
- 7) Clients with a confirmed HIV-positive diagnosis must be provided with or referred for medical evaluation, partner counseling and referral services, and other appropriate prevention services.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Arrange appropriate referral agreements (for medical and social services) and develop strategies for follow-up.
- Define process for confirmatory testing to occur with Health Department including:
 - Obtain detailed locating information on clients whose test results are preliminary positive so that they can be contacted and encouraged to come in for care if they fail to return for their follow-up appointment. The Health Department and the testing program should specify who is responsible for follow-up if clients fail to return for confirmatory test results.
- Assemble the testing supplies for easy storage and transportation to each testing site. Individually packaged rapid test kits include all the supplies and materials necessary to facilitate single client testing in non-clinical settings.

EVALUATION AND MONITORING:

- Collect and report client level data.
- Collect and report standardized process and outcome data consistent with CDC’s Requirements.
- Use the CDC developed PEMS (Program Evaluation Monitoring System) to report data electronically.
- Collect and report data consistent with CDC’s requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:
 - **B.1** Percent of newly identified, confirmed HIV-positive test results among all tests reported by HIV counseling, testing, and referral sites.
 - **B.2** Percent of newly identified, confirmed HIV-positive test results returned to clients.

Greby S, Frey B, Royalty J, et al. Use of simple oral fluid HIV-tests in CDC-funded facilities. In: Program and abstracts of the XIV International Conference on AIDS; July 2002; Barcelona, Spain. Abstract TuPeD4991.

Rasmussen H, Chen M, Myrick R, Truax S. An evaluation of California’s neighborhood interventions geared to high-risk testing (NIGHT) outreach program. In: Program and abstracts of the XIV International Conference on AIDS; July 2002; Barcelona, Spain. Abstract ThOrD1401.

DiFrancesco W, Holtgrave DR, Hoxie N, et al. HIV seropositivity rates in outreach-based counseling and testing services: program evaluation. *J Acquir Immune Defic Syndr* 1998;19:282-288.

Dean HD, Gates CH. Conducting HIV counseling, testing and referral within the context of rapid assessment, response and evaluation in crisis response team cities. In: Program and abstracts of the XIV International Conference on AIDS; July 2002; Barcelona, Spain. Abstract MoPeF3980.

Sy FS, Rhodes SD, Choi ST, et al. The acceptability of oral fluid testing for HIV antibodies: a pilot study in gay bars in a predominantly rural state. *Sex Transm Dis* 1998; 25:211-215.

Valleroy LA, MacKellar DA, Karon JM, et al. HIV prevalence and associated risks in young men who have sex with men. *JAMA* 2000; 284:198-204.

Keenan PA, Keenan JM. Rapid HIV testing in urban outreach: a strategy for improving posttest counseling rates. *AIDS Educ Prev* 2001;13:541-550.

Molitor F, Bell RA, Truax SR, et al. Predictors of failure to return for HIV test result and counseling by test site type. *AIDS Educ Prev* 1999;11:1-13.

Spielberg F, Branson BM, Goldbaum GM, et al. Overcoming barriers to HIV testing: preferences for new strategies among clients of a needle exchange, a sexually transmitted disease clinic, and sex venues for men who have sex with men. *J Acquir Immune Defic Syndr* 2003; 32:318-328.

CDC Model Performance Evaluation Program for Rapid HIV Testing:
<http://www.phppo.cdc/mpep/enrollment.asp>

CDC Revised Guidelines for HIV Counseling, Testing, and Referral.
<http://www.cdc.gov/mmwr/PDF/rr/rr5019.pdf>

CDC Technical Assistance Guidelines for CDC's HIV Prevention Program Performance Indicators. <http://www.cdc.gov/hiv/dhap>

CLIA application and requirements: www.cms.hhs.gov/clia

NASTAD Primer on implementing rapid HIV testing:
<http://www.nastad.org/PDF/RAPIDPRIMER.PDF>

Occupational Safety and Health Administration: www.osha.gov

Product information, OraQuick Rapid HIV-1 Antibody Test: <http://www.orasure.com/products/>

Quality Assurance Guidelines for Testing Using the OraQuick Rapid HIV-1 Antibody Test:
http://www.cdc.gov/hiv/rapid_testing/materials/QA_Guidelines_OraQuick.pdf

Rapid HIV Testing: www.cdc.gov/hiv/rapid_testing

U.S. Department of Health and Human Services, OPHS Office of Minority Health. (2001). National Standards for Culturally and Linguistically Appropriate Services in Health Care.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (Dec 2003). Draft CDC Procedural Guidance for Selected Strategies and Interventions. http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf

TARGET POPULATION: Injecting Drug Users

PROGRAM MODEL: TAKING IT TO THE POPULATION

For more information: Casey Rudd 556-1139 or Vicki Peterson 275-4913

INTERVENTION GOALS: To promote factors that support safer injection behaviors between IDU's and ultimately reduce the risk for HIV.

INTERVENTION TYPE: Group Level Intervention (GLI)

PROGRAM OVERVIEW: The intervention is based on the Informational-Motivational-Behavioral-Skills Model (IMB). Taking it to the Population focuses on HIV risk behavior reduction, which incorporates 1) information regarding the prevention of HIV 2) strategies designed to enhance motivation to engage in HIV preventative behaviors 3) and the skills needed to practice HIV preventative behaviors. The likelihood that IDUs will initiate and maintain patterns of HIV preventative behavior depends on the extent to which they are well informed, motivated to act, and possess the behavioral skills to act effectively.

CORE ELEMENTS are those components that are the critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) One-hour HIV educational outreach program
- 2) Intervention will be conducted by an indigenous outreach worker (preferable) or a qualified service provider who's characteristics include:
 - a. the ability to relate to active drug users on their own terms
 - b. the skill to communicate genuine concern and respect for IDUs and their risks
 - c. the capacity to be an advocate for those at risk by relaying as much information as possible
 - d. the capability to develop a trusting relationship with IDUs
 - e. possess adequate knowledge of effective ways to reduce the chance of infection and transmission
 - f. ability to successfully network with groups of individuals at risk
 - g. ability to recognize and maintain appropriate personal boundaries
- 3) Information regarding HIV transmission and prevention, and counseling, testing and referral sources.
- 4) The Taking to the System intervention needs to be implemented prior to or simultaneously with this intervention for optimal effectiveness.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- A participatory opening activity that emphasizes the value and self-worth of the individuals in the audience.
- A personal narrative told by the facilitator that relates his/her personal struggles with addiction and injection drug use, and his/her success of overcoming his/her addiction and staying clean, to the individuals in the audience.
- Information regarding support services and resources for the audience once they are released from the treatment centers.
- A personal story told by the facilitator designed to stress the importance of social support and to increase the audiences desire to ask for support with their problems from their social community.
- A verbal quiz of the audience designed to test their knowledge of HIV and transmission, prevention strategies, harm reduction, and their feelings of self worth.
- A final story told by the facilitator regarding the principles he/she lives by to maintain his/her drug free life, accompanied by a request for the audience to read the principles, from a handout out-loud with his/her.

EVALUATION AND MONITORING:

- Collect and report client-level data. (optional)
- Collect and report standardized process and outcome monitoring data consistent with CDC requirements.
- Use of the CDC developed PEMS (Program Evaluation Monitoring System) to report data electronically.
- Collect and report data consistent with CDC's requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:
 - **H.1** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), groups level interventions (GLI), and Prevention Case Management (PCM).

The National Institutes on Drug Abuse (NIDA) Community-Based Outreach Model: A Manual To Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users
<http://www.nida.nih.gov/>

Substance Abuse and Mental Health Services Administration (SAMSHA)
Website: <http://www.samhsa.gov>

Center for Substance Abuse Treatment (CSAT) <http://www.treatment.org/Externals/tips.html>

Centers for Disease Control & Prevention Division of HIV/AIDS Prevention, New Attitudes & Strategies: A comprehensive approach to preventing blood-borne infections among IDUs.
www.healthstrategies.org/Publications/publications.html

TARGET POPULATION: Injecting Drug Users

PROGRAM MODEL: OUTREACH based on Recruitment model from CDC
(Complete program details can be requested from DPHHS or visit
http://www.cdc.gov/hiv/partners/AHP/CBOPcedures_15Dec03_FinalDraft.pdf)

INTERVENTION GOALS: To reach at risk IDU populations to help them take advantage of HIV prevention intervention, programs, and services.

INTERVENTION TYPE: Outreach

PROGRAM OVERVIEW: Outreach is a common means of meeting potential high-risk clients in their own environment to deliver HIV prevention messages and services and to bring them into additional prevention services. These activities may take place in specific venues where high-risk individuals congregate and/or in places where high risk behaviors take place or can be conducted at virtual sites including the Internet or telephone hotlines. Finally, outreach can take place as the result of contacts established through the use of social networking techniques that demonstrate connections between high-risk persons. Agencies can work with current clients to reach partners or friends who may also be at high risk.

Within- and between-agency referrals are other common ways for organizations to bring clients to services. Often an agency will use its existing programs or interventions to refer clients to other services within the agency. A benefit of this strategy is that it takes advantage of the trust that is already developed by clients who have previously been engaged with an agency. When a referral is made to another service within that agency, the client may be more likely to accept and access the referral.

CORE ELEMENTS are those components that are critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Use of information from multiple sources to describe common characteristics of the target population, which can be used for targeting outreach activities.
- 2) Develop and deliver appropriate health messages for the setting (either to be delivered by an outreach worker or by a referral source).
- 3) Recruit for specific services (e.g., counseling, testing, and referral services, PCM, other prevention interventions). Outreach must be linked to counseling, testing, and referral services for clients of unknown status, and to care and prevention services for people living with HIV (PLWH).
- 4) Track completion of referral to monitor the effectiveness of the referral strategy.
- 5) Revise strategies or venues, as appropriate.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

On-site Outreach

- Develop criteria that will trigger a referral from providers of other services within the agency.
- Providers of services within the organization should assess all consumers to determine appropriateness for prevention services delivered within the organization and make appropriate referrals to those services.
- Develop targeted and appropriate messages to be delivered by individual members of an agency or by mass messaging strategies (e.g., on posters hung throughout the agency).

Off-site Peer Outreach

- Go to venues where potential clients congregate if possible, and at the times when they are present.
- Conduct outreach in teams to improve the safety of outreach workers.
- Screen clients to determine their needs for specific prevention services (e.g., counseling, testing, and referral (CTR); prevention case management (PCM); or other prevention interventions).
- Develop and deliver tailored and appropriate health and prevention promotion messages.
- Provide tailored and appropriate materials that describe programs and services to potential clients.
- When possible, use peers as outreach workers.

Outreach through Referral Networks

- Establish linkages with those service providers that members of the target population are most likely to access and provide training to these providers related to prevention services.
- Develop formal agreements with appropriate service providers for ongoing screening and bidirectional referrals.
- Provide tailored and appropriate materials to referral agents that advertise programs and services.
- Provide tailored and appropriate materials that describe programs and services to potential clients.

EVALUATION AND MONITORING:

- Collect and report client-level data. (optional)
- Collect and report standardized process and outcome monitoring data consistent with CDC requirements.
- Use of the CDC developed PEMS (Program Evaluation Monitoring System) to report data electronically.

- Collect and report data consistent with CDC’s requirements to ensure data quality and security and client confidentiality.
 - Collect and report data on the following indicators:
 - **H.3** The mean number of outreach contacts required to get one person to access any of the following services: Counseling & Testing, Sexually Transmitted Disease Screening & Testing, ILI, GLI or PCM.
-

NIDA Outreach Manual. To obtain copies, contact: The National Clearinghouse for Alcohol and Drug Information, PO Box 2345, Rockville, MD 20847 (1-800-729-6686) or visit <http://www.drugabuse.gov>.

Disseminating Effective Behavioral Interventions <http://www.effectiveinterventions.org>.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (1994). Planning and conducting street outreach process evaluation.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (Nov 2003). Draft CDC Technical Assistance Guidelines for CBO HIV Prevention Program Performance Indicators.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (Dec 2003). Draft CDC Procedural Guidance for Selected Strategies and Interventions. http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (1998). What we have learned from the AIDS evaluation of street outreach projects. (1-888-232-3228, press 2, 5, 1, and 1 as prompted and request “What we have learned” from AESOP).

U.S. Department of Health and Human Services, OPHS Office of Minority Health. (2001). National Standards for Culturally and Linguistically Appropriate Services in Health Care.

TARGET POPULATION: Injecting Drug Users

PROGRAM MODEL: Harm Reduction Task Force

INTERVENTION GOALS: To build capacity among IDU community members, representatives and/or service providers on (1) conducting HIV/STD prevention and outreach and (2) planning and evaluating effective interventions for IDU. The Task Force will also serve in an advisory capacity related to HIV prevention planning in the State of Montana.

INTERVENTION TYPE: Structural Intervention

PROGRAM OVERVIEW: The Montana Harm Reduction Task Force will be a statewide group of IDU community members, representatives or service providers, and will meet four times a year. The task force will advocate for HIV interventions targeted for IDU. Members will be leaders in their community and work closely with community based organizations and HIV prevention sites. Members will promote interventions and events planned by the HRTF in their own communities. Meetings will be held throughout the state to ensure adequate representation and facilitate participation of members in various regions.

CORE ELEMENTS are those components that are critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Quarterly meetings held at different communities throughout Montana.
- 2) Community leaders who represent IDU population from various regions of the state.
- 3) Review, develop and evaluate IDU interventions occurring in local communities and / or statewide.
- 4) Plan and assist in implementing statewide interventions for IDU.
- 5) Build capacity among members through trainings and learning opportunities about IDU risks for HIV / STDs and prevention strategies.
- 6) Administrative support to coordinate the meetings and facilitate communication among members.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Build social support among members through team building exercises and group meals.
- Members bring ethnic, socioeconomic, geographic, age, and HIV status diversity to the

group.

- Members support and encourage each other and their peers about safer injecting behaviors, safer sex and community health.
- Members are knowledgeable about HIV prevention, local IDU communities, IDU risks related to HIV / STDs, public health, and community services for IDU.
- Members promote statewide and local interventions for IDU by participating at State programs/meetings.

EVALUATION AND MONITORING:

- Collect and report standardized process monitoring data consistent with CDC requirements.
 - Agendas and pre-meeting reading materials packet.
 - Meeting minutes.
 - Evaluations.
- Use of the CDC developed Program Evaluation Monitoring System (PEMS) to report data electronically.
- Collect and report data consistent with CDC's requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:
 - **G.1** Proportion of providers who have received at least one health department supported capacity building assistance episode, specifically in the form of trainings/workshops in the design, implementation or evaluation of science-based HIV prevention interventions.

RESEARCH RESULTS:

- The Montana Gay Men's Task Force has been active since December 1992 and continues to be one of the most important resources for planning and evaluating effective HIV interventions for MSM in Montana. Based upon this existing model, the Montana Harm Reduction Task Force for the IDU population will be developed. GMTF members have proven to be effective leaders for HIV prevention and outreach in their own communities as well as statewide. Over the past several years, Gay Men's Task Forces have been developed in Washington, Georgia, California and other states.

Fishbone, M. (1997). Predicting, understanding, and changing socially relevant behaviors – lessons learned. In C. McGarty and A. Halam (Eds.), *The Message of School Psychology* (pp. 77-91). Oxford, England: Blackwell Publishers.

Williamson L. M., Hart G. J., Flowers P., Frankis J. S., Der G. J. (2001). The gay men's task force: the impact of peer education on the sexual health behavior of homosexual men in Glasgow. *Sexually Transmitted Infections*, 77, 427-432.

TARGET POPULATION: Injecting Drug Users

PROGRAM MODEL: TAKING IT TO THE SYSTEM

For more information: Casey Rudd 556-1139 or Vicki Peterson 275-4913

INTERVENTION GOALS: To focus attention on ways in which program managers and staff, policy makers, HIV prevention community planners, and others in the public health community, throughout the state, can more effectively reach and influence IDUs and intensify efforts to develop and carry out prevention strategies directed to IDUs, their sex partners and children.

INTERVENTION TYPE: Group level (GLI) and capacity building

PROGRAM OVERVIEW: The project was designed to share the principles and strategies outlined in the “New Attitudes and Strategies” booklet developed by AED for CDC, specifically for IDU HIV prevention, with agencies throughout the state, who may come in contact with IDUs, their sex partners and children. This is done by offering presentations/in-house trainings by letter, to social service agencies, health care providers and chemical dependency treatment centers throughout the state.

CORE ELEMENTS are those components that are the critical features of an intervention’s intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Bring information to individual locations is most efficient. This allows for each agency to schedule presentations when it is convenient for their staff.
- 2) Agencies that meet basic needs of IDU, their sex partners and children are targeted first.
- 3) Work collaboratively with local Health Department.
- 4) To educate service providers about risk assessment and the importance of referring IDU clients to HIV counseling, testing and referral sources.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Maintain contact with service providers who received training
 - Provide updated information on IDU population and relevant issues

EVALUATION AND MONITORING:

- Collect and report standardized process and outcome monitoring data consistent with CDC requirements
 - Use of the CDC developed Program Evaluation Monitoring System (PEMS) to report data electronically.
 - Collect and report data consistent with CDC requirements to ensure data quality and security, and client confidentiality.
 - Collect and report data on the following indicators:
 - **G.1** Proportion of providers who have received at least one health department supported capacity building assistance episode, specifically in the form of trainings/workshops in the design, implementation or evaluation of science-based HIV prevention interventions.
-

The National Institutes on Drug Abuse (NIDA) Community-Based Outreach Model: A Manual To Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users
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Substance Abuse and Mental Health Services Administration (SAMSHA)

Website: <http://www.samhsa.gov>

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Centers for Disease Control & Prevention Division of HIV/AIDS Prevention, New Attitudes & Strategies: A comprehensive approach to preventing blood-borne infections among IDUs.
www.healthstrategies.org/Publications/publications.html

High Risk Heterosexual (HRH): Individuals who participate in unprotected oral, vaginal, and anal sex in high-risk situations. These include, but are not limited to, adult females with sexually transmitted diseases (STD); adult females who have sex with MSMs; females who are sex workers (exchange sex for resources, survival or drugs); male and female substance abusers; male and female sexual partners of IDUs; or youth* in high-risk situations.

