



**HIV PREVENTION STRATEGIC PLAN
FOR FEDERALLY FUNDED HIV
PREVENTION PROGRAMS IN KANSAS**

**Developed by the Kansas HIV Prevention Community
Planning Group In Collaboration and Partnership with
the Kansas Department of Health and Environment
HIV/AIDS Section**

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PREAMBLE

The HIV Prevention Community Planning Group (CPG) is committed to a variety of strategies to take on the challenges required to reduce and eliminate HIV infection. Our team acknowledges the needs and recommendations of communities decimated by this disease. It is imperative that we continue to better prepare for the future by exploring innovative methods of working together to confront our vision of a world without HIV infection. The CPG is finding through its work that the association of HIV/AIDS with gay, bisexual, transgender, males-who-have-sex-with-males, injection drug users, HIV positive individuals, and people of color, greatly hampers the efforts of communities to respond to the epidemic. It is our contention that unaddressed issues of homophobia, racism, and sexism remain as unseen factors in the spread of AIDS. These issues must be properly and adequately addressed as the basis of an objective, focused response to the epidemic.

We also believe that:

Effective harm reduction, outreach, and needle exchange programs are necessary for prevention efforts focused on injection drug users.

Advocacy strategies and media efforts by people living with HIV infection increases familiarity, helps lessen stigma, reduces discrimination and fosters acceptance by making the epidemic more realistic, non-mythical and more visible.

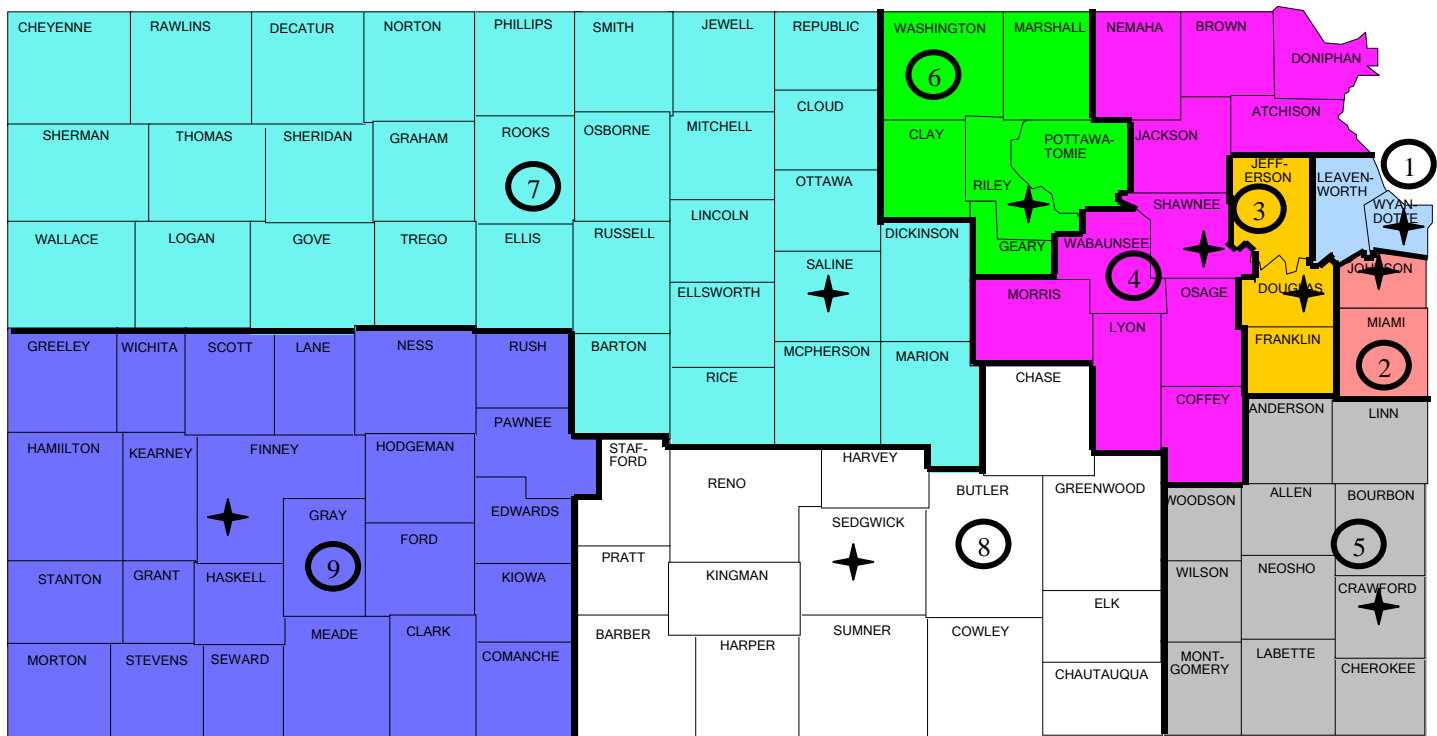
Effective strategies for preventing disease progression and secondary infections should be an integral part of all prevention efforts.

GLOSSARY OF TERMS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARC	American Red Cross
BEDP	Bureau of Epidemiology and Disease Prevention
CARE	Comprehensive AIDS Resources Emergency Act
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CPG	Community Planning Group
CRCS	Comprehensive Risk Counseling and Services
CTR	Counseling Testing Referral
CTS	Counseling and Testing Site
DIS	Disease Intervention Specialist
DOC	Department of Corrections
Epidemiology	The study of disease patterns in populations
HC/PI	Health Communication/Public Information (type of intervention)
HD	Health Department
HE/RR	Health Education & Risk Reduction
Het Sex	Heterosexual sex: All high-risk sex between a male and a female. As used in this profile, it generally refers to the risk behavior of Females having sex with a bisexual male, IDU or person known to be HIV positive.
HIV	Human Immunodeficiency Virus
IDG	HE/RR Intervention Delivered to a Group
IDI	HE/RR Intervention Delivered to an Individual
IDU	Injection drug use: Illegal drugs, or drugs being used without prescription administered into the body with a needle.
KDHE	Kansas Department of Health and Environment
LHD	Local Health Department
LTC	Linkage to Care
MSM	Men who have sex with men, whether they identify as homosexual, heterosexual, bisexual, or transgender. As used in this profile, it generally refers to the risk behavior of unsafe, unprotected male to male sex.
MSM/IDU	Men who have sex with men (whether they identify as bisexual, heterosexual, or homosexual) and also inject drugs.
OES	Office of Epidemiologic Services

Opportunistic Infection	Disease caused by agents that are commonly found in the body or in the environment and take advantage of the suppressed immune system
PIR	Parity Inclusion & Representation
Prevalence	The estimated total number of living cases at a specific point in time
Prevalent Cases	For this document, prevalent cases are those people presumed to be living with HIV or AIDS. If no date of death is reported for an individual, that individual is presumed to be still living.
STD	Sexually Transmitted Disease

HIV Regions in Kansas



- Region 1- Kansas City City
- Region 2- Shawnee
- Region 3- Lawrence
- Region 4- Topeka
- Region 5- Pittsburg
- Region 6- Manhattan
- Region 7- Salina
- Region 8- Wichita
- Region 9- Garden City
- Major Cities

Chapter 1

Overview of the Community Planning Process

THE COMMUNITY PLANNING PROCESS

HIV prevention community planning is one of nine required essential components of a comprehensive HIV prevention program. The purpose of HIV prevention community planning is to improve HIV prevention programs by strengthening the scientific basis, community relevance and population or risk based focus of HIV prevention interventions in each project area.

In 1994 the Kansas Department of Health and Environment (KDHE) began the process of HIV Prevention participatory community planning using funds provided by the federal Centers for Disease Control and Prevention (CDC). HIV Prevention Community Planning is an ongoing process whereby KDHE and members (or representatives) of communities /populations at-risk for HIV infection set priorities and develop goals and objectives designed to promote effective HIV prevention programming. Kansas has one statewide HIV Prevention Community Planning Group (CPG) that is responsible for creating a comprehensive statewide prevention plan. **The structure and processes of the CPG are governed by the Community Planning Group By-Laws (See Appendix 1).**

In year two of prevention planning, the CPG restructured itself into five committees to make it more efficient and facilitate the inclusion of communities across Kansas. The five committees were made up of three to four CPG members each. The remainder of committee membership is composed of non-CPG community activists across Kansas who have an interest or expertise in the affairs of that committee. Membership on all committees is flexible and on-going. Committees complete a series of necessary planning tasks identified by the CPG. In October 2006 and November 2008 the CPG voted to make changes in the committee structure. At present the committees are:

- Programs, Strategies and Population Prioritizing
- Membership, Recruitment and PIR
- By-Laws
- Prevention/Care Collaboration

In addition to these standing committees, CPG maintains a task force committee to meet special concerns in the state prison system.

The Kansas CPG continues to increase its effort to market community planning to diverse populations by:

- Involving community members by making meetings more accessible;
- Gathering information from community members on how we can involve them in the process;
- Informing service providers about HIV prevention data & recommendations.
- A multi-day educational retreat and participant evaluations.

MEMBERSHIP

How are CPG members Recruited and selected?

For Kansas, the need to include the perspectives of the diverse populations in HIV prevention planning, particularly those most affected by the HIV/AIDS epidemic, is paramount. Members on the CPG represent high risk, high prevalence target populations and areas of expertise related to HIV prevention. The Recruitment Committee recruits and selects nominees to the CPG on a statewide basis. Public notice of the nomination process is provided by distributing information through key individuals, flyers, E-mail, targeted publications, announcements at public meetings, and conferences. Based on an inclusion survey of the current CPG membership (membership must be representative of individuals most affected/infected by the epidemic), nominees are selected and asked to interview with the Recruitment Committee. If selected, the nominee participates in an orientation training conducted by the KDHE CPG co-chair and members from the same geographic area. Interested applicants are encouraged to actively participate in the CPG process whether or not they are selected to serve on the 25 member-planning group. Any person interested in participating in the Community Planning Process should contact the chair of the Recruitment Committee or the KDHE HIV Prevention Program at 785-296-6174.

What is the current composition of the Kansas CPG Membership?

The demographic distribution of persons comprising the CPG voting membership as of July 1, 2009 is shown summarized in Table One. Other representatives include front line providers of HIV prevention, substance abuse, and mental health services; community based organizations, local health departments, behavioral scientists and health planners. State agencies with member representation are the Kansas Department of Corrections (KDOC), Social and Rehabilitation Services (SRS) for alcohol/substance use services, and the Kansas Department of Education.

CPG Voting Membership	7/1/2007		7/1/2008		7/1/2009	
Profile	Total-%		Total-%		Total-%	
<u>GEOGRAPHIC DISTRIBUTION</u>	20	100%	19	100%	17	100%
Urban Metro	14	70%	14	74%	15	12%
Urban non-Metro	5	25%	4	21%	2	0%
Rural	1	5%	1	5%	0	0%
<u>AGENCY/REPRESENTATION</u>	20	100%	19	100%	17	100%
Faith Community	1	5%	1	5%	1	6%
Minority Board CBO	1	5%	1	5%	1	6%
Non-Minority Board CBO	7	35%	6	30%	4	24%
State Health Dept.	1	5%	1	5%	1	6%
Other Government (State)	3	15%	3	15%	1	6%
Local Health Department	1	5%	1	5%	3	18%
Academic/Primary Care Inst.	0	0%	0	0%	1	6%
Individual	6	30%	6	30%	5	29%
<u>GENDER</u>	20	100%	19	100%	17	100%
Male	11	55%	9	47%	6	35%
Female	9	45%	10	53%	11	65%
Transgender	0	0%	0	0%	0	0%

Table 1

CPG Membership	7/1/2007		7/1/2008		7/1/2009	
Profile	Total-%		Total-%		Total-%	
<u>EXPERTISE</u>	20	100%	19	100%	17	100%
Epidemiologist	0	0%	0	0%	0	0%
Behavioral or Social Scientist	3	15%	2	11%	4	24%
Evaluation Researcher	0	0%	0	0%	0	0%
Primary Intervention Specialist	8	40%	8	42%	6	35%
Health Planner	2	10%	2	11%	1	6%
Community Representative	7	35%	7	37%	6	35%
<u>AGE</u>	20	100%	19	100%	17	100%
13-19	0	0%	9	47%	1	6%
20-29	2	10%	10	53%	1	6%
30-39	2	10%	0	0%	3	18%
40-49	8	40%	0	0%	6	35%
50-OVER	8	40%	19	100%	6	35%
<u>RACE</u>	20	100%	19	100%	17	100%
African American	6	30%	4	21%	4	24%
White	12	60%	14	74%	10	59%
Asian	0	0%	0	0%	0	0%
Native Hawaiian/Pacific Islander	0	0%	0	0%	0	0%
Alaska/Native American	2	10%	1	5%	2	12%
Other/Multi-Racial	0	0%	0	0%	1	6%
<u>Ethnicity</u>	20	100%	19	100%	17	100%
Hispanic /Latino	3	15%	3	16%	3	18%
non-Hispanic/Latino	17	85%	16	84%	14	82%
<u>Representation of HIV Exposure</u>	20	100%	19	100%	17	100%
MSM	4	20%	4	21%	2	12%
IDU	0	0%	0	0%	1	6%
MSM/IDU	0	0%	0	0%	0	0%
Heterosexual	6	30%	6	32%	14	82%
None/Not Reported	10	50%	9	47%	17	100%
<u>Prevention Planning Region</u>	20	100%	19	100%	17	100%
1- Kansas City (Urban metro)	2	10%	1	5%	2	12%
2- Kansas City (Suburban, rural)	2	10%	3	16%	0	0%
3- Lawrence (Urban non-metro, rural)	0	0%	1	5%	1	6%
4- Topeka (Urban, rural)	4	20%	4	21%	4	24%
5- Southeast Kansas (Rural)	1	5%	0	0%	0	0%
6- North Central Ks. Riley/Geary Co. (Rural)	3	15%	2	11%	1	6%
7- Northwest Kansas, Salina (Rural)	0	0%	1	5%	0	0%
8- Wichita, S. Central Ks (Urban, rural)	7	35%	6	32%	8	47%
9- Southwest Kansas (Rural)	1	5%	1	5%	1	6%

Table 1

Chapter 2

Epidemiologic Profile

OVERVIEW

The complete HIV/AIDS Epidemiologic Profile is included in its entirety as Appendix 2 of this document. Copies can also be obtained from the HIV/AIDS Section of the Bureau of Epidemiology and Disease Prevention, Kansas Department of Health and Environment (KDHE) or by calling 785-296-5223. A current version is also available online at the KDHE website <http://www.kdheks.gov/hiv/surveillance.html>. Surveillance data reported and analyzed for the epidemiologic profile includes AIDS and HIV cases reported as of December 31, 2006 and Sexually Transmitted Disease (STD) data in defined populations of Kansas. In addition to the Epidemiologic Profile, a surveillance report newsletter is compiled and distributed bi-annually with the most recent HIV/AIDS statistics as of December 31, 2008 available. This information is also available on-line at the KDHE website above.

Kansas is divided into nine HIV/AIDS case management and Prevention regions (see map on page 5). The regions are not equal in population, geographic size or in the burden of HIV/AIDS infection. The larger population centers are located in northeastern Kansas along Interstate-70 from Topeka (the state capital) to Kansas City, Kansas. However, the largest city, Wichita, is located in the south central part of the state. Much of the rest of the state is rural, having a population density that is about half that of the United States as a whole. Thirty-one of the 105 counties in Kansas are designated as frontier counties having a population density of less than six persons per square mile.

EXECUTIVE SUMMARY

At the end of 2007, a total of 2,495 persons were presumed to be living with HIV infection in the state of Kansas; of these, 53% (1,330) were AIDS cases. Approximately 70% of all counties in Kansas have individuals living with HIV/AIDS. Five of the 105 counties in Kansas contain more than 100 prevalent HIV/AIDS cases. From 2000 to 2007 the number of prevalent cases of HIV/AIDS has increased by 100% (1,243 to 2,495).

Due to the advent of highly active antiretroviral therapy (HAART) in 1996, the number of AIDS related deaths has sharply declined. In the state of Kansas, from 2001-2007 there were on average 38 deaths per year with 22 occurring in 2007. HIV is slowly becoming a chronic health condition as opposed to an acute illness. According to the CDC persons infected with the disease are now able to live longer and more productive lives, with HAART.

Over the past few years, the infection rates for both the non Hispanic Black and Hispanic populations in the state of Kansas has increased, although the number total number of cases for these groups are small. These two minority groups make up approximately 15% of the state's population and account for 46% of the states newly diagnosed HIV/AIDS cases thus showing a need for increased prevention and education efforts in these populations. Blacks however show the greatest burden with the infection rate for Blacks currently 8 times that of Whites and 3 times that of Hispanics.

The total number of newly diagnosed HIV/AIDS cases in Kansas has increased

by 55% from 132 cases in 2000 to 205 cases in 2007. Among the 205 newly diagnosed cases of HIV/AIDS in 2007, 54.1 % (111) were new AIDS cases and 45.9% (94) were new HIV (non-AIDS) cases.

Men continue to be the most impacted gender group. The number of women reported as positive in Kansas has been relatively consistent. Men who have sex with men (MSM) continue to be the highest risk population among all of the risk categories. At the end of 2007 there were a total of 104 newly diagnosed cases noting their exposure risk as MSM, followed by 28 cases noting heterosexual risk. It is worth noting that Black and Hispanic MSM have higher infection rates than that of White MSM. The most impacted age groups are those between the ages of 25-44.

Region 1, which includes Wyandotte and Leavenworth counties, currently has the highest infection rate for newly diagnosed HIV cases, compared to any other region in the state. Region 8 continues to have the largest population of persons living with HIV and AIDS in the state. Region 8 also had the largest proportion of newly diagnosed female cases of HIV in 2007.

Chapter 3

Community Services Assessment

COMMUNITY SERVICES ASSESSMENT

Data relating to HIV prevention services has enhanced and significantly improved HIV prevention planning in Kansas. Community Services Assessment (CSA) documents can be found online at <http://www.kdheks.gov/hiv/cpg.html>.

In 2002 an outside contractor, The Jones Institute Of Excellence at Emporia State University, conducted a CSA. The intent was to survey HIV prevention activities and consumer perceptions of HIV prevention services in Kansas. Sixteen focus group discussions with a total of 141 participants, survey responses from 53 HIV prevention contractors, and surveys received from approximately 182 prevention service clients provided the CPG with baseline data highlighting prevention activities and consumer perceptions.

In January 2006, the Jones Institute for Educational Excellence of Emporia State University was given another six-month Capacity Building grant by the Kansas Department of Health and Environment (KDHE) and the Kansas HIV Prevention Committee Planning Group (CPG). The four primary goals of this grant and the community planning process were:

Goal 1: Conduct a follow-up Needs Assessment

Conduct an additional assessment of the HIV prevention needs of the Kansas state population to follow-up the initial focus group work done in the 2002-2003 CSA.

Goal 2: Conduct a Technical Needs Survey

Assess HIV Prevention agency technical needs and training resources as part of a Capacity Building plan.

Goal 3: Conduct a Gap Analysis

Using the needs assessment follow-up and technical needs survey data, identify barriers, and met/unmet HIV prevention needs particularly in regard to high-risk state populations and determine if there are discrepancies between need and availability.

Goal 4: Make Recommendations

Make recommendations on how to reduce barriers and improve HIV preventions services.

The entire 2006 CSA update can be found in Appendix 3 of this Prevention Plan. The Executive Summary and recommendations of the 2006 Update are as follows:

EXECUTIVE SUMMARY

1. The Jones Institute for Educational Excellence at Emporia State University undertook a six-month Needs Assessment follow-up and Capacity Building grant for the Kansas Department of Health and Environment and Kansas HIV Prevention Community Planning Group that involved both focus groups and HIV-related agencies across the state of Kansas.
2. Following up previous focus groups from a similar 2002 grant, eight focus groups were conducted involving 89 participants around the state. Their responses are reported both as separate groups and collectively as a whole within this report.
3. The overall perception from the focus group members is that more HIV/AIDS-related education, advertising, information, resources, funding, and training is needed across the state. It seems that sex education and parental involvement are two areas that are underutilized in this regard. More and better agencies (as well as funding) also seem to be desired. Free or low cost services also rank high. Finally, regular clients of the HIV-related agencies seem to be familiar with many of said agencies in their local community, however, it is very unclear as to how aware the general public is of these agencies and their services.
4. The capacity building portion of the grant involved a technical needs survey that was mailed to 27 state agencies that provide HIV-related services. Eighteen total agencies responded for a response rate of 67%. Directors of community-based organizations with an HIV emphasis and local health department administrators were the most common respondents.
5. The technical needs survey identified Engaging the Target Populations, Developing Interventions, Grant Writing, Writing Realistic Program Goals and Objectives, Evaluating Client Level Outcomes, Faithfully Implementing Scientifically Proven/Evidence-Based Interventions, and Matching Community Needs to Interventions as the training areas with the biggest need. Unfortunately, few agencies are willing or able to provide training to other agencies and most are unable to devote more than 1-2 days a month toward technical need training issues. Training needs related to specific population groups/areas was very diverse and varied by agency location.
6. One day training workshops are clearly the most preferred type of training format while travel and lodging costs to these workshops are seen as the largest barrier. Time constraints were also seen as a major barrier and as such, multiple day workshops were the least preferred training format. Multiple one day regional workshops within the state may be preferable to single location statewide training.
7. Copies of all materials and instruments from the study are in the Appendices.

Focus Group Conclusions and Recommendations

The focus group format proved to be a very effective method of obtaining information about HIV-related services and other items of interest. Most groups were very talkative, friendly, and helpful. Below is a final summary of the main conclusions drawn from the focus groups that are generally very similar to the previous study.

- People already using HIV-prevention services are familiar with some HIV-related agencies in their area. However, the general public's knowledge is unknown.
- Effective agencies have professional, bilingual, friendly, and knowledgeable staff who can maintain client confidentiality and privacy. Having a wide variety of programs, resources, and lots of information (brochures, pamphlets, free condoms, etc.) is also very important. As many services as possible should be free or low cost so that people will utilize them.
- The HIV/AIDS message should be transmitted across as many different mediums as possible. The information must be accurate and personal.
- More education, awareness, and advertising is needed to reach people in the state especially in regard to schools and sex education. Parents need to be involved in the process.
- Model agencies should be identified and used as a template for new agencies (TAP seems particularly well liked).

Technical Needs Survey Conclusions and Recommendations

Based on the survey responses, some overarching conclusions can be drawn:

- Engaging the Target Populations, Developing Interventions, Grant Writing, Writing Realistic Program Goals and Objectives, Evaluating Client Level Outcomes, and Matching Community Needs to Interventions are clearly identified as the top technical assistance needs and program intervention/evaluation that should be focused on for future workshops, conferences, and training sessions.
- The intervention skills/areas that needed training were more diverse but Faithfully Implementing Scientifically Proven/Evidence-Based Interventions was viewed as the greatest need.
- Collectively, few agencies are willing or able to provide training to other agencies.
- There is considerable variability as to which population group agencies feel the need for technical assistance. There were 21 categories and all ranged between 0 and 5 votes with no population need being particularly dominant. As such, population needs tend to be specific to the agency in question.
- Most of the training needs were identified as very few additional training need topics were listed and none of them received more than a single acknowledgment.
- Agencies feel that they can generally only devote 1-2 days a month for either giving or receiving training. The biggest obstacles to attending training are clearly travel/lodging costs and time constraints. Agencies may want to do more regional training within the state (perhaps a 10 county area) so that travel and time issues are reduced.
- A one-day training format is clearly the most preferred for technical need issues while a multiple day format is the least preferred.