* CDC Definition: “Youth in high-risk situations are aged 10-24. These youth include, but are not limited to, youth who have run away or are homeless; are not in school and are unemployed; seek treatment for substance abuse, especially for injecting drugs and using crack cocaine; are juvenile offenders; are medically indigent; require mental health services; are in foster homes; are migrants; are gay and lesbians; have had sexually transmitted diseases, especially genital ulcer disease; have been psychologically, physically, or sexually abused; are pregnant; seek counseling and testing for HIV infection; exhibit signs or symptoms of AIDS or HIV infection without alternative diagnosis; barter or sell sex; are in alternative or continuation schools; are in gangs.” Montana also considers youth engaging in unprotected sex with multiple partners in this priority population.

HRH PREVENTION OBJECTIVES:

- Decrease in transmission of HIV, STDs, and HCV.
- Increase condom use.
- Increase sense of self-esteem,
- Increase knowledge, understanding of HIV transmission and prevention.
- Increase number of individuals who know their HIV status.
- Enhance harm reduction behaviors among women that lead to a reduction in the transmission of HIV, STDs, and HCV.
- Continue to provide HIV prevention training to health care professionals and community caregivers.
- Provide general support for safe behaviors, dispel myths about transmission, and support efforts for personal risk reduction.
- Inform people at risk for HIV infection of how to obtain prevention, care, and treatment services including CTR and STD screening and treatment.
- Routinely provide programs that address risk assessment, risk reduction information and building decision-making and sexual negotiation skills in settings serving high-risk youth, including youth correctional programs.
- Support education about, and access to, condoms for sexually active youth.
- Support peer education activities in settings that target high-risk youth to provide risk reduction education and opportunities for skills building for young people

TARGET POPULATION: High Risk Heterosexuals

PROGRAM MODEL: RAPID/ORAL FLUID TESTING IN NON-CLINICAL SETTINGS

(Complete program details can be requested from DPHHS or visit

http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf)

INTERVENTION GOALS: To increase knowledge of serostatus among target population.

INTERVENTION TYPE: Counseling, Testing and Referral Services (CTR)

PROGRAM OVERVIEW: Testing programs in non-clinical venues are more likely to reach members of some racial and ethnic minorities and persons at increased risk for HIV.

CORE ELEMENTS are those components that are the critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Assess the community to determine
 - a. in which populations HIV is likely to be under-diagnosed (because risk is underestimated, and/or because traditional counseling, testing, and referral services are not used)
 - b. where persons at risk and/or underdiagnosed can be reached.
- 2) The agency must have a written agreement with the state Health Department and/or a laboratory to ensure compliance with the Clinical Laboratory Improvement Amendments (CLIA) (for rapid testing) and state and local regulations and policies.
- 3) A clear supervisory structure should be delineated to ensure responsibility for training and guidance, oversight for testing procedures, and coordination.
- 4) Train or ensure training of non-clinical providers to perform rapid/oral fluid HIV testing including the following essential elements:
 - a. Perform the test, including procedures performed before, during, and after testing
 - b. Integrate rapid/oral fluid testing into the overall counseling and testing program
 - c. Develop and implement a quality assurance (QA) program
 - d. Collect and transport specimens for confirmatory testing
 - e. Ensure specimen integrity
 - f. Document and deliver confirmatory testing results to persons whose rapid test results had been preliminary positive
 - g. Comply with universal and biohazard safety precautions
 - h. Ensure confidentiality and data security
 - i. Ensure compliance with relevant state or local regulations
- 5) In conjunction with the state policy or local health department and community mental health providers, establish or utilize existing guidelines and define sobriety standards for counselors to use to determine when clients are not competent to provide consent.

- 6) Confirmatory testing of preliminary positive tests must be assured for rapid testing.
- 7) Clients with a confirmed HIV-positive diagnosis must be provided with or referred for medical evaluation, partner counseling and referral services, and other appropriate prevention services.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Arrange appropriate referral agreements (for medical and social services) and develop strategies for follow-up.
- Define process for confirmatory testing to occur with Health Department including:
 - Obtain detailed locating information on clients whose test results are preliminary positive so that they can be contacted and encouraged to come in for care if they fail to return for their follow-up appointment. The Health Department and the testing program should specify who is responsible for follow-up if clients fail to return for confirmatory test results.
- Assemble the testing supplies for easy storage and transportation to each testing site. Individually packaged rapid test kits include all the supplies and materials necessary to facilitate single client testing in non-clinical settings.

EVALUATION AND MONITORING:

- Collect and report client level data.
- Collect and report standardized process and outcome data consistent with CDC’s Requirements.
- Use the CDC developed PEMS (Program Evaluation Monitoring System) to report data electronically.
- Collect and report data consistent with CDC’s requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:
 - **B.1** Percent of newly identified, confirmed HIV-positive test results among all tests reported by HIV counseling, testing, and referral sites.
 - **B.2** Percent of newly identified, confirmed HIV-positive test results returned to clients.

Greby S, Frey B, Royalty J, et al. Use of simple oral fluid HIV-tests in CDC-funded facilities. In: Program and abstracts of the XIV International Conference on AIDS; July 2002; Barcelona, Spain. Abstract TuPeD4991.

Rasmussen H, Chen M, Myrick R, Truax S. An evaluation of California’s neighborhood interventions geared to high-risk testing (NIGHT) outreach program. In: Program and abstracts of the XIV International Conference on AIDS; July 2002; Barcelona, Spain. Abstract ThOrD1401.

DiFrancesco W, Holtgrave DR, Hoxie N, et al. HIV seropositivity rates in outreach-based counseling and testing services: program evaluation. *J Acquir Immune Defic Syndr* 1998;19:282-288.

Dean HD, Gates CH. Conducting HIV counseling, testing and referral within the context of rapid assessment, response and evaluation in crisis response team cities. In: Program and abstracts of the XIV International Conference on AIDS; July 2002; Barcelona, Spain. Abstract MoPeF3980.

Sy FS, Rhodes SD, Choi ST, et al. The acceptability of oral fluid testing for HIV antibodies: a pilot study in gay bars in a predominantly rural state. *Sex Transm Dis* 1998; 25:211-215.

Valleroy LA, MacKellar DA, Karon JM, et al. HIV prevalence and associated risks in young men who have sex with men. *JAMA* 2000; 284:198-204.

Keenan PA, Keenan JM. Rapid HIV testing in urban outreach: a strategy for improving posttest counseling rates. *AIDS Educ Prev* 2001;13:541-550.

Molitor F, Bell RA, Truax SR, et al. Predictors of failure to return for HIV test result and counseling by test site type. *AIDS Educ Prev* 1999;11:1-13.

Spielberg F, Branson BM, Goldbaum GM, et al. Overcoming barriers to HIV testing: preferences for new strategies among clients of a needle exchange, a sexually transmitted disease clinic, and sex venues for men who have sex with men. *J Acquir Immune Defic Syndr* 2003; 32:318-328.

CDC Model Performance Evaluation Program for Rapid HIV Testing:
<http://www.phppo.cdc/mpep/enrollment.asp>

CDC Revised Guidelines for HIV Counseling, Testing, and Referral.
<http://www.cdc.gov/mmwr/PDF/rr/rr5019.pdf>

CDC Technical Assistance Guidelines for CDC's HIV Prevention Program Performance Indicators. <http://www.cdc.gov/hiv/dhap>

CLIA application and requirements: www.cms.hhs.gov/clia

NASTAD Primer on implementing rapid HIV testing:
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Product information, OraQuick Rapid HIV-1 Antibody Test: <http://www.orasure.com/products/>

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Rapid HIV Testing: www.cdc.gov/hiv/rapid_testing

U.S. Department of Health and Human Services, OPHS Office of Minority Health. (2001). National Standards for Culturally and Linguistically Appropriate Services in Health Care.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (Dec 2003). Draft CDC Procedural Guidance for Selected Strategies and Interventions. http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf

TARGET POPULATION: High Risk Heterosexuals

PROGRAM MODEL: OUTREACH based on Recruitment model from CDC
(Complete program details can be requested from DPHHS or visit
http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf)

INTERVENTION GOALS: To reach HRH populations to help them take advantage of HIV prevention intervention, programs, and services.

INTERVENTION TYPE: Outreach

PROGRAM OVERVIEW: Outreach is a common means of meeting potential high-risk clients in their own environment to deliver HIV prevention messages and services and to bring them into additional prevention services. These activities may take place in specific venues where high-risk individuals congregate and/or in places where high risk behaviors take place or can be conducted at virtual sites including the Internet or telephone hotlines. Finally, outreach can take place as the result of contacts established through the use of social networking techniques that demonstrate connections between high-risk persons. Agencies can work with current clients to reach partners or friends who may also be at high risk.

Within- and between-agency referrals are other common ways for organizations to bring clients to services. Often an agency will use its existing programs or interventions to refer clients to other services within the agency. A benefit of this strategy is that it takes advantage of the trust that is already developed by clients who have previously been engaged with an agency. When a referral is made to another service within that agency, the client may be more likely to accept and access the referral.

CORE ELEMENTS are those components that are the critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Use of information from multiple sources to describe common characteristics of the target population, which can be used for targeting outreach activities.
- 2) Develop and deliver appropriate health messages for the setting (either to be delivered by an outreach worker or by a referral source).
- 3) Recruit for specific services (e.g., counseling, testing, and referral services, PCM, other prevention interventions). Outreach must be linked to counseling, testing, and referral services for clients of unknown status, and to care and prevention services for people living with HIV (PLWH).
- 4) Track completion of referral to monitor the effectiveness of the referral strategy.
- 5) Revise strategies or venues, as appropriate.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an

intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

On-site Outreach

- Develop criteria that will trigger a referral from providers of other services within the agency.
- Providers of services within the organization should assess all consumers to determine appropriateness for prevention services delivered within the organization and make appropriate referrals to those services.
- Develop targeted and appropriate messages to be delivered by individual members of an agency or by mass messaging strategies (e.g., on posters hung throughout the agency).

Off-site Peer Outreach

- Go to venues where potential clients congregate at the times when they are present.
- Conduct outreach in teams to improve the safety of outreach workers.
- Screen clients to determine their needs for specific prevention services (e.g., counseling, testing, and referral (CTR); prevention case management (PCM); or other prevention interventions).
- Develop and deliver tailored and appropriate health and prevention promotion messages.
- Provide tailored and appropriate materials that describe programs and services to potential clients.
- When possible, use peers as outreach workers.

Outreach through Referral Networks

- Establish linkages with those service providers that members of the target population are most likely to access and provide training to these providers related to prevention services.
- Develop formal agreements with appropriate service providers for ongoing screening and bidirectional referrals.
- Provide tailored and appropriate materials to referral agents that advertise programs and services.
- Provide tailored and appropriate materials that describe programs and services to potential clients.

EVALUATION AND MONITORING:

- Collect and report client-level data. (optional)
- Collect and report standardized process and outcome monitoring data consistent with CDC requirements.
- Use of the CDC developed PEMS (Program Evaluation Monitoring System) to report data electronically.
- Collect and report data consistent with CDC's requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:

- **H.3** The mean number of outreach contacts required to get one person to access any of the following services: Counseling & Testing, Sexually Transmitted Disease Screening & Testing, ILI, GLI or PCM.
-

NIDA Outreach Manual. To obtain copies, contact: The National Clearinghouse for Alcohol and Drug Information. PO Box 2345, Rockville, MD 20847 (1-800-729-6686) or visit <http://www.drugabuse.gov>.

Disseminating Effective Behavioral Interventions <http://www.effectiveinterventions.org>.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (1994). Planning and conducting street outreach process evaluation.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (Nov 2003). Draft CDC Technical Assistance Guidelines for CBO HIV Prevention Program Performance Indicators.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (Dec 2003). Draft CDC Procedural Guidance for Selected Strategies and Interventions. http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (1998). What we have learned from the AIDS evaluation of street outreach projects. (1-888-232-3228, press 2, 5, 1, and 1 as prompted and request “What we have learned” from AESOP).

U.S. Department of Health and Human Services, OPHS Office of Minority Health. (2001). National Standards for Culturally and Linguistically Appropriate Services in Health Care.

TARGET POPULATION: High Risk Heterosexuals

PROGRAM MODEL: based on SISTA

(Complete program details can be requested from DPHHS or visit

http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf)

INTERVENTION GOALS: To increase consistent condom use, sexual behavior self-control, sexual communication, and sexual assertiveness skills.

INTERVENTION TYPE: Group Level Intervention (GLI)

PROGRAM OVERVIEW: The SISTA project is a social skills training intervention for women at risk aimed at reducing HIV sexual risk behavior. It is comprised of five two-hour sessions delivered by peer facilitators in a community –based setting. The sessions are gender- and culturally-relevant and include behavioral skills practice, group discussions, lectures, role play, a prevention video, and take-home exercises.

CORE ELEMENTS are those components that are critical features of an intervention’s intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Small group sessions to discuss the session objectives, address the challenges and joys of being a woman, model skills development and role play women’s skills acquisition.
- 2) Use of a skilled facilitator to implement the group sessions because the success of the SISTA Program depends on the skill of the facilitator.
- 3) Use of cultural and gender appropriate materials to acknowledge pride, enhance self worth in being a woman (e.g., use of poetry, artwork by women).
- 4) Training of women in sexual assertion skills so that they can both demonstrate care for partners and negotiate safe behaviors.
- 5) Teaching women proper condom use skills. SISTA is designed to foster positive attitudes and norms towards consistent condom use and provide women the appropriate instruction for placing condoms on their partner.
- 6) Discussions of the cultural and gender triggers that may make it challenging to negotiate safer sex.
- 7) Emphasis on the importance of the partner’s involvement in safer sex. The homework activities that are included in the SISTA Project are designed to involve the male partner.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Flexibility to be tailored for different populations of women, for example, women in substance abuse treatment facilities, incarcerated women, women residing in shelters, sex workers and women living in rural areas.
- Passion, such that the facilitators can deliver the intervention with conviction and purpose.
- Cultural competency, in that it was developed by African American women and for African American women. This can be modified to fit our needs in Montana for example, American Indian population or the rural culture.
- Broad content that includes discussions not only about HIV prevention, but also about relationships, dating, and sexual health.

EVALUATION AND MONITORING:

- Collect and report client-level data. (optional)
- Collect and report standardized process and outcome monitoring data consistent with CDC requirements.
- Collect and report data on the percent of participants who report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with partners of known or unknown status.
- Use of the CDC developed Program Evaluation Monitoring System (PEMS) to report data electronically.
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:
 - **H.1** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), group level interventions (GLI), and Prevention Case Management (PCM).

RESEARCH RESULTS:

- Participants in the social skills intervention demonstrated increased consistent condom use, sexual behavior self-control, sexual communication, and sexual assertiveness skills.
- Additionally, the partners of participants in the social skills intervention were more likely to adopt and support consistent condom use.

DiClemente RJ, Wingood GM. A Randomized controlled trial of an HIV sexual risk reduction intervention for young African American women. *The Journal of the American Medical Association*, 1995, 274(16), 1271-1276.

Wingood GJ, DiClemente RJ. Partner influences and gender-related factors associated with noncondom use among young adult African American women. *American Journal of Community Psychology*, 1998, 26(1), 29-49.

Wingood GM, DiClemente RJ. Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Education & Behavior*, 2000, 27(5), pages 539-565.

The SISTA Project intervention box was developed by Sociometrics. For more information on receiving training on this intervention, please visit www.effectiveinterventions.org.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. (Dec 2003). Draft CDC Procedural Guidance for Selected Strategies and Interventions. http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf

TARGET POPULATION: High Risk Heterosexuals

PROGRAM MODEL: YOUTH SURVIVAL

Missoula AIDS Council program, 127 N Higgins #207, Missoula, MT 59802
543-4770.

INTERVENTION GOALS: To provide information skills and communication tools to help youth make the best sexual decisions for themselves and reduce their risk in engaging in unhealthy sexual behaviors.

INTERVENTION TYPE: Group Level Intervention (GLI)

PROGRAM OVERVIEW: Six sessions of interactive risk reduction activities and discussions. Topics include: communication skills, STI prevention and education, HIV risk reduction, identification of values, the effects of substance abuse on decision making, healthy relationships, sexual orientation.

CORE ELEMENTS are those components that are critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) Ask it basket is present at each session for anonymous questions to be answered by facilitator.
- 2) Follow curriculum for objectives and activities. A curriculum is available from Missoula AIDS Council (contact information is listed above) or you may use curriculum developed by individual sites.
- 3) Use age appropriate materials
- 4) Trained and experienced facilitator(s)

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Can have more than one facilitator available for sessions
- Can be offered in many different settings ie: youth homes, detention centers, substance abuse treatment centers, typical size classroom, church groups.
- Sessions can be offered weekly or monthly.

EVALUATION AND MONITORING:

- Collect and report client-level data. (optional)
- Collect and report standardized process and outcome monitoring data consistent with CDC requirements.

- Collect and report data on the percent of participants who report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with partners of known or unknown status.
- Use of the CDC developed Program Evaluation Monitoring System (PEMS) to report data electronically.
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:
 - **H.1** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), group level interventions (GLI), and Prevention Case Management (PCM).

TARGET POPULATION: All Populations

PROGRAM MODEL: SOCIAL MARKETING / MEDIA CAMPAIGN

Laura Dybdal, University of Montana, (406) 243-6988, lgdybs@selway.umt.edu

INTERVENTION GOALS: To increase awareness and perception of HIV risk in Montana's at-risk populations. To reduce sexual and drug using behaviors and maintain protective behaviors related to HIV. To establish healthy social norms relating to HIV, HIV prevention, and sexuality.

INTERVENTION TYPE: Structural Intervention

PROGRAM OVERVIEW: Social marketing is a prevention strategy that is theory driven and places a target population at the center of data collection, program development and program delivery. Social marketing addresses non-tangible products like behaviors, attitudes, beliefs and perceptions. The goal of social marketing is to make a non-tangible product, such as inducing at-risk individuals to modify their behavior, appeal to the selected market. Social Marketing utilizes communication channels that the target population frequents and perceives as important. For example, the Internet has been noted as an important communication channel for young MSM. The strategies of Social Marketing can also target individuals who engage in risk behaviors but who do not identify with the risk group. For this reason, it is essential that information be disseminated into the general population to not only influence the HIV/AIDS attitudes and perceptions of those other than the targeted risk population, but more importantly, to target those individuals who do not associate themselves with the targeted risk population but still engage in the same behaviors.

CORE ELEMENTS are those components that are critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) HIV/AIDS prevention messages and marketing strategies have been developed to increase HIV/AIDS knowledge and perceptions of risk, decrease perceptions of HIV positive stigma and sexuality stigma, decrease at-risk behaviors, and decrease barriers to HIV counseling and testing.
- 2) For new HIV/AIDS prevention messages and marketing strategies behavior theory and needs assessment data from the targeted populations will be utilized.
- 3) For new HIV/AIDS prevention messages and marketing strategies ongoing feedback from the target populations will be utilized.
- 4) Existing or new HIV/AIDS prevention messages will be disseminated through multiple communication channels/media strategies to target risk populations.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Needs assessment data is collected/used to develop specific prevention messages tailored to target population/s.
- Behavior theory is used to develop effective messages and media strategies and to provide measurement indicators for outcome evaluation.
- Individuals from the targeted populations participate in message and strategy development and provide data for process evaluation.
- Prevention messages are developed, pilot-tested, and refined.
- Communication/media channels are selected that will market the prevention messages to the target population/s.
- The media campaign includes innovative strategies such as motion design movies and Internet strategies.
- Media and graphic design is developed by media arts professionals with input from the target population/s.
- Multiple communication/media channels are utilized to saturate the market of the target population/s.
- The media campaign targets and saturates geographical “pockets” of the state as opposed to targeting the whole state at once.
- The media campaign is disseminated to the target population/s.

EVALUATION AND MONITORING:

- Collect and report standardized process and outcome monitoring data consistent with CDC requirements.
 - Process evaluation includes:
 - assessing the type and number of marketing channels/venues such as posters, theater slides, motion design movies, television ads, web sites, videos, CD’s, and movie previews.
 - assessing target population input and feedback in the development of prevention messages via focus groups and interviews
 - assessing message and media preferences by the target population
 - assessing access to media channels via number of movie hits, the frequency of hits, the number of movie downloads, web site surveys, demographic information , marketing reach surveys etc..
 - monitoring pre-production, production, and post-production media development
 - Outcome evaluation includes:
 - developing a research design to assess the effectiveness of the social marketing campaign
 - instrument/survey development based upon health behavior theory
 - pre and post assessment of the effects of the social marketing intervention
 - analyzing and interpreting statistical significant outcomes and important findings
- Use of the CDC developed Program Evaluation Monitoring System (PEMS) to report data electronically.
- Collect and report data consistent with CDC’s requirements to ensure data quality and security and client confidentiality.

RESEARCH RESULTS:

- 24 areas of HIV/AIDS health beliefs had statistically important differences between the experimental group (social marketing intervention) and the control group (traditional knowledge-based intervention) in the young MSM population.
- MSM participants in the social marketing/motion design group reported significantly **less often** than MSM participants in the traditional knowledge-based video group the following beliefs:
 - “It is unlikely I could contract HIV in a rural state”.
 - “Being young makes it less likely I could contract HIV”.
 - “I can usually tell by the way a person looks they don’t have HIV”.
 - “I can usually tell by whom a person hangs out with that they don’t have HIV”.
 - “It is unlikely I could contract HIV in a small city”.
 - “If I contracted HIV my life wouldn’t change”.
 - “Being infected with HIV isn’t any more serious than being infected with other sexually transmitted diseases”.
 - “I’m not worried about being infected with HIV because there are medications to treat it”.
 - “People’s judgment of me affects how I feel about my sexuality”
 - “I feel bad about who I am”.
 - “Homophobia is an obstacle to feeling good about myself”.
 - “Homophobia is a major stressor in my life”.
 - “I care about what other people think of my sexuality”.
 - “I feel it is important to get tested for HIV”.
- MSM participants in the social marketing/motion design group reported significantly **more often** than MSM participants in the traditional knowledge-based video group the following beliefs:
 - “Being in loving and trusting relationships is effective in controlling and preventing HIV”.
 - “Having a strong support system is effective in controlling and preventing HIV”.
 - “Loving myself is effective in controlling and preventing HIV”.
- Overall, MSM participants in the social marketing/motion design media group reported feeling more susceptible to HIV/AIDS than MSM participants in the traditional knowledge-based video group.
- Overall, MSM participants in the social marketing/motion design media group reported believing HIV/AIDS was a more serious disease than MSM participants in the traditional knowledge-based video group.
- Overall, MSM participants in the social marketing/motion design media group reported feeling more comfortable with their sexuality and less homophobic than MSM participants in the traditional knowledge-based video group.

Janssen RS, Holtgrave DR, Valdiserri RO, Shepherd M, Gayle HD, DeCock KM. The serostatus approach to fighting the HIV epidemic: prevention strategies for infected individuals. *Am J Pub Health* 2001;91:1019--24.

International HIV/AIDS Alliance (July 2003) Positive Prevention: Prevention Strategies for People with HIV/AIDS

Dybdal, L & Albertson, R, (2004). Evaluation of Motion Design Strategies in the Young MSM Population: A Social Marketing Campaign Targeting HIV in Montana, Final Report, The Montana Department of Public Health & Human Services: HIV/STD Section.

MMWR Weekly April 18 2003 52 (15) 329-332, Advancing HIV Prevention: New Strategies for a Changing Epidemic --- United States, 2003

TARGET POPULATION: All Populations

PROGRAM MODEL: COUNSELING, TESTING AND REFERRAL

(Complete program details can be requested from DPHHS or visit

http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf)

INTERVENTION GOALS: To increase knowledge of serostatus among target populations.

INTERVENTION TYPE: CTR

PROGRAM OVERVIEW: HIV Counseling, Testing and Referral (CTR) refers to a collection of activities designed to increase a client's knowledge of his/her HIV serostatus, encourage and support risk reduction, and to secure needed referrals for appropriate medical, prevention, and partner counseling and referral services (PCRS).

CORE ELEMENTS are those components that are critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently should be maintained to ensure program effectiveness.

- 1) HIV CTR is a voluntary service that can only be delivered after informed consent is obtained.
- 2) Information and education are provided regarding;
 - a. risk for transmission and how HIV can be prevented
 - b. the type of HIV antibody test used
 - c. the meaning of the test result including a discussion of the window period for HIV seroconversion (the time after infection, before antibodies are produced by the body in which an antibody test might be negative despite the presence of HIV.
 - d. where to obtain further information, counseling, or other services (medical or mental health care).
- 3) Client-centered counseling is provided to address the client's readiness for testing as well as his/her personalized risk assessment, steps taken to reduce risk, risk-reduction goals, support systems, referral needs, and plans for obtaining results if necessary (if testing is provided and the agency is not using rapid testing).
- 4) In conjunction with the state policy or local health department and community mental health providers, establish or utilize existing guidelines and define sobriety standards for counselors to use to determine when clients are not competent to provide consent.
- 5) HIV testing is conducted using a Food and Drug Administration (FDA) approved testing technology. When rapid HIV testing is offered, please see the Procedural Guidance for Implementation of Rapid Testing in Non-Clinical Settings in this document.
- 6) Test results are delivered in a supportive fashion and in a way that is understandable to the client.
- 7) Referral needs in support of risk reduction or medical care are assessed and appropriate referrals are provided with assistance linking clients with providers. A system must be in place for emergency medical or mental health referral if needed.
- 8) Referrals made and completed are tracked.
- 9) A clear supervisory structure should be delineated to ensure responsibility for training and guidance, oversight for testing procedures, and coordination.

KEY CHARACTERISTICS are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy.

- Information giving and educational elements of testing may be provided through face-to-face contact, in small or large group settings, or using brochures, handouts, videos, tape recording, or other non-personalized information delivery manner.
- Client-centered counseling and test results should be delivered in an individual, face-to-face session. While some providers have given negative test results over the telephone when a face-to-face session is not feasible, it is recommended that positive results be given in person to ensure the client has the necessary support and completes referrals for care and prevention services.
- A variety of specimens and test types are used in conducting HIV-antibody testing depending on the setting in which it is conducted and the needs of the organization and the client.
- Service referrals that match the client's self-identified priority needs are more likely to be completed, however priority should be placed on referrals for medical care and PCRS (for clients testing positive), and for prevention and support services.

EVALUATION AND MONITORING:

- Collect and report client level data.
- Collect and report standardized process and outcome data consistent with CDC's Requirements.
- Use the CDC developed PEMS (Program Evaluation Monitoring System) to report data electronically.
- Collect and report data consistent with CDC's requirements to ensure data quality and security and client confidentiality.
- Collect and report data on the following indicators:
 - **B.1** Percent of newly identified, confirmed HIV-positive test results among all tests reported by HIV counseling, testing, and referral sites.
 - **B.2** Percent of newly identified, confirmed HIV-positive test results returned to clients.

CDC. Advancing HIV prevention: New strategies for a changing epidemic. MMWR 2003; 52;3 329-332.

CDC. Revised guidelines for HIV counseling, testing, and referral. MMWR 2001; 50 RR-19. Powderly WG, Mayer KH. (2003). Centers for Disease Control and Prevention revised guidelines for human immunodeficiency virus (HIV) counseling, testing, and referral: Targeting HIV specialists. Clin Infect Dis [year?]; 37:(15), 83

CDC, Division of HIV/AIDS Prevention-Intervention, Research and Support, Capacity Building Branch, Training and Development Team; HIV Prevention Train the Trainer Course Series:

Fundamentals of HIV Prevention Counseling, “Making Effective Referrals” Unit 5
Assuring the Quality of HIV Prevention Counseling: Practical Approaches for Supervisors

CDC. Revised Guidelines for HIV Counseling, Testing, and Referral.
<http://www.cdc.gov/mmwr/PDF/rr/rr5019.pdf>

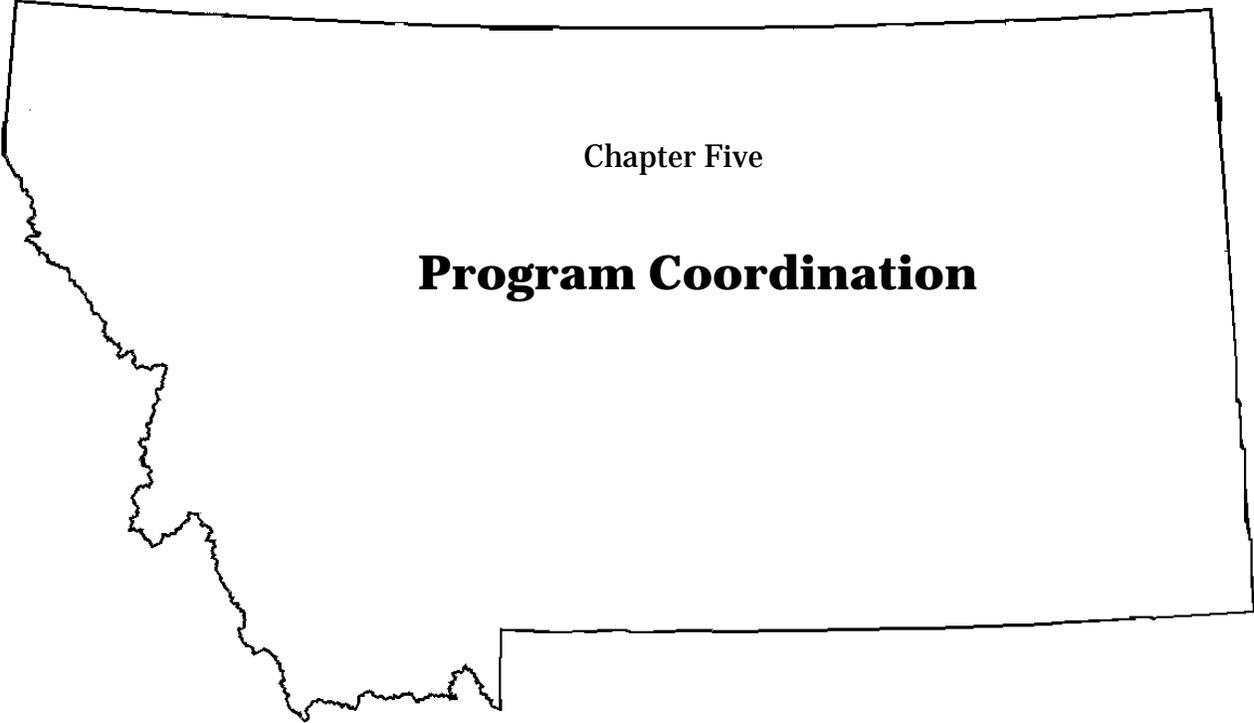
RESPECT Counseling, Testing, and Referral Protocol.
<http://www.cdc.gov/hiv/projects/respect/default.htm>

Rapid Testing website. http://www.cdc.gov/hiv/rapid_testing/

U.S. Department of Health and Human Services, OPHS Office of Minority Health. (2001).
National Standards for Culturally and Linguistically Appropriate Services in Health Care.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention.
(Nov 2003). Draft CDC Technical Assistance Guidelines for CBO HIV Prevention Program
Performance Indicators.

U.S. Department of Labor, Occupational Safety and Health Administration. Occupational Safety
and Health Standards. Toxic and Hazardous Substances. Blood borne Pathogens. Part 1910.1030,
Appendix A



Chapter Five

Program Coordination

PROGRAM COORDINATION

Individual Community Group Members provide invaluable information to the Community Planning Group (CPG) based on their local resources, culture, and community norms and values. Coordination recommendations are intended to maximize the use of local and state resources in order to strengthen prevention efforts and stop the spread of HIV in Montana.

Coordination with CBO's Directly Funded by CDC

The relationship between directly funded Community Based Organizations (CBO's) and the local Health Departments (HD's) is crucial to ensure a comprehensive provision of services, including HIV care, treatment, prevention, and support, to persons living with HIV/AIDS, and individuals at-risk of infection in the community.

Montana Targeted Prevention (MTAP)

The STD/HIV Prevention Section works to coordinate and collaborate with Montana Targeted Prevention (MTAP), the only CDC directly funded CBO in the State of Montana. Coordination of HIV/AIDS Prevention Activities occurs to maximize funding sources and impact the maximum number of individuals in an effort to decrease the spread and transmission of HIV/AIDS and encourage HIV+ individuals to access appropriate services.

MTAP is a statewide HIV prevention program, providing street and community outreach and working to stop the spread of HIV and Hepatitis C throughout Montana. MTAP's target populations are injection drug users (IDU), men who have sex with men (MSM) and men who have sex with men who also inject or use other drugs (MSM/IDU). In collaboration with local community-based organizations and Native American tribes MTAP hires, trains, and supports outreach workers in communities across the state. MTAP offers the following services: HIV & HCV prevention information, counseling and testing, risk reduction materials and agency referrals.

DPHHS reviewed the application for funding for MTAP; at that time, an agreement was signed by both parties to avoid duplicating services in our communities. The current MTAP coordinator is a member of the CPG, which allows for collaboration and coordination of service planning. MTAP enters their process data into the HIV SAFE System on a biannual basis. MTAP and DPHHS will continue with collaborative efforts.

Coordination with CBO's not funded by CDC

The state health department contracts directly with CBO's, which are not directly funded by CDC, to provide services and coordinate HIV/AIDS Prevention Activities to maximize funding sources and impact the maximum number of individuals in our efforts to decrease the spread and transmission of HIV/AIDS and encourage HIV+ individuals to access appropriate services.

Coordination with Other Programs

HIV/AIDS Care Programs

HIV prevention services for individuals infected with HIV/AIDS occur in the state through various means. The Ryan White Title II Program Manager is located in the STD/HIV Prevention Section and attends CPG meetings, providing expertise based on knowledge, skills, and abilities as appropriate to the situation. The CPG Health Department Co-chair and the Community Co-chair attend meetings of the Ryan White advisory/planning body, the Statewide Planning Committee (SPC), sharing their perspective and knowledge when appropriate as well. The SPC is a statewide association of health care and support service providers, as well as consumers of HIV services. It provides input toward decision-making about services, and develops and maintains a continuum of care for PLWH (People Living With HIV/AIDS).

Linkages between HIV primary prevention and the secondary prevention activities accomplished by Ryan White Title II and Title III case managers occur in several ways. All of the organizations, except one, that house the Ryan White Title II and Title III programs also provide HIV primary prevention services. The clients are able to access a continuum of care for their health needs within these organizations.

Substance Abuse Prevention and Treatment Programs

HIV prevention counseling and testing services are offered and supported at the Montana Chemical Dependency Center (MCDC). HIV Prevention Contractors also implement interventions for staff and clientele, consistent with community planning priorities, in their local communities. Educational materials are offered during intervention implementation.