Chapter 4

PRIORITIZATION PROCESS INTERVENTIONS

OVERVIEW: Risk Group Definitions

PRIORITY ONE: HIV+ INDIVIDUALS

- HIV+ Individuals includes members of all risk groups and demographics.
- HIV+ Individuals is limited to HIV+ persons who are aware of their sero-status.
- HIV+ Individuals may or may not be proficient in their understanding of HIV transmission or prevention.
- HIV+ Individuals includes persons who need education on their responsibility to disclose their sero-status to partners.
- HIV+ Individuals are persons who are often isolated and reluctant to engage with others regarding their sero-status.
- HIV+ Individuals should be in or referred to care.

PRIORITY TWO: MEN WHO HAVE SEX WITH MEN (MSM)

Target Population: White, MSM age 25 – 44, in region 2 and 8; Black, MSM age 18 – 44, in region 1 and 8.

- Men Who Have Sex With Men (MSM) are men who may or may not identify as gay, bisexual, transgender or heterosexual, but do engage in sex with other men.

PRIORITY THREE: HIGH RISK WOMEN

Target Population: Black, heterosexual women, in region 1 and 8.

- Women that belong to a racial/ethnic groups that have been identified by the Kansas HIV Prevention CPG as having disproportionately high rates of HIV infection.
- Women who engage in high-risk behavior. (I.e.) Exchange sex for money and or drugs, injection drug use, alcohol and other drug use, partner and or domestic abuse victims and homeless.
- Women who have sex with men or other high-risk partners that could put them at risk for HIV Transmission. (I.e.) Partners who are injection drug users or men who have sex with men.

PRIORITY FOUR: HIGH RISK YOUTH

Target Population: Youth age 15 – 24.

High-risk youth are described as persons between the ages of 15-24 who fall under any of the following categories:

- Homeless Youth
- Runaways
- Not in school
- Unemployed
- Youth in rehabilitation
- Incarcerated youth
- Medical Indigent
- Youth in mental Health services
- Foster homes

- Migrant farm workers
- Gay/Lesbian/Bisexual/Transgender Youth
- Youth with Sexually Transmitted Diseases
- Sexually abused youth
- Pregnant
- Youth seeking counseling and testing
- Youth with signs and symptoms of HIV infection
- Sex trade workers
- Injection and non injection illegal drug use
- Engaging in Unprotected oral, anal and vaginal sex

PRIORITY FIVE: INJECTION DRUG USERS (IDU)

Target Population: IDU in region 1, 4, 5, 7 and 8.

- Use of injected drugs or steroids, during which equipment (such as needles, syringes, cotton, water) and blood were shared with others.
- Infection from blood borne pathogens, including HIV, resulting from sharing contaminated syringes, needles and other injection paraphernalia.
- High-risk unprotected sex due to impaired judgement while high on injected substances.
- Engaging in high-risk unprotected sex to obtain drugs and /or money to purchase drugs.
- The injection drug user is at high risk for a multiplicity of both blood borne and sexually transmitted pathogens, including HIV.

PRIORITY SIX: HIGH RISK INDIVIDUALS

Target Population: High Risk Individuals including those that are incarcerated and/or diagnosed or treated for Hepatitis, TB, or an STD such as Gonorrhea, Syphilis Herpes or any CDC recognized STD.

- Unprotected vaginal, anal, or oral sex (that is, sex without using condoms) with multiple partners, or anonymous partners.
- Exchanged sex for drugs or money
- Been given a diagnosis of, or been treated for, hepatitis, tuberculosis (TB), or a sexually transmitted disease (STD) such as syphilis, gonorrhea, herpes, or any CDC recognized STD.
- Received a blood transfusion or clotting factor during 1978 –1985
- Had unprotected sex with someone who has any of the risk factors listed above.

PRIORITIZATION PROCESS

The CPG agreed to use a method of selecting a set of factors as a basis on which to evaluate each target population, assigning a weight to each factor, rating each target population on each factor, calculating a weighted score (weight x rating), and then adding the weighted scores of the factors together for a total score for the population. The first step was to decide on the target priority populations to be scored. After reviewing epidemiological data, behavioral surveys and the current set of priority populations the CPG decided on a set of target priority populations. These populations were prioritized at a meeting on September 7, 2006.

Nine factors were selected as criteria for prioritizing the five populations. CPG members assigned weights to the factors and the results were tabulated to assign the aggregate average to that factor. CPG members were then provided data appropriate for evaluating that factor for each population. The first four factors were evaluated strictly by data from the HIV Surveillance program. The remaining factors were evaluated by each CPG member utilizing the data available for that factor and population. The results were tabulated for an aggregate average rating and a score was calculated for that factor. The factor scores were then summed to find the total score for that population. After the populations were ranked according to their scores (CDC specifies that HIV+ will be the first priority), the CPG members then assigned the percent of resources they want allocated to that population. The results are summarized in Table 2. Populations six and seven were added to facilitate evaluation activities after the prioritization process had been completed.

Priority	Target Population	Score	Estimated Population Size
1	HIV Positive Individuals	450	2,330
2	Men who have Sex with Men	391	17,000
3	High Risk Women	311	
4	High Risk Youth	292	
5	IDU	291	10,000
6	High Risk Individuals		
	General Public (HC/PI activities)		

Table 2

Interventions

There are seven types of HIV prevention interventions currently in use. They are as follows:

Counseling, Testing and Referral: HIV testing by standard blood drawn samples with pre and post test HIV Prevention counseling and referrals to other services. This testing is usually located in fixed sites (84) such as local health departments and clinics. Test results usually take two weeks, so the problem of follow-up for notification and post test counseling is significant if the client does not return for results. Oral testing eliminates the problem of drawing blood and does not require a fixed site, so it can be used in outreach situations; but results still take two weeks. Rapid testing requires only

a finger stick and results are available in about twenty minutes, however it requires stable environment to conduct the test.

Partner Services: This is a service to locate, counsel, test, and provide referrals to sex and needle sharing partners of HIV+ individuals. For confidentiality reasons, all partner counseling and referral is conducted by state Health Department Disease Intervention Specialists.

Health Education/Risk Reduction: Sessions between a Health Education/Risk Reduction Educator and clients to teach HIV risk reduction skills. Interventions are based on theories of behavior change. The design of the intervention may be for one or multiple sessions. HE/RR sessions may be conducted for individuals (IDI's), couples or groups (IDG's). The goal is to provide educational interventions that promote and reinforce safer behaviors. Interpersonal skills training and support is provided in negotiating and maintaining safer sexual and needle-sharing behavior. Emphasis is on the relationship between substance use and risky behaviors and referrals to appropriate services.

Outreach Interventions: Outreach interventions are designed to change individual behavior by providing motivation, knowledge, risk reduction materials, and referrals to services that support behavior change. Such programs access at-risk individuals on the street, in malls, parks, bars, public sex environments (PSE's), or other community settings. Outreach is directed towards a clearly defined target population. These populations are defined by their demographic characteristics and risk behaviors through the Community Planning Process.

Comprehensive Risk Counseling and Services: Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.

Linkage to Care: A Linkage to Care (LTC) model uses strengths-based case management to link HIV positive clients to HIV care. By having a Linkage to Care Worker act as an intensive case manager and use a strengths-based case management approach, clients that may otherwise not engage in care will choose to engage in care. The resources support and advocacy that the Linkage to Care Worker offer will be essential to client in their choice to engage in care. In collaborating closely with Disease Intervention Services (DIS), a Linkage to Care Worker can follow up immediately with clients that test HIV positive. The relationship between DIS and LTC is essential to ensure comprehensive client care with an active referral whenever possible.

Health Communication/Public Information : The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection how to obtain specific services.

Electronic Media: Means by which information is electronically conveyed to large groups of people.

Print Media: These formats also reach a large-scale or nationwide audience;

Hotline: Telephone service (local or toll-free) offering up-to-date information and

referral to local services, e.g., counseling/testing and support groups.

Clearinghouse: Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide a responsive information service to the general public as well as high-risk populations.

Presentations/Lectures: These are information-only activities conducted in group settings.

Recommendations for interventions for the target populations were based on the following criteria selected by a CPG committee:

1. Is the intervention reflective of the culture of the intended target population?
2. Is it appropriate for the behavioral and ethnic characteristics of the population?
3. Has the intervention been shown to be effective for the specified target population and did the target population have input in the development of the intervention?
4. Does the intervention have clear and specific goals?
5. Is the intervention based on a behavioral or social science theory?
6. Is the intervention acceptable to the community's norms and values including geographical location?
7. Does the intervention target a specific behavior?
8. Can the intervention be implemented without any significant barriers?
9. Can the intervention be evaluated?

Behavior Theory Applied to HIV Prevention Interventions for Priority Populations

Key to the recommendations above is the mandate to utilize interventions based in behavioral science theory. CPG members are provided technical assistance in this area by the HIV Prevention Program Community Partnership Consultants. The document "Intervention Models and Guidelines" (see attachment) serves as a resource for planning and delivering HIV Prevention interventions. Briefly those theories are as follows:

Diffusion of Innovation: The process by which any new idea or an innovation is communicated to the members of a group or population based on four key components:

1. The actual communication channel (word of mouth, telephone, newspapers, etc);
2. Visible respected opinion leaders who can assist in dispersing the message;
3. Time and process (this is required for the message to reach community members and people receive and accept messages at different time intervals); and
4. The social network to link members.

Research shows that diffusion theory can inform effective intervention for the gay community and injection drug users if the core concepts are appropriately adapted.

Health Belief Model: The premise of the theory is that health related behaviors depend on four key beliefs; all of which must be operating for a risk reducing/health promoting

behavior to occur. They are:

1. Perceived susceptibility (I could get it);
2. Perceived severity (it could be bad if I get it);
3. Perceived benefits of performing the behavior;
4. Perceived barriers of performing the behavior.

Evaluation research of HIV intervention programs based on this theory generally support its usefulness as a behavior change model. By using this model a provider can separately target the beliefs necessary for behavior change and barriers to prevention regardless of the target populations demographic characteristics, as long as the intervention components are culturally appropriate.

Theory of Reasoned Action: This theory is based on the premise that in order for behavior change to occur, one must have an intention to change and intentions are influenced by two major factors. The first factor is the attitude toward the behavior; and second subjective norms about the behavior. Both attitudes and beliefs toward the behavior, along with the perception of what significant others think an individual should do, influence intentions toward performing a behavior. While other behavior theories target the individual, the theory of reasoned action incorporates the social and interactional aspects of human behavior. This is useful for intervening with sexual behavior which is inherently social in nature.

Social Cognitive Theory: This theory emphasizes that behaviors are dynamic, and influenced by both personal and environmental factors; behavior is learned through direct experience, by modeling others, or through observation. There is a reciprocal interaction of behavior, social and physical factors and that a change in any one of the three factors influences the others. The two primary forces that affect change in these factors are expectancies and incentives. Acquisition of new skills is often required. The chances of a behavior being repeated depend on the person's assessment of its costs/benefits. Evaluation of HIV prevention interventions that employ social cognitive theory concepts have documented its usefulness as a model for designing programs. Perceived self efficacy to negotiate condom use with partners has proved a strong predictor of sexual behavior change among gay men, adolescents, and college students. Influencing social outcome expectancies to heighten positive social norms for safer sex and drug use likewise has shown to affect HIV risk-taking behavior.

GAP ANALYSIS AND RECOMMENDATIONS OF THE CPG

Priority 1: HIV+ Individuals

Need: Lack Of Information
Solution: Peer Education, Health/Prevention Ed., Tailored Education
Intervention Type: Outreach, Individual/Group HE/RR*

Need: Negotiation Skills
Solution: Negotiation Skills Training
Intervention Type: Individual/Group HE/RR*

Need: Supportive Network Of Friends
Solution: Facilitate Effective Communication With Peers
Intervention Type: Individual/Group HE/RR*

Need: Resources
Solution: Information Referrals
Intervention Type: Web-Based/Individual/Groups/Outreach

Need: Medical Services
Solution: Referral
Intervention Type: Web-Based/Individual/Groups/Outreach

Need: Disclosure
Solution: Peer Education/Support; PS***, CRCS**
Intervention Type: Individual/Group HE/RR*

Need: Co-Infection Issues
Solution: Education Referrals
Intervention Type: Group

Recommended CDC Procedural Guidance interventions:
Partner Services (PS)
Comprehensive Risk Management and Services (CRCS)

CPG recommended Evidence Based Interventions:
Partnership for Health
Healthy Relationships
CLEAR
WILLOW
RESPECT

*HE/RR: Health Education/Risk Reduction

Priority Two: Men Who Have Sex With Men

- Need: Lack Of Information
Solution: Cultural Information; Peer Education; Tailored Education
Intervention Type: Individual/Group HE/RR*
- Need: Supportive Network Of Friends
Solution: Community Based/Peer-Led Support Groups
Intervention Type: Individual/Group HE/RR*
- Need: Access To Condoms
Solution: Distribution in Bars, Clubs, Testing Sites, Prisons, Diversion Programs, Drug Abuse Treatment Facilities, Adult Bookstores, Gay Organizations,
Intervention Type: CTR IDI, HE/RR, Community Outreach
- Need: Ages Issues
Solution: Culturally based age appropriate interventions
Intervention Type: IDI and IDG HE/RR*, Outreach
- Need: Negotiation Skills
Solution: Role Playing and Peer Models
Intervention Type: IDI and IDG HE/RR, Outreach
- Need: Online Behavior Risks
Solution:
Intervention Type: HE/RR, Individual Outreach

Recommended CDC Procedural Guidance interventions:
Counseling and Testing Services (CTS)
Comprehensive Risk Management and Services (CRCS)

CPG recommended Evidence Based Interventions:
D-Up
Many Men Many Voices
Popular Opinion Leader
MPowerment
RESPECT

*HE/RR: Health Education/Risk Reduction

Priority Three: Women

Need: Self-Care
Solution: Testing, Health Education
Intervention Type: Individual/Group HE/RR*; Outreach

Need: Negotiation Skills
Solution: Negotiation Practice
Intervention Type: Individual/Group HE/RR*

Need: Support
Solution: Referrals/Support Group
Intervention Type: Tailored Individual/Group HE/RR*

Need: Control; Self-Sufficiency; Education; Resources
Solution: Employment Training; Life Skills Training
Intervention Type: Individual/Group HE/RR*; Outreach

Need: Identify Risks
Solution: Health (Risk) Education/Assessment
Intervention Type: Individual/Group HE/RR*; Outreach

Need: Living Jc/Group Home; Homeless
Solution: Positive Health
Intervention Type: Individual/Group HE/RR*; Outreach

Need: Addiction Alcohol/Drug
Solution: Positive Health
Intervention Type: Individual/Group HE/RR*

Need: Relationships; Sexual Addiction
Solution: Positive health
Intervention Type: Individual/Group HE/RR*

Recommended CDC Procedural Guidance interventions:
Counseling and Testing Services (CTS)
Comprehensive Risk Management and Services (CRCS)

CPG recommended Evidence Based Interventions:
SISTA
RAPP
Sister to Sister
SiHLE
Voices/Voces
RESPECT

*HE/RR: Health Education/Risk Reduction

Priority Four: Youth

Need: Education
Solution: Peer Education, Sex Education
Intervention Type: IDI and IDG HE/RR*, Outreach

Need: Access
Solution: Education Awareness for Decision Makers/Parents, Community Environment
Intervention Type: Education Referrals, IDI and IDG HE/RR, Web Based Media

Need: Communication
Solution: Education, Negotiation Skills, Peer Education
Intervention Type: Web Based or Electronic Media Interventions, IDI and IDG HE/RR*, Outreach

Need: Risk Assessment
Solution: Youth Risk Behavior Study
Intervention Type: HE/RR*

Recommended CDC Procedural Guidance interventions:
Counseling and Testing Services (CTS)
Comprehensive Risk Management and Services (CRCS)

CPG recommended Evidence Based Interventions:
MIP
Street Smart
Nia
Focus on Youth with IMPACT
SiHLE
CLEAR
RESPECT

*HE/RR: Health Education/Risk Reduction

Priority 5: IDU

Need:	NEP (Needle Exchange Program)
Solution:	Community HE/RR* Advocate On Legislative HE/RR*
Intervention Type:	Community HE/RR*
Need:	Blood Borne Pathogen Education
Solution:	Education/Training
Intervention Type:	Group /Individual HE/RR*
Need:	STD Education
Solution:	Education/Training
Intervention Type:	Group /Individual HE/RR*
Need:	Resources
Solution:	Legislative Advocates And Case Management Collaborations
Intervention Type:	Community Level/Outreach
Need:	Lack Of Decision Making Skills
Solution:	HE/RR, Training For Negotiation
Intervention Type:	Individual/Group HE/RR*,
Need:	Lack Of Drug Treatment
Solution:	Legislative Advocates And Case Management Collaborations
Intervention Type:	Community Level/Outreach
Need:	Lack Of Supportive Networks
Solution:	Education For Opponents To HEP, HCPI/Support Groups
Intervention Type:	Group HE/RR* Intervention
Need:	Legislation
Solution:	Advocates for Needle Exchange/IDU Care
Intervention Type:	Health Communication/Public Information (HC/PI)

Recommended CDC Procedural Guidance interventions:
Counseling and Testing Services (CTS)
Comprehensive Risk Management and Services (CRCS)

CPG recommended Evidence Based Interventions:
MIP
Safety Counts
SHEILD
CLEAR
RESPECT

*HE/RR: Health Education/Risk Reduction

Priority Six: High Risk Individuals

Need: Negotiation Skills
Solution: Health Education
Intervention Type: Individual/Group HE/RR*

Need: Education
Solution: Health Education
Intervention Type: Individual/Group HE/RR*

Need: Incarcerated Men
Solution: Health Education
Intervention Type: HE/RR And Aggregate

Need: Heterosexual Outreach
Solution: Bar Outreach; Clinics; Condom Distribution
Intervention Type: Aggregate

Recommended CDC Procedural Guidance interventions:
Counseling and Testing Services (CTS)
Comprehensive Risk Management and Services (CRCS)

CPG recommended Evidence Based Interventions:
Safety Counts
CLEAR
CONNECT
Project START
Nia
Community Promise
Voices/Voces
RESPECT

*HE/RR: Health Education/Risk Reduction

Chapter 5

GOALS, OBJECTIVES and ACTIVITIES:

A 5 YEAR PLAN FOR HIV PREVENTION IN KANSAS

National and State Linked Prevention Objectives

The document "Healthy People 2010", published in November 2000, proposes 17 broad objectives for the prevention of HIV infection and its related illness and death. Concurrently, the Centers for Disease Control and Prevention Department of HIV/AIDS Prevention (CDC-DHAP) and the Institute Of Medicine outlined new objectives and strategies for lowering the rate of new HIV infections. Other seminal documents were the Institute of Medicine Report "No Time To Lose: Getting More from HIV Prevention" (November 2001) and the CDC-DHAP draft 5-year Strategic Plan for HIV Prevention (January 2002).

In May 2003 there was a growing perception that HIV prevention efforts were not making progress. CDC-DHAP announced the initiative "Advancing HIV Prevention: New Strategies for a Changing Epidemic-United States". This initiative addressed specific steps to meeting goals with the following objectives: 1) Incorporate HIV testing as a routine part of care in traditional medical settings; 2) Implement new models for diagnosing HIV infections outside medical settings; 3) Prevent new infections by working with people diagnosed with HIV and their partners; 4) Further decrease mother-to-child HIV transmission. Kansas has paid close attention to this process and dynamically prepared for it in how it structured its approach and mechanisms for evaluation.

While at first this plethora of goals stated nationally may seem confusing, overlapping and complementary needs emerged. One such need is to extend Counseling and Testing to those who are HIV positive and unaware of their sero-status. Not only are these persons at high risk for transmitting HIV to uninfected individuals; they are also deprived of medical services capable of greatly improving their duration and quality of life. Complimentary to this is a mandate to make HIV positive persons the highest priority for HIV prevention efforts beyond testing. Thus increased emphasis is placed on Partner Services, Comprehensive Risk Counseling and Services (CRCS) and Linkage-to-Care Services (LTC).

Another common theme (not expressed above) is increased accountability for how HIV Prevention resources are allocated and utilized. This places a great emphasis on Evaluation and Quality Assurance. These are integral to the CQI approach utilized. As noted above, investments in new technologies are required to meet these needs. An example of this is web based evaluation reporting that has been in use for 8 years in Kansas. It is the key for responding to the CDC-DHAP evaluation reporting system "PEMS" and the development of quantitative Indicators of program performance.

The Kansas Community Planning Group is in the final stages of completing a three-year planning process that includes a Community Services Assessment, prioritized target populations and recommended interventions. This information has been compiled to direct HIV Prevention activities for the next five years of HIV prevention efforts in Kansas. Concurrent to this, new RFP's are being released to solicit competitive HE/RR proposals based on the HIV Prevention Plan. Selected proposals will be contracted to start on July 1, 2010. Thus the one unknown for this Prevention Plan is that at present it is not known who the contractors will be and exactly what interventions will be implemented. What is certain is that these programs and

interventions will be consistent with the goals and objectives of CDC-DHAP and the recommendations of the Kansas Community Planning Group.

Kansas has developed an integrated and linked continuum of prevention and care services to support the national objectives and provide quantitative and qualitative data measuring progress toward goals and objectives. The goals, objectives and targets of this Plan are interdependent with other program elements to ensure effective prevention and care for HIV and sexually transmitted diseases within the state. It is a comprehensive approach. The state utilizes a Continuous Quality Improvement oriented approach to all activities to ensure ongoing improvement of efforts toward the goals. The content of this Plan illustrates the relative success of the program in laying the foundation to succeed in meeting requirements of the guidance.

CPG PREVENTION PLAN GOALS AND OBJECTIVES FOR KANSAS

Overarching Goal: Reduce the incidence of HIV infections in the state of Kansas.

Overarching Objective: Reduce the incidence of newly diagnosed HIV infections by 15% over the next 5 years. (2009-2014)

Goal One: Provide culturally sensitive, appropriate, client centered, affordable HIV Counseling, Testing and Referral services (CTRS) to individuals at high risk for HIV infection in Kansas.

Objective One: Increase the proportion and number of people at high risk for HIV infection that access CTRS services in Kansas.

Objective Two: Increase the number of HIV+ and HCV+ persons who know their HIV and HCV Serostatus.

Objective Three: Promote the utilization of advancing technologies such as rapid testing to reach high-risk populations. Increase the number of Community Based Organizations (CBO's) that provide rapid testing and counseling for high-risk HIV individuals.

Objective Four: Initiate contacts with hospital emergency rooms, medical office providers and federally funded Primary Care Clinics to promote provision of routine HIV testing and counseling in the office as a part of a normal physical exam.

Goal Two: Provide culturally sensitive and appropriate client centered Health Education/Risk Reduction (HE/RR) services to individuals at high risk for HIV infection or HIV transmission.

Objective One: Encourage implementation of and increase the number and proportion of Individual and Group HE/RR, and Outreach Interventions that are based on Behavior Science theory and proven effective, as prescribed in the Kansas HIV Prevention Plan.

Objective Two: Increase the number of individuals and the number of sessions per individual in Individual and Group HE/RR and Outreach interventions as

prescribed in the Kansas HIV Prevention Plan.

Objective Three: Conduct Health Communication/Public Information interventions as needed to support other HE/RR activities and inform the general public on HIV prevention efforts.

Objective Four: Evaluate the efficacy of HE/RR interventions with measurable client level outcome monitoring.

Goal Three: Provide culturally sensitive and appropriate client centered support and referral services for those infected with HIV, those at high risk for infection, or those affected by HIV.

Objective One: Provide culturally sensitive and appropriate client centered Comprehensive Risk Counseling and Services (CRCS). Demonstrate the efficacy of CRCS with measurable outcome monitoring.

Objective Two: Increase referrals into services for routine medical, mental health, substance abuse, housing, job training/employment, education, legal aid and other services. These services are to promote the social capital and well-being of clients and provide support to individuals infected with HIV, those at risk for infection, or those affected by HIV.

Objective Three: Promote activities such as World AIDS Day and HIV Testing Day that remove the cultural, social and economic barriers that prevent access to HIV/AIDS prevention and care services and lessen stigma and discrimination associated with HIV/AIDS.