Corrections

The STD/HIV Prevention Section staff members encourage all HIV Prevention contractors to collaborate with Correctional Services. Including implementing individual level and group level interventions, counseling and testing, community collaboration and capacity building, as well as distribution of materials within the correctional systems. These activities occur at juvenile detention centers; male and female pre-release centers; and local jails. Yellowstone City-County Health Department and the Yellowstone AIDS Project implement a group level intervention at the Montana Women's Prison. Topics covered include identifying risk behaviors as well as benefits of healthy behaviors.

Native Americans

Native American Individuals comprise our largest minority population within the State of Montana. The STD/HIV Prevention Section currently contracts with six tribal entities in the State of Montana as well as two Urban Indian Centers. The CPG has prioritized Native Americans as a community for representation in the community planning process. Currently there are five (5) representatives from this group on the CPG. The Department attempts to collaborate and coordinate HIV Prevention Services with the tribal entities whenever possible.

Hepatitis

The Immunization Section, which houses the Hepatitis B and C Coordinators, is located in the same bureau as the STD/HIV Prevention Section. The Hepatitis Prevention Coordinators, the STD/HIV Health Educator, the STD Program Supervisor, and members of the CPG will collaborate in planning a biennially scheduled HIV/Hepatitis/STD prevention conference. Planning for the CY2005 conference will start during CY2004.

Collaboration between the sections also occurs in data tracking and chart review activities. The STD/HIV Prevention Section staff members track Hepatitis C testing on the counseling and testing form. The Immunization Section staff members audit hospital birthing records to assess compliance with Hepatitis B immunization and testing requirements. They will provide data to the STD/HIV Prevention Section on HIV testing concerning audited charts of pregnant women in Montana.

Tuberculosis/HIV

Ongoing collaboration between the HIV Disease Surveillance Coordinator and the TB Program Manager assures that suspected and confirmed cases of dual HIV/TB are recognized both for reporting and case management purposes. In addition, an HIV/AIDS/TB case registry match is performed on an annual basis. Organizationally, the HIV/AIDS prevention program and the TB program are located within the same bureau, which facilitates ease of collaboration and communication on an as needed basis. Weekly disease meetings are held in which both programs staff participate, providing collaboration, interaction, and updates as necessary.

Women and Men's Health Section

The STD/HIV Prevention Section staff and the Women's and Men's Health Section Staff continue to meet on a routine basis to discuss programmatic issues and over arching goals and objectives.

Laboratory support

The Laboratory Services staff members and the STD/HIV Prevention Section staff members attend weekly disease meetings. The HIV/STD Prevention Section contracts with the state lab to perform HIV serum testing, quality assurance work for the rapid test, and training on rapid test technology implementation. The HIV/AIDS Prevention Section utilizes CDC funds to support the cost of HIV testing for specimens obtained via counseling and testing activities. Support is provided for the Virology Supervisor to attend the ASTPHLD Retro Virology Conference.

Program funds are used to pay for, on a fee-for-service basis, HIV testing that is submitted to the MT Public Health Laboratory (MTPHL) from counseling and testing sites up to the cap allotment. Currently, HIV-1 EIA screening is performed daily at the MTPHL, and Western Blot confirmation testing is performed on a STAT basis, rather than batch tested once a week. This provides same day turn around time (TAT) for negative specimens received in the morning, and 2-3 working day TAT for positive specimens. The MTPHL is a CLIA certified laboratory, and subscribes to the CAP proficiency for HIV testing as well as the CDC Model Performance Evaluation Program (MPEP). Laboratory performance on these check samples has been excellent. The MTPHL does not perform CD4 or viral load testing.

In addition, the MTPHL is actively participating with the HIV rapid test program. The MTPHL Technical Supervisor designed a quality assurance program, exposure control plan, and all necessary documentation for rapid testing (OraQuick). In coordination with the HIV Health Educator, the MTPHL Technical Supervisor trains personnel for HIV OraQuick testing, in a one day (9 hour) session, incorporating counseling for a preliminary positive result, all the aspects necessary for performing the CLIA waived testing, including finger stick specimen collection, actual test performance, QA, QC, biohazard exposure, and proper record keeping. The MTPHL Quality Assurance (QA) Committee oversees the testing performed and serves as a technical consultant to the rapid test sites. The sites submit their QA documentation on a monthly basis for review by the QA Committee. These sites are currently enrolled in the rapid testing CDC MPEP.

Because of the impact of rapid HIV testing on the MTPHL, the HIV program is directly supporting a small portion of the QA activities associated with the HIV rapid test program.

HIV/AIDS Epidemiologic and Behavioral Surveillance

The HIV Disease Surveillance Coordinator under the direction of the State Epidemiologist develops the epidemiologic profile. This document is posted onto the State of Montana DPHHS Web Page. The epidemiologic profile is updated yearly and distributed to CPG members. The HIV Disease Surveillance Coordinator responds to the surveillance data needs of HIV prevention contractors and to CPG members. This individual is available to provide information regarding analysis, interpretation, and presentation of surveillance data. This individual also prepares and updates the epidemiologic profiles and other reports for use by the CPG and contractors. The HIV Disease Surveillance Coordinator undertakes other related activities that directly improve and support the implementation and evaluation of HIV prevention activities on a case-by-case basis. Collaboration occurs to ensure data from other surveillance programs and CDC is incorporated into the epidemiologic profile.

Northwest AIDS Education and Training Center (NW AETC)

The Yellowstone City-County Health Department through a grant from the Northwest AIDS Education and Training Center (NW AETC), offers HIV treatment education, clinical consultation, capacity building and technical assistance to health care professionals and agencies in Montana. The purpose of the AETC is to increase providers' capacity to provide high quality HIV/AIDS care within the region's health care systems. Our target audience includes physicians, physician assistants, nurse practitioners, nurses, dental professionals, clinical pharmacists, and other members of the health care team. We train providers from Ryan White CARE Act funded agencies, federally funded community and migrant health centers, tribal health clinics, state and local health departments, corrections facilities and private practice settings serving persons with HIV and AIDS. The NW AETC is part of a network of regional AETCs that covers the United States, Puerto Rico and the U.S. Virgin Islands. Funded through the Health Resources and Services Administration, the national AETC network is the professional training arm of the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act.

There are a variety of educational opportunities for health care providers and organizations offered in Montana to meet specific HIV/AIDS education needs. Some of the opportunities

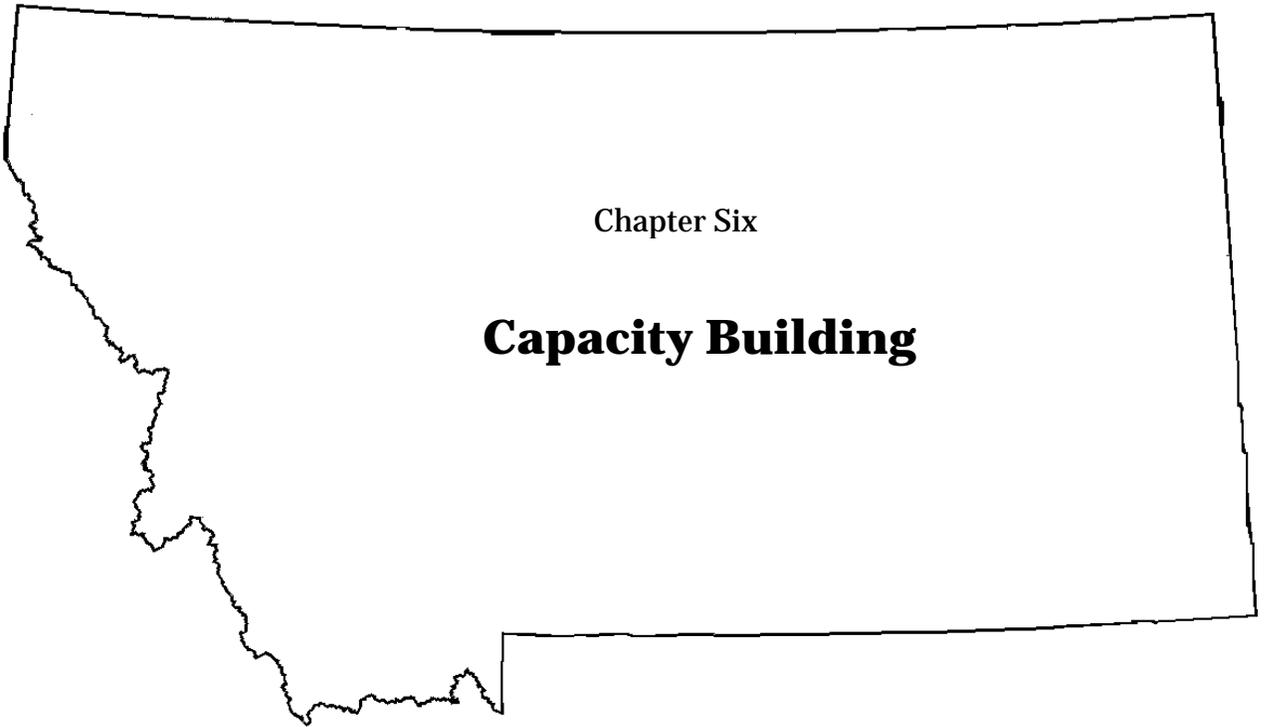
include didactic lectures and seminars, interactive workshops, case-based presentations, clinical preceptorships, e-mail, phone and on-site clinical consultations, capacity building, and web-based learning modules. For more information regarding the NW AETC or to inquire about trainings, please contact Molly Hale, program coordinator, at 406-247-3320.

Governor's AIDS Advisory Council

The HIV Prevention Grant provides funding for the Governor's AIDS Advisory Council. The Governor's AIDS Advisory Council meets four times a year. The STD/HIV Prevention Section provides administrative support for the Council. The Council reviews substantive issues and represents the best interests of those infected and affected by HIV. During the 2003 legislative session, the Montana Legislature reauthorized \$84,010 in funding for care and treatment of HIV+ individuals. The funds are used to close service gaps such as housing and dental care.

Housing Opportunities for Persons With AIDS (HOPWA)

Tri-State HELP HOPWA (Housing Opportunities for Persons With AIDS) is a partnership between one State agency and four private agencies serving Montana, North Dakota and South Dakota, and its service area is the entirety of all three states. Tri-State HELP represents the first multi-state model for delivery of HIV/AIDS housing and related social services. It provides a continuum of housing and related support service opportunities for people living with HIV/AIDS and their families such as long term and emergency rental assistance as well as housing coordination services.



Capacity Building

Capacity building involves the delivery of a wide range of consultative and training services to those responsible for HIV prevention community planning – the DPHHS, the CPG, and HIV prevention service providers. The DPHHS and the CPG will continue to expand, strengthen, and evaluate HIV community planning through a variety of sources. CPG members wrote the following 3-year plan to address capacity building at the June 2004 CPG meeting.

The following goals apply to DPHHS staff members.

Goal I: Strengthen DPHHS staff members' role in the planning process.

Objectives

- A. Increase staff members' knowledge about HIV prevention planning by identifying at least one section staff member to attend the national HIV prevention conference sponsored by CDC.

Goal II: Strengthen DPHHS staff members' ability to evaluate HIV prevention programs.

Objectives

- A. Increase staff members' knowledge about evaluation by attending CDC sponsored trainings on PEMS and the evaluation guidance.

The following goals apply to CPG members.

Goal I: Strengthen CPG members' role in the planning process.

Objectives

- A. Increase understanding of the HIV planning process and roles for new members by designing and conducting a new member orientation two times per year as appropriate.
- B. Increase members' knowledge about HIV prevention planning as follows:
 - By the December meeting of each year, conduct training sessions for CPG members.
 - Determine by each Spring meeting, at least one CPG member from each community to attend a national conference on HIV/AIDS, community planning, etc. Those attending conferences will present reports back to the CPG by the December meeting of each year.

Goal II: Strengthen CPG members' role in making decisions regarding HIV prevention planning.

Objectives

- A. Increase CPG members' understanding of the Epidemiological Profile (EPI) by presenting the EPI to CPG members each summer meeting.
- B. Increase members' understanding of the Community Services Assessments (CSA) by presenting the CSA to CPG members once within the three year plan period prior to the priority-setting process/planning cycle.

Goal III: Assess and regularly evaluate the community planning process and the involvement of the CPG.

Objectives

- A. Through a CPG member survey, identify the strengths and weaknesses of the CPG process by each Fall meeting.
- B. Analyze survey results and present finding to the CPG by the December meeting, making changes as appropriate.

The following goals apply to HIV prevention service providers.

Goal I: Strengthen providers' capacity for evaluation.

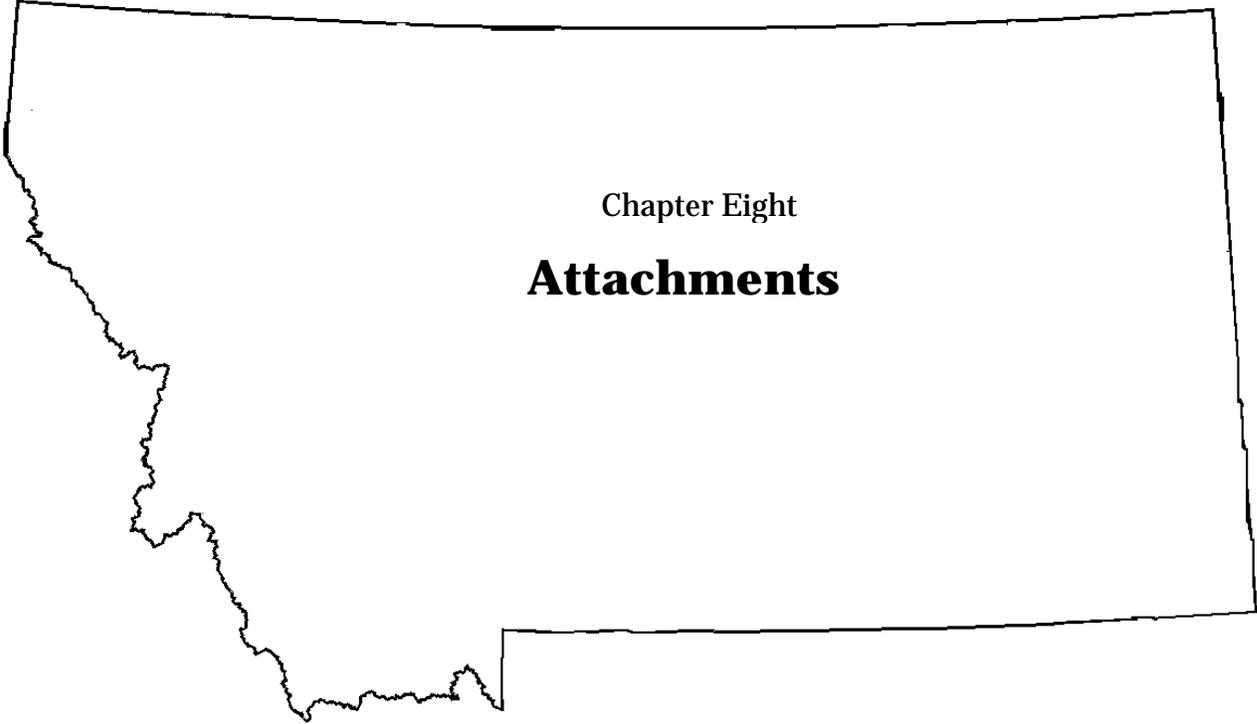
Objectives

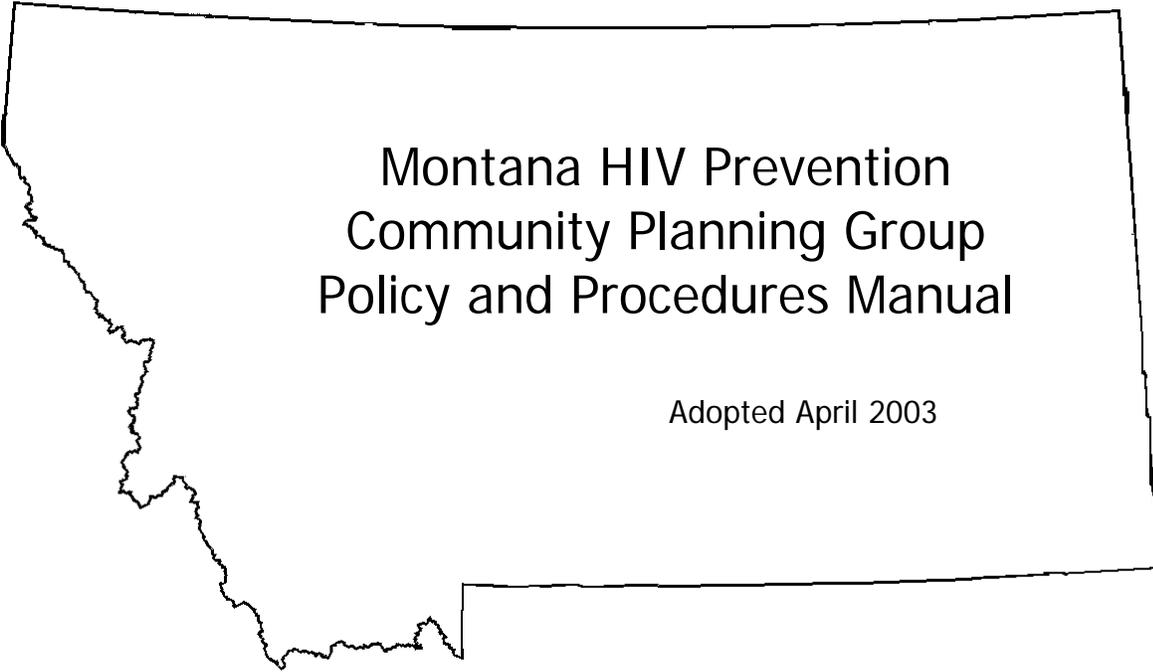
- A. Strengthen providers' ability to evaluate intervention effectiveness by conducting a minimum of one training at each Contractor's meeting by December of each year.
- B. In order to fully utilize PEMS, conduct training and/or site visits on PEMS with the timeline to be determined by those involved.

Goal II: Strengthen providers' capacity to implement effective interventions.

Objectives

- A. On an annual basis, provide effective interventions for rural and hard-to-reach communities through trainings and user-friendly curriculum on interventions.





Montana HIV Prevention
Community Planning Group
Policy and Procedures Manual

Adopted April 2003

Montana HIV Prevention Community Planning Group Policies and Procedures Manual

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Introduction

The HIV Prevention Community Planning Group (CPG) is a group of people working together who are concerned about the spread of HIV/AIDS in Montana. Using the most recent information about the infection trends and the people impacted, the CPG chooses the most effective ways to prevent the spread of HIV/AIDS. Members and others participate in committees and workgroups to create The Montana Comprehensive HIV Prevention Plan. The Department of Public Health and Human Services, STD/HIV Prevention Section, hereinafter referred to as 'Department', uses the Plan as a guide to write the annual funding continuation application.

The CPG Policies and Procedures Manual provides detailed information about the CPG and how it operates. The CPG adheres to its Bylaws for the governing of its members and the regulation of its affairs. The HIV Prevention Community Planning Guidance defines the Centers for Disease Control and Prevention's (CDC) expectation of health departments and HIV prevention community planning groups in implementing HIV prevention community planning.

The CPG Policies and Procedures Manual may be amended or revised based on recommendations of CPG members. Changes will be submitted to the co-chairs or planning coordinator who will refer them to the appropriate committee for consideration and recommendation to the CPG.

All CPG members receive a copy of this Manual. Copies may be obtained by contacting the Montana Department of Public Health and Human Services STD/HIV Prevention Section, Helena, MT, (406) 444-3565.

SECTION I

GOVERNANCE

Section I: Governance

A. Conflict of Interest Disclosure *[Bylaws, Article II – Section 4]*

All members sign, upon appointment to the CPG, the Conflict of Interest Disclosure Form (Appendix B).

1. Completed forms shall be kept on file at the Department STD/HIV Prevention Section office and made available for public inspection.
2. CPG members shall review and update their information on an annual basis, or as otherwise precipitated by a change in employment, Board service, consultative relationship, or other status.
3. All CPG members are encouraged to identify conflict of interest or request a review of a potential conflict of interest of another member.
4. In the event of a conflict of interest or during the period of review of identified conflict of interest, the member(s) may participate in the discussion of the matter in conflict/question but shall abstain from the call for consensus on that matter.
5. All concerns regarding conflict of interest shall be recorded in the CPG meeting minutes and referred to the Executive Committee for review.
6. Based on the Committee's recommendation, the full CPG shall take whatever action it deems appropriate assuring compliance with CPG policy.

B. Confidentiality of Information *[Bylaws, Article II – Section 4]*

All CPG members sign the Certification Regarding Confidentiality of Information form. (Appendix C)

1. Completed Certifications shall be kept on file at the Department STD/HIV Prevention office and made available for public inspection.
2. All CPG members shall review and renew their Certifications on an annual basis at the first CPG meeting of the year.
3. All concerns regarding confidentiality issues shall be referred to the Executive Committee for review

c. Decision-making Process

[Bylaws, Article IV – Section 4]

Decisions, with the exception of the election of the community co-chair, are determined by consensus of all members present.

1. Steps in forming the proposal or clarifying the issue for a decision are:
 - a. A proposal/issue for resolution is put forward.
 - b. Modify the proposal/issue through discussion or withdraw it if it seems to be a dead end.
 - c. Articulate differences and concerns clearly during the discussion.
 - d. All CPG members are responsible to propose alternative suggestions/solutions to address minority considerations as needed.
 - e. Allow public comment within the allocated time during the discussion.
 - f. When the proposal seems to be well understood by everyone and there are no new changes asked for, the co-chair or designee will call for consensus by stating the proposal three (3) times.
 - g. Record the decision in the meeting minutes.
 - h. Consider a vote if consensus is blocked and no new consensus can be reached.
 - i. When a vote is taken, the decision will be passed with a 2/3 majority of members present.
 - j. Only members are allowed to vote.

D. Roles in the Consensus Process

1. The co-chair or designee will direct the process by:
 - a. Setting a time frame and keeping the discussion moving,
 - b. Focusing discussion to the point-at-hand,
 - c. Assuring everyone has the opportunity to participate, and
 - d. Formulating and testing the proposal to see if consensus has been reached.

2. When an outside facilitator (non-member) directs the process, he/she must never make a decision for the group and must remain neutral in behavior and attitude.

E. Conflict Resolution *[Bylaws, Article III, Section 6]*

Specific conflict resolution procedures are available.

1. The Membership Appointment Conflict Resolution Procedure is used to resolve conflicts with the Department Director's concern about an individual selected for membership (Appendix D).
2. The Internal Membership Conflict Resolution Procedure is used to resolve conflicts resulting from the Membership Committee's action or inaction (Appendix E).
3. Conflicts that arise among members during the business of the CPG, its committees or workgroups shall be addressed as follows:
 - a. The parties involved shall make every effort to resolve the conflict themselves.
 - b. If conflicts cannot be resolved, either party may request assistance from a co-chair through involvement of the Executive Committee or revert to State policy regarding Advisory Council requirements. (Examples: sexual harassment, alcohol/drug use, etc.)

F. CPG Meeting Agenda

1. The CPG meeting agenda, with date(s), time, and location shall be available to members and all interested parties not less than thirty-days (30) before the meeting.

G. CPG Meeting Attendance *[Bylaws, Article III, Section 7]*

1. Members shall not be absent from more than one CPG meeting per year unless there are extenuating circumstances.
2. The Membership Committee has responsibility for reviewing attendance records and notifying the Executive Committee of a member's lack of attendance.
3. Standing committee/workgroup members are expected to participate to the full extent possible to assure committee/workgroup tasks are completed

H. Member Dismissal and Resignation *[Bylaws, Article III, Section 10]*

1. Standards of participation of members are necessary to ensure an effective and efficient community planning process. Should members be unable to fulfill their roles and responsibilities on the CPG, this policy outlines options for discontinuing membership.
2. Should a CPG member wish to resign from the CPG, they should submit their resignation in writing to the CPG co-chairs or planning coordinator.
 - a. The letter should contain the date the resignation takes effect and reasons for resigning.
 - b. The CPG co-chairs shall hold exit interviews. Refer to Appendix F for sample exit interview questions. The planning coordinator shall record the exit interviews.
3. CPG members may be dismissed or asked to resign from the CPG for "failure to fulfill their responsibilities". These responsibilities are outlined in the Policy and Procedures Manual Section II: Role and Responsibilities. The procedure for member dismissal is as follows:
 - a. The CPG co-chairs will meet to discuss the member and the current situation.
 - b. The CPG co-chairs will contact the member either by phone or in person to let them know that they are going to discuss the situation with the Executive Committee and Membership Committee chair.
 - c. The Executive Committee, CPG co-chairs and the Membership Committee chair will discuss the concerns referring to the member. They will either make a decision or schedule a call with the member to further discuss the situation.
 - d. The decision will be conveyed to the member verbally and in writing.
 - e. Should the Executive Committee, CPG co-chairs and the Membership Committee chair determine that a CPG member is not fulfilling their responsibilities, they shall recommend to the director of DPHHS that the member's appointment to the CPG be revoked.

SECTION II

ROLES AND RESPONSIBILITIES

Section II: Role and Responsibilities

This section outlines the role and responsibilities of all members, the Montana Department of Public Health and Human Services (hereinafter referred to as 'Department'), and the public.

A. CPG Members' Role

[Bylaws, Article III]

Members represent their community by facilitating communication between the CPG and their community. The CPG communities are (listed alphabetically):

1. Heterosexual
2. HIV – Positive
3. IDU (Injection Drug Users)
4. MSM (Men Who Have Unprotected Sex With Men)
5. Native American
6. Prevention Services Contractors

B. CPG Members' Responsibilities

A CPG member's responsibilities are:

1. Commit to a three-year term with the option of submitting an application to be considered for an additional term,
2. Attend all annual meetings in their entirety unless there are extenuating circumstances,
3. Participate on a standing committee or workgroup unless there are extenuating circumstances,
4. Participate in all decision-making and problem solving issues at the committee and CPG level,
5. Be prepared by reviewing all meeting minutes and materials,
6. Ask questions about issues that aren't clear,
7. Be prepared to offer solutions in an effort to reach consensus,
8. Create a comprehensive HIV prevention plan intended to improve the effectiveness of Department's HIV prevention programs,

9. For the concurrence process, review the Department's funding application and compare it to the current Comprehensive HIV Prevention Plan to assure the priorities addressed are identified in the application.
10. Authorize the co-chairs to write the letter to concur, not concur, or concur with reservations that the application is consistent with the current Plan.
11. Protocol for outside communications:
CPG members must qualify their statements by first stating that they are speaking as "individual" CPG members and their comments may not necessarily reflect the "official" CPG or Department position on a particular issue,
12. Protocol for communication with the media:
CPG members must refer media inquiries to the CPG co-chairs.
13. State appointed CPG members shall conduct themselves in a manner that reflects positively on the CPG.

C. Community and Department Co-chairs' Role and Responsibilities

[Bylaws, *Article III- Section 8*]

In addition to a member's responsibilities listed above, CPG co-chairs include the following:

1. Plan and preside over all CPG meetings,
2. Co-chair the Executive Committee,
3. Attend the annual HIV Prevention Community Planning Leadership Summit,
4. Review CPG meeting minutes and ensure they accurately reflect the discussions and decisions made,
5. Ensure the development and review of timelines for the CPG's work,
6. Participate as member of all standing committees,
7. Guide the conflict resolution process,
8. Represent the CPG when preparing the letter of concurrence, non-concurrence, or concurrence with reservations, to accompany the Department's funding application, and

9. Represent the CPG on official CPG business

D. Co-chair Elect Role and Responsibilities

In addition to a member's responsibilities listed above, the co-chair elect's responsibilities include the following:

1. Attend the annual HIV Prevention Community Planning Leadership Summit,
2. Assume the role and responsibilities of the community co-chair if he/she is unable to serve or be present at meetings, and
3. Participate on all standing committees.

E. Past Community Co-chair Role and Responsibilities

In addition to a member's responsibilities listed above, the past community co-chair's responsibilities include the following:

1. Mentor the co-chair elect,
2. Provide historical guidance as needed,
3. Serve in the absence of both the co-chair and the co-chair elect, and
4. Serve as a member of the Executive Committee and other standing committees as needed.

F. Planning Coordinator Role and Responsibilities:

In addition to a member's responsibilities listed above, the planning coordinator's responsibilities include the following:

1. Assist the CPG in the creation of the Comprehensive HIV Prevention Plan,
2. Provide coordination and informational services to CPG members, local and state agencies, communities, community-based organizations, and the public regarding community planning,
3. Provide and distribute minutes of all CPG meetings, standing committee meetings, and other communication as needed,
4. Coordinate logistics of all CPG, standing committee, and workgroup meetings,
5. Write the annual funding application utilizing the Plan and assure compliance with state and federal requirements,

6. Coordinate CPG technical assistance needs and associated committees and workgroups,
7. Assure all CPG meetings are advertised in accordance with Department policy and procedures, and
8. Maintain a "special interest" mailing list containing the names and addresses of individuals/agencies interested in receiving notice of CPG meetings and happenings.

G. Department Role and Responsibilities

The Department STD/HIV Prevention Section has the responsibility for the administration of HIV prevention programs and assisting the CPG with its tasks.

1. Assure the funding application complies with state and federal requirements and adheres to the Comprehensive HIV Prevention Plan,
2. Assess resource allocations and prepare the annual budget with input by the CPG Budget Committee,
3. Assure an HIV prevention epidemiological profile and community HIV prevention services assessments are available for planning purposes,
4. Assure an evaluation of the community planning process occurs,
5. Process reimbursements for CPG members' participation at authorized meetings, conferences, etc.,
6. Provide budget reports, prevention services contractors' reports, CDC updates and other information as needed for planning purposes,
7. Submit all CDC required reports and funding application by the stated deadlines,
8. Retain copies of comprehensive HIV prevention plans, needs assessments, resource directories, and CPG, committee, and workgroup meeting minutes in accordance with Department retention policy. Copies are available to the public upon request, and
9. Provide the community co-chair with relevant equipment necessary to perform his/her responsibilities as needed. The equipment will be returned to the Department at the end of his/her term.

H. Members of the Public

The CPG encourages community participation in the planning process. Members of the public shall:

1. Speak during the CPG meeting public comment period (s) and participate in community forums, surveys, meetings, etc., and
2. Shall not participate in the call for consensus nor the election of the community co-chair.

SECTION III

STANDING COMMITTEES AND WORKGROUPS

Section III: Standing Committees and Workgroups

A. Standing Committee Composition

[Bylaws, Article V]

1. Each standing (permanent) committee will be comprised of members; one representative from each community and CPG co-chairs. Each community will determine representation for each committee.
2. Annually, each community will select one member to represent them on each standing committee. The community member not on a standing committee may choose to participate as an observer on a committee of his/her choice but is not required to do so. He/She should participate on a workgroup unless there are extenuating circumstance.

B. Standing Committee Term

1. Committee members serve a one-year term beginning at the first CPG meeting of the year, and
2. If the selected member is not able to participate, his/her primary community will meet to designate another member.

C. Number and Name of Standing Committees

The CPG has four (4) standing committees:

1. Executive Committee
2. Budget Committee
3. Membership Committee
4. Effective Interventions Committee

D. Standing Committee Operating Principles

Community members will meet to:

1. Select a chair and chair alternate,
2. Determine chair responsibilities,
3. Determine tasks, timelines, and responsibilities,
4. Set up communications process (e.g., phone tree), and
5. Identify and request technical assistance as needed.

E. Committee Chair Responsibilities

Suggested chair responsibilities are:

1. Facilitate committee meetings,
2. Develop meeting agenda, and
3. Monitor representation from all CPG communities.

F. Executive Committee's Role and Responsibilities

1. Execute authority on the CPG's behalf to address its functions and requirements, etc., and to deal directly with the Department in the intervals between scheduled meetings,
2. Determine the annual CPG tasks/timelines and responsibilities,
3. Prepare the meeting agenda,
4. Provide CPG orientation to new members as needed,
5. Determine TA needs and source(s),
6. Assist in implementing the evaluation of the community planning process,
7. Administer the Membership Appointment Conflict Resolution Procedure and the Internal Membership Conflict Resolution Procedure as needed,
8. Identify solutions for unresolved issues and conflicts upon request, and
9. Review conflict of interest and confidentiality concerns and recommend action(s) required.

G. Budget Committee's Role and Responsibilities

1. Execute authority on the CPG's behalf to provide input in the preparation of the annual budget,
2. Solicit input regarding possible prevention projects and effective interventions for use of either Carry Forward funds and/or Supplemental Funds when available,

3. Prioritize funding of prevention projects and effective interventions and determine appropriate allocations per project as required by the CDC for Carry Forward or Supplemental Funds. If necessary, execute authority on the CPG's behalf to make funding recommendations to the Department, and
4. Recommend an appropriate funding application process (RFP, Bid Proposals, and/or Direct Award) for projects and effective interventions.

H. Membership Committee's Role and Responsibilities

1. Execute authority on the CPG's behalf to select members,
2. Maintain and define the membership criteria application criteria
3. Assess and implement a recruiting process to fill positions as necessary,
4. Review term records,
5. Review and revise as needed, the membership application form and criteria,
6. Review CPG meeting and standing committee attendance records,
7. Periodically review membership composition to ensure continued PIR (parity, inclusion, representation) as required,
8. Identify and fill vacancies within 90 days, and
9. Request nominations and coordinate the annual community co-chair election.

I. Effective Interventions Committee Role and Responsibilities

1. Review the requirements for determining target at-risk populations and interventions,
2. Conduct a literature review of effective interventions and research trends in target population high-risk behaviors,
3. Select/Write effective interventions for each target population, and
4. Assist the CPG in the selection and prioritization of effective interventions for each target population.

J. Workgroups

[Bylaws, Article V, Section 2]

1. Workgroups are task driven, working until the task is completed and then disbanded.
2. Workgroups will be comprised of members and non-members based on experience, interest, and expertise.
3. The workgroup will:
 - a. Select a chair and chair alternate, and
 - b. Determine chair responsibilities (refer to committee chair responsibilities in Section III, E.)

SECTION IV

COMMUNITY CO-CHAIR ELECTION AND MEMBERS' TERMS

Section IV: Community Co-chair Election and Members' Terms

A. Community Co-chair Election

[Bylaws, Article III, Section 8]

1. A CPG member is elected by the membership to serve as community co-chair.
2. Any member, except the Department co-chair and the HIV prevention planning coordinator, may serve as the community co-chair.
3. A CPG member must have been a member for at least one year to be nominated.
4. CPG members shall receive nomination forms and a list of eligible members at least two months before the election is held.
5. Members can nominate more than one member.
6. The election is held at the fourth CPG meeting of the year.
7. Members must contact the person they nominate and get his/her agreement before they place his/her name in nomination.
8. The election is conducted by written ballot.
9. Only CPG members are allowed to vote.
10. The prevailing candidate must receive a majority of the votes of the CPG members present.
11. In the event of a tie, another vote will be taken.
12. An announcement of the prevailing candidate will be made at the meeting.
13. The community vacancy created by the election of the community co-chair will be filled by application, community specific, within 90 days.

B. Nominee Requirements

1. Each nominee shall prepare a statement that includes the following elements for presentation before the CPG.
 - a. Brief biography,

- b. Statement of qualifications, and
- c. Why they want to be community co-chair.