Objective Four: Increase the percent of newly diagnosed HIV+ individuals who are referred into and access appropriate and affordable medical and social services.

Objective Five: Maintain HIV Prevention Program funding for Disease Intervention Specialists who conduct Partner Counseling and Referral Services (PS) in the KDHE STD Program.

Goal Four: Conduct a community planning process in accordance with the Centers for Disease Control HIV Prevention Community Planning Guidance

Objective One: Maintain a Community Planning Group (CPG) that supports broad-based community participation in HIV prevention planning and whose members reflect the demographics of the HIV epidemic.

Objective Two: The Kansas CPG will conduct a process to examine epidemiological data regarding HIV/AIDS, conduct Community Services Assessments, determine priority populations at risk for HIV infections and recommend appropriate interventions for priority populations.

Objective Three: The Kansas CPG, in collaboration with the Kansas Department of Health and Environment, will develop and maintain a comprehensive HIV Prevention Plan for the state of Kansas.

Goal Five: the Kansas CPG will encourage collaboration between the Kansas CPG and the Ryan White Part B Planning Body to provide prevention and care services to HIV/AIDS infected and affected individuals.

Objective One: The Kansas CPG and Ryan White Part B Planning Body will promote activities that address the role of acute infection in spreading the HIV/AIDS virus.

Objective Two: The Kansas CPG will maintain an internet web site to provide information regarding the Kansas CPG and Ryan White Part B Planning Body activities and provide direct contact between members to discuss issues regarding HIV/AIDS.

Counseling, Testing, and Referral (CTR) Services

The Kansas CTR program provides both anonymous and confidential HIV counseling and testing with traditional technology (blood based EIA/Western Blot) by means of approximately 84 active counseling and testing sites. Kansas Law requires that public HIV testing be available within 100 miles of each Kansas citizen.

KDHE will utilize several strategies for improvement of efforts to identify newly infected persons. There are approximately 32 private sites for counseling and testing in high prevalence settings such as correctional facilities and drug treatment centers. Oral and Rapid testing has been provided on an outreach basis to high-risk clients in 20 locations. The primary objective is to take testing into venues where the highest risk behaviors were taking place and to provide a testing opportunity to individuals in outreach locations. These venues include areas where individuals engage in intravenous drug use and anonymous public sex environments.

During 2008, CTRS performed 25,039 total tests for HIV. This was a 90% increase from 2007 (n=13,130). Of these, 64 were newly identified positive tests, an increase of 18.5% from 2007. The confidential testing rate in Kansas exceeds 90%. The post-test counseling rate for all tests was 56% and the 2008 post-test positive counseling rate was 80%.

Conventional Testing 2008: KDHE sites performed 23,121 conventional HIV tests. This was a 101 % increase from 2007 (n=11,486). Of these, 46 were newly identified positive tests. The post-test counseling rate for conventional tests was 54% and the post-test positive counseling rate was 73%.

Rapid Testing 2008: KDHE sites performed 1,828 Rapid HIV tests. This was an 11% increase from 2007 (n=1,641). Of these, 16 were newly identified positive tests. The post-test counseling rate for rapid tests was 91.5% and the post-test positive counseling rate was 100%.

Twenty-one of the larger health department sites and a non-health department clinic are supported with additional funds to help defray the cost of counseling. All sites are provided free lab services and the use of DIS for post-test counseling and partner counseling and referral. Unfunded sites include health departments, community based organizations and other settings that express interest in providing counseling and testing services.

Partner Services

The overall goal of Partner Services in Kansas is to provide partner counseling and referral to all newly diagnosed HIV and AIDS cases not previously diagnosed with HIV. This includes both public and non-health department settings.

Disease Intervention Specialists (DIS) within the STD Section in Kansas are trained, motivated and evaluated in HIV prevention and intervention. DIS follow the HIV Partner Counseling and Referral Services Guidelines from CDC when performing counseling and referral services. HIV/AIDS Section Management is committed to interviewing all new HIV infections in Kansas and referring these clients into services. Additionally, management is committed to counseling and referring the client's partners into services. DIS have been interviewing HIV/AIDS cases in Kansas since the early 1990s. DIS provided approximately 20 interviews a year prior to July 1999 when there was only AIDS reporting. With the approval of HIV named reporting in July 1999 the number of interviews jumped to around 80 interviews per year. The majority of HIV+ clients that are provided PS interviews are tested by private health care providers.

DIS in Kansas are fully trained in STD and HIV/AIDS counseling. DIS are required to learn all modules in the CDC STD Development Guide, make at least an 80 percent on tests following the modules and at least 80 percent on the comprehensive test for the entire STD Development Guide. Then training begins on the art of interviewing and investigating HIV/AIDS. This process starts with the successful completion of Introduction to STD Intervention (ISTDI), a two-week interview training course provided by a regional training site. Additionally, DIS are required to complete basic HIV counseling courses provided by the state. During this entire process new DIS are shadowing their peers and learning from real life interview and investigation situations. The total training process usually takes three to six months. The training process is strictly monitored and supervised by the Manager of Field Operations.

Kansas utilizes a continuous quality improvement based approach to all areas of the HIV/AIDS Program. The outcome oriented targets and objectives of the program reflect the processes involved in providing Partner Services and feeds back into the system as an improvement loop.

Prevention for HIV-Infected Persons

Linkage To Care

Fully implemented in 2009, Linkage to Care counselors work with Clients for 90 days or 5 visits and then the client is actively referred to a Ryan White Case Manager for permanent services. This active referral allows for the client to build rapport with his/her new case manager while still being supported by their Linkage Care Worker. This active referral is meant to strengthen the likelihood that the client will remain in care and follow up with their new Ryan White Case Manager. Once this transition has taken place, the Ryan White Case Manager will follow up with the client, continue to empower the client and troubleshoot any barriers that the client may have with retention. Electronic documentation will be used to evaluate retention rates for clients that have participated in the Linkage to Care project.

The Linkage To Care worker completes a Ryan White Acuity Level Assessment Tool and authorizes Ryan White services for immediate medical care.

During the 90-day period a referral is made to a Ryan White Case Manager for a seamless continuum of care to increase retention within the model of care.

The Linkage To Care worker also completes a Substance Use and Mental Illness Symptoms Screener (SAMISS) upon the initial referral for Strengths Based Case Management services. The SAMISS is a 13 item screening tool for detecting the co-occurring disorders of mental illness and substance abuse. The SAMISS takes about 5-10 minutes to administer, making it quick and easy to incorporate into standard patient care without requiring significant expenditures or sacrifices from other areas of patient care. Co-Occurring mental illness and substance use disorders are not uncommon among people living with HIV

Comprehensive Risk Counseling and Services

Comprehensive Risk Counseling and Services (CRCS) has been adopted in Kansas as a time limited behavioral intervention designed to assist individuals who are HIV sero-positive. The program is designed for those individuals having, or likely to have difficulty initiating and sustaining practices that limit the transmission and acquisition of HIV. CRCS is a service provided by the HIV/AIDS section of the Kansas Department of Health and Environment. There is currently one Licensed Specialist Clinical Social Worker providing direct client services.

Referrals to CRCS began in January of 2006 with most referrals coming from within the KDHE HIV Prevention program and Ryan White program contractors. By the end of the 2nd quarter of 2006, CRCS enrolled clients were accessing additional services based on referrals made by the CRCS case manager.

Eligibility for CRCS is based on the completion of a HIV behavior risk assessment pre-screening tool conducted with the potential client. During the 2nd quarter of 2006 two revisions were made to the pre-screening tool to include attention to adherence to HIV antiretroviral therapies and completion of the Substance Use and Mental Illness Symptoms Screener (SAMISS).

Once individuals are determined to be eligible for CRCS and enrolled, a comprehensive assessment is completed. The comprehensive assessment is utilized to develop a client-centered prevention plan to monitor the progress of the specific prevention intervention. On average, clients receive 12 individual sessions throughout a six-month period. In providing client centered CRCS services for positives, Comprehensive Risk Counselors utilize a wide spectrum of behavioral theories or concepts in order to provide individualized prevention services which include the following; cognitive therapy, Transtheoretical model, motivational interviewing, crisis counseling, dialectical behavior therapy, and risk reduction strategies. Key to providing direct services to individuals who are HIV positive and receiving CRCS services include incorporating harm reduction strategies, looking at motivation of self or other, recognition of responsibility to not transmit HIV, recognition of oppression and socio-cultural factors and the importance of client engagement in the process of recovery.

Comprehensive Risk Counselors are required to be certified in HIV counseling and testing, and they must be able to identify risk factors in clients. Moreover, certification of Comprehensive Risk Counselors is directly linked to training in HIV prevention. Specifically, Comprehensive Risk Counselors must complete certification requirements in HIV/AIDS Basic Training; Basic HIV Program: Fundamentals and

Prevention Skills; Orasure Testing; Behavior Change Counseling Strategies; Cultural Diversity: Sexual Minorities and HIV Services; Cultural Diversity: populations of Color and HIV Services. Comprehensive Risk Counselors are required to have a Masters degree in Social Work and be licensed by the State of Kansas Behavioral Sciences Regulatory Board.

Client data is collected utilizing four instruments. Client Intake Form, CRCS Services Tracking Form, Behavioral Risk Assessment Pre-Screening Tool, and the Client Functioning Assessment Tool (CFAT). The Client Intake Form contains nine items capturing demographic characteristics. The CRCS Services Tracking Form contains five items including length of the session, location, use of incentives, and service phase. The CFAT is completed by the Comprehensive Risk Counselor at baseline and at the end of each quarter. The CFAT has seven domains that address the following areas: engagement in services, connections/involvement, physical and emotional and self-efficacy, personalizing risk of HIV transmission/infection, use of alcohol and drugs, sexual risk behavior, and finances/housing/employment/school.

Health Education and Risk Reduction Services (HE/RR)

KDHE contracts with Local Health Departments and community based organizations to provide services to clients for learning HIV Prevention risk reduction skills. KDHE oversees these contracts and works with contractors in order to:

- Show evidence that their programs focus on populations, priorities and interventions determined by the HIV Prevention Plan and Community Planning Group. See Table 1 and “Gap Analysis And Recommendations Of The CPG” for priority populations and interventions.
- Demonstrate that their Interventions are based on scientific theory consistent with the CDC Compendium of HIV Prevention Interventions and demonstrated evidence of effectiveness. (See “Gap Analysis And Recommendations Of The CPG” for a list of interventions that will be funded for each priority target population).
- Are culturally relevant as indicated by the statewide Community Planning Group and conform to the norms and values of the intended population.
- Include a program evaluation plan that is in accordance with the KDHE Evaluation Plan and meets the criteria for PEMS reporting.
- Participate in the KDHE administered statewide Web-based program evaluation system, requiring all grantees to report intervention specific data and target population/demographic information. Grantees are required to submit quarterly and end of year progress reports as well as on-going reporting of intervention activities.

Perinatal Transmission Prevention Activities

- Provide voluntary HIV testing available to pregnant women at high risk for HIV infection.

- Ensure that HIV-infected women and HIV-exposed infants have access to appropriate prevention interventions to reduce perinatal HIV transmission, and that HIV-infected women have access to appropriate treatment services.

Evaluation of HIV Prevention Activities

The purpose of HIV prevention program evaluation activities, interventions and services is to accomplish goals in the following two areas:

HIV Prevention Interventions

- Assess the quality of proposed interventions to make sure that they are scientifically sound, well organized and that the goals are clear and reasonable.
- Conduct process evaluation of HIV prevention interventions for the purpose of prioritizing prevention efforts and improving the contractor's ability to measure accomplishments in conducting prevention activities.
- Conduct outcome monitoring of HE/RR individual and group level interventions for the purpose of measuring on-going behavior change in at-risk populations.
- Gather and monitor information from contractors to ensure that targeted populations receive necessary services and/or are referred to other providers that will address the psycho social issues associated with high priority populations in Kansas.
- Provide client level and aggregate level data to CDC through the PEMS reporting system.

Implementation of HIV Prevention Community Planning in Kansas

- Document the recruitment of community planning group members and representation of affected communities and areas of expertise on the CPG.
- Verify the application of the Community Services Assessment and a HIV/AIDS Epidemiology Profile to prioritize target populations and strategies for HIV prevention activities and the application of scientific knowledge in the selection of prevention strategies.
- Develop and monitor goals and measurable objectives for the community planning process and calculate the cost of the process.
- Determine the extent to which the health department distributes resources to match the epidemiologic profile and conducts prevention activities that match the Kansas Community Planning Group recommendations.

HIV Prevention Technical Assistance and Capacity Building Plan

The purpose of HIV Prevention Technical Assistance and Capacity Building planning is to assess the current and projected needs of HIV Prevention service providers and members of the CPG. Following the assessment to then provide the necessary technical assistance and training that they have identified in order to build on their skills and knowledge. This plan encompasses the following goals:

- Provide technical assistance to service providers and CPG members in the areas of grant writing, coalition building, behavioral science and theory based prevention activities, HIV prevention program planning, implementation, and evaluation.
- Solicit and contract with agencies, workers, and volunteers who are representative of populations at high risk for HIV infection to conduct prevention activities.
- Ensure that all HIV Prevention contractors successfully complete the KDHE “Basic HIV/AIDS Program” including Fundamentals and Prevention Skills training.
- Provide sensitivity training to HIV Prevention providers that includes issues of communities who are denied access to privileges and benefits based on skin color, gender, sexual orientation, economic circumstance, disability, language and/or spiritual belief.
- Strengthen the communication network between HIV prevention service providers and coordinate HIV prevention services and programs.
- Develop and continue to make available an on-going statewide HIV prevention and care resource service directory.

KDHE provides technical assistance and training to contractors in the following areas: skills based training to counselors and persons providing HIV related services; basic HIV/AIDS counselor and education training (with co-trainers who are of color, and/or represent target groups at risk for infection); program planning, development, evaluation, grant writing, coalition building, capacity building; funding development, problem identification, and action planning. KDHE will continue to assess the technical assistance needs by comparing its prevention program with the needs of the communities at-risk, programs in similar rural states, and the latest prevention research and literature.

Collaboration, Coordination, and Linkage with Other Related Programs

Linkages between Primary and Secondary HIV Prevention Activities:

The term “primary prevention” refers to preventing the transmission of HIV from one person to another. The term “secondary prevention” refers to preventing progression of HIV infection to severe immune-suppression, and preventing morbidity and mortality from opportunistic infections in persons already infected with HIV. “Linkage” between

primary and secondary prevention refers to linkage between services for primary prevention and services for secondary prevention.

CPG recommendations for linking primary and secondary prevention services in counseling and testing sites includes 1) develop case management models that target HIV+ individuals and their sex partners for the purpose of teaching behavior modification techniques that decrease the risk of HIV transmission; 2) establish appropriate sources (used in the counseling process), to medical, care, social, and psychological services; 3) provide services to HIV infected individuals and their sex partners that encompass on-going health education and skills training for risk reduction; facilitate the development of peer-to-peer networking structures; provide and/or refer HIV+ individuals and their sex partners to counseling services as appropriate, assist consumers in making long term risk reduction behavior changes; and provide support and education regarding secondary infection. Services must be empowering, culturally, linguistically, age, and gender appropriate. The CPG recommended the development of an electronic and group network within HIV positive communities to provide information, enhance the sharing of knowledge, increase the visibility and decrease the alienation of individuals infected with the virus.

Linkages with HIV Prevention Related Activities:

This linkage means to set up networks and/or focus groups with at risk communities in order to identify and assess continuing HIV prevention needs, and to disseminate the results of targeted prevention and community planning activities.

KDHE will promote the community planning process and make survey information, needs assessment results, recommendations, and the epidemiologic profile available to HIV prevention service providers and the public. An evaluation tool should be provided to KDHE contractors to assist them in developing, assessing, and disseminating the results of behavior change surveys for at-risk populations. HIV prevention activities should be integrated and linked with other disciplines such as drug treatment programs, STD treatment, and university-based research.

Access to STD Diagnosis and Treatment:

KDHE HIV/AIDS Section collaborates with the STD Section to accomplish the following:

- Provide early detection and treatment of curable STD's by expanding screening and treatment programs for STDs in settings where the diseases are prevalent and populations congregate.
- Collaborate and coordinate HIV and STD prevention programs to ensure STD's are diagnosed and referred for treatment by offering onsite, diagnostic services and referrals for treatment of other STDs.

School Based Efforts For Youth:

KDHE collaborates with the Department of Education to:

- Provide school based programs that use the basic philosophy recommended by Buckingham, Doyen, and Main, 1995, and are theoretically-based, adhere to sound instructional strategies and are recommended by students in the Kansas school system.

- Provide prevention programs that allow youth to integrate what they have learned into their own experience, using real life situations and peers to model and reinforce desired behaviors.

All programs should be skills-based and help to develop self-efficacy.

Programs for Prisons, Correctional and Detention Facilities:

In order to meet the HIV Prevention needs of clients in Prisons, Correctional and Detention Facilities, a Memorandum of Agreement between the Kansas Department of Health and Environment (KDHE) and the Kansas Department of Corrections (KDOC) was signed in 2005. The Kansas Community Planning Group Corrections Task Force Committee served as the focal point in developing this MOA. Key provisions of the MOA are as follows:

“Mission: The mission of this agreement between KDOC and KDHE is to coordinate correctional health programming through collaboration, hereinafter known as the Kansas Corrections HIV Initiative in order to more efficiently and effectively utilize all health resources for prevention, care, and treatment services in correctional facilities for inmates at risk for HIV and inmates living with HIV and AIDS in the State of Kansas.

1. KDHE shall:

- a. Actively participate, promote, and support the CPG-Corrections Task Force and KDOC for the Kansas Corrections HIV Initiative to coordinate preventative education, care, and treatment services for inmates, with duties related to but not limited by the following:
 - i. Assistance with scheduling and providing meeting space or technical support for CPG-Corrections Task Force Meetings and Conference Calls.
 - ii. Ensure scheduling, planning, and coordination of collaborative training on August 31, 2005 through September 1, 2005 for key staff and community partners from KDHE in conjunction with KDOC.
 - iii. Provide state health department staff and community partners who provide HIV Prevention and Ryan White Title II program services guidelines and training in coordination with KDOC and the Corrections Task Force.
 - iv. Assist KDOC and the CPG-Corrections Task Force in identifying, screening, and training eight (8) Volunteer Health Educators assigned to state correctional facilities to provide pre-release Behavior Change Classes as well as provide Basic HIV/AIDS training to clinical and correctional staff. KDHE will inform all volunteers of KDOC requirements including a required background check and volunteer orientation.
 - v. Assist with the coordination of community services between KDOC Release Planners and Ryan White Case Managers for inmates living with HIV and AIDS during pre-release and post-release.
 - vi. Adhere, observe, and comply with KDOC guidelines for state correctional facilities and instruct key staff and community partners

comply with said guidelines, including but not limited to, safety, conduct, and ethics.

- vii. Appoint a state health department representative to work with a designated KDOC representative to research, develop, and present core components of this initiative for interested state and national officials.

2. KDOC shall:

- a. Actively participate, promote, and support the CPG-Corrections Task Force and KDHE for the Kansas Corrections HIV Initiative to coordinate preventative education, care, and treatment services for inmates.
- b. Facilitate and provide funding whenever possible for the collaborative training for release planners, parole officers, and clinical staff with key staff and community partners from KDHE on August 31, 2005 through September 1, 2005.
- c. Coordinate on-site training in correctional facilities for corrections staff and inmates with designated Volunteer Health Educators from the CPG-Corrections Task Force and KDHE.
- d. Schedule, coordinate, and attend CPG-Corrections Task Force Meetings and Conference Calls.
- e. Inform the designated state health department representative from KDHE of scheduled presentations and coordinate mutually agreeable deadlines for presentation materials.
- f. Provide clear guidance and expectations of policies and procedures for state correctional facilities for volunteer health educators, key health department staff, and community partners.”

A brief timeline for the process that brought this about is as follows:

2000: The CPG Prison Task Force determined that its goal is to identify unmet needs and recommend priority interventions to be conducted with the incarcerated population in Kansas. To identify the unmet needs it was necessary for the committee to discover information related to the following 3 areas:

1. Identify prevention activities currently being conducted in Kansas.
2. Identify what needs to happen to reduce the spread of HIV within our prison walls and when the person is released.
3. Make recommendations for prevention program activities.

Based on this, the Prison Task Force completed a corrections staff survey that found:

1. 5,200 inmates are released per year
2. Other states conduct peer to peer outreach. Kansas regulations prevent such programs.
3. Wichita Work Release: Unit managers provide minimal HIV/AIDS orientation.
4. Correctional Officers provide minimal education to inmates
5. Winfield: Medical staff provides education. Only 1/3 of the inmates are

reached.

6. Norton: Corrections and clinic staff are not updated. Inmates have no consistent information.

7. KDOC has no line item funding, but is placed within communicable diseases.

8. Five year plan/contract is in place that can not be changed.

2001: Prison Task Force completed inmate survey consisting of 5 basic questions approved by Roger Haden the Secretary of Corrections. Over 100 inmates were surveyed. The five questions were:

1. Tell us what you know about HIV infection.

2. How can we help decrease or minimize the spread of HIV?

3. Are you aware that sharing needles, having unprotected anal, vaginal, and oral sex can put a person at risk for HIV infection?

4. What type of information and materials would be most helpful to reduce HIV infection in your environment?

5. How can this information be used in your environment to reduce the spread of HIV?

General observations were:

- Inmates lack basic HIV/AIDS information.

- Inmates lack basic prevention skills.

- Provide education at multiple steps, i.e.. RDU, Clinical visit and Pre-Release.

- Look at running education videos on corrections cable.

Recommendations were made with a priority rating.

Goal: All inmates in KDOC would receive information on HIV/AIDS, risks, and how to prevent its transmission.

1. The first recommendation was to hire (either by KDOC or KDHE) one person whose job duties would be to provide education to inmates, correctional/clinical staff on HIV/AIDS.

2. If that was not possible it was recommended that someone, either KDOC or KDHE, design a program where all clinical/correctional staff and inmates receive current, correct, and consistent education on HIV/AIDS.

2002 : The CPG completed a State Needs Assessment which included a Focus Group of 15 inmates at Hutchinson Correctional Facility. The main finding was that HIV Testing was denied or results were not held confidential.

2003. Viola Riggan, CPG member and contract manager for prison medical services, began to implement changes from many of the recommendations and comments.

2004: In 2004 the Prison Task Force decided on the following responsibilities:

- Research current environment

- Identify needs in corrections environment

- Make recommendations to CPG

2005: After several meetings the next step became obvious. It required a joint project that included staff from both KDOC and KDHE yet required no additional funds.

- Secretaries of both departments sign a Memorandum of Understanding.
- Establish points of contact for both prevention and care with appropriate KDOC staff.
- Establish next steps to assure Wardens and Parole Directors are aware of and support this project.

Work proceeded on developing the MOA. On August 12, 2005 a presentation outlining the past efforts of collaboration was given in the presence of the secretaries of Department of Health and Department of Corrections as well as key staff. The MOA was signed. On August 25, 2005 the presentation was given again to the Secretary of Corrections and all of the correctional facility wardens.

On August 31 and September 1, 2005 a Joint Training Conference was conducted which included KDHE HIV prevention staff, Ryan White II C.A.R.E. case management staff, KDOC wardens, release planners, discharge planners, and clinic staff. On September 28, presentations were made to the staff at El Dorado and Hutchinson Correctional Facilities. On October 4, presentations were made at Wichita Correctional Facility and Wichita Work Release Facility. On October 20, presentations were given at Topeka Correctional Facility and Larned Correctional Facility.

In 2006, contractors in community based organizations began implementing a standardized curriculum for an intervention targeted at pre-release inmates.

Kansas Title X Family Planning Program Opt-Out HIV Testing:

The mission of the Kansas Title X Family Planning (FP) Program is to provide individuals the information and means to exercise personal choice in determining the number and spacing of their children. FP clinics continue to provide comprehensive family planning services to men and women throughout Kansas who cannot obtain services from the private sector, due either to economic barriers or lack of medical resources.

Family planning partnerships are vital in order to maximize resources, avoid duplication of services and provide referral avenues to promote continuity of care for those clients with health concerns beyond the scope of that which Title X is able to provide. The FP Program works closely with the Bureau of Disease Control and Prevention (BDPC) as well as the Kansas Division of Health and Environment Laboratory (KDHEL) to ensure availability of affordable laboratory screening and testing related to common sexually transmitted infections including Syphilis, Chlamydia, Gonorrhea, and HIV.

This Proposal is intended to support expanded HIV/AIDS prevention activities in Title X-funded service projects by implementing the September 2006 CDC "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings" to make HIV testing a routine part of medical care, by incorporating an opt-out approach to screening clients during initial or annual FP visits. This expanded screening will be implemented by two delegate agencies selected for their diverse populations, demonstrated ability to conduct HIV counseling, testing and referral services in addition to Title X FP clinical services, and willingness to participate.

Implementation of "opt-out" testing for HIV will likely increase the number of clients who are aware of their infection status, and for those who are identified as

infected, will allow for timely referral services/early intervention. These funds are requested for SFY 2008, with anticipated renewal in years 2009 and 2010 contingent upon the availability of funds. Data resulting from the implementation of opt-out testing in these sites may provide guidance related to the need to modify HIV screening criteria elsewhere in or across the state. Setting a goal of 75% participation in the opt-out HIV testing expansion project, and using projected State Fiscal Year (SFY) 2008 User numbers for the two participating delegate agencies to estimate number of clients receiving an initial or annual in that time period, it is estimated that nearly 5,000 clients will be screened.

1. All clients will be informed both orally and in writing that HIV testing will be performed unless they decline (opt-out screening). Oral and written information will include an explanation of HIV infection, the meanings of both positive and negative test results, and an opportunity to ask questions as well as decline testing. HIV testing must be voluntary and free from coercion. Patients must not be tested without their knowledge (MMWR 55 [14]: 1-17, September 22, 2006, CDC). Counseling related to opt-out HIV screening is generally provided by nursing or mid-level provider staff and may add several minutes to the initial or annual "comprehensive" visit.
2. Subsequent HIV opt-out screening will be offered annually for those FP clients who are at increased risk for HIV infection, meaning heterosexual clients who themselves or whose sex partners have had more than one sex partner in the previous year (MMWR 55 [14]: 1-17, September 22, 2006, CDC).
3. Participating delegates must submit their agency's informed consent form for KDHE approval prior to implementation of opt-out HIV testing.
4. In accordance with KDHE CTR Program requirements, all Title X clinical staff at participating sites must complete the KDHE approved training to ensure basic understanding of HIV/AIDS, and as well as annual web-based updates to ensure dissemination of current information. Specific activities related to staff training required prior to provision of opt-out HIV screening are detailed in the Program Work Plan page 28.
5. Modified Program Evaluation Monitoring System (PEMS) forms will be used to ensure uniform data collection and reporting. Staff training activities related to completion of lab requisitions, minimum data elements, data collection and reporting procedures are listed in the Program Work Plan.
6. All participating project sites will send blood specimens to KDHEL for HIV testing.
7. All clients receiving opt-out HIV testing will be instructed how/when to obtain HIV test results. Clients will be notified of negative HIV test results by delegate agency staff. Documentation of client's receipt of test results will be conducted in accordance with acceptable medical standards.
8. Per existing KDHE procedures, all clients with a previously unknown positive HIV test result will be referred to KDHE Disease Intervention Specialist (DIS) for intensive post-test counseling, Partner Care and Referral Services (PCRS), and referral to care.
9. HIV positive clients returning to the FP clinic for care within the scope of the Title X Project will be provided prevention messages consistent with current management guidelines. All participating sites will be provided with a copy of the July 18, 2003 MMWR, (RR-12) "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV".

Goals and Objectives

There are two Goals for this expansion Project:

GOAL 1: Expand HIV testing by incorporating opt-out HIV screening as a part of routine clinical care in participating clinical service sites in order to increase clients' awareness of their infection status. Opt-out testing is likely to increase the number of clients screened for HIV infection and foster earlier detection of HIV infection since it is not tied to identification of specific risk factors or symptoms. The long term impact of this project would include identification of trends to identify the need for expanded HIV screening elsewhere in the state.

GOAL 2: Identify and counsel persons with unrecognized HIV infection and link them to clinical and prevention services. Pre-pregnancy client awareness of HIV infection, linkage to and utilization of clinical and prevention services may further reduce perinatal HIV transmission.

Chapter 6

REGIONAL PROFILES

KANSAS – Cumulative HIV Cases Diagnosed January 2005 – December 2007

RACE/ETHNICITY	HIV: not yet AIDS (N)	HIV: already AIDS (N)	Total HIV (N)	Total HIV (%)	Population Size* (N)	Population Size (%)	Estimated # Cases/100,000/yr
White Non-Hispanic	128	168	296	47.4 %	2,236,328	81.1 %	4.4
Black/African Am. Non-Hispanic	99	95	194	36.6 %	158,784	5.8 %	40.7
Hispanic	34	59	93	12.6 %	236,910	8.6 %	13.1
Multi-Race Non-Hispanic	4	1	5	1.5 %	43,718	1.6 %	3.8
American-Indian Non-Hispanic	2	2	4	0.7 %	23,691	0.9 %	5.6
Asian/Hawaiian/PI Non-Hispanic	3	1	4	1.1 %	59,186	2.1 %	2.3
Total	270	326	596	100 %	2,758,617	100 %	7.2

Region	Male HIV (N)	Male HIV (%)	Female HIV (N)	Female HIV (%)	Total HIV (N)	Total HIV (%)	Population Size* (N)	Population Size (%)	Estimated # Cases/100,000/yr
1	93	19.3 %	21	18.3 %	114	19.1 %	226,165	8.3 %	16.8
2	122	25.4 %	34	29.5 %	156	26.2 %	545,486	19.9 %	9.5
3	20	4.2 %	4	3.5 %	24	4.0 %	157,231	5.6 %	5.1
4	43	8.9 %	7	6.1 %	50	8.4 %	303,801	11.1 %	5.5
5	12	2.5 %	8	7.0 %	20	3.4 %	191,738	7.0 %	3.5
6	13	2.7 %	0	0 %	13	2.2 %	141,247	4.8 %	3.0
7	20	4.2 %	7	6.1 %	27	4.5 %	287,081	10.5 %	3.1
8	142	29.5 %	29	25.2 %	171	28.7 %	735,928	26.9 %	7.8
9	16	3.3 %	5	4.3 %	21	3.5 %	169,940	5.9 %	4.1
Total	481	100.0	115	100 %	596	100 %	2,758,617	100 %	7.2

RACE/ETHNICITY	Male HIV (N)	Male HIV (%)	Female HIV (N)	Female HIV (%)	Total HIV (N)	Total HIV (%)
White Non-Hispanic	261	54 %	35	30 %	296	50 %
Black/African American Non-Hispanic	137	28n %	57	50 %	194	32 %
Hispanic	75	15 %	18	15 %	93	15 %
American-Indian Non-Hispanic	4	1 %	0	0 %	4	0.7 %
Asian/Hawaiian/PI Non-Hispanic	2	0.4 %	2	2 %	4	0.7 %
Multi-Race Non-Hispanic	2	0.4 %	3	3 %	5	0.8 %
Total	481	100 %	115	100 %	596	100 %

KANSAS – Cumulative HIV Cases Diagnosed January 2005 – December 2007

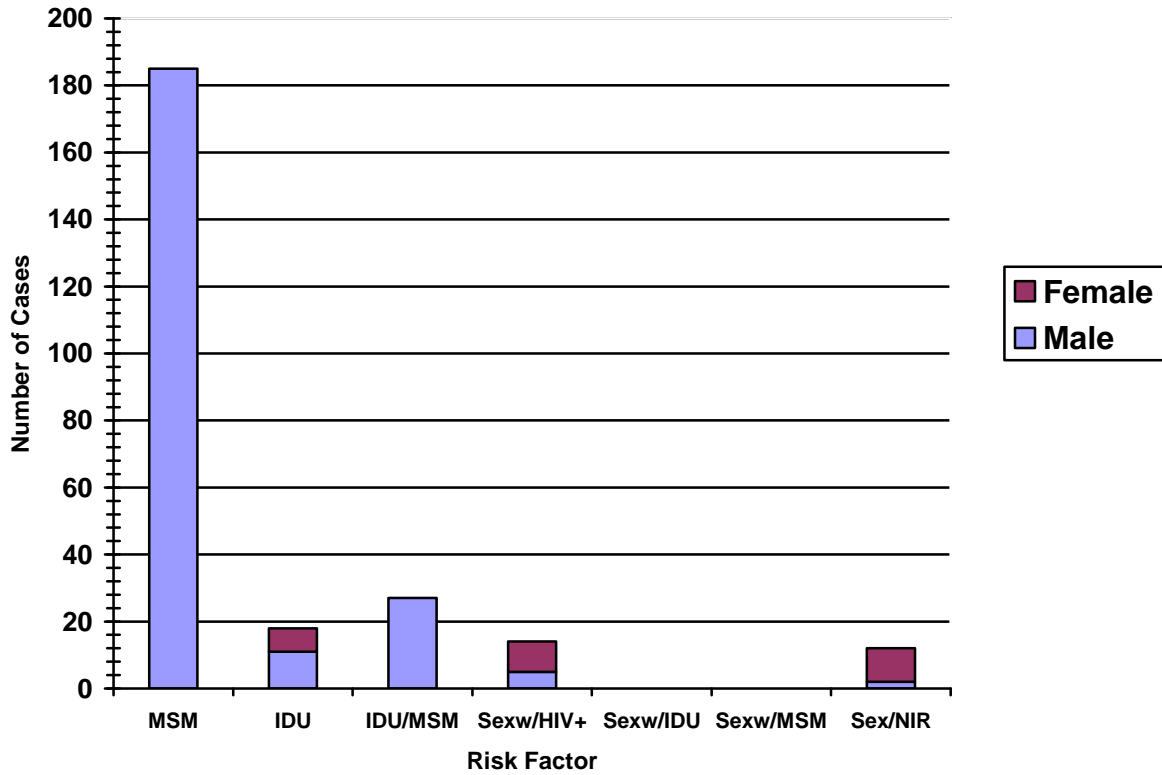
MODE of EXPOSURE	Male HIV (N)	Male HIV (%)	Female HIV (N)	Female HIV (%)	Total HIV (N)	Total HIV (%)
Men who have Sex with Men (MSM)	308	64.0 %			308	51.7 %
Injection Drug User (IDU)	24	4.9 %	14	12.2	38	6.4 %
MSM and IDU	36	7.5 %			36	6.0 %
Heterosexual Contact	25	5.2 %	61	53.0	86	14.4 %
Tissue/Blood Product Recipient	0	0.0 %	0	0.0	0	0.0 %
Perinatal Transmission	1	0.2 %	2	1.7	3	0.5 %
No Identified Risk (NIR)	87	18.1 %	38	33.0	125	21.0 %
Total	481	100 %	115	100.0	596	100 %

Age at HIV Diagnosis	Male HIV (N)	Male HIV (%)	Female HIV (N)	Female HIV (%)	Total HIV (N)	Total HIV (%)	Population Size* (N)	Population Size* (%)
<15 Years Old*	2	0.4 %	2	1.7 %	4	0.7 %	575,104	20.8 %
15-24 Years Old	68	14.1 %	13	11.3 %	81	13.6 %	412,329	14.9 %
25-34 Years Old	142	29.5 %	34	29.6 %	176	29.5 %	353,201	12.8 %
35-44 Years Old	151	31.4 %	33	28.7 %	184	30.9 %	373,370	13.5 %
45-54 Years Old	83	17.3 %	24	20.9 %	107	18.0 %	402,070	14.6 %
55-64 Years Old	26	5.4 %	8	7.0 %	34	5.7 %	284,245	10.3 %
65+ Years Old	9	1.9 %	1	0.7 %	10	1.7 %	358,298	13.0 %
Total	481	100.0	115	100.0	596	100.0	2,758,617	100.0

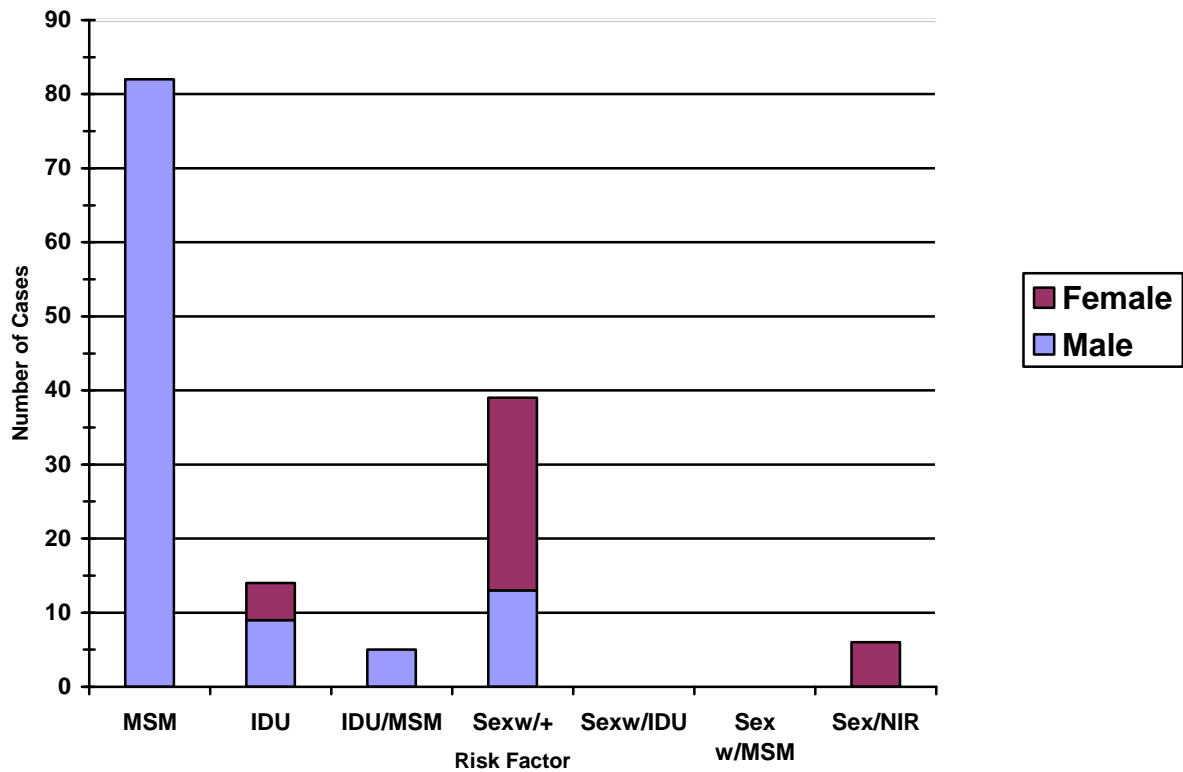
Population size is the average of the census estimates for 2005, 2006, & 2007.