C. Community Co-chair Term

- 1. The community co-chair's three-year term will be served as: Year one as community co-chair elect, Year two as the active community co-chair, and Year three as the past community co-chair.
- 2. Each term's start date is the first day of the year following his/her election and the end date is the last day of the third year.

D. Members' Terms

[Bylaws, Article III]

- 1. Members shall serve a three-year term.
- 2. Terms are staggered within each community.
- 3. When a member's term expires, he/she must submit an application to be considered for another term.
- 4. Midterm vacancies will be filled by application, community specific, within 90 days.
- 5. Each term's start date is the first day of the calendar year of appointment; the end date is the last day of the third year.

SECTION V

REIMBURSEMENTS

Section V: Reimbursements

A. Reimbursement Policy

Each CPG member will be reimbursed for expenses directly related to attending CPG meetings and all CPG related meetings such as face-to-face standing committee meetings and/or workgroup meetings.

1. Reimbursed expenses are:
 - a. Travel (mileage at current State rate or airline/bus, whichever is cheaper)
 - b. Lodging (current State rate) of one or two nights depending on circumstances, such as weather.
 - c. Meals (per current State rates/timetable)
2. Members must complete and submit the STD/HIV Prevention Section Travel Expense Worksheet.
3. Members needing assistance with travel must contact the agency in their area two-weeks prior to travel. (CPG Member Travel Assistance Policy – Appendix L)
4. Members cannot claim meeting expenses if the expenses are claimed and covered through employment or another source.

B. Stipend Policy

Members are eligible to receive a stipend for CPG meeting attendance only if their employer or other source does not cover this cost.

1. The amount of the stipend is \$25 per day per CPG meeting.
2. The stipend will not be paid for a partial day's attendance unless there are extenuating circumstances.
3. Members cannot receive stipends for conference calls.

APPENDIX

Appendix A	Bylaws
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APPENDIX A

BYLAWS

MONTANA HIV PREVENTION
COMMUNITY PLANNING GROUP
BYLAWS

Adopted February 7, 2003

ARTICLE I – Name and Location

- Section 1: The name of the organization shall be the Montana HIV Prevention Community Planning Group (CPG).
- Section 2: The Headquarters shall be located in the Montana Department of Public Health and Human Services (DPHHS), Helena.

ARTICLE II – Guiding Principles

- Section 1: The CPG is organized for the purpose of creating a comprehensive HIV prevention plan intended to improve the effectiveness of the DPHHS HIV prevention programs.
- Section 2: The mission of the CPG is to reduce the number of Montanans who become HIV positive or re-infected with HIV.
- Section 3: The CPG is an advisory council to the DPHHS under Montana Statute (MCA 2-15-122).
- Section 4: All appointed members sign a Conflict of Interest statement.
Conflict of interest occurs when:
- a. A member (or relative or partner, etc.) has a financial interest, or appears to have a financial interest, in the outcome of a decision,
 - b. A member has an affiliation that implies or suggests influence over the outcome of a decision, or
 - c. A member uses threats or coercion to influence the conduct of the CPG.
- Section 5: All appointed members sign a confidentiality statement acknowledging the confidential nature of some discussions in the community planning process.
- Section 6: The Executive Committee will address conflict of interest occurrences and confidentiality issues.

ARTICLE III – Membership

Section 1: Membership shall consist of applicants selected by the Membership Committee who are subsequently appointed by the DPHHS Director.

Section 2: Number of Members

The CPG shall consist of thirty-five (35) members; five from each of the six Communities, three community co-chairs (past, current, and elect), one Department appointed co-chair, and the HIV prevention planning coordinator.

Section 3: Member Community Affiliation

The six Communities (listed alphabetically) are:

- a. Heterosexual
- b. HIV Prevention Services Providers
- c. HIV-Positive
- d. IDU (Injection Drug Users)
- e. MSM (Men Who Have Unprotected Sex With Men)
- f. Native American

Section 4: Membership Application

- a. Interested individuals must complete and submit an application to the CPG Membership Committee.

Section 5: Terms

- a. Members shall commit to a three-year term with the option of submitting an application to be considered for additional terms.

Section 6: Membership Conflicts

Conflicts with the membership selection process will be resolved by either of the following procedures:

- a. Membership Appointment Conflict Resolution Procedure
- b. Internal Membership Conflict Resolution Procedure

Section 7: Member Participation Responsibilities

- a. Members shall not be absent from more than one meeting per year (unless there are extenuating circumstances).
- b. The Executive Committee will contact members who miss more than one scheduled meeting to assess extenuating circumstances and their ability to remain active members.
- c. Members are encouraged to serve on a standing committee and/or workgroup.
- d. Members are encouraged to serve on only one standing committee.
- e. Members may serve on more than one workgroup.

Section 8: CPG Leadership

Four co-chairs guide the CPG; three community co-chairs and one Department appointed co-chair.

- a. Community Co-chair
 - 1) The CPG elects the community co-chair.
 - 2) Any member, except the Department co-chair and the HIV prevention planning coordinator, may serve as the community co-chair.
 - 3) The community co-chair's three-year term is: Year one as community co-chair elect, Year two as the active community co-chair, and Year three as the past community co-chair.
- b. Department Co-chair
 - 1) The STD/HIV Prevention Section Supervisor in collaboration with the Communicable Disease Control and Prevention Bureau Chief recommends a Bureau employee to the DPHHS Director for appointment as the DPHHS co-chair.
- c. Co-chair Shared Responsibilities
 - 1) Plan and preside over all CPG meetings.

- 2) Chair the Executive Committee.
- 3) Member of all standing committees.
- 4) Liaison for the HIV Treatment Statewide Planning Committee (SPC).
- 5) Draft the letter of concurrence/nonconcurrence on behalf of the CPG for inclusion with the DPHHS annual funding application.

Section 9: Vacancies

The Membership Committee will identify vacancies and make recommendations to the DPHHS Director to fill them.

Section 10: Resignations

Resignations shall be submitted in writing to the CPG co-chairs.

ARTICLE IV – Meetings

Section 1: There will be four (4) meetings each year convened at a central location. CPG meetings shall be open to the public.

Section 2: The date, time, and location of annual meetings shall be set at the third meeting for the following calendar year.

Section 3: Quorum: A simple majority of appointed members.

Section 4: Decisions, with the exception of the community co-chair election, will be determined by consensus by all members who are present.

- c. When consensus cannot be reached, a vote will be considered.
- d. When a vote is taken, the decision will be passed with a 2/3 majority.

Section 5: The CPG will keep minutes and other records of all proceedings for the proper conduct of its business.

ARTICLE V – Standing Committees and Work Groups

Section 1: Standing Committees

- a. There will be four (4) standing committees:
 - 1) Executive
 - 2) Budget
 - 3) Membership
 - 4) Effective Interventions
- b. Each committee will be comprised of members; one representative from each community (6), all CPG co-chairs (4), and the STD/HIV Prevention Section Supervisor or his/her designee.
- c. Members of each community will determine committee representation.

Section 2: Workgroups

- a. Workgroups will be comprised of members and non-members based on experience, interest, and expertise.
- b. Workgroups are task driven, working until the task is completed and then disbanded.

ARTICLE VI – Roles and Responsibilities

Section 1: The CPG adheres to the requirements stated in the Centers for Disease Control and Prevention (CDC) Guidance for HIV Prevention Community Planning for health departments and CPGs.

ARTICLE VII – Adopting and/or Changing Bylaws

Section 1: New bylaws and/or amendments may be adopted utilizing the established decision-making process (Article IV, Section 4).

These Bylaws were approved at a meeting of the CPG on February 7, 2003.

Signature
Rick Holman
Community Co-chair

Signature
Amy Kelly
Health Department Co-chair

Bylaws Appendix I

COMMUNITY DEFINITIONS *(Listed alphabetically)*

Community representation is the act of serving as a CPG member reflecting the perspective of a specific community. You do not have to be a member of the community but should truly reflect that community's values, norms, and behaviors. You should have expertise in understanding and addressing the specific HIV prevention needs of the community. You must be able to participate as CPG members in objectively weighting the overall priority prevention needs of the community.

High Risk Heterosexuals (HRH)

Definition: Individuals who participate in unprotected oral, vaginal, and anal sex in high-risk situations. These include, but are not limited to, HIV+ partners, females with sexually transmitted diseases (STD); females who have sex with MSM; females who are sex workers (exchange sex for resources, survival or drugs); male and female substance abusers; male and female sexual partners of IDUs; or youth* in high-risk situations.

CDC Definition: "Youth in high-risk situations are aged 10-24. These youth include, but are not limited to, youth who have run away or are homeless; are not in school and are unemployed; seek treatment for substance abuse, especially for injecting drugs and using crack cocaine; are juvenile offenders; are medically indigent; require mental health services; are in foster homes; are migrants; are gay and lesbians; have had sexually transmitted diseases, especially genital ulcer disease; have been psychologically, physically, or sexually abused; are pregnant; seek counseling and testing for HIV infection; exhibit signs or symptoms of AIDS or HIV infection without alternative diagnosis; barter or sell sex; are in alternative or continuation schools; are in gangs." Montana also considers youth engaging in unprotected sex with multiple partners in this priority population.

HIV Prevention Services Providers

Definition: Individuals who provide or have provided, direct HIV prevention services to at-risk populations defined in the current Montana Comprehensive HIV Prevention Plan.

HIV-Positive Individuals (HIV+)

Definition: Individuals who are infected with the Human Immunodeficiency Virus (HIV).

Injecting Drug Users (IDU)

Definition: Individuals who inject drugs and share the equipment with others

Men Who Have Unprotected Sex With Men (MSM)

Definition: Men who participate in unprotected oral and anal sex with other men in high-risk situations. These include but are not limited to Men Who Have Sex With Men (MSM) who are adults (over age 24); are young (age16-24); are in communities of color; are incarcerated; who are sex workers (exchange sex for resources, survival); who have sex with HIV+ partners.

Native American

Definition: Native American individuals who engage in high-risk behaviors.

Bylaws Appendix II

CPG MEMBERSHIP CRITERIA

Note: The following criteria are considered in assuring broad representation on the CPG. Care will be taken to attempt to balance the representation from each community regarding age, geography, expertise, and life experience.

Communities: *(Five representatives from each.)*

- o High Risk Heterosexuals
- o HIV Prevention Services Providers
- o HIV-Positive Individuals
- o IDU
- o MSM
- o Native American

Age Category:

- o 16-24
- o 25-39
- o 40+

Geography

- o Urban: reside in a county with a population greater than 30,000
- o Rural: reside in a county with a population between 5,000 and 30,000
- o Frontier: reside in a county with a population less than 5,000

Expertise

- o Community-based HIV prevention services
- o Community participation
- o Mental health services
- o Personal Experience
- o Public Health
- o Research and Evaluations
- o Substance use prevention and treatment

Personal Statement briefly addressing the individual's involvement with the identified primary and secondary community and how he/she would interact with that community as a CPG member to carry out the Mission.

APPENDIX B

CONFLICT OF INTEREST DISCLOSURE FORM

CONFLICT OF INTEREST DISCLOSURE FORM

The Montana Community Planning Group (CPG) has members who are professionally or personally affiliated with organizations that have, or may request, or receive funds for HIV prevention activities. Because of the potential for conflict of interest, the CPG has adopted this Disclosure Form, which all CPG members sign. Completed forms are kept on file with the HIV Prevention Planning Coordinator.

The reputation and credibility of the CPG rests on its ability to make fair, objective and impartial decisions. Accordingly, it is essential to avoid situations where a conflict of interest may influence, or appear to influence, the decision-making process. Conflict of interest occurs when:

1. A member (or a relative or partner, etc.) has a financial interest, or appears to have a financial interest, in the outcome of a decision,
2. A member has an affiliation that implies or suggests influence over the outcome of a decision, and
3. A member uses threats or coercion to influence the conduct of the CPG.

GENERAL

From time to time, a member may serve as an officer, staff member, director, trustee, active volunteer or consultant to an organization with a vested interest in the outcome of the decision-making process. Situations may also arise where a member’s business or personal interests may be affected by the outcome of a decision. In all such cases, the potential for conflict should be recognized and disclosed, and appropriate steps taken to prevent influence or favoritism by such members in the decision-making process.

DISCLOSURE

Each member is under an obligation to the CPG and to the other CPG members to inform them of any position they and/or a family member and/or household member serve or have served in the past twelve (12) months in a staff, consultant, officer, board member, advisor capacity, and the investment in any business, or any volunteer activities that may result in a possible conflict of interest with the following organizations that received, may seek, and/or are eligible for HIV Prevention funding within the scope of CPG influence. A member should also disclose any activity or interest that may cause bias for or against a particular action or policy being considered by the CPG.

Each member shall sign and file a Disclosure Statement.

Organization: _____
Title: _____ Period of Affiliation: _____

(Please attach additional pages if necessary.)

CPG Member Name (Please print): _____
Signature: _____ Date: _____
Date Form Received by the Planning Coordinator: _____

APPENDIX C

CERTIFICATION REGARDING CONFIDENTIALITY OF INFORMATION FORM

(07/04)

MONTANA HIV PREVENTION COMMUNITY PLANNING GROUP

CERTIFICATION REGARDING CONFIDENTIALITY OF INFORMATION

All appointed Community Planning Group (CPG) members sign a confidentiality statement acknowledging the confidential nature of some discussions in the community planning process.

I fully understand the confidential nature of some discussions in the community planning process and agree to:

1. Destroy or return all review-related material regarding the member and nominating process.
2. Not to discuss any information regarding the health status of members and advisors in the community planning process.
3. To defer all inquiries made of me concerning official community planning positions to the co-chairs or designated representative of the CPG.

CPG Member Name (*Please Print.*): _____

Signature: _____ Date: _____

Date Certification Received by the Planning Coordinator: _____
Renewal Date: _____

APPENDIX D

MEMBERSHIP APPOINTMENT CONFLICT RESOLUTION PROCEDURE

(Adopted 01/01; Rev.03/03)

HIV PREVENTION COMMUNITY PLANNING GROUP (CPG)
MEMBERSHIP APPOINTMENT CONFLICT RESOLUTION PROCEDURE

PREMISE: The Director of the Department of Public Health and Human Services (DPHHS) appoints members to the Community Planning Group for HIV Prevention (CPG) based on the CPG Membership Committee's selection process and recommendations. The CPG operates as Department Advisory Council as stated in a Memorandum of Understanding.

Procedure for resolving conflicts with the DPHHS Director regarding membership appointments to the CPG:

1. The CPG Membership Committee periodically presents the names of individuals recommended for CPG membership to the Director. Upon the Director's approval, a letter of appointment is sent to the individuals. Approval letters are sent within 30 days of appointment.
2. If the Director has reason for concern about a particular potential appointment, he/she will first discuss this concern with the CPG Planning Coordinator and the DPHHS Co-Chair of the CPG.
3. The Director may choose to interview the potential appointee in person or on the telephone, in an effort to allay concerns about the appropriateness of this appointment.
4. If the Director is unable to resolve the concerns, he/she will prepare a memo to the CPG Planning Coordinator and the Health Department Co-Chair, outlining the reasons that he/she is not inclined to appoint this particular individual to the CPG. This should occur within 30 days of receiving the initial recommendation.
5. The CPG Planning Coordinator and the Health Department Co-Chair will share this information with the CPG Community Co-Chair. The Co-Chairs will decide whether it is necessary to pursue the matter further.
6. Within seven (7) days of the Director's memo, either Co-Chair may decide to call a meeting of the CPG Executive Committee to review the Director's decision.
7. The CPG Executive Committee will review the Director's memo and decide whether it is appropriate to pursue the matter. The Executive Committee may:
 - a. Request a meeting with the Director;
 - b. Put their concerns in writing to the Director; or
 - c. Decide to not pursue the matter further.

8. Within 30 days of either meeting with the Executive Committee or reviewing the Committee's written concerns, the Director will make a final decision regarding the appointment in question. This decision will be communicated, in writing to the CPG Co-Chairs and the potential appointee.

APPENDIX E

INTERNAL MEMBERSHIP CONFLICT RESOLUTION PROCEDURE

(Adopted 01/01; Rev. 03/03)

HIV PREVENTION COMMUNITY PLANNING GROUP

INTERNAL MEMBERSHIP CONFLICT PROCEDURE

PREMISE: The CPG Membership Committee recruits and recommends individuals as CPG members. The Membership Committee tracks the term and all membership criteria to assure parity, inclusion, and representation on the CPG.

Procedure for resolving conflicts resulting from the CPG Membership Committee's action or inaction:

- A. The Membership Committee distributes CPG Membership Applications as needed.
- B. The Membership Committee Chair notifies all applicants of the status of their applications.
- C. An unsuccessful applicant may request a re-review of his/her application if he/she believes any of the following circumstances occurred.
 - 1. The Committee was not fully informed of his/her qualifications
 - 2. The Committee review was not conducted properly. For example, there was not a Committee quorum as stated in the CPG Policy and Procedures Manual.
 - 3. His/Her application was not presented to the Committee.

NOTE: When requesting a re-review of his/her application, the applicant must do so in writing and must specify the reason(s) for the request, and provide any additional information regarding his/her qualifications substantiating the reason(s).

- D. Within thirty (30) days of the request, the Membership Committee will re-review the application.
- E. At least seven (7) days in advance of the review, the Membership Committee Chair will notify the applicant, in writing, of the date and time of the application review. The applicant does not participate in the review.
- F. At least seven (7) days prior to the review, the Membership Committee Chair will provide each Committee member with copies of the written request and all additional information submitted by the applicant.