* Cases <15 Years Old are not included in the regional analysis that follows

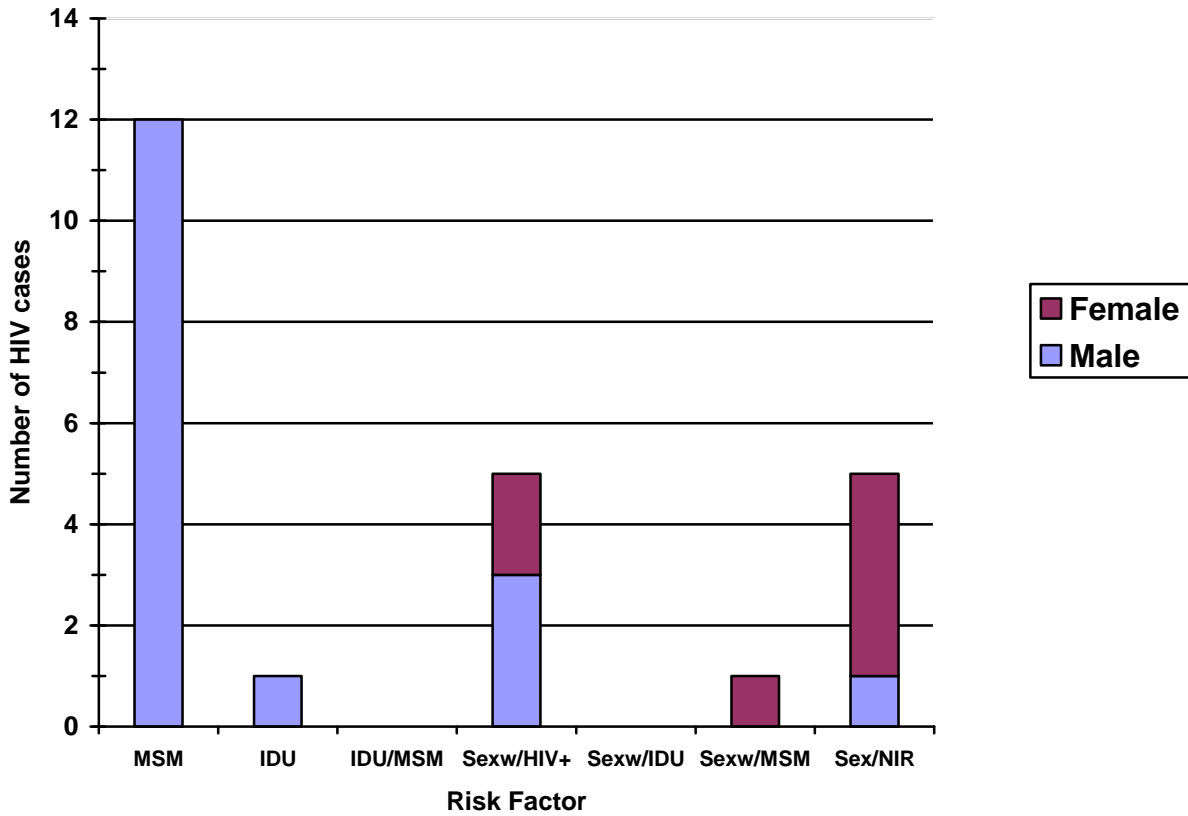
Caucasian HIV Cases 2005-2007



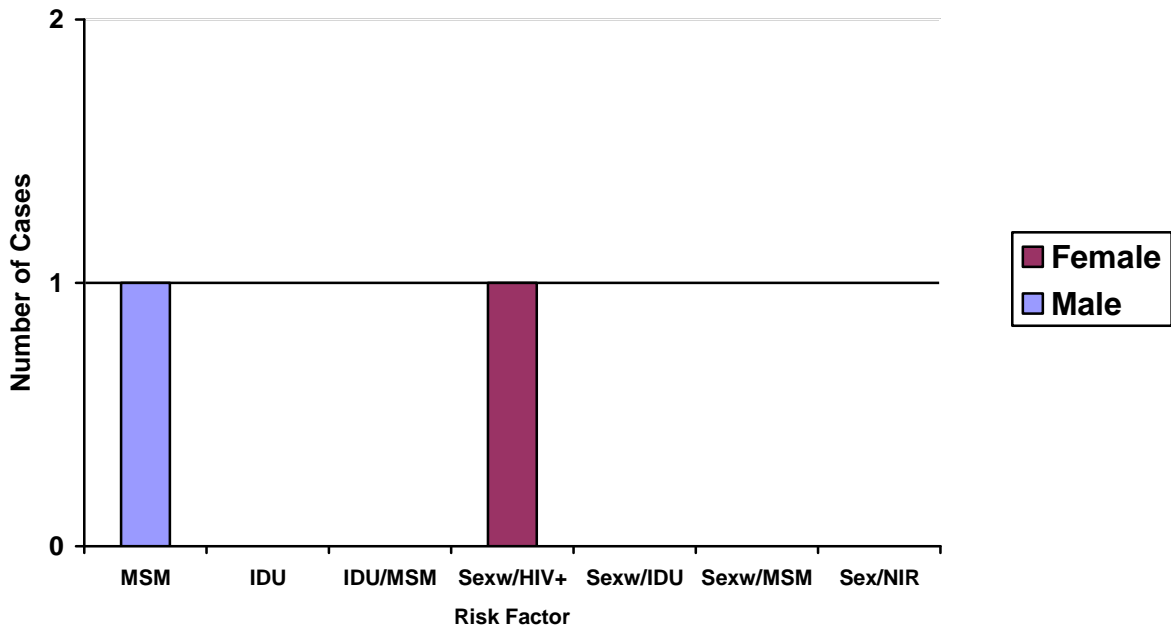
African American HIV cases 2005-2007



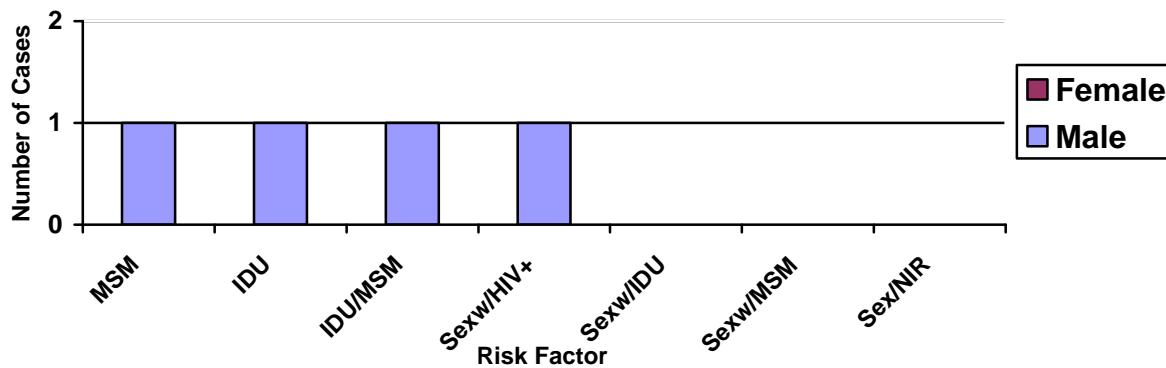
Hispanic/Latino HIV Cases 2005-2007



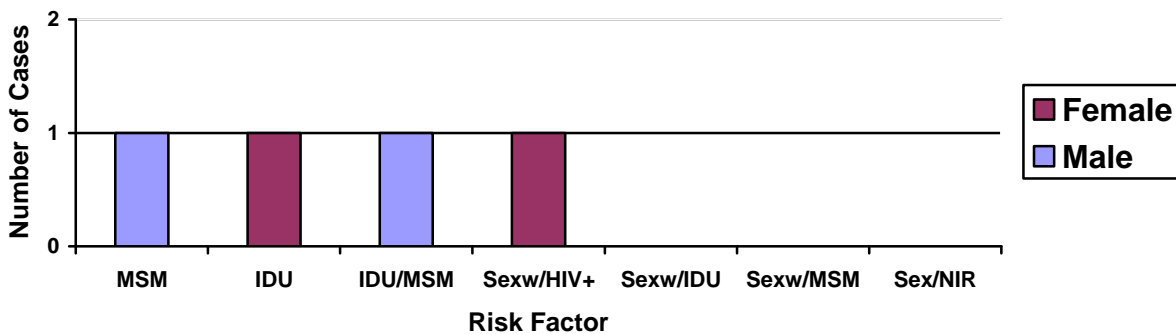
Asian/Hawaiian/PI HIV cases 2005-2007



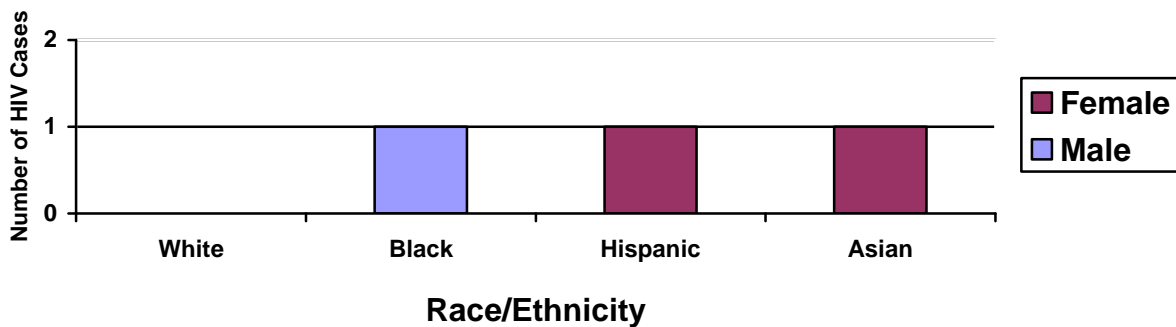
American Indian HIV cases 2005-2007



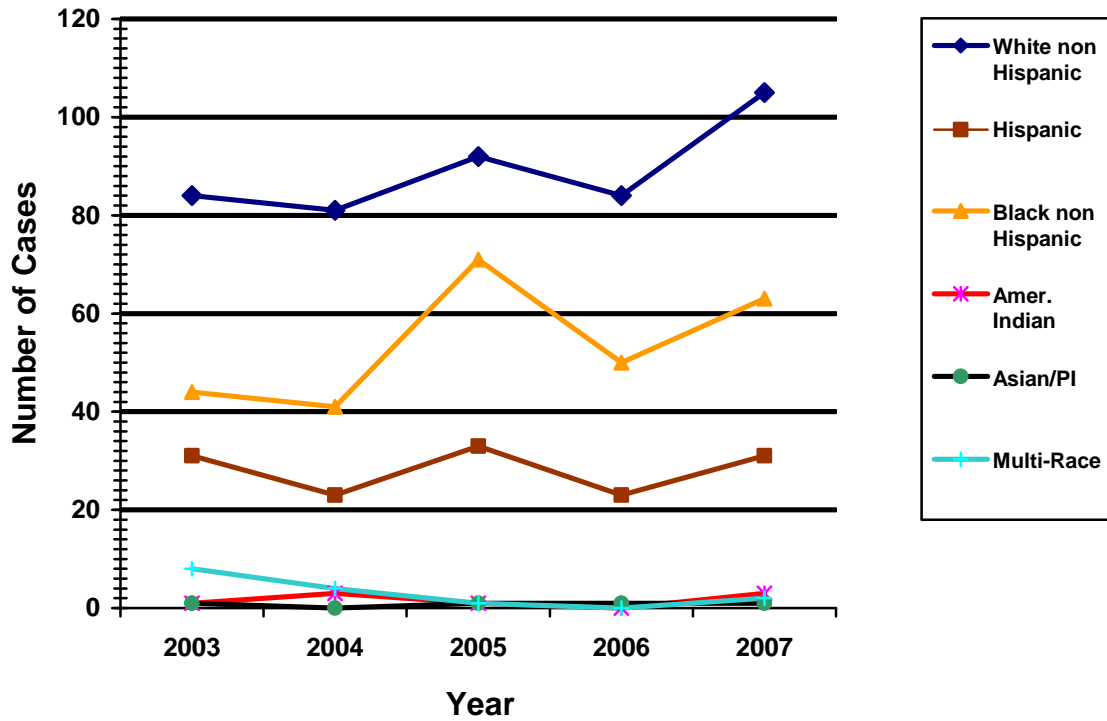
Multi-Race HIV cases 2005-2007



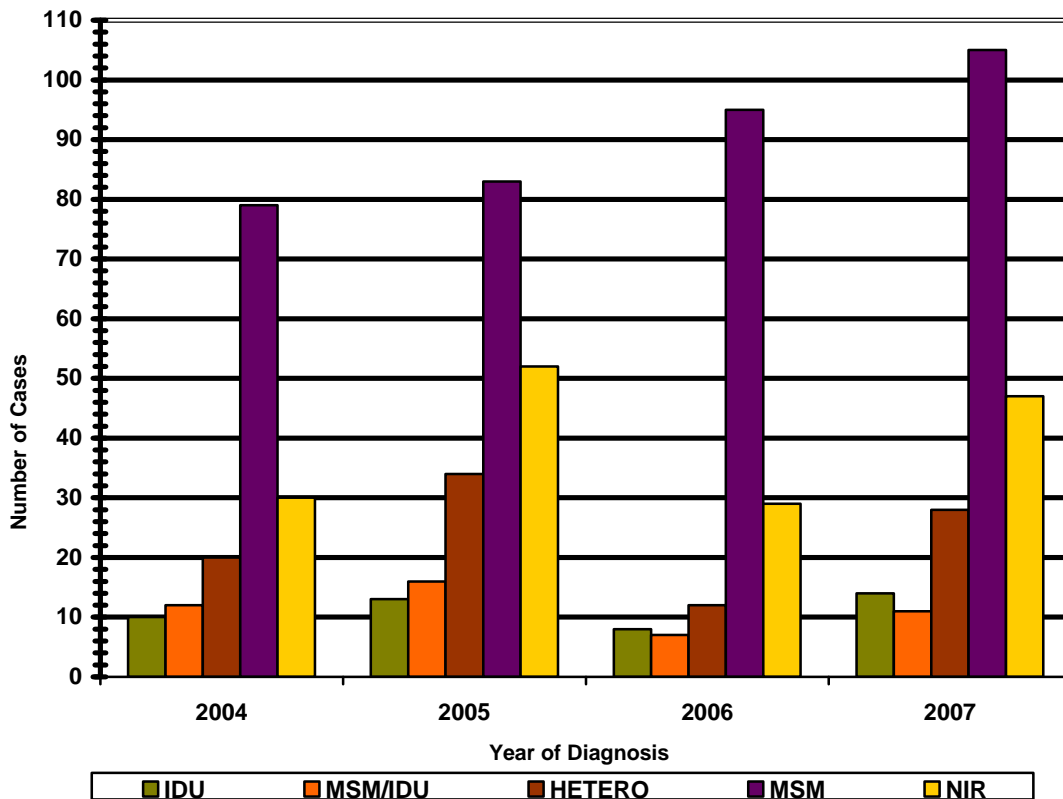
Perinatal Transmission 2005-2007



HIV/AIDS cases by Race/Ethnicity and Year of Diagnosis



Newly Diagnosed HIV by Mode of Exposure and Year of Diagnosis 2004-2007



REGION 1 – Cumulative Adult HIV Cases (January 2005 – December 2007)

Adult HIV Cases Region 1 MODE of EXPOSURE	Male HIV (N)	Male HIV (%)	Female HIV (N)	Female HIV (%)	Total HIV (N)	Total HIV (%)	State Average (%)
Men who have sex with men (MSM)	54	58 %			54	47.3 %	52.0 %
Injection Drug User (IDU)	2	2.2 %	1	4.8 %	3	2.6 %	6.4 %
MSM and IDU	4	4.3 %			4	3.5 %	6.1 %
Heterosexual Contact with HIV+	5	5.4 %	14	66.6 %	19	16.7 %	10.8 %
Heterosexual Contact with IDU	1	1.1 %	0	0	1	0.9 %	2.2 %
Heterosexual Contact with MSM			1	4.8 %	1	0.9 %	0.7 %
No Identified Risk (NIR)/Other	27	29 %	5	23.8 %	32	28.1 %	21.8 %
Total	93	100 %	21	100 %	114	100 %	100 %

Adult HIV Cases Region 1 RACE/ETHNICITY	Male HIV (N)	Female HIV (N)	Total HIV (N)	Total HIV (%)	State Average (%)	Population Size* (N)	Popula- tion * (%)	Estimated # Cases/ 100,000/yr	State Average rate
Caucasian Non-Hispanic	27	2	29	25.4 %	50 %	134,279	59.4 %	7.2	4.4
African American Non-Hispanic	47	11	58	50.9 %	32 %	47,176	20.9 %	41.0	40.5
Hispanic	18	7	25	21.9 %	15 %	35,925	15.9 %	23.2	12.9
Multi-Race Non-Hispanic	0	1	1	0.9 %	0.7 %	3,661	1.6 %	9.1	3.8
American Indian Non-Hispanic	0	0	0	0	0.7 %	1,398	0.6 %	0	4.2
Asian/Hawaiian/PI Non-Hispanic	1	0	1	0.9 %	0.8 %	3,726	1.6 %	9.0	1.7
Region 1 Total	93	21	114	100 %	100 %	226,165	100 %	16.8	7.2

REGION 1	PRIORITY POPULATION					
	HIV+	MSM	Women at High Risk	Youth at High Risk	IDU	High Risk Other
Estimated Population Size	630	2,844	2,392	706	850	2,345

REGION 2 – Cumulative Adult HIV Cases (January 2005 – December 2007)

HIV Cases Region 2 MODE of EXPOSURE	Male HIV (N)	Male HIV (%)	Female HIV (N)	Female HIV (%)	Total HIV (N)	Total HIV (%)	State Average (%)
Men who have sex with men (MSM)	81	66 %			81	53 %	52.0 %
Injection Drug User (IDU)	2	2 %	1	3 %	3	2 %	6.4 %
MSM and IDU	5	4 %			5	3 %	6.1 %
Heterosexual Contact with HIV+	7	6 %	18	56 %	25	16 %	10.8 %
Heterosexual Contact with IDU	1	1 %	2	6 %	3	2 %	2.2 %
Heterosexual Contact with MSM			1	3 %	1	1 %	0.7 %
No Identified Risk (NIR)/Other	26	22 %	10	31 %	36	23 %	21.8 %
Total	122	100 %	32	100 %	154	100 %	100 %

HIV Cases Region 2 RACE/ETHNICITY	Male HIV (N)	Female HIV (N)	Total HIV (N)	Total HIV (%)	State Average (%)	Population Size* (N)	Popula- tion * (%)	Estimated # Cases/ 100,000/yr	State Average rate
Caucasian Non-Hispanic	78	7	85	55 %	50 %	467,609	86 %	6.1	4.4
African American Non-Hispanic	22	22	44	29 %	32 %	20,213	4 %	72.6	40.5
Hispanic	21	2	23	15 %	15 %	29,323	5 %	26.1	12.9
Multi-Race Non-Hispanic	0	0	0	0 %	0.7 %	7,039	1 %	0	3.8
American Indian Non-Hispanic	0	0	0	0 %	0.7 %	2,135	0.4 %	0	4.2
Asian/Hawaiian/PI Non-Hispanic	1	1	2	1 %	0.8 %	19,167	4 %	3.5	1.7
Region 2 Total	122	21	154	100 %	100 %	545,486	100 %	9.4	7.2

REGION 2	PRIORITY POPULATION					
	HIV+	MSM	Women at High Risk	Youth at High Risk	IDU	High Risk Other
Estimated Population Size	589	3,490	1,394	411	801	1,367

REGION 3– Adult Cumulative HIV Cases (January 2005 – December 2007)

Adult HIV Cases Region 3 MODE of EXPOSURE	Male HIV (N)	Male HIV (%)	Female HIV (N)	Female HIV (%)	Total HIV (N)	Total HIV (%)	State Average (%)
Men who have sex with men (MSM)	16	80 %			16	67 %	52.0 %
Injection Drug User (IDU)	0	0 %	1	25 %	1	4 %	6.4 %
MSM and IDU	2	10 %			2	8 %	6.1 %
Heterosexual Contact with HIV+	0	0 %	0	0 %	0	0 %	10.8 %
Heterosexual Contact with IDU	0	0 %	2	50 %	2	8 %	2.2 %
Heterosexual Contact with MSM			0	0 %	0	0 %	0.7 %
No Identified Risk (NIR)/Other	2	10 %	1	25 %	3	13 %	21.8 %
Total	20	100 %	4	100 %	24	100 %	100 %

Adult HIV Cases Region 3 RACE/ETHNICITY	Male HIV (N)	Female HIV (N)	Total HIV (N)	Total HIV (%)	State Average (%)	Population Size* (N)	Popula- tion * (%)	Estimated # Cases/ 100,000/yr	State Average rate
Caucasian Non-Hispanic	16	3	19	79 %	50 %	136,304	87 %	4.6	4.4
African American Non- Hispanic	1	0	1	4 %	32 %	5,163	3 %	6.5	40.5
Hispanic	2	1	3	13 %	15 %	5,386	3 %	18.6	12.9
Multi-Race Non-Hispanic	0	0	0	0 %	0.7 %	3,153	2 %	0.0	3.8
American Indian Non- Hispanic	1	0	1	4 %	0.7 %	2,870	2 %	11.6	4.2
Asian/Hawaiian/PI Non- Hispanic	0	0	0	0 %	0.8 %	4,355	3 %	0.0	1.7
Region 3 Total	20	4	24	100 %	100 %	157,231	100 %	5.1	7.2

REGION 3	PRIORITY POPULATION					
	HIV+	MSM	Women at High Risk	Youth at High Risk	IDU	High Risk Other
Estimated Population Size	121	582	450	133	334	442

REGION 4 – Adult Cumulative HIV Cases (January 2005 – December 2007)

HIV Cases Region 4 MODE of EXPOSURE	Male HIV (N)	Male HIV (%)	Female HIV (N)	Female HIV (%)	Total HIV (N)	Total HIV (%)	State Average (%)
Men who have sex with men (MSM)	29	67 %			29	58 %	52.0 %
Injection Drug User (IDU)	3	7 %	2	29 %	5	10 %	6.4 %
MSM and IDU	3	7 %			3	6 %	6.1 %
Heterosexual Contact with HIV+	2	5 %	3	43 %	5	10 %	10.8 %
Heterosexual Contact with IDU	0	0 %	0	0 %	0	0 %	2.2 %
Heterosexual Contact with MSM			1	14 %	1	2 %	0.7 %
No Identified Risk (NIR)/Other	6	14 %	1	14 %	7	14 %	21.8 %
Total	43	100 %	7	100 %	50	100 %	100 %

HIV Cases Region 4 RACE/ETHNICITY	Male HIV (N)	Female HIV (N)	Total HIV (N)	Total HIV (%)	State Average (%)	Population Size* (N)	Popula- tion * (%)	Estimated # Cases/ 100,000/yr	State Average rate
Caucasian Non-Hispanic	27	3	30	60 %	50 %	249,592	82 %	4.0	4.4
African American Non-Hispanic	12	4	16	32 %	32 %	17,591	6 %	30.3	40.5
Hispanic	3	0	3	6 %	15 %	24,115	8 %	4.1	12.9
Multi-Race Non-Hispanic	0	0	0	0 %	0.7 %	5,284	2 %	0.0	3.8
American Indian Non-Hispanic	1	0	1	2 %	0.7 %	4,131	1 %	8.1	4.2
Asian/Hawaiian/PI Non-Hispanic	0	0	0	0 %	0.8 %	3,088	1 %	0.0	1.7
Region 4 Total	43	7	50	100 %	100 %	303,801	100 %	5.5	7.2

REGION 4	PRIORITY POPULATION					
	HIV+	MSM	Women at High Risk	Youth at High Risk	IDU	High Risk Other
Estimated Population Size	280	1,357	1,022	301	1,290	1,001

REGION 5 – Adult Cumulative HIV Cases (January 2005 – December 2007)

HIV Cases Region 5 MODE of EXPOSURE	Male HIV (N)	Male HIV (%)	Female HIV (N)	Female HIV (%)	Total HIV (N)	Total HIV (%)	State Average (%)
Men who have sex with men (MSM)	5	42 %			5	25 %	52.0 %
Injection Drug User (IDU)	2	17 %	2	25 %	4	20 %	6.4 %
MSM and IDU	1	8 %			1	5 %	6.1 %
Heterosexual Contact with HIV+	0	0 %	1	13 %	1	5 %	10.8 %
Heterosexual Contact with IDU	1	8 %	2	25 %	3	15 %	2.2 %
Heterosexual Contact with MSM			1	13 %	1	5 %	0.7 %
No Identified Risk (NIR)/Other	3	25 %	2	25 %	5	25 %	21.8 %
Total	12	100 %	8	100 %	20	100 %	100 %

HIV Cases Region 5 RACE/ETHNICITY	Male HIV (N)	Female HIV (N)	Total HIV (N)	Total HIV (%)	State Average (%)	Population Size* (N)	Popula- tion * (%)	Estimated # Cases/ 100,000/yr	State Average rate
Caucasian Non-Hispanic	7	3	10	50 %	50 %	172,900	90 %	1.9	4.4
African American Non-Hispanic	2	3	5	25 %	32 %	5,182	3 %	32.2	40.5
Hispanic	2	1	3	15 %	15 %	5,024	3 %	19.9	12.9
Multi-Race Non-Hispanic	1	1	2	10 %	0.7 %	3,958	2 %	16.8	3.8
American Indian Non-Hispanic	0	0	0	0 %	0.7 %	3,315	2 %	0.0	4.2
Asian/Hawaiian/PI Non-Hispanic	0	0	0	0 %	0.8 %	1,359	1 %	0.0	1.7
Region 5 Total	12	8	20	100 %	100 %	191,738	100 %	3.5	7.2

REGION 5	PRIORITY POPULATION					
	HIV+	MSM	Women at High Risk	Youth at High Risk	IDU	High Risk Other
Estimated Population Size	86	452	882	260	1,075	865

REGION 6 – Adult Cumulative HIV Cases (January 2005 – December 2007)

HIV Cases Region 6 MODE of EXPOSURE	Male HIV (N)	Male HIV (%)	Female HIV (N)	Female HIV (%)	Total HIV (N)	Total HIV (%)	State Average (%)
Men who have sex with men (MSM)	8	62 %			8	62 %	52.0 %
Injection Drug User (IDU)	0	0 %	0	0 %	0	0 %	6.4 %
MSM and IDU	2	15 %			2	15 %	6.1 %
Heterosexual Contact with HIV+	1	8 %	0	0 %	1	8 %	10.8 %
Heterosexual Contact with IDU	0	0 %	0	0 %	0	0 %	2.2 %
Heterosexual Contact with MSM			0	0 %	0	0 %	0.7 %
No Identified Risk (NIR)/Other	2	15 %	0	0 %	2	15 %	21.8 %
Total	13	100 %	0	0 %	13	100 %	100 %

HIV Cases Region 6 RACE/ETHNICITY	Male HIV (N)	Female HIV (N)	Total HIV (N)	Total HIV (%)	State Average (%)	Population Size* (N)	Popula- tion * (%)	Estimated # Cases/ 100,000/yr	State Average rate
Caucasian Non-Hispanic	5	0	5	39 %	50 %	117,966	83 %	1.4	4.4
African American Non-Hispanic	7	0	7	54 %	32 %	9,620	7 %	24.3	40.5
Hispanic	1	0	1	8 %	15 %	6,313	5 %	5.3	12.9
Multi-Race Non-Hispanic	0	0	0	0 %	0.7 %	2,924	2 %	0.0	3.8
American Indian Non-Hispanic	0	0	0	0 %	0.7 %	826	1 %	0.0	4.2
Asian/Hawaiian/PI Non-Hispanic	0	0	0	0 %	0.8 %	3,598	3 %	0.0	1.7
Region 6 Total	13	0	13	100 %	100 %	141,247	100 %	3.1	7.2

REGION 6	PRIORITY POPULATION					
	HIV+	MSM	Women at High Risk	Youth at High Risk	IDU	High Risk Other
Estimated Population Size	94	259	499	147	203	490

REGION 7 – Adult Cumulative HIV Cases (January 2005 – December 2007)

HIV Cases Region 7 MODE of EXPOSURE	Male HIV (N)	Male HIV (%)	Female HIV (N)	Female HIV (%)	Total HIV (N)	Total HIV (%)	State Average (%)
Men who have sex with men (MSM)	12	60 %			12	44 %	52.0 %
Injection Drug User (IDU)	4	20 %	0	0 %	4	18 %	6.4 %
MSM and IDU	2	10 %			2	7 %	6.1 %
Heterosexual Contact with HIV+	0	0 %	0	0 %	0	0 %	10.8 %
Heterosexual Contact with IDU	0	0 %	4	57 %	4	15 %	2.2 %
Heterosexual Contact with MSM			0	0 %	0	0 %	0.7 %
No Identified Risk (NIR)/Other	2	10 %	3	43 %	5	18 %	21.8 %
Total	20	100 %	7	100 %	27	100 %	100 %

HIV Cases Region 7 RACE/ETHNICITY	Male HIV (N)	Female HIV (N)	Total HIV (N)	Total HIV (%)	State Average (%)	Population Size* (N)	Popula- tion * (%)	Estimated # Cases/ 100,000/yr	State Average rate
Caucasian Non-Hispanic	14	5	19	70 %	50 %	263,877	92 %	2.4	4.4
African American Non-Hispanic	4	1	5	19 %	32 %	3,975	1 %	41.9	40.5
Hispanic	2	1	3	11 %	15 %	12,935	5 %	7.7	12.9
Multi-Race Non-Hispanic	0	0	0	0 %	0.7 %	3,093	1 %	0.0	3.8
American Indian Non-Hispanic	0	0	0	0 %	0.7 %	1,209	0.4 %	0.0	4.2
Asian/Hawaiian/PI Non-Hispanic	0	0	0	0 %	0.8 %	1,992	1 %	0.0	1.7
Region 7 Total	20	7	27	100 %	100 %	287,081	100 %	3.1	7.2

REGION 7	PRIORITY POPULATION					
	HIV+	MSM	Women at High Risk	Youth at High Risk	IDU	High Risk Other
Estimated Population Size	128	582	378	111	1,074	371

REGION 8 – Adult Cumulative HIV Cases (January 2005 – December 2007)

HIV Cases Region 8 MODE of EXPOSURE	Male HIV (N)	Male HIV (%)	Female HIV (N)	Female HIV (%)	Total HIV (N)	Total HIV (%)	State Average (%)
Men who have sex with men (MSM)	95	68 %			95	56 %	52.0 %
Injection Drug User (IDU)	9	6 %	7	24 %	16	10 %	6.4 %
MSM and IDU	16	11 %			16	10 %	6.1 %
Heterosexual Contact with HIV+	6	4 %	4	14 %	10	6 %	10.8 %
Heterosexual Contact with IDU	0	0 %	0	0 %	0	0 %	2.2 %
Heterosexual Contact with MSM			0	0 %	0	0 %	0.7 %
No Identified Risk (NIR)/Other	14	10 %	18	62 %	32	19 %	21.8 %
Total	140	100 %	29	100 %	169	100 %	100 %

HIV Cases Region 8 RACE/ETHNICITY	Male HIV (N)	Female HIV (N)	Total HIV (N)	Total HIV (%)	State Average (%)	Population Size* (N)	Popula- tion * (%)	Estimated # Cases/ 100,000/yr	State Average rate
Caucasian Non-Hispanic	82	10	92	54 %	50 %	587,641	80 %	5.2	4.4
African American Non-Hispanic	38	15	53	31 %	32 %	47,637	7 %	37.1	40.5
Hispanic	18	3	21	12 %	15 %	61,239	8 %	11.4	12.9
Multi-Race Non-Hispanic	1	1	2	1 %	0.7 %	13,354	2 %	5.0	3.8
American Indian Non-Hispanic	1	0	1	1 %	0.7 %	6,854	1 %	4.9	4.2
Asian/Hawaiian/PI Non-Hispanic	0	0	0	0 %	0.8 %	19,303	3 %	0.0	1.7
Region 8 Total	140	29	169	100 %	100 %	735,928	100 %	7.7	7.2

REGION 8	PRIORITY POPULATION					
	HIV+	MSM	Women at High Risk	Youth at High Risk	IDU	High Risk Other
Estimated Population Size	911	7,046	3,527	1,041	3,641	3,458

REGION 9 – Adult Cumulative HIV Cases (January 2005 – December 2007)

HIV Cases Region 9 MODE of EXPOSURE	Male HIV (N)	Male HIV (%)	Female HIV (N)	Female HIV (%)	Total HIV (N)	Total HIV (%)	State Average (%)
Men who have sex with men (MSM)	8	50 %			8	38 %	52.0 %
Injection Drug User (IDU)	2	13 %	0	0 %	2	10 %	6.4 %
MSM and IDU	1	6 %			1	5 %	6.1 %
Heterosexual Contact with HIV+	0	0 %	3	60 %	3	14 %	10.8 %
Heterosexual Contact with IDU	0	0 %	0	0 %	0	0 %	2.2 %
Heterosexual Contact with MSM			0	0 %	0	0 %	0.7 %
No Identified Risk (NIR)/Other	5	31 %	2	40 %	7	33 %	21.8 %
Total	16	100 %	5	100 %	21	100 %	100 %

HIV Cases Region 9 RACE/ETHNICITY	Male HIV (N)	Female HIV (N)	Total HIV (N)	Total HIV (%)	State Average (%)	Population Size* (N)	Popula- tion * (%)	Estimated # Cases/ 100,000/yr	State Average rate
Caucasian Non-Hispanic	5	2	7	33 %	50 %	106,160	62 %	2.2	4.4
African American Non-Hispanic	3	1	4	19 %	32 %	2,227	1 %	59.9	40.5
Hispanic	8	2	10	48 %	15 %	56,650	33 %	5.9	12.9
Multi-Race Non-Hispanic	0	0	0	0 %	0.7 %	1,352	1 %	0.0	3.8
American Indian Non-Hispanic	0	0	0	0 %	0.7 %	953	1 %	0.0	4.2
Asian/Hawaiian/PI Non-Hispanic	0	0	0	0 %	0.8 %	2,598	2 %	0.0	1.7
Region 9 Total	16	5	21	100 %	100 %	169,940	100 %	4.1	7.2

REGION 9	PRIORITY POPULATION					
	HIV+	MSM	Women at High Risk	Youth at High Risk	IDU	High Risk Other
Estimated Population Size	98	388	654	193	732	642

Kansas HIV/AIDS Community Planning Group Strategic Plan

APPENDIX 1

CPG BY-LAWS

KANSAS HIV PREVENTION COMMUNITY PLANNING GROUP BY-LAWS
(Updated 5-28-09)

ARTICLE I NAME

The name shall be the Kansas HIV Prevention Community Planning Group; subsequently known as the CPG.