- G. The Membership Committee will review the application and make a decision. Within seven (7) days of the review, the Membership Committee Chair will inform the applicant, in writing, of the decision.
- H. If the applicant is not satisfied with the decision based on his/her belief the re-review process was not carried out appropriately, he/she may file a complaint with the CPG Co-Chairs. The complaint must be filed within thirty (30) days of receipt of the decision. The complaint will be considered only if it addresses the selection process. Complaints about specific individuals involved in the process will not be addressed, unless the complaint involves abuse of the process.
- I. If the CPG Co-Chairs determine a complaint is valid (the complaint deals with problems in the process), the complaint will be referred to the Executive Committee. Within seven (7) days, the Executive Committee will discuss the situation with the Membership Committee Chair.
- J. Within thirty (30) days, the Executive Committee will consider the matter at a scheduled meeting.
- K. The Executive Committee will consider the history of the application and the process used to reach the decision. The Committee may choose to interview the applicant and/or members of the Membership Committee.
- L. The Executive Committee can take any of the following actions.
 - 1. Refer the matter back to the Membership Committee.
 - 2. Determine that the complaint is not valid and notify the applicant.
 - 3. Determine that the complaint is valid and recommend appropriate changes to the Membership Committee process.

APPENDIX F

MEMBERSHIP ANNOUNCEMENT AND APPLICATION FORM

MONTANA
HIV PREVENTION COMMUNITY PLANNING GROUP (CPG)

MEMBERSHIP ANNOUNCEMENT

PURPOSE OF HIV PREVENTION COMMUNITY PLANNING

The purpose of HIV prevention Community Planning Group (CPG) is to plan! The main product that CPG members create is a comprehensive HIV prevention plan for Montana that best represents the needs of the various communities at risk for, or infected with, HIV. The CPG works in partnership with the Montana Department of Public Health and Human Services (DPHHS) to create the plan. The Centers for Disease Control and Prevention (CDC) is the federal agency responsible for HIV prevention in the United States. The CDC awards funds through its Cooperative Agreement. The CDC provides the Guidance for HIV Prevention Community Planning, which outlines the required plan components, the roles and responsibilities of the state health department, the CPG, and the CDC, and all aspects of community planning. Community planning supports broad-based community participation in HIV prevention planning, identifies priority HIV prevention needs, and ensures that HIV prevention resources target priority populations and interventions.

MISSION STATEMENT

The mission of the HIV Prevention Community Planning Group (CPG) is to reduce the number of Montanans who become HIV positive or re-infected with HIV.

CPG MEMBERSHIP

Montana's HIV Prevention Community Planning Group (CPG) is seeking individuals to become members who will reflect the perspective of a specific community at risk for, or infected with, HIV. Individuals do not have to be a member of the community but should truly reflect that community's values, norms, and behaviors. These individuals should have expertise in understanding and addressing the specific HIV prevention needs of the community. The representative communities are: High Risk Heterosexual, HIV Prevention Services Providers, HIV-Positive, Injection Drug Users (IDU), Men who have sex with Men (MSM), and Native American.

The CPG Membership Committee reviews applications and makes selections based on membership criteria. The names of selected individuals are submitted to the Department of Public Health and Human Services (DPHHS) Director who formalizes the selection by written acknowledgement.

THE ROLE AND RESPONSIBILITIES OF A MEMBER

CPG members shall commit to a three-year term with the option of submitting an application to be considered for additional terms. There will be four (4) meetings each year convened at a

central location. Members are encouraged to participate on a standing committee and/or workgroup(s) throughout the year in addition to attending regular CPG meetings.

MEETING REQUIREMENTS

CPG members shall not be absent from more than one meeting per year (unless there are extenuating circumstances). Members are reimbursed at current State rates for expenses (travel, meals, lodging), plus a stipend, for attending meetings. New members receive an orientation to HIV prevention community planning.

- Members of each community select committee representation each year. Periodically, work groups are established to deal with specific short-term projects or issues. The frequency of committee or workgroup meetings is determined by the committee/workgroup.
- Committee/workgroup meetings are usually held via telephone conference calls or in conjunction with CPG meetings whenever possible. Members are reimbursed for face-to-face meeting expenses.

HOW TO APPLY

You can request an application by contacting the HIV Prevention Planning Coordinator at phone: (406) 444-1604 or write to: P O Box 202951, 1400 Broadway, Cogswell Building, Room C-211 Helena, MT 59620. If you have any questions you may direct them to this individual.

All information provided in the application is kept strictly confidential.

➤ **DETACH AND MAIL THE FOLLOWING APPLICATION TO:**

HIV Prevention Planning Coordinator
1400 Broadway, Cogswell Building, Room C-211
P O Box 202951
Helena, MT 59620

➤ **MARK THE ENVELOPE 'CONFIDENTIAL'.**

MONTANA
HIV PREVENTION COMMUNITY PLANNING GROUP (CPG)

CPG MEMBERSHIP APPLICATION

ALL INFORMATION PROVIDED IN THIS APPLICATION WILL BE KEPT STRICTLY CONFIDENTIAL.

Name of Applicant	
Residential Address	Residential Phone:
Residential FAX and/or E-Mail:	

Send correspondence to: Home Ot

COMPLETE EACH OF THE FOLLOWING FIVE SECTIONS

Section I. Community Involvement

Mark the box to indicate your primary and secondary representation. Communities are listed alphabetically. Check one box only in a primary community and one box only in a secondary community.

Primary Community Representation

Secondary Community Representation

High Risk Heterosexual

High Risk Heterosexual

HIV Services Providers

HIV Services Providers

HIV-Positive

HIV-Positive

IDU (Injection Drug User)

IDU (Injection Drug User)

MSM

MSM

Native American

Native American

***Representation** is the act of serving as a CPG member reflecting the perspective of a specific community. You do not have to be a member of the community but should truly reflect that community's values, norms, and behaviors. You should have expertise in understanding and addressing the specific HIV prevention needs of the community. You must be able to participate in objectively weighting the overall priority prevention needs of the community.*

The following criteria are considered in assuring broad representation on the CPG. Care will be taken to attempt to balance the representation from each community regarding age, geography, expertise, and life experience.

Section II. Geographic Distribution

Mark the box to indicate your county of residence.

- Urban: Reside in a county with a population greater than 30,000
- Rural: Reside in a county with a population between 5,000 and 30,000
- Frontier: Reside in a county with a population less than 5,000

Section III. Expertise/Experience

Mark all boxes that apply. Expertise/experience should directly relate to your selected communities.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Community-Based HIV Prevention Services | Includes HIV risk-reduction counseling, partner notification, interventions, peer education, or prevention case management | <input type="checkbox"/> Public Health | Includes STD/HIV/TB prevention/treatment, health promotion and disease prevention, or public health administration |
| <input type="checkbox"/> Community Participation | Includes community organizing, community outreach and education, grass roots activism, volunteer work, religious institution, or advocacy | <input type="checkbox"/> Research and Evaluations | Includes HIV surveillance, epidemiology, research of at-risk populations, HIV prevention program evaluation, behavioral/social sciences |
| <input type="checkbox"/> Mental Health Services | Includes community-based and hospital-based mental health services | <input type="checkbox"/> Substance Use Prevention and Treatment | Includes drug and alcohol abuse prevention and treatment, or harm reduction/recovery readiness |
| <input type="checkbox"/> Personal Experience | LWHA, partner, relative, MSM, IDU, alcohol/substance abuse, sex worker, etc. | | |

Section IV. Demographic: Age

Mark the box to indicate your age category.

16-24

25-39

40 +

Section V. Personal Identification

Briefly describe your personal experience/involvement as indicated in Section III, in your identified primary and secondary community as it relates to planning. Include specific examples of how you can interact with your community as a CPG member. You may attach additional pages if needed.

DIRECT QUESTIONS AND/OR MAIL APPLICATION TO:

HIV Prevention Planning Coordinator
1400 Broadway, Cogswell Bldg. Room C-211
P O Box 202951
Helena, MT 59620
Phone: (406) 444-1604

MARK THE ENVELOPE 'CONFIDENTIAL'.

APPENDIX G

SAMPLE EXIT INTERVIEW QUESTIONS

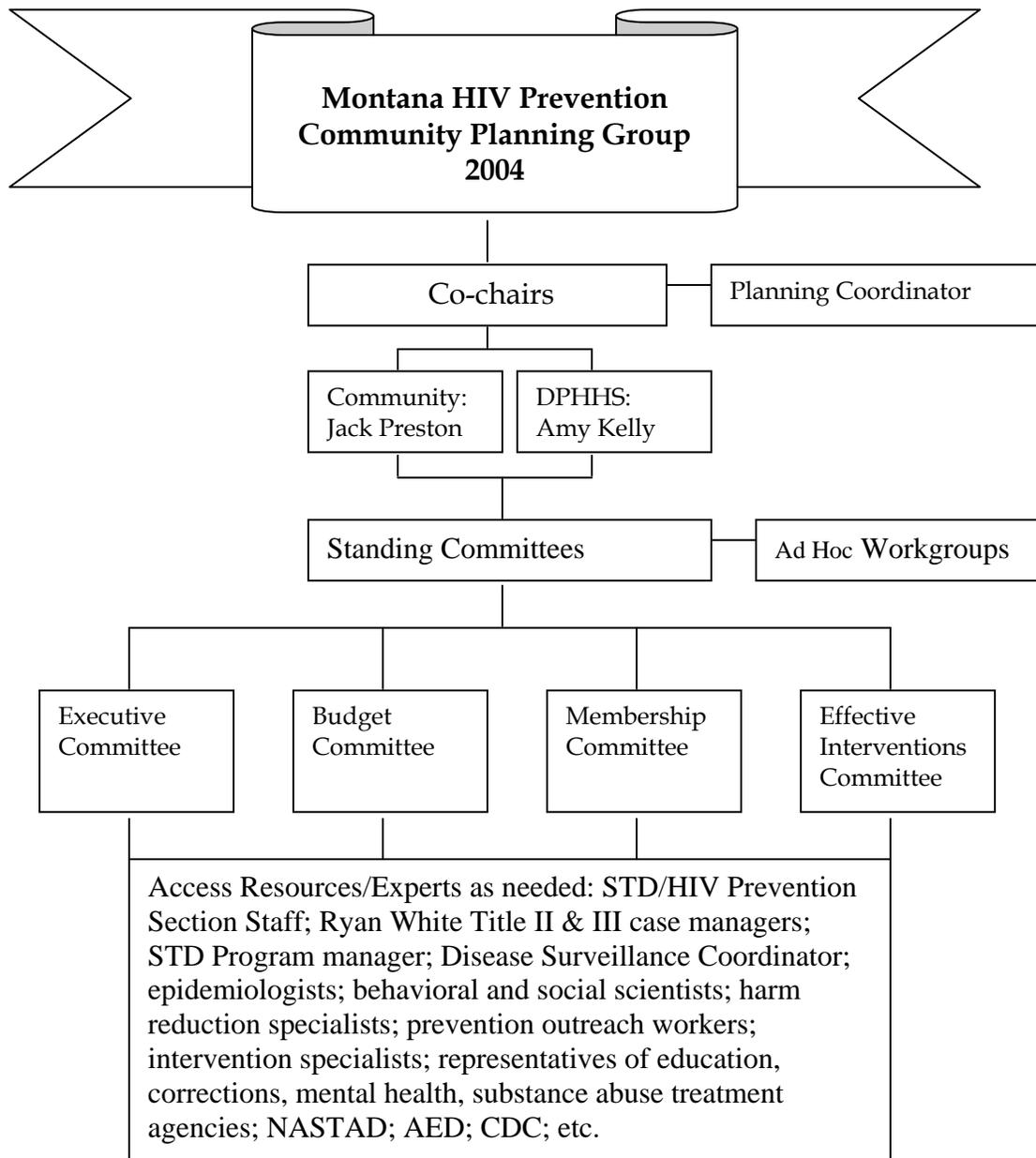
SAMPLE EXIT INTERVIEW QUESTIONS

The following questions may be used by CPG co-chairs for interviewing CPG members who have resigned. The co-chairs will conduct the exit interview over the phone or in person. The Community Planning Coordinator will document the interview.

- 1) Under what conditions would you have continued as a CPG member?
- 2) What strengths do you see pertaining to the CPG and the HIV prevention planning process?
- 3) What did you like most/least about your experience?
- 4) What suggestions, if any, would you have to improve the CPG?
- 5) Other comments?

APPENDIX H

ORGANIZATION CHART



APPENDIX I

ACRONYMS

HIV PREVENTION COMMUNITY PLANNING ACRONYMS

ADAP	AIDS Drug Assistance Program (Ryan White Title II)
AED	Academy of Educational Development, Washington DC
CBO	Community Based Organization
CDC	The Centers for Disease Control and Prevention, Atlanta, GA
CPG	Community Planning Group
CSA	Community Services Assessment
CTR	Counseling, Testing & Referral Services
DPHHS	MT Department of Public Health and Human Services
EIP	Early Intervention Program (Title II/III)
EPI	Epidemiological Profile of HIV In Montana
FSR	Final Status Report (fiscal) to CDC
GLI	Group Level Intervention (Type of Activity)
GMTF	Gay Men's Task Force
HCV	Hepatitis C Virus
HE/RR	Health Education/Risk Reduction (Intervention Category)
HIV	Human Immunodeficiency Virus
HIV SAFE	HIV Prevention Statewide Activities For Evaluation System
HPS	HIV Prevention Site
HRSA	Health Resources Services Administration; Ryan White Care Act
IDU	Injection Drug User (target population)
IHS	Indian Health Service
ILI	Individual Level Intervention (Type of Activity)
MMWR	Morbidity and Mortality Weekly Report (from CDC)
MSM	Men Who Have Sex With Men (target population)
MTAP	Montana Targeted Prevention Program
NAPWA	National Association of Persons Living with HIV/AIDS
NASTAD	National Association of State & Territorial AIDS Directors
NMAC	National Minority AIDS Council, Washington DC
NPIN	National Prevention Intervention Network
OPI	Office of Public Instruction, State of Montana
PCM	Preventive Case Management (Intervention Category)
PCRS	Partner Counseling and Referral Services
PIR	Parity, Inclusion and Representation (CPG Membership Composition)
PLWA	People Living With AIDS
PSE	Public Sex Environment
RFP	Request for Proposals (For contracted services providers)
SAFE	Statewide Activities For Evaluation System
SPC	Statewide Planning Committee (Ryan White Title II)
STD	Sexually Transmitted Diseases

TA
YRBS

Technical Assistance
Youth Risk Behavior Survey

APPENDIX J

GLOSSARY

HIV Prevention Glossary

Accountability: A framework that has been created to determine how a group and its members will be responsive and responsible to itself and the community as it carries out its mission.

Advocacy: Representation of the needs of a particular community. This can involve education of health and social service providers, local policy makers, elected officials and the media.

AIDS: Acquired Immunodeficiency Syndrome; clinical definition of illnesses caused by HIV: A CD4 count less than or equal to 200, or one or more diagnosed opportunistic infections.

Anonymous: As in anonymous testing, an individual's identifying information is not linked to testing information.

Antibodies: Proteins made in the blood that identify foreign particles and stimulate an immune response.

Antigen: any substance that provokes an immune response when introduced into the body, viruses and bacteria.

At-Risk Population: Specific group of people who have a greater chance of becoming HIV-infected due to behaviors or actions common to the group (i.e., injection drug users, men who have sex with men).

Behavioral Risk Factor Surveillance System (BRFSS): A telephone survey conducted by nearly all states that provides information about a variety of health risk behaviors, from smoking and alcohol use to seat belt use and knowledge of HIV transmission.

Behavioral Science: A science, such as psychology or sociology, that seeks to survey and predict responses (behaviors and actions) of individuals or groups of people to a given situation, i.e. why people do what they do.

Behavioral bisexual: Describing a person who has sex with male and female partners, but who may self-identify as heterosexual.

Bylaws: Standing rules written by a group to govern their internal function. Bylaws address issues of voting, quorums, attendance, etc.

Capacity Development: Building the abilities and knowledge of individuals or groups so that they may fully participate in a process or organization.

CBO: Community-based organization, a structured group offering services to specific groups of people in a defined area. These groups may include minority groups, housing for the homeless, and AIDS service organizations.

CDC: The Centers for Disease Control and Prevention; this is the federal agency responsible for tracking diseases that endanger public health, such as HIV and tuberculosis.

CD4 (or T4): A type of white cell that oversees the action of the immune system and is the main target of HIV. Also called a helper T-cell.

Chlamydia: The most common bacterial sexually transmitted infection.

Co-Chairs: Person(s) assigned by the State Health Department or elected by planning groups who are responsible for organizing, convening, and leading the HIV community prevention planning groups.

Coalition: An alliance of community groups, organizations or individuals to meet a goal or purpose.

Collaboration: A group of people or organizations working together to solve a problem in a process where individual views are shared and discussed and may be changed as the group progresses toward its goals.

Community: A group of people limit who share a common language, ethnicity, geographic area, behavior or belief.

Community Planning Groups (CPGs): groups responsible for conducting HIV Prevention Community Planning; CPGs are composed of community representatives, scientist and other technical experts, non-governmental organizations, and departments of health, education, corrections, substance abuse prevention, mental health treatment, etc.

Community Prevention Planning: An ongoing process in which state and local health departments share responsibility for developing a prevention plan with other governments and nongovernmental agencies and representatives of the community.

Comprehensive HIV Community Prevention Plan: The result of the Community HIV prevention planning process, this is a plan that has taken 'into account many different points of view and perspectives in order to provide the most effective prevention efforts within a specific area.

Confidential HIV testing: a person is tested for HIV and gives his or her name; specimens are marked with a code number, but can be linked to a name.

Conflict of Interest: A conflict between one's obligation to the public good and one's self-interest; for example, if the board of a community-based organization is deciding whether to receive services from Company A and one of the board members also owns stock in Company A, that person would have a conflict of interest.

Cost Effective: Economical and beneficial in terms of the goods or services received for the money spent.

Counseling and Testing: The voluntary process of client-centered, interactive information sharing in which an individual is made aware of the basic information about HIV/AIDS, testing procedure, how to prevent the transmission and acquisition of HIV infection, and given tailored support on how to adapt this information to their life.

Diverse / Diversity: Made up of all kinds; having a variety of people, perspectives, etc. in one organization, process, etc.

Efficacy: Power or capacity to produce a desired effect. If a prevention program has efficacy, it has been successful in achieving what it was intended to do.

Epidemic: A disease that has spread rapidly among a large number of people within a short period of time.

Epidemiological Profile: a description of the current status, and impact of an infection diseases or other health-related condition in a specified geographic area.

Epidemiology: The study of epidemics and epidemic diseases such as HIV and tuberculosis; in prevention planning, this epidemiological information shows us which populations, age groups, ethnic groups, etc., are affected by HIV in a defined area.

Ethnicity: A group of people who share the same place of origin, language, race, behaviors, or beliefs.

Evaluation Goal: A broad statement about the purpose of the evaluation; what will be gained by conducting an evaluation of the community planning process.

Evidence-Based: In prevention planning, based on evidence that is collected from scientific data, such as reporting of AIDS cases to health departments and needs assessments conducted in a scientific manner.

Focus Group: An open-ended discussion and interview process to determine attitudes and opinions and to test new ideas among a small number of people who share common knowledge of the subject being discussed.

Forum: A meeting or other outlet that provides an opportunity to share ideas and concerns a particular topic in order to resolve disputes.

Gonorrhea: a bacterium, which is the principal cause for sexually transmitted disease in males and females. In both sexes it can cause skin lesions, arthritis and rarely meningitis or endocarditis.

Grant: The money received from an outside group for a specific program or purpose. Applying for a grant is a competitive process that involves detailed explanations of why there is a need for the money and how it will be spent.

Grantee: The person or group receiving funds from an outside source. Term referring to state and local health departments that have received money from the CDC for prevention planning in their areas.

Grassroots: Social groups at a local level rather than at the center of a major political activity or area, referring to locally based community members being the actively involved in program activities.

Guidance: The CDC document which gives information about Community Planning.

Guidelines: Rules and structures for creating a program.

Harm Reduction: Behavior changes that reduce the chance of hurting one's self or another person; making changes in action to improve health and well being.

Hepatitis C Virus (HCV): A form of viral hepatitis, previously referred to as non A non-B hepatitis, has been the most common form of blood transfusion acquired hepatitis. Transmission though sexual contact is considered much less common exposure to blood exposure. Risk factors include recent blood transfusion, IV drug abuse or occupational exposure to blood products. There is no specific treatment. There is a test for hepatitis C antibody that indicates prior exposure.

High-Risk Behavior: Actions or choices that may allow HIV to pass from one person to another, especially through such activities as sexual intercourse and injecting drug use.

Hepatitis B Virus (HBV): A form of viral hepatitis, or inflammation of the liver, caused by an infectious agent called the Hepatitis B Virus (HBV). HBC may by

transmitted through contact with infected body fluids, including blood, saliva, seminal fluid, vaginal secretions, and breast milk.

HIV (Human Immunodeficiency Virus): a type of retrovirus that is responsible for acquiring immunodeficiency syndrome. Two closely related species have been identified.

Type 1: the predominant retrovirus recognized as the agent that induces AIDS.

Type 2: a virus closely related to HIV-1 that also leads to immune suppression.

HIV-2 is not as virulent as HIV-1 and is epidemic only in West Africa.

HIV Prevention Community Planning: A program in which people from at-risk populations and those who are HIV-infected meet with scientists and other professionals in order to decide on the most effective HIV prevention programs and methods for stopping the spread of HIV in their area.

HIV-Related Mortality Data: Statistics that represent deaths caused by HIV infection.

HIV Seroprevalence Data: Statistics that measure the level of HIV infection among selected populations that have been targeted for surveys.

HRSA / Health Resources Service Administration: A federal agency responsible for overseeing the Ryan White CARE Act.

IDU: Injecting drug user; intravenous drug user; term used to refer to people who inject drugs directly into their bloodstream by using a needle and syringe.

Immune System: The body's defense system against disease and infection.

Inclusion: An assurance that all affected populations are represented in the community planning process.

Intercourse: Intimate sexual contact between the penis and vagina or anus, or the mouth and sex organs.

Intervention: An activity whose objective is to change or avert high-risk behavior that may result in HIV infection.

Jurisdiction: An area or region that is within the responsibilities of a particular government agency; in prevention planning, this term usually refers to an area whose HIV prevention activities are monitored and managed by a state or local health.

Letter of Concurrence: A part of a grantee's application to the CDC. This letter states that the planning group agrees with the prevention programs outlined in the grant

application. This letter will explain how the planning group created their HIV prevention plan.

Letter of Justification: A part of a grantee's application to the CDC. If the planning group does not agree with the prevention plan in the health department grant application, the health department must explain why they want a different plan in a letter of justification.

Letter of Non-Concurrence: A part of a grantee's application to the CDC. If a planning group does not agree with the health department's prevention plan in the grant application, the group must include a letter explaining why members disagree with the plan.

Mandate: A directive, or command, which can be used to refer to, a call for change as authorized by a government agency.

Measurable Objective: An intended goal that can be proved or evaluated.

MSM: Men who have unprotected sex with men. Men who report sexual contact with other men (i.e., homosexual contact) or men who report sexual contact with both men and women (i.e., bisexual contact).

MSM/UDU: Men who report both sexual contacts with other men and injection drug use.

Name/ Reporting: A law in effect which requires health departments to use a person's name when reporting their HIV status or disease condition to the CDC and other agencies.

Needle Exchange: A prevention program in which injection drug users can get clean needles by turning in their used needles. Such programs may include education in MV risk reduction and rehabilitation opportunities.

Needs Assessment: The process of obtaining and analyzing findings about community needs. Needs assessments may use several methods of information and data collection to determine the type and extent of unmet needs in a particular population or community. For example, a needs assessment may use personal interviews or questionnaires with a diverse group of community members in order to find out what they know about protecting themselves from HIV infection.

Networking: Establishing links among agencies and individuals that may not have existed previously; also strengthening links that are used infrequently. Working relationships can be established to share information and resources on MV prevention and other areas.

NIH / National Institutes of Health: A division of the federal Health and Human Services agency which conducts medical research and offers the AIDS Clinical Trials program.

OAR / Office of AIDS Research: A division of the National Institutes of Health (NIH), which is dedicated to studies of HIV and its related diseases.

Opportunistic Infection: An infection or disease that occurs due to the inability of the immune system to fight off bacteria, viruses and microbes.

Outcome Evaluation: Evidence of whether a prevention intervention has resulted in the intended short-term effects.

Outcome Objectives: Specific desired outcomes of a prevention intervention.

Pandemic: An epidemic that occurs in a large area or globally as with HIV and AIDS.

Parity: A situation in which all members have equal voice, vote and input in a decision making process.

Partner Notification: Law requiring, or program encouraging, people who test positive for HIV to give the health department the names of partners with whom they have engaged in high risk activities (sexual, needle sharing) so that the health department can notify these individuals that they may have been exposed to HIV.

PHS/Public Health Service: This federal agency addresses all issues of public health in the United States (the CDC is part of the Public Health -Service).

PIR: Parity, inclusion and representation.

Planning Process: Steps taken and methods used to gather information, interpret it, and produce a plan for rational decision-making.

Prevalence: the proportion of individuals in given population who have a particular disease at a point or interval of time.

Prevention Program: A group of interventions designed for reduction of disease among individuals whose behavior, environment or genetic history places them at high risk for exposures

Prevention Services: Interventions, programs and structures designed to change behaviors that lead to HIV infection.

Primary Prevention: Interventions and education which is intended to help people stop behaviors that may lead to their becoming infected with HIV, may include condom education, counseling that reduces the number of sex partners, HIV antibody testing/counseling, or needle exchange programs and drug abuse counseling.

Prioritize: A process of deciding which program or items are most important, with a given set of criteria. In prevention planning, this refers to helping the greatest number of people in need who are at the greatest risk for HIV infection, with the most effective programs available.

Process: The method used in undertaking a project; different groups think about and act upon projects and tasks differently and may use diverse decision-making styles, timeframes and methods.

Process Evaluation: Documentation that a particular prevention intervention has been carried out.

Process Objectives: Specific activities involved in the implementation of a program in order to produce the desired results.

Program Announcement: The CDC mandate in which the agency awards grants to state and local health departments to fund HIV prevention programs.

Program Goal: A broad statement about the ultimate purpose of a program.

PWA/PLWA: Person with AIDS; person living with AIDS.

Quantifiable: Referring to the ability to measure; if an action or program has an outcome that can be measured in terms of numbers or statistics, it is quantifiable.

Representation: Assurance that members of a planning group who represent a portion of the affected community actually share that community's values, norms and behaviors.

Risk behavior: behavior that places a person at risk for disease; for HIV/AIDS, includes such factor as sharing of injection drug use equipment, unprotected male-to-male sexual contact, commercial sex work without the use of condoms. Risk factor includes non-behavioral elements.

Ryan White CARE Act: Congress passed The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990; it provided us with the first federal funding levels for HIV/AIDS care.

Secondary Prevention: Prevention programs that serve the, needs of people infected with HIV, informing them about how they can protect their health and prevent the further spread of the virus.

Sero-Incidence: A statistical term that refers to the number or rate of new HIV or AIDS cases in a particular period of time (one year, five years, etc.).

Sero-Prevalence: A statistical term referring to the long-term rate or percentage of people infected with HIV or- diagnosed with AIDS in a defined population.

Sexually-Transmitted Disease / STD: A disease that is spread through intimate sexual contact, such as HIV, herpes, syphilis, gonorrhea.

Social Science: The study of individuals and groups, their behaviors and actions in relationship to society.

Stakeholders: Those individuals/groups who have a major interest and involvement in a process; participants in the community planning process.

Surveillance: Statistics representing people with HIV or AIDS in a given area that are reported to the CDC from public health officials who collect them from testing sites, treatment facilities and other groups, and analyze them to produce a fun picture of trends in the epidemic in the states and throughout the nation.

Syndrome: A group of signs or symptoms that indicate a specific disease.

Syphilis: a contagious disease that can be spread sexually or from infected mother to her child causes by the organism *Treponema pallidum*. Also known as lues and "bad blood".

Target Populations: Groups of people who are the focus of HIV prevention efforts due to high rates of HIV infection among those groups; they are defined by using CDC AIDS surveillance data broken down by ethnicity, gender, sexual orientation and other factors.

Technical Assistance: Training and skills development which allows people and groups to do their jobs better; this includes education and knowledge development in areas that range from leadership and communications to creating an effective needs assessment tool and understanding statistical data.

Transgender: a general term for any person who adopts a gender identity that does not strictly identify with their biological sex (i.e.. biological male who identifies as a woman, or vice-versa). The term transgender includes biological males who live their entire lives as women and biological females who live their entire lives as men whether

or not they have had surgical procedures to alter the appearance of their genitalia. The term also refers to individuals who either publicly or privately cross-dress (dress in clothing traditionally worn by another gender), and those who are intersexes (born with ambiguous genitalia and/or sex chromosome)

Viral Load: The number of viral particles (usually HIV) in a sample of blood plasma. HIV viral load is increasingly employed as a surrogate marker for disease progression. It is measured by PCR and bDNA tests and is expressed in number of HIV copies or equivalents per milliliter.

Youth Risk Behavior Surveillance System (YRBSS): National, state and local school-based surveys of adolescents addressing health issues that include drug use and sexual behavior.

APPENDIX K

GROUND RULES

HIV Prevention Community Planning Group Ground Rules

All members will –

- Honor the mission and remember that we are here for the community we serve.
- Stay focused on the task and demonstrate facilitative behaviors that help others stay on task.
- Demonstrate respect for each other by:
 - Listening actively and honorably.
 - Not interrupting the group with side conversations.
 - Using “I” statements.
 - Turning off cell phones.
- Address issues rather than personalities; don’t take it personally and don’t give it personally.
- Avoid assumptions – when it’s unclear, ask.
- Don’t let assumptions about a member or a Community get in the way of the “whole picture”.
- Avoid judgments and learn from diversity.
- Get to the point.” Speak when it’s necessary and not be repetitive – be aware of group time and your communication style and behaviors.
- Honor the spirit of confidentiality by:
 - Only speaking for yourself and your community and about yourself and your community.
 - “Keeping it” in the group.
 - Honoring the reputation of others in all our comments and avoiding personalizing.
 - Agreeing on what can be shared from each meeting.
- State appointed CPG members shall conduct themselves in a manner that reflects positively upon the CPG.

APPENDIX L

Member Travel Assistance Policy

Community Member Travel Assistance Policy

1. FDH & Associates and Yellowstone AIDS Project (YAP) will be the two sites that will assist community-planning members with travel advances.
2. Members will need to contact the agency in their area two-weeks prior to travel. FDH & Associates (406) 829-8075 and YAP (406) 245-2029.
3. The Agency will work with the client to cover travel, meal and lodging expenses (*Only if hotel and meals are **not** covered during the meeting*). The total advance is not to exceed the state reimbursement rate.

Reimbursement Rates:

Hotel - May 15 through Oct 15 \$55 a night
Oct 16 through May 14 \$35 a night

The member will need the Original receipt with zero balance attached to the travel worksheet.

Meals – Members will need to be in travel status for a minimum of 3 hour from time they leave home to the time they return.
\$5 breakfast if they leave before 7:00 am
\$6 lunch if they leave before 12:00 noon
\$12 for dinner if they return after 6:00 pm

Mileage - .375/ mile (if person is wanting a bus ticket or plan ticket that exceeds the mileage reimbursement the agency will need to obtain prior approval from the STD/HIV Prevention Section).

4. Members will complete the **TRAVEL EXPENSE WORKSHEET** and attach their hotel receipt and return it to the to state staff at the meeting.
5. The agency will send the invoice to the STD/HIV Prevention Section for payment including a \$10 administration fee per client they assist.

A SURVEY OF HIV PREVENTION INTERVENTIONS IN MONTANA

Name & Title of Person Completing this Form _____

Name of Agency _____

Phone # _____ E-Mail _____

Address of Agency _____

Email Survey: Annie.Sondag@mso.umt.edu

Fax or Mail Survey: ATTN: Effective Interventions Workgroup; DPHHS; P.O. Box 202951; 1400 Broadway, Cogswell Rm C-211; Helena, MT 59620. Fax (406) 444-6842

1. **Please list all HIV prevention services or interventions that you offer.** (make copies of this survey if you would like to list more than four services or interventions)

a) Intervention #1: _____

How is this intervention funded?

State funded Federally funded Other funding (specify) _____

What population does this intervention target?

MSM IDU HIV+ At Risk Heterosexuals General Population

If this intervention is state funded, under what category does it fall?

Individual Level Group Level Community Level
 Prevention Case Management Health Communications/Public Information

b) Intervention #2: _____

How is this intervention funded?

State funded Federally funded Other funding (specify) _____

What population does this intervention target?

MSM IDU HIV+ At Risk Heterosexuals General Population

If this intervention is state funded, under what category does it fall?

Individual Level Group Level Community Level
 Prevention Case Management Health Communications/Public Information

c) Intervention #3: _____

How is this intervention funded?

State funded Federally funded Other funding (specify) _____

What population does this intervention target?

MSM IDU HIV+ At Risk Heterosexuals General Population

If this intervention is state funded, under what category does it fall?

Individual Level Group Level Community Level
 Prevention Case Management Health Communications/Public Information

d) Intervention #4: _____

How is this intervention funded?

State funded *Federally funded* *Other funding (specify)* _____

What population does this intervention target?

MSM *IDU* *HIV+* *At Risk Heterosexuals* *General Population*

If this intervention is state funded, under what category does it fall?

Individual Level *Group Level* *Community Level*
 Prevention Case Management *Health Communications/Public Information*

2. Of the intervention you have listed above list two that you believe are most effective and describe briefly any information you have about their effectiveness.

a) Intervention #1 _____

Information regarding effectiveness (scientific basis, curriculum utilized, anecdotal):

b) Intervention #2 _____

Information regarding effectiveness (scientific basis, curriculum utilized, anecdotal):

3. If you could do any intervention you wanted to, what would it be and why?

4. Is there someone in your area who is doing effective HIV Prevention work that you would like to see recognized for that work?

Additional Comments?

FORM B: ESTABLISHING INTERVENTION PRIORITIES

Use a separate form for each intervention you are considering implementing.

TARGET POPULATION _____

NAME OF INTERVENTION _____

FACTORS TO CONSIDER IN SETTING PRIORITIES AMONG POSSIBLE INTERVENTIONS*			
1.	Is the intervention legal?	YES	NO UNSURE
2.	Does the intervention meet the needs of one of your priority target populations?	YES	NO UNSURE
3.	Did the target population have input in the development of the intervention?	YES	NO UNSURE
4.	Is the intervention acceptable to the community's norms and values?	YES	NO UNSURE
5.	Is the intervention acceptable to the target population's norms and values?	YES	NO UNSURE
6.	Is there research that demonstrates the effectiveness of this type of intervention?	YES	NO UNSURE
7.	Is the intervention realistic?	YES	NO UNSURE
8.	Are there sufficient resources to carry out the intervention?	YES	NO UNSURE
DECISION: IS THIS AN ACCEPTABLE INTERVENTION?		YES	NO UNSURE

*This checklist should be considered a "tool" in the decision making process. It should be used as a forum for discussion and does not necessarily need to dictate final decisions.

Please briefly describe the process your group went through in choosing interventions. For example, when and where did the decision making process take place; who was a part of the process; was group consensus required or were decisions made by majority vote, etc.