ARTICLE II MISSION and VISION STATEMENT

Section a.

Mission Statement: To develop an on-going, comprehensive HIV prevention plan for Kansas that is responsive to community identified needs.

Section b.

Vision Statement: The Kansas HIV Prevention Community Planning Group vision is to deliver comprehensive HIV Prevention services for Kansans through community education, advocacy, and mobilization until the end HIV and AIDS.

ARTICLE III MEMBERSHIP

Section a.

Initial planning group members were solicited through nominations at the January, 1994 Kansas AIDS Networking Project (KANP) and through the state.

Section b.

The CPG will consist of up to twenty-five (25) members. This group shall reflect the diversity of the community. Recruitment shall be guided by the principles of inclusiveness, representation, and parity as established by CDC in Section 1.3.2.1, CDC Criteria, Handbook for HIV Prevention Community Planning. (SEE ADDENDUM A).

Section c.

A minimum of three positions will be filled by individuals with HIV infection. As many as two persons who meet the other criteria of the Recruitment Committee may be elected as alternates for any position filled by an individual with HIV infection. The Kansas HIV Prevention CPG will include a minimum of two members who are youth ages 18 – 24 and a minimum of two members representing the Ryan White Part B Planning Body.

Section d.

Not more than four positions will be filled by representatives of state agencies.

Section e.

The Community Planning Group will hold harmless any member from any suit, damage, claim, judgments, or liability arising out of, or asserted to arise out of, conduct of such person in his or her capacity as a member.

Section f.

Each member will maintain full-time residence in Kansas except an individual

who resides outside the state of Kansas may become a member of the CPG if he or she is an official representative of a recognized Kansas HIV program.

ARTICLE IV TERMS OF MEMBERSHIP

Section a.

All non-state representative members shall serve for a period of two years beginning with the month of their election to the Community Planning Group. This two year period shall be considered one term. (SEE ADDENDUM B).

Section b.

Nominees completing the Review Process under the direction of the Recruitment Committee shall be presented to the CPG for election. The KDHE Co-Chair may conduct a telephone poll seeking concurrence on the nomination. However, election must be confirmed by a roll call vote of the CPG at the next scheduled meeting attended by the nominee.

Section c.

Any member may nominate themselves for a second term on the CPG. At the end of the second term of two years, members may nominate themselves for additional one year terms without limit. All nominees will be subjected to the CPG Review Process developed by the Recruitment Committee. (SEE ADDENDUM C)

Section d.

Four state-wide agencies are designated for indefinite representation on the CPG by the Kansas Department of Health and Environment (KDHE). The state-wide agencies represented are:

- The Kansas Department of Health and Environment (KDHE)
- The Kansas Department of Corrections (DOC)
- The Kansas Department of Education (KDE)
- The Kansas Addiction and Prevention Services (KAPS)

For the purposes of this document, these agencies will be referred to as state agencies from this point forward.

ARTICLE V VACANCIES

Section a.

All vacancies will be subject to the guidelines developed in the Selection Criteria, created by the Recruitment Committee. (SEE ADDENDUM D)

Section b.

An open nomination process will be used to fill all vacancies.

Section c.

If a vacancy is created before the expiration of a non-state member's term of service, the person who fills that vacated position will begin serving a two year term at the next scheduled meeting attended or participated in by the nominee. This will be considered the individual's first two-year term of service.

Section d.

All vacancies occurring after December 31, 1994, with the exception of the four designated state agencies, will be subject to the CPG Review Process developed by the Recruitment Committee. (SEE ADDENDUM C)

Section e.

Should a state representative vacate their position, the Director of the KDHE HIV/AIDS Section will contact the state agency to request a replacement representative be assigned to the committee.

Section f.

Should a state agency vacate their position on the CPG, the Director of the KDHE AIDS Section, will contact an appropriate state agency (as determined by the CPG and KDHE) to request a replacement representative be assigned to the committee.

ARTICLE VI OFFICERS, ELECTION AND DUTIES

Section a.

The officers of the Community Planning group shall be two Co-Chairs, a Co-Chair Designate and Sergeant-At-Arms. One Co-Chair shall be a designated employee of the KDHE HIV/AIDS Prevention Program, hereinafter referred to as the KDHE Co-Chair. The other Co-Chair, elected by the membership, shall be known as the Community Co-Chair. Officers, with the exception of the KDHE Co-Chair, shall be selected from among those members of the Community Planning Group who are not State officials.

Section b.

The Community Co-Chair, the Co-Chair Designate, and Sergeant-At-Arms shall be elected by a majority vote of the entire membership. These officers shall be elected to serve a one-year term beginning at the first meeting of each calendar year or the next meeting following a vacancy. The Co-Chair Designate serves in that capacity for one year. In the following year she or he serves as the Community Co-Chair for one year.

Section c.

At least thirty (30) days prior to the meeting designated for the election of officers, the Chair of the Recruitment Committee will ensure that requests for nominations for all offices be mailed to all voting members of the Community Planning Group. During the meeting designated for election of officers, the Recruitment Committee shall present a ballot of the nominated candidates to the membership.

Section d.

Duties of the Community Co-Chair. The Community Co-Chair shall preside at meetings; shall develop the agenda for meetings along with the KDHE Co-Chair, and shall act as Chair of the Executive Committee. The Community Co-Chair shall involve the Co-Chair Designate in meetings, planning and leadership.

Section e.

Duties of the KDHE Co-Chair. The KDHE Co-Chair shall work with a recorder on the minutes and reports; shall counsel and support the committees of the CPG; shall keep in regular contact with CPG members; and shall be responsible for process progression according to the needs of KDHE.

Section f.

Co-Chair Designate. This elected official is the next Community Co-Chair. The responsibilities of office are limited, but this person should be included in conversations between the Co-Chairs and kept current on the responsibilities and activities of the CPG. In the absence of the Community Co-Chair, the Co-Chair Designate shall carry out the tasks of the Community Co-Chair.

Section g.

Sergeant-at-Arms. This elected official shall be responsible for maintaining order and executing directions from Co-Chairs.

ARTICLE VII COMMITTEES OF THE GROUP

The Community Planning Group shall have exclusive power and authority to manage the affairs of the organization, provided, however, that the Group may delegate all or a portion of its functions from time to time to committees consisting of such individuals as are designated by the CPG. The CPG shall retain the authority to have final approval of all action taken by each committee.

Section a.

The Executive Committee may act in place and stead of the CPG between meetings of the CPG on all matters, except those specifically reserved by the CPG by these By-Laws, pursuant to delegation of authority to such committee by the CPG. The Executive Committee shall be made up of the chairperson from each small committee, the Community Co-Chair and the KDHE Co-Chair. Attendance from seventy-five percent (75%) of the Executive Committee members are required for a quorum. The Community Co-Chair shall be the only one to call meetings of the Executive Committee. Actions of the Executive Committee shall be reported to the members of the CPG for ratification by mail or at the next CPG meeting. This committee shall be subject to the orders of the CPG and none of its acts shall conflict with actions taken by the CPG. The Executive Committee shall advise the Community Co-Chair on the recommendations of small committee assignments.

Section b.

The following is a list of the standing committees of the CPG:

- Programs and Strategies Planning Prioritization
- Recruitment
- By-Laws
- Prevention/Care Collaboration
- Executive Committee
- Care and Prevention Committee

Section c.

Each Committee shall have a chair elected by the committee, or if a

committee cannot elect a chair, a chair shall be appointed by the Community Co-Chair of the CPG.

Section d.

Core membership from the CPG on each standing committee shall be as representative as possible. The Recruitment Committee has the authority to reassign members if representation cannot be achieved voluntarily. Any member of the CPG can be a part of any standing committee meeting, regardless of which committee they normally have membership.

Section e.

All committee meetings will be governed by the same set of rules as established in ARTICLE VII, "MEETINGS" and ARTICLE VIII, "ATTENDANCE".

Section f.

The CPG can create, delete, and/or rename committees.

ARTICLE VIII MEETINGS

Section a.

All meetings shall be open to the general public and follow a written agenda. Requests for inclusion of a specific item to the agenda should be made no later than seventy-two (72) hours prior to any scheduled meeting. Written minutes shall be provided to all CPG members prior to subsequent meetings.

Section b.

The CPG shall follow a general open meeting format with specific structure to be determined by Co-Chairs.

Section c.

All decisions of the CPG shall be made by consensus. Consensus shall be defined as all members willing to support and "sign-off" on decisions.

Section d.

If consensus is not possible, the decision of the CPG shall be made by vote.

Section e.

Any CPG member may call for a vote if consensus is not reached. Vote must be passed by 2/3 of members present.

Section f.

In order to vote, CPG members must be present. PLWA members are exempt from this rule.

Section g.

Only CPG members shall be allowed to participate at meetings, unless the Co-Chairs have made a decision to plan requests on the meeting agenda.

Section h.

An open forum will be held at the end of each meeting. Any individual may call a Co-Chair to request to speak at the open forum. They will be assigned

a date and time with a five-minute presentation limit.

Section i.

Written notice of the time and place of all CPG meetings shall be given to committee members.

Section j.

When community forums are held, notice will be given through various media, including, but not limited to, newspaper, announcements in community centers, posters, public bulletin boards, etc.

Section k.

Proxy voting will be permitted. Community Planning Group members can deliver their vote by proxy to another member of the CPG who will be attending the meeting. The Proxy will submit a signed Proxy statement (Addendum G) to the Health Department Co-Chair, by mail or fax, and received at least 24 hours prior to the CPG meeting.

Section l.

The presence in person or by proxy of not less than one-third of the current number of members shall constitute a quorum for the transaction of business. The members present at a duly called or held meeting at which a quorum is present may continue to do business until adjournment, notwithstanding the withdrawal of enough members to leave less than a quorum.

Section m.

The following statement will be on the sign-in sheet at each regular CPG meeting or read prior to each teleconference call. The purpose of this statement is to ensure that the information provided during meetings is not discussed or shared with persons outside of the Kansas CPG:

"I hereby agree that the information that is discussed in the Kansas Community Planning Group meetings will be treated as confidential information and will not be discussed or released to persons outside of the Kansas CPG."

ARTICLE IX ATTENDANCE

Section a.

All CPG members will be allowed three (3) absences in a 12-month calendar period running from January to December each year. Attendance includes scheduled in-person and CPG teleconference meetings.

Section b.

If a member has more than three absences within a twelve month calendar period, the Health Department Co-Chair shall inform the Community Co-Chair. The Community Co-Chair will write to the member, informing them of their attendance record. In that written communication, the Community Co-Chair will request that the member make written response within two weeks indicating whether the member wishes to continue on the CPG and what might have changed in their situation that will allow them to attend meetings

in future months. The member's response to this request will be reported at the next meeting of the CPG. If there is no response, if the member does not wish to continue, or there are no changes in personal circumstance, the CPG may vote to remove the member from the CPG. If there is such a vote, the Recruitment Committee will be advised to solicit for a replacement.

ARTICLE X ADMINISTRATION

Section a.

All CPG members shall be provided a current edition of CPG's By-Laws. A signed statement of receipt of those By-Laws shall be kept on file.
(ADDENDUM E)

Section b.

All CPG members shall be required to sign a Job Description Statement and a Disclosure Statement during his/her orientation to CPG. (ADDENDUM B & F)

ARTICLE XI CONFLICT OF INTEREST

Section a.

In making recommendations to the Department of Health and Environment concerning priorities, the planning group must operate in compliance with all applicable state and local conflict of interest laws. In order to safeguard the planning group's recommendations from potential conflict of interest, each member shall disclose any and all professional, and/or personal affiliations with agencies that may pursue funding. A Disclosure Statement form will be completed by each group member and kept on file. On issues where a group member's affiliate is the potential recipient of funds, that member may not vote on that issue.

Section b.

The administrative agency (KDHE) shall develop and publish a policy and procedures regarding conflict of interest. Said policy and procedures shall be developed in order to safeguard the Committee's recommendations and actions from potential conflict of interest. Each member shall disclose any and all professional and/or personal affiliations with agencies that may pursue funding. On issues where a Committee member's affiliate is the potential recipient of funds, that committee member may not vote on that issue.

Section c.

During his/her orientation to CPG, each member shall disclose in writing any and all professional client or personal affiliations with agencies that may pursue HIV prevention funding. A Disclosure Statement form shall be completed annually at the first meeting of each calendar year, on or before June 15th, and kept on file.

ARTICLE XII CONFLICT RESOLUTION

Section a.

In the event of disagreements and/or differences which cannot be resolved through discussion and other By-Law procedures, do not bring resolution, the CPG may vote to seek the help of an outside mediator.

Section b.

The CPG will use the services provided by the current agency contracted with through the Centers of Disease control and Prevention who will attempt to arbitrate the matter.

Section c.

Should it be impossible to resolve the issue(s) in this manner, a person from the contracted agency in Section II will make a binding decision.

ARTICLE XIII PARITY AND TRAINING

Section a.

All new members elected to the CPG will be given a Handbook which will contain, but not be limited to: the past 12-months minutes of the CPG meetings; the By-Laws; the current HIV Prevention Strategic Plan, supplemental applications, and EPIDEMIOLOGICAL profile; the *Orientation Guide* developed by the Academy for Educational Development (AED), and *Positive Input* developed by National Association of Persons Living With AIDS (NAPWA). This package will be developed by KDHE staff as directed by the By-Law Committee.

Section b.

Each new member would be assigned a mentor from the current membership on the CPG. Mentors would be listed first by tenure, and then by alphabetical order. The Co-Chairs of the CPG would be excluded from this list.

Section c.

After the meeting of the CPG when a new member is elected and before the next scheduled meeting, the Co-Chair(s) and mentors, or community members, will hold an orientation meeting with the new member(s). The presentations during this meeting are primarily the work of the Co-Chairs and the purpose is to bring the new member(s) up to the current stage of the work being done by the CPG. At this meeting, and at least before the next CPG meeting, a new member will select on which of the five committees they will serve. This information will be given to the mentor and then communicated to the Community Co-Chair.

Section d.

The expectations of the mentor are a) to attend the orientation; b) to be available to the new member for information and counsel for six months; and c) to contact the Community Co-Chair with information on what small committee the new member selected to serve.

ARTICLE XIV REIMBURSEMENT

Section a.

All non-state employee voting members of the statewide Kansas CPG are considered consultants to KDHE. CPG consultants will be compensated for their services at the pro-rated amount of \$75.00 per day for each scheduled CPG meeting.

In addition, all non-state members will be reimbursed for mileage at the state reimbursement rate for each scheduled CPG meeting; and, when appropriate,

mileage for each scheduled small committee meeting.

In addition, all non-state representatives will be reimbursed for lodging expenses necessary to attend each scheduled CPG meeting and each scheduled small committee meeting with this one condition, that prior approval be given by the Executive Committee for lodging at the state reimbursement rate.

Section b.

Compensation for CPG consultant fees shall not exceed a total of \$1,999.99 in any given state fiscal year, July 1 through June 30.

ARTICLE XV PARLIAMENTARY AUTHORITY

Section a.

The rules continued in the current edition of Robert's Rules of Order, Newly Revised, shall govern in all cases to which they are applicable and in which they are not inconsistent with these By-Laws and any operating procedures previously adopted by the CPG.

ARTICLE XVI MODIFICATION OF BY-LAWS

Section a.

These by-laws may be changed and/or amended by a vote of two-thirds (2/3) of the members of the CPG.

ADDENDUM A

Section I.3.2.1. CDC Criteria

Members should:

1. Reflect the characteristics of the epidemic in terms of current AIDS cases, persons with HIV infection, and those at highest risk for HIV/AIDS. Criteria such as age, race/ethnicity, gender, sexual orientation, geographic distribution, HIV exposure status and category will be used as selection criteria.
2. Be able to articulate and have expertise in understanding and addressing the specific HIV prevention needs of the populations they represent.
3. Include scientific experts; service providers; representatives of organizations, such as state and local health departments and education agencies; other relevant governmental agencies (substance abuse, mental health, corrections); experts in epidemiology, behavioral and social sciences, evaluation research, and health planning representatives providing HIV prevention and related services.

ADDENDUM B

Job Description Statewide HIV Prevention Community Planning Group Member

The following job description is provided to give you an idea about the role and responsibilities of group members of the Statewide HIV Prevention Community Planning Group. Please read the description and sign below if you agree to serve in this capacity on the group.

A. Role Statement

As a member of the Kansas Statewide HIV Prevention Community Planning Group, it is your role to make a commitment to the process and its results by:

- 1) Participating in all decisions and problem solving
- 2) Undertaking special tasks, as requested by the Planning Group
- 3) Gathering data and information as needed.

B. Length of Commitment

All terms for Planning Group members not representing State agencies will be for two years.

Participation by Planning Group members representing State agencies is for an indefinite term, unless specified otherwise by the appointing authorities for those agencies.

C. Estimated Time Required

Monthly meeting and/or teleconference meetings of one to nine hours each, plus special meetings called when needed. Possible additional meetings of ad hoc committees. Up to eight hours per month for specific task completion.

D. Major Duties and Tasks from Supplemental Guidance, Section H

1. Delineate technical assistance/capacity development needs for effective community participation in the planning process.
2. Review available epidemiologic, evaluation, behavioral and social science, cost effectiveness, and needs assessment data and other information required to prioritize HIV prevention needs and collaborate with the AIDS Section of KDHE on how best to obtain additional data and information.
3. Assess existing community resources to determine the community's capability to respond to the HIV epidemic.
4. Identify unmet HIV prevention needs within defined populations.
5. Prioritize HIV prevention needs by target populations and proposed high priority strategies and interventions.

6. Identify the technical assistance needs of community-based providers in the areas of program planning, intervention, and evaluation.
7. Consider how the following are addressed with the Comprehensive HIV Prevention Plan:
 - Counseling, testing, referral, and partner notification (CTRPN), early intervention, primary care, and other HIV related services;
 - STD, TB, and substance abuse prevention treatment;
 - Mental health services; and
 - Other public health needs.
8. Develop goals and measurable objectives for HIV prevention strategies and interventions in defined target populations.
9. Evaluate the HIV Prevention Community Planning process and assess the responsiveness and effectiveness of the AIDS Section's application for federal HIV prevention funds in addressing the priorities identified in the Comprehensive HIV Prevention Plan.

I have read the job description and am prepared to make a commitment to this HIV Prevention Community Planning process and its results.

Name

Date

ADDENDUM C REVIEW PROCESS

This criteria has been developed by the Recruitment Committee to ensure that an open and fair mechanism is created which allows for the identification, nomination and selection of participants to the Community Planning Group.

1. ENSURE FOR INCLUSIVENESS AND REPRESENTATION

A. Compare the results of the CPG Inclusion/Representation Survey (required of all serving CPG members) to the current Epidemiological Profile for the State of Kansas. Identify non-represented individuals or organizations, using the guidelines established by CDC in Section 1.3.2.1 CDC Handbook for HIV Prevention Community Planning (Article III, Section III of the CPG By-Laws).

B. Undertake recruitment efforts that assure identified target populations who represent at-risk groups are informed and included in the nomination process. This can include advertising in publications which serve target populations, public announcements, recruitment from key sources such as CBO's, meetings, well known spokespersons or agencies, etc.

2. ASSESS CANDIDATES FOR MEMBERSHIP USING DEVELOPED ASSESSMENT STANDARDS SO THAT THE MOST APPROPRIATE INDIVIDUALS ARE SELECTED.

A. Distribute completed nomination forms to all Recruitment Committee members for the purpose of "scoring" the candidates. Selection criteria developed by the Recruitment Committee must be used to score the candidates.

B. Discuss and compare scores for the purpose of selecting the most qualified candidates to be interviewed. Consideration must be given to the level and type of experience and the resources that each nominee can bring to the planning group.

C. Interview candidates with standardized interview questions. These questions must be developed to help identify candidates who can best meet the current needs of the CPG as identified by the Recruitment Committee in accordance with the CPG By-Laws and the Review Process guidelines.

D. Using the guidelines developed by the Recruitment Committee for selection criteria (See Addendum D), review and discuss qualifications of appropriate candidate(s). Recommend selected candidates to the CPG for approval.

3. NOTIFY CANDIDATES APPROVED BY THE CPG OF THEIR SELECTION

4. ENCOURAGE INDIVIDUALS WHO WERE NOT SELECTED TO PARTICIPATE AS A COMMUNITY CONTRIBUTOR.

ADDENDUM D

For Interview Purposes Inclusion/Representation Selection Criteria

To establish an objective, uniform and equitable review process, the following selection criteria were developed by the Recruitment Committee to serve as the basis for rating each nominee.

1. The ability to make a time commitment to be a full participant and have a willingness to undertake special tasks as assigned by the CPG group.
2. The ability and desire to be a team player, which includes being able to provide constructive feedback.
3. The ability to keep key organizations and/or communities informed of the HIV Prevention Community Planning Group's work.
4. The ability to bring representation, yet be flexible and mature enough to focus on the overall plan, to see the "big picture."
5. Expertise in HIV prevention/education.
6. Is a member of a target and/or under served group(s) represented in the state epidemiological profile or speaks for, is a part of, works with, and has expertise in understanding and addressing the specific HIV prevention needs of a community represented in the state epidemiological profile. (Individuals who are members of target and/or under served group(s) will be given extra consideration.)

Each criteria will be given 10 points for a total of 60 points. Using the criteria established above, the members of the Inclusion/Representation Subcommittee will assign a score to all applicants after the interview process is completed.

In addition to the selection criteria mentioned above, other factors such as the need to ensure diversity and parity will also be considered.

ADDENDUM E

Receipt of By-Laws

I have received a copy of the HIV Prevention Community Planning Group By-Laws.

Signed: _____

Date: _____

ADDENDUM F

DISCLOSURE FORM

The State Wide Community Planning Group of Kansas
Conflict of Interest Disclosure Form

The State Wide Community Planning Group of Kansas 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, this Disclosure Form has been adopted by the State Wide Community Planning Group of Kansas and must be completed by all current and future group members.

By my signature below, I certify that:

- 1) I have read, understand, and support State Wide Community Planning Group's "Conflict of Interest" By-Laws.

- 1) I and/or a family member am/are (has/have been) within the past twelve months, serv(d) in a staff, consultant, officer, board member, or advisor capacity with the following organization(s) that has/have received, may seek or is/are eligible for funding HIV prevention activities. (Please attach additional pages if necessary)

Organization: _____

Title: _____ Period of Affiliation: _____

Organization: _____

Title: _____ Period of Affiliation: _____

Organization: _____

Title: _____ Period of Affiliation: _____

Group Member: _____

Signature: _____

Date of Signature: _____

Date Form Received by CPG: _____

ADDENDUM G

Proxy Statement

I, _____, authorize and give

(Name of person to be represented)

(Representative's Name)

this proxy vote on my behalf at the _____ meeting of the
Kansas

(Date of Meeting)

HIV Prevention Community Planning Group.

APPENDIX 2

2007 HIV/AIDS EPIDEMIOLOGIC PROFILE

Go to:

<http://www.kdheks.gov/hiv/surveillance.html>

Kansas HIV/AIDS Community Planning Group Strategic Plan

APPENDIX 3

COMMUNITY SERVICES ASSESSMENT

Please contact the KDHE HIV Prevention Program
for a current copy of the Community Services
Assessment

APPENDIX 4

INTERVENTION MODELS AND GUIDELINES

SEE:

<http://www.cdc.gov/hiv/resources/guidelines/herrg/index.htm>

or

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

APPENDIX 5

PRIORITIZATION WORKSHEET

SCORING WORKSHEET FOR: [NAME OF TARGET POPULATION]					
OBJECTIVE: Score Target Population					
Assign a score for each Factor. Multiply the score times the weight for the factor.					
FACTOR	VALUE (For Priority Population)	SCALE	SCORE (For Priority Population)	FACTOR WEIGHT	WEIGHTED SCORE
HIV Incidence (2003-2005 cumulative cases)		5: 200 or more 4: 150 to 199 3: 100 to 149 2: 50 to 99 1: less than 50		5	
HIV Prevalence (2005)		5: 1000 or more 4: 750 to 999 3: 500 to 749 2: 250 to 499 1: less than 250		2	
HIV Rates (2003- 2005 Incidence per 100,000 estimated Population per year)		5: 400 or more 4: 250 to 399 3: 100 to 249 2: 10 to 99 1: less than 10		5	
STD Data		5: High rate STD 4: Moderate/High rate STD 3: Moderate rate STD 2: Moderate/Low rate STD 1: Low rate STD		4	
Behavioral Risk Survey Data		5: High rate behavioral risks 4: Moderate/high risks 3: Moderate rate risks 2: Moderate/low risks 1 Low rate behavioral risks:		3	
Trends (2001-2005 incidence graphs)		5: Increasing % Incidence 4: Maybe % Increase 3: Level % Incidence 2: Maybe % Decrease 1: Decreasing % Incidence		3	
Population Demographics (estimated size of population)		5: 1,000,000 or more 4: 100,000 to 999,999 3: 50,000 to 99,999 2: 10,000 to 49,999 1: Less than 10,000		2	
Needs Assessment (Community Services Assessment)		5: Many unmet needs 4: Moderate/high unmet need 3: Moderate unmet needs 2: Moderate/low unmet need 1: Few unmet needs		1	
Barriers/Accessibility (Ability to reach the population with services)		5: No barriers, high access 4: Few barriers, accessible 3: Barriers exist, some access 2: Many barriers, low access 1: Total barriers, no access		3	
				TOTAL SCORE	

APPENDIX 5

PROVEN EFFECTIVENESS OF INTERVENTIONS

RATIONALE FOR RECOMMENDATIONS

Counseling and Testing

Counseling and testing provides a personalized, client-centered encounter in which an individual can learn his/her serostatus as well as obtain tools to assess his/her own risk. Counseling can also help clients develop personal methods for behavior change that decrease risk for HIV and helps in maintaining a low risk status. Clients can also receive referrals and information relevant to their needs as well as assistance in notifying partners.

Counseling and testing services can motivate individuals to recognize their risk, ask questions about safer sex in a safe environment, and formulate personal risk reduction plans. Counseling and testing programs also allow prevention providers to identify new target populations.

Demonstrated Effectiveness

The effectiveness of HIV counseling and testing on behavior change has been examined for several populations, mainly to inform the debate about the value of public and privately supported wide-scale testing programs. Higgins et al. (1991) compiled and compared to a group of studies examining the impact of counseling and testing of various population groups. Her findings support the assertion that while HIV counseling and testing programs are important, they should not necessarily be the center of HIV prevention efforts. Most of the studies cited in Higgins's report do not examine the effect of counseling, but, rather, examine the effect of HIV testing or knowledge of serostatus. Many of the studies make no reference to whether the individuals received any counseling, or if they did, to what extent. A more thorough examination of the studies cited reveals that even those studies that did provide counseling vary from viewing a video to a didactic lecture format to extensive counseling. When studies are viewed in this context, it appears that when HIV counseling and testing affects behavior change, it is because it is provided in a manner consistent with the recommendations provided by the Centers for Disease Control on "appropriate" counseling.

In a more recent review of the literature on prevention programs, Choi and Coates (1994) come to conclusions similar to those of Higgins. They conclude that HIV counseling and testing have a place in HIV risk reduction, but are not sufficient for HIV reduction. HIV counseling and testing do not have impact on certain behaviors in certain populations. For example, HIV counseling and testing is associated with lowering sexual risk behavior among homosexual men, and injecting drug use among IDU. HIV counseling and testing with couples is associated with reductions in transmission among sero discordant couples. However, HIV counseling and testing has not had an impact on pregnancy decisions among seropositive women, and only modest effects were demonstrated with STD clinic patients.

A study of women at community health clinics in Connecticut found limited effects of HIV counseling and testing on subjects' risk behaviors and psychological functioning related to HIV. While there appeared to be no change in sexual behavior among women who were tested, there was a decrease in intrusive thoughts around HIV (Ickovics et al., 1994). Erhardt's (1995) review of effectiveness studies of counseling and testing and other individual counseling interventions targeting women, found it difficult to be conclusive about the impact of these interventions on women.

In a study of gay males in bars in small cities, HIV risk behavior was examined as it related to HIV antibody testing practices (Roffman et al., 1995). Researcher found that men who had been tested tended to be more sexually active, more likely to have sex with multiple partners, and engaged in more protected and low-risk sexual activities than men who were not tested. The authors offered two explanations for this: 1) men who have been tested, rather than reducing sexual activity as a means of avoiding risk, choose to adopt protective behaviors when engaging in higher risk activities; and 2) these men may also be “more likely to make distinctions about the contexts for anal intercourse with which condom use is either necessary or unnecessary (e.g., with a long term partner who is HIV negative). From this, the study authors concluded that increased safer sex practices were associated with HIV antibody testing at both the community and individual level. The implications of these findings, as proposed by the authors, is that HIV testing should be made more available to this population and policies should be established to encourage test-seeking.

All cognitive and learning based theories have an informational component. People need information on HIV/AIDS transmission and prevention. Counseling provides valuable information to raise awareness for a need to change, and can alter the beliefs, attitudes, and/or intentions that influence behavior (social cognitive theory). According to more complex theories of behavior change, and empirical data, information is necessary but insufficient in producing sustained behavior change. Individuals must have the skills and the beliefs (self-efficacy) that they can carry out the preventive behaviors. Referral of both seropositive and sero negative individuals to other sources for continued support, education, counseling, and risk reduction skills training should be emphasized, given that research shows information alone is not enough to sustain behavior change.

Suggested Uses

Counseling Testing Referral (CTR) is universally applicable, although different groups may be reached through anonymous and confidential testing or through different testing venues. Anonymous testing serves the needs of clients who fear the repercussions of reporting of their HIV status, or who simply do not want their name on record. Confidential services expand the possibilities for follow-up and case management of the testing client. With youth and pregnant women, it may make more sense to focus on confidential testing and the capability for referral to services. There is some debate over the most appropriate environment for CTR (e.g., a site created just for HIV CTR or a primary care facility) and the most appropriate kind of provider (e.g., a primary care physician -doctor or nurse - or an HIV testing counselor). The primary care context may be more appropriate for communities in which there is more stigma attached to HIV and/or a greater likelihood that people will seek care from a single provider and for general health concerns. It is important, however, to ensure that doctors or nurses providing test results are fully trained to do the counseling and referral work for their clients. Training of all CTR providers should be ongoing and central to the program. CTR can function as a method of HIV prevention; it becomes part of a regimen of health care. CTR may have fewer benefits for people in a situation of total isolation and lack of social support. It may have fewer benefits for people in an early stage of recovery from substance abuse, although CTR can become part of the recovery program if it is done properly and/or the client responds well.

Partner Services (PS)

Partner services is a traditional disease control intervention used in fighting sexually

transmitted diseases. It involves public health officials taking responsibility for locating and notifying the sexual and needle sharing partners of people who have tested positive for HIV. Voluntary partner notification and counseling should be offered to every individual who tests positive for HIV infection at a publicly funded testing site and in a comprehensive manner to all private providers reporting a new infection. Each HIV positive individual and private provider reporting a new HIV infection should also be offered information regarding referral services to local care providers and Ryan White case management services. The choice to participate in the process must reside with the patient provider and the client.

Documented Effectiveness

Several researchers have conducted evaluations of partner notification programs. A study of partner notification in North Carolina found that provider-referred notification was more successful than the patient-referral method. Half of the provider-referral group were notified compared to only 7% of the patient referral group. The study was limited by the large number of tested individuals who declined to participate. The authors also note that the effectiveness of partner notification can be limited by those who test positive and do not return for their results (Landis et al., 1992).

A retrospective analysis of partner notification services in Colorado found that patients referred only 20% of eligible partners compared to 71% referred by the provider. Heterosexual men referred a greater proportion of partners through patient referral than did gay men. The proportion of patient referrals among white patients was higher than that of Latino and African American patients (Spencer et al., 1993).

In a different Colorado study, Hoffman et al. (1995) compared the effectiveness of partner notification services of an anonymous test site with those of confidential test sites. The researchers found that confidential test sites were 30 to 50% more likely to have notified and counseled the partners of HIV-positive clients. While there was no tracking of the ATS clients' rate of partner notification on their own, the authors cite other research that found that patient-referral partner notification was less effective than provider-referral notification.

Suggested Uses

Partner notification is generally applicable for anyone wishing to inform partners of their positive HIV status, often it may be the only means by which people who are at risk as partners become informed of their risk. Partner notification is especially valuable for anyone who wishes to notify a partner who is not currently in their life or who may have a violent or abusive reaction to hearing the news from the client. The intervention can be done by the service provider alone, or can be done jointly by the service provider and the client, depending on what is more comfortable and safe for the client. Partner notification is always an in-person service, allowing for on-the-spot counseling and referrals.

Health Education and Risk Reduction

The goals of health education and risk reduction activities are to provide information, education, and counseling that assists individuals in developing the skills, abilities, and self-esteem to carry out behavior change (CDC, 1995). Health education and risk reduction interventions can be delivered at individual, group, community, or outreach levels. HE/RR activities can include counseling, workshops, educational

programs and materials, presentations, and outreach activities.

Rinck and associate (1995) established the need for education and risk reduction strategies in the Kansas Needs Assessment. First, counseling and testing services, which include the provision of information, were clearly not sufficient to change and maintain risk reduction strategies among gay, bisexual, and MTSM respondents. Next, based on consumer feedback, the authors recommended more and expanded education on HIV transmission, more effective risk counseling, and counseling and workshops on decision making, skill building, communication, alternative methods, and sexuality. Consumers suggested follow-up training and condom and needle distribution in street outreach programs as strategies to improve prevention. Risk reduction strategies are needed in various areas. For example, research by Peterson and colleagues (1992) exemplifies the literature on barriers to condom use. The authors cite condom norms, condom efficacy, and negative expectations about using condoms as reasons for non use. They conclude that risk reduction interventions should build skills to eroticize condoms and encourage their use. Social cognitive theory (Bandura, 1994) states that for individuals to institute behavior changes, they must believe they have the skills, and are capable of initiating and sustaining the actions necessary to implement the desired changes (self-efficacy). Self-efficacy is malleable, and skills training in risk reduction behaviors can change perceived self-efficacy (Bandura, 1994; Valdiserri et al. 1992) and enhance the adoption of risk-reduction strategies.

In an outreach intervention in which community health workers provided AIDS education and substance abuse treatment referrals and distributed bleach bottles, Wattersers and associates (Wattersers, Downing, Case, Lorvick, Cheng & Ferguson, 1990) reported significant increases in needle cleaning and condom use and reductions in needle sharing. Choi and Coates (1994), reporting on a study by Weibel and colleagues over a four year period, noted a substantial reduction in needle sharing among IDUs after a peer-outreach program was conducted. Finally, a multi-city street outreach intervention, the National AIDS Demonstration Research Program, designed to deliver HIV risk reduction messages and promote participation in HIV prevention services, yielded a large reduction of needle sharing and an increase in condom usage (Stephens, Simpson, Coyle, McCoy, & the National AIDS Research Consortium, 1993).

Individual-level Counseling

Individual-level counseling is one-on-one, peer intervention involving a wide range of skills, information, and support. Individual-level counseling, or prevention case management, is an intensive, individualized support intervention designed to assist persons at high risk for or infected with HIV to either remain sero negative or to reduce their risk of transmission to others. Prevention case management offers services in a repeated, intensive manner in order to promote and support on-going safer behavior.

Demonstrated Effectiveness

Personal efficacy, one of the strongest predictors of low sexual risk-taking, can be built through prevention case management (Stall, Coates, & Hoff, 1988). Although there are no formal evaluations of prevention case management as an intervention, there are many reasons to believe that it could act as an effective strategy. Extensive evidence supports, for example, comprehensive and intensive prevention programs and prevention case management are able to assist an individual to address all of the potential risk factors that can lead to unsafe behavior.

Group-level Counseling

Group level interventions shift the delivery of services from the individual to groups of varying sizes. Group-level counseling uses peer or non-peer models involving a wide range of skills, information, and support.

Single Session Group Workshops

A single session group workshop consists of a one-time, intensive session or gathering focusing on information about HIV (e.g., transmission and behavior change), motivational activities, and skill-building. It may also touch on other relevant issues. This intervention can take a variety of forms, such as involving impromptu groups, using vans as session sites, and before/after bar groups. The specific intervention is planned or requested, usually based on advertising or promotion of the availability of the service.

Documented Effectiveness

According to service providers, multi-session group interventions have a greater impact on participants than single-session interventions. Providers note, however, that single-session interventions are also effective and give access to members of target populations who would not attend multi-session programs. Group interventions are more effective when they address other social or personal issues such as racism, domestic violence, or poverty. There are many studies evaluating the effectiveness of group presentations as an HIV prevention strategy. Presentations that emphasize skills for behavior change and that are more interactive are more effective than those that simply rely on the didactic transfer of information. The effectiveness of the didactic transfer method for information is still uncertain. Some studies say it does affect behavior, while others claim that it does not. It is safe to say, however, that basic information on HIV transmission and prevention is an essential element for changing behavior.

A study of African American/Black male adolescents from Philadelphia found that a one-time five-hour intervention designed to increase AIDS related knowledge and waken problematic attitudes toward risky sexual behavior was effective. Compared to a control group, at a three-month follow-up assessment, the intervention group had higher AIDS knowledge, weaker intentions to engage in unsafe sexual activity, and reported engaging in less risky sexual behavior in the three months following the intervention. (Jemmott, Jemmott, Fong, 1992). Conversely, Calabrese, Harris, and Easley (1987) found that neither attendance at a safe sex lecture, reading a safe sex brochure, receiving advice from a physician about AIDS, testing for HIV antibodies, nor counseling at an alternative test site were associated with participation in safe sex (Stall, Coates, and Hoff, 1988).

Two one-day peer-led interventions for gay and bisexual men in Philadelphia were evaluated. Intervention 1, a small group "AIDS 101" type lecture was less effective in increasing condom use than Intervention II, which included skills training utilizing role play and group process. Although Intervention II was more effective, both interventions increased condom use for insertive anal sex, but neither had any effect on receptive anal sex (Valdiserri et al., 1989).

A project in Los Angeles that used peer leaders for 4 to 15 gay and bisexual men in groups lasting several hours found that subjects "improved in terms of knowledge, attitudes, and behavioral intentions". (Institute for Policy Studies, 1993). Effectiveness of one-time condom skills training sessions for women at risk was difficult to assess

based on several studies reviewed by Ehrhardt et al. (1995). Fewer women were found to have multiple partners, but the effect on condom use was inconclusive. These authors also reviewed two studies of single session relational skills interventions for STD clinic patients neither of which found impacts on STD reinfection rates.

In a Seattle study of injection drug users, researchers found that a 90 minute educational intervention did not appear to impact the participants' involvement in high-risk behaviors. There were no significant differences between those who had received the intervention and those who did not at the four month follow-up (Calsyn et al., 1992).

Advantages and Strengths

Single session interventions can be run as one-time skills-building workshops, especially for those people who have been assessed as having knowledge, attitudes, and beliefs favoring risk reduction, but have not changed behavior. A single session format can be also beneficial for groups that cannot commit to multiple sessions and can serve as a first step or launching pad for clients' other prevention-oriented activities, if they focus on creating linkages. Single session presentations can be good for populations at lesser risk that have fairly good information, but want to build awareness and sensitivity (e.g., friends, family, or employers of people with HIV) and can be designed specifically to educate people who might become educators or advocates. It can clarify to people at low risk that they are at low risk, and in this way reduce the demands made on testing centers by people who are just worried about HIV in an unspecified way, not having to do with any actual risk behaviors. Single session groups may be provided in mobile vans, as an effective way of accessing higher-risk groups in their venues.

Considerations

Single session groups are less helpful for people with serious mental health issues; and a single session intervention may also be less beneficial/less feasible for the highest risk populations and those most in denial.

Multiple Session Group Workshops

Multiple session group workshops are a series of workshops, groups, or meetings introducing HIV issues and linking them to other life issues not as easily or immediately understood as relating to HIV. Workshop topics usually build on each other from session to session. Groups may be closed or drop-in, mixed or serostatus-specific, structured or need or issue driven groups for risk reduction and psycho social support. Multiple sessions provide an opportunity to go into greater depth about HIV risk reduction issues and strategies, and this format provides enhanced opportunity for behavior change. The intervention can draw people in with other (not directly HIV-related) activities. Groups can be held in vans or run as before/after bar groups.

Documented Effectiveness

There are much data suggesting that multi-session groups can be very effective at changing the risk behavior of group participants, and certainly at changing their level of knowledge. Multiple sessions have a greater possibility of effecting consistent behavior changes than one-time interventions. They also have more potential to deal with the underlying causes of unsafe behavior. Multiple session groups, however, can be only as effective as the facilitator or teacher who leads them. A facilitator or teacher who is not trained in AIDS education, or is not comfortable speaking frankly about sexuality and drug or other needle use, cannot lead an effective HIV prevention program.

A study of a two-session classroom AIDS education program involving seventh and tenth grade classes in Rhode Island showed positive results. Following instruction, students reported more knowledge, greater tolerance of AIDS patients, and more hesitancy toward high-risk behaviors, but the changes were modest (Brown, Fritz, and Barone, 1989). Similar results were found in a school-based AIDS prevention program presented in an inner-city school in Northern California serving predominantly African American/ Black and Asian students. In this population, however, changes in high-risk behaviors could not be detected, perhaps due to the small number of sexually active students (Siegel et. Al.). A study of an open-enrollment, pass/fail course at UCLA in 1988 showed positive impact on students' AIDS-related knowledge, attitudes, and behaviors. Compared to the control group, the students who took the lecture course changed their attitudes about critical public policy issues (e.g., mandatory HIV testing) to be in line with current public health policy. The nature of the effect was to bring students toward greater appreciation of 'individual rights' (Abramson, Seckley, Berk, and Cloud, 1989). An evaluation of an AIDS intervention program at a shelter for homeless adolescents in New York demonstrated significant increases in condom use and decreases in risky behavior. The intervention had no effect on abstinence. The intervention focused on skills training, behavior self-management, and group and social support from peers (Rotheram-Borus et al., 1991). A study of African American gay and bisexual men in San Francisco demonstrated that men who participated in multiple session groups had higher levels of behavior change, and maintained behavior change over time than those who attended single sessions groups (Peterson, 1993).

An evaluation of a six-session skill-building intervention conducted with high school student demonstrated that this approach was effective in increasing STD and AIDS knowledge and increasing skills to prevent risky sexual behaviors, but not drug use behaviors (Shafer and Boyer, 1991). In a review of NIMH sponsored research on prevention interventions, the authors outlined several studies that found that multiple session group workshops were successful in reducing high-risk behavior in gay men, women of color, and homeless youth. In particular, reported condom use was much higher for workshop participants than for control groups. These workshops included skill building for assertiveness, relationships, and social support. Multi-session interventions that included a cognitive-behavioral component showed more success in increasing condom use among African American youth than a single session information-only intervention (Office on AIDS et al., undated manuscript).

In their review of interventions for women at risk, Ehrhardt et al. (1995) found evidence that interventions that involved three or more sessions and whose skill-based content was targeted specifically to women (as opposed to men and women) were more successful in reducing high-risk sexual practices, at least in the short term, compared to information-only interventions. Positive results were found for IDU women or sex partners of IDUs and at-risk, inner-city or low income women.

For injection drug users in treatment, participants in an enhanced, sex session intervention on HIV education showed better ability to make decisions about risky behavior immediately following the intervention than participants receiving a single session information intervention. However, follow-up data did not reflect significant differences in behavior among the two groups (McCusker et al., 1992).

Kelly et al. (1994) were able to demonstrate behavior changes in female patients at

an urban clinic who received a five session workshop on HIV/AIDS risk reduction. Participants showed significant changes in condom use and sexual communication and negotiation skills at a three month follow-up. A comparison group receiving health education on other topics showed no change after three months.

Gay and bisexual adolescents participating in an HIV prevention intervention showed changes in their practices of unprotected anal and oral sex. These changes were pronounced for African American youths (Rotherum-Borus et al., 1994).

In addition to the research on HIV prevention interventions, studies on health education interventions for other health concerns also show the effectiveness of a multi-session approach. For example, patients participating in a six session educational program on cardiovascular health demonstrated greater improvements in their lifestyle and diet than did patients receiving the “usual advice” from a health care provider (Lindholm et al., 1995).

Advantages and Strengths

Multi-session groups are most applicable for people with high perception of personal risk is most useful for people who are already highly motivated to attend groups. Structured groups may provide a needed/desired structure for some populations (e.g., some homeless and/or jobless people). Multiple session groups also attract people who perceive themselves to be part of a culture, group, or community, and who are seeking connection with others who have shared experiences and interests. Services may be utilized more fully by women, who tend to take advantage of discussion and support groups and to work well with relational models. The group sessions can also be the first opportunity for people who are unaccustomed to engaging in group activities or to talking about sexual and drug-related behaviors with their peers. Multiple session groups can draw MTSMs (many older and Latino MTSMs, for example) who are seeking social contacts and support outside of the gay bar scene. Group sessions are especially feasible and easy to integrate when conducted in institutional settings (e.g., youth in schools, clients at in-house treatment centers, and incarcerated persons).

Considerations

Group sessions tend to be more helpful to participants if they are interactive rather than didactic. Providers can encounter difficulty in trying to retain participants for continuing groups; they may require a “hook” other than HIV prevention alone, to motivate regular attendance (note: this is absolutely essential for youth participation). Multiple group sessions may not be feasible for people with limited free time (e.g., people who are struggling to hold onto housing/employment or juggling house, kids, education, work, etc.).

Street and Community Outreach Programs

Street and community outreach programs are defined by their focus of activity and by the content of their offerings. Both have important subcategories of peer and non-peer models.

Peer Education

Peer education involves services provided by individuals who are recruited from a

targeted population. These individuals are trained in HIV/AIDS (epidemiology, prevention, resources, etc.), peer counseling, outreach, and the issues of population groups which are difficult to reach with HIV information alone. The peer model can draw on established social networks to disseminate information. Peer providers are a direct link to members of the target population who do not normally present at primary channels such as counseling and testing sites (Edelstein and Gonyer, 1993). Peer education can be used in individual, group and community-level interventions.

The importance of peers as educators is based on Diffusion of Innovation Theory and the subjective norms of the Theory of Reasoned Action. Diffusion Theory suggests that information and learning flows through natural social networks; people are more likely to adopt new behaviors if they are introduced by someone who is similar to them and is perceived to be a role model (Coates and Greenblatt, 1990; Dorfman et al., 1992). Peer educators may be similar to the target population by behavior, culture, race, age, ethnicity, gender, or other factors salient to the target population.

The Theory of Reasoned Action postulates that the intention to perform self-protective behavior is a function of the individual's attitudes toward that behavior or outcome and the perceived beliefs of the normative peer group. (Fishbein et al., 1994). To promote adoption of positive behavior change, interventions should be directed at the attitudes of the individual toward the behavior and also at the attitudes of the normative group. In other words, individual behavior is dependent in part upon the extent to which the person is influenced by the norms of the peer group.

Since peer norms appear to be important influences on adolescent behavior, peer education can assist in changing the perception of norms with respect to HIV and risk behaviors (DiClemente, 1993). Research has shown that successful adolescent peer educators are able to evaluate AIDS information, reconstruct it, and use their own personal experiences to filter through information. They then pass along this information and advice. Positive peer role models have been successful in helping to bring about risk-reduction changes in individual and group behavioral norms, and in serving as influential models to help young people's attitudes towards themselves and their health. Peer-based education can also be effective in helping the young person to understand his or her own risk and to translate the significance of this realization into his or her own life and behaviors. This personalization should, however, take place only in a safe setting where self-disclosure is met with acceptance, support, and confidentiality.

Participants in focus groups sponsored by the CPG in 1996 emphasized the importance of receiving information from peers. Peer education plays an important role in helping people perceive their own personal HIV-related risks. Perception of personal risk is an important factor in ultimately changing personal risk behavior.

Demonstrated Effectiveness

Ideally, research evaluating peer programs would measure behavioral outcome in addition to changes in knowledge and attitudes. Additionally, investigations should make direct comparisons between the same interventions using peers and those using non peers. Very few studies have done this. After reviewing a number of evaluation studies on peer education in academic settings, Fennell (1993) concluded that the literature offers little in judging the effectiveness of peer education programs in producing positive behavioral change in students.

Peer education programs have been used extensively in academic settings. They have been shown to be uniquely effective in providing a service with an economy of cost and person power (Zapka and Mazur, 1997). More recently they have been recommended and utilized in HIV prevention programs as a method for outreach, counseling, and changing norms. Peers can act as valuable change agents because they can communicate in ways that professionals cannot, and act as trustworthy role models (Perry, 1989). Persons are better able to accept communications that may influence attitudes, norms, and behaviors if ; they perceive the communicator is someone with whom they can identify and who may share similar problems (Sloane and Zimmer, 1993).

AIDS research has produced good evidence for conducting peer-led interventions. Rickert and colleagues (Rickert, Jay, & Gottlieb, 1991, cited in Sloane & Zimmer, 1993) compared a peer-led versus an adult-led AIDS education intervention with adolescents and found that participants asked more questions of peer leaders than of adult presenters. They concluded that perceptions of personal risk may be affected more by peer presenters than by adult presenters.

Kelly and associates (Kelly, St. Lawrence, Brasfield, Kalichman, et. Al., 1991) found that a peer-led intervention reduced the number of participants who engaged in unprotected anal intercourse. They concluded that interventions that employ peer leaders to endorse change may produce or accelerate population behavior changes to lessen risk for HIV infection. In a later study, researchers (Kelly et. al., 1992) produced similar findings. They reported that a peer-led outreach intervention targeting gay men frequenting bars resulted in a marked decrease in the proportion of men engaging in unprotected anal intercourse. Jemmott and Jemmott (1991) found a significant relationship between future intentions to use condoms when participants had support from parents or sexual partners for condom use.

Groups led by peers may be more effective at motivating behavior change than those led by non-peers. Catania et. al. (1991) found that positive support from friends, family, and lovers is related to changes in sexual behavior and increased condom use whereas helpful support from more formal sources (e.g., physicians, psychologists, etc.) was not associated with changes in condom use.

Using peers as educators may be useful for helping targeted population more accurately perceive their personal level of HIV-related risk. Peer educators can positively effect group norms, and peer educators are better able to talk frankly about sensitive issues around sex and drug use. Eroticizing condom use and emphasizing the erotic appeal of safer sex are critical components of interventions designed to change sexual behavior (Catania, et. al., 1991). Peer educators may be better equipped to understand what a particular group may or may not find erotic.

An additional benefit of peer-led programs is the positive effect they have on the peer educators themselves (McLean, 1994; Sloane & Zimmer, 1993; Stevens, 1994). Because they undergo training which involves increasing HIV risk knowledge, sensitivity and skills training, studies report increased prevention behaviors in the peer leaders in addition to the target populations (McLean, 1994; Sloane & Zimmer, 1993; Stevens, 1994).

The effectiveness of peer programs is dependent upon the quality of the support

and training of peer-leaders and the implementation and delivery of the program and its messages. Efforts can and should be made to control and maintain quality throughout the life of the program with ongoing-evaluations of service delivery and of outcomes (Croll, Jurs, & Kennedy, 1993). Only ongoing monitoring and outcome evaluation can help identify training needs in delivery sensitivity of peer leaders, and assess the impact of the interventions that are implemented (Croll et. al., 1993).

Advantages and Strengths

Peer education as a strategy is generally applicable to all populations, with a few exceptions. It is especially suited for populations who do not initially perceive themselves to be at risk.

Considerations

A peer approach may not appeal as much to members of small/close communities where information travels fast and stigma may still be attached to HIV concerns. Some groups may prefer to receive HIV prevention services from people they view as outside of their immediate community, so that they can talk more freely and not fear leakage of information. Peer education may not be appropriate for individuals desiring anonymity. Confidentiality should always be emphasized.

Street and Community Outreach

Street and community outreach refers to HIV prevention education and counseling that is delivered at informal sites where persons engaged in high-risk activities congregate, such as streets, bars, parks, shooting galleries, bathhouses, beauty parlors, etc. The strategy involves a broad range of models, from occasional condom drops to the long-term placement of highly skilled workers in the community. Street and community outreach programs may be highly interactive and engaging, or they may involve only a cursory risk message and delivery of referral information. Some outreach programs strive to develop long-term relationships with individuals on the street, thus the service s repeatedly delivered to an individual over time.

Street outreach involves more than the distribution of condoms and bleach. The more difficult task of the outreach workers is encouraging lifestyle changes by developing relationships through repeated outreach and a continuous presence. Not surprisingly, studies have found that increased exposure over time results in more significant behavioral changes (Stephens, et., al., 1993). However, the same studies have also indicated that there were not significant differences in behavioral changes based on the level of intensity of the intervention. Other studies of outreach projects, however, including a report by the Centers for Disease Control on AIDS community development project, indicate that the presence of outreach workers needs to be consistent and continuous, not just sporadic visits (Johnson, et. al., 1990; Stephens, et. al., 1993; Dorfman et. al., 1992).

A study of enhanced vs. standard interventions indicates that there is some, but not major, difference between the responses to the enhanced and standard interventions offered. Their recommendation is that more and not less enhanced intervention would make an outreach program more successful. The CDC study also confirms this analysis: "Counseling oriented interventions may need to address other issues or behaviors in an individual's life (such as childbearing plans among female sex partners of IDUs; crack use among IDUs; addiction to injectable illegal drugs; and alcohol abuse among gay/.bisexual men) before HIV prevention can be effectively addressed (CDC,

1992).

Street outreach workers may become trusted health care professionals. Lack of transportation and an intimidating appointment system can be a barrier to historically under served risk groups receiving HIV counseling and testing as well as STD and other health care services. Street outreach workers bring the services to the streets instead of asking people to make a production of getting to a clinic. Information that is presented in pamphlets kept at health clinics or broadcast through other media sources such as newsprint and television are less likely to impact historically under served individuals engaging in high-risk behaviors on the streets. The street outreach workers make it easy to get information by being accessible and available instantly (Wattersers, et. al., 1990).

In a study of community-based outreach to urban sex workers conducted by Dorfman, et. al., (1992) it is noted that the dedication of street outreach workers was noticed and appreciated by the community. Johnson, et. al., (1990), in their analysis of 28 street outreach programs around the country, conclude that the success or failure of community-based HIV prevention programs is dependent on the skills and dedication of the outreach worker.

Field staff should be indigenous to the community. It is important that outreach workers can relate to their contacts. It is important for street outreach workers to know when people are approachable. It is well documented from the earliest studies involving outreach that it is important for outreach workers to speak the same language (including the slang/jive of the community) and come from the same ethnic and socioeconomic background as their contacts. Reports indicate that street outreach workers are more readily trusted if they have at some point in their lives experienced the activities that they are talking about (Dorfman, 1992).

Different types of outreach strategies work in different types of communities. One study compared proactive and reactive strategies of street outreach. Proactive outreach consists of cold calls, walking up to people and making an introduction and actively initiating contact and interacting with individuals. Reactive outreach is a more passive form of outreach. This type of street outreach involves a constant community presence. Outreach workers “hang out” and are available for people to approach with questions. With this technique, the contacts have control over when outreach happens. The conclusion of the study indicated that different strategies worked for different risk groups. The proactive style was used most frequently within African American/Black communities by black outreach workers. The reactive strategy “emerged as a calculated response to the idiosyncrasies of particular communities...The black, Hispanic, and gay multi-ethnic neighborhoods differ in their general willingness to openly acknowledge and discuss drug abuse, illness and HIV-related diseases...The emergence of a proactive style of outreach in the black community was appropriate to the setting. On the other hand, the Hispanic community generally views drug abuse and HIV related diseases as taboo subjects” (Johnson, 1990).

Demonstrated Effectiveness

Research data, focus group participants, key informants, and providers all emphasize that outreach services must be appropriate to the target population and its norm. Clients should be able to identify with outreach workers. For example, research shows that using outreach workers from the community contributes to the positive

impact of outreach programs targeting IDUs (Coates and Stryker, 1994). Several studies discuss the effectiveness of outreach programs and of the core elements that influence that effectiveness. Researchers state that the most critical factor to effectiveness is the outreach staff themselves. Staff field workers, as much as pamphlets, condoms, and bleach handed out, need to be considered as intervention strategies in themselves. For an outreach program to be effective, the staff delivering the intervention needs to be respected, trusted, credible, open, friendly, dedicated, non-threatening, and non-judgmental. Once such trust is established, however, the results can be impressive. In one study of 554 IDUs in San Francisco, almost one quarter (24%) reported learning about bleach use from a community health outreach worker (Wattersers et. al., 1990).

Research and other data show street outreach is successful in communicating prevention messages to many populations and is associated with behavior changes, especially when it involves peer leaders, targets particular communities, and reaches them near the location of risky behavior (Givertz and Katz, 1993; Wattersers, et. al., 1990).

It is notable that street and community-based outreach services are the only intervention proven in published research to be somewhat successful with youths, one of the most difficult groups to reach with prevention messages (Givertz and Katz, 1993). Additional research has shown that staff who were from the targeted community and population were more likely to gain access to sex workers and became role models for behavior change (Dorfman, et. al., 1992). Building trust with members of the target population has been found to be an important factor for continued participation of the target population (Dorfman, et. al., 1992).

Erhardt, et. al.'s (1995) review of interventions for at-risk women found an increased condom use among female sex partners of IDUs living in housing projects who were the target of outreach efforts. A review of HIV prevention interventions by Choi and Coates (1994) found only three studies reporting on the effectiveness of community outreach to commercial sex workers; all showed increased condom use. In addition, the authors found two studies looking at street outreach to out-of treatment IDUs that found the intervention to be effective in reducing needle sharing and to a lesser extent, increasing condom use.

Advantages and Strengths

Outreach is especially appropriate for populations who 1) have a low perception of personal risk for HIV; 2) lack of access to health and social services; and 3) need basic information. Outreach can also serve as an opportunity to recruit clients targeted for other prevention activities. Additionally, the Center for AIDS Prevention Studies (CAPS) at UCSF lists community outreach as an effective approach leading to changed behaviors among IDUs.

Considerations

Outreach may not be suitable for individuals with serious mental health stressors. It is not as appropriate for populations that are well-informed but continue to show high rates of infection. Outreach may not be appropriate or allowed in certain venues; the needs assessment can help to determine the feasibility of outreach and the intervention may lose its impact if it is over-concentrated in a venue. After saturating a venue over a period of time, the intervention needs to adapt.

Condoms, Latex Barriers, Bleach Distribution

Through this strategy, health workers distribute bleach, condoms, and risk reduction barriers; demonstrate their use; and provide referrals in areas where people at risk for HIV congregate. Limited opportunities for one-on-one health education or risk reduction are offered by this strategy, which by definition, focuses on behavioral changes.

Access to Sterile Injection Equipment

Needle exchange programs provide sterile needles to injection drug users, and to hormone, steroid, vitamin, and insulin users. Needle exchange programs are community or street-based. Within this intervention framework, prevention workers distribute clean needles (syringes) and other supplies to individuals who use needles to inject drugs, usually in exchange for used needles. They also provide referrals to HIV-related services in areas where persons involved in high-risk behaviors congregate. A limited opportunity for one-on-one health education and/or risk reduction intervention may occur in this context, as may a chance to help link an infected possible infected person to HIV care services. Needle exchange programs focus specifically on behavior change related to needle usage, and less on sexual behaviors. Needle exchange programs are designed to reach individuals on a repeated basis.

A variety of factors may limit the effectiveness of needle exchange programs, including a lack of resources and of information in target communities about existing services. Providers note that overall, only a fraction of IDUs use needle exchanges. And IDUs who would utilize needle exchange programs do not always know how to access them. Providers say IDUs fear that law enforcement officials or social service authorities will intercept them at needle exchange sites. Providers also say that some women IDUs fear their children will be taken from them if they participate in needle exchange programs.

Demonstrated Effectiveness

The majority of studies demonstrate decreased rates of HIV drug risk behavior through needle exchange, but not sex risk behavior. Available data do not provide evidence that Needle Exchange Programs change overall community levels of drug use (Lurie & Reingold, 1993). There is also evidence to suggest that laws restricting access to syringes can potentially increase HIV infection rates.

Perinatal Transmission Prevention Activities

Between 1994 and 1998, the provision of antiretroviral therapies during the perinatal period resulted in substantial decreases in mother-to-child transmission of HIV from 20-25% to 5-10%. Despite this important success in HIV prevention, there are still groups of women and infants in the United States who do not benefit from antiretroviral therapy.

Studies have indicated that not all providers are offering HIV testing to all their prenatal patients. A CDC study found that one of the major reasons for women not accepting testing was that they did not perceive that their provider thought it was important. It has also been shown that private providers are less likely to offer HIV counseling and testing than are public setting providers. The Institute of Medicine's (IOM) recent report recommended that prenatal HIV testing be universal among pregnant women and become a routine part of prenatal care recommended by all providers. Women who may not be accessing these services include, among others,

those who are abusing substances, incarcerated, undocumented, non-English speaking, uninsured, homeless, teens, and those who are unaware of, or in denial about their risk for being HIV-infected. The infants of these mothers also are not receiving services and may include additionally those who are orphaned and abandoned.

Several services must take place to assure the lowest risk of perinatal HIV transmission. Missed opportunities at any point may increase the risk of transmission. The services needed to reduce perinatal transmission includes:

- prenatal care,
- education about the importance of HIV testing,
- voluntary Opt-Out HIV testing,
- for those who test positive, post-test counseling and zidovudine (ZDV) to reduce perinatal transmission,
- antiretrovirals for the benefit of the women's own health,
- other HIV-related prevention and care services during the perinatal period, and
- avoidance of breast-feeding to prevent HIV transmission to infants.

Access to STD Diagnosis and Treatment

The intimate inter-relationships between HIV infection and other sexually transmitted diseases are clear: the organisms are transmitted in similar fashions, many of the same populations are involved, other STDs increase the risk of HIV transmissions at least 2-5-fold, STD treatment may reduce HIV incidence, and HIV infection alters the natural history and response to standard therapy of several STDs. Behavior modifications to avoid risk-taking such as using condoms correctly and consistently, decreasing the number of one's sex partners, becoming monogamous, reduces the risk of transmission of HIV and other STDs. Despite these similarities, STDs and HIV infection are often looked upon as distinct and separate problems. Although STD diagnosis and treatment is funded primarily through the STD prevention cooperative agreement, there clearly should be a close programmatic collaboration and linkages between HIV and STD prevention programs, especially when there is a high incidence of both problems. HIV prevention programs need to develop close linkages with STD prevention programs to ensure STDs are diagnosed and referred for treatment. When feasible, applicants should try to offer onsite, at counseling and testing sites, diagnostic services and referrals for treatment of other STDs. Closely coordinating HIV prevention and STD prevention services is necessary and cost-effective and should be accomplished to reduce the transmission of HIV and other STDs. As of June 2000, the STD and HIV/AIDS programs were administratively combined into one HIV/AIDS section.

School Based Programs

Public Health Reports, 1994, found that some, but not all, HIV and sex education programs delayed the initiation of sexual intercourse, reduced the frequency of intercourse, reduced the number of sex partners, or increased the use of condoms or other contraceptives. No program was found to increase sexual activity.

A review of effective curricula indicates that they share the following characteristics:

- A narrow focus on reducing specific sexual risk-taking behaviors that may lead to HIV infection, other sexually transmitted diseases (STDs), or unintended pregnancy.

- Use of the four components of social learning theory (knowledge, motivation, outcome expectancy, and self-efficacy) as a foundation for program development.
- Provision of basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse.
- Instruction on social and media influences on sexual behaviors.
- Reinforcement of individual values and group norms against unprotected sex.
- Activities to increase skills in communicating and negotiating, as well as confidence in these skills.

Ineffective curricula covered a broader array of topics, but failed to emphasize those particular facts, values, norms, and skills needed to postpone sex or avoid unprotected sex. Ineffective curricula also taught decision-making skills, but did not explicitly guide students to make health-enhancing decisions. Schools can help reduce HIV, STDs, and unintended pregnancy. To ensure success, however, schools should implement programs that have been proven effective or that incorporate the key features of effective programs.

Linkage to Care

The majority of the clients noted in the 2007 Kansas Ryan White Data Report to the Health Resources and Services Administration further supports the need for effective linkages into care and maintenance once in the system. The 2008 Statewide Coordinated Statement of Need noted specifically regarding the state continuum of care stating, “As identified in the results of the survey (2008 Kansas Needs Assessment Survey) Kansas has not created a strong methodology of reaching individuals not in care or considered to be lost to care. Epidemiology data shows that Kansas has many HIV+ cases that convert to AIDS within 1 year. Individuals testing late in their infection could indicate a propensity to not engage in routine healthcare. Kansas needs to develop a strong model of care that indoctrinates the client into care from the moment they are diagnosed with HIV. A strong case management model that supports client advocacy, medication adherence and routine healthcare is a need to keep clients healthy and in care.”

Retention in HIV medical care improves adherence to antiretroviral therapy, slows progression to AIDS, increases survival and may decrease probability of transmitting HIV infection.²⁷ Intervention programs that demonstrate success include use of HIV system navigators and patient empowerment.^{26,27} Many HIV-infected individuals often seek help from multiple organizations to obtain services.²⁵ Patient navigation has been described as an emerging model of care coordination with HIV care. Navigators assist HIV-infected patients to make better use of available resources, develop effective communication with providers, sustain HIV care over time, and navigate the complexities of multidisciplinary treatment over time.²⁵

The strengths-based perspective of case management was originally developed at the University of Kansas, School of Social Welfare, to help a population of persons with severe and persistent mental illness make the transition from institutionalized care to independent living, formally known as Community Support System (CSS) within mental health service providers. The foremost two principles on which the model rests are (1) providing clients support for asserting direct control over their search for resources, such as housing and medical services, and (2) examining clients’ own strengths and assets as the vehicle for resource acquisition. To help clients take control and find their strengths, this model of case management encourages use of informal

helping networks (as opposed to institutional networks), promotes the primacy of the client-case manager relationship, and provides an active, aggressive form of outreach to clients.

The strengths-based model of case management was adapted to work with individuals recently diagnosed with HIV in the CDC's Linkage to Care Studies: ARTAS-I (2001-03) and ARTAS-II (2004-2007). The Centers for Disease Control and Prevention (CDC) approached Center for Interventions, Treatment and Addictions Research (CITAR) to develop a brief behavioral approach to encourage newly diagnosed HIV positive individuals to enter medical care promptly after their diagnosis. CITAR staff developed a five-session, strengths-oriented case management intervention and developed and implemented the training protocols for case managers in the Antiretroviral Treatment Access Study (ARTAS). "ARTAS Linkage Case Management (ALCM) was found to improve linkage with medical care; after one year, 64% of case managed participants, compared to 50% of non-case managed participants were linking to care, an adjusted 37% difference" (Gardner et al. 2004).

Any definition of case management today is inevitably contextual, based on the needs of a particular organizational structure, environmental reality, and prior training of the individuals who are implementing the services. While definitions are useful in guiding general discussions, functions are a more helpful way to approach case management as it is actually practice. One widely accepted set of functions comprises (1) assessment, (2) planning, (3) linkage, (4) monitoring, and (5) advocacy (Joint Commission on Accreditation of Healthcare Organizations, 1979). The National Association of Social Workers' standards for social work case management include assessing, arranging, coordinating, monitoring, evaluating, and advocacy (National Association of Social Workers, 1992). Case management is one of eight counseling skills identified by the National Association of Alcoholism and Drug Abuse Counselors (National Association of Alcoholism and Drug Abuse Counselors, 1986) and one of five performance domains developed in the Role Delineation Study (International Certification and Reciprocity Consortium, 1993). Another framework is supplied by the Addiction Technology Transfer Center (ATTCs), established by CSAT to providers in the field. The essential elements of case management are laid out in their publication "Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice" (CSAT, 1998).

The Linkage To Care worker administers the Ryan White Acuity Level Assessment Tool and authorize Ryan White services for immediate medical care. During the 90-day period a referral is made to a Ryan White Case Manager for a seamless continuum of care to increase retention within the model of care.

The Linkage To Care worker administers a Substance Use and Mental Illness Symptoms Screener (SAMISS) upon the initial referral for Strengths Based Case Management services. The SAMISS is a 13 brief item screening tool for detecting the co-occurring disorders of mental illness and substance abuse. The SAMISS takes about 5-10 minutes to administer, making it quick and easy to incorporate into standard patient care without requiring significant expenditures or sacrifices from other areas of patient care. Co-Occurring mental illness and substance use disorders are not uncommon among people living with HIV. The HIV Cost and Services Utilization Study (HCSUS), which sampled HIV-positive persons receiving medical care in the United States, documented high mental illness (47%), substance use problems (19%) and co-

occurring mental illness and substance use problems (13%) among HIV-infected individuals in comparison to the general population, 22%, 9.5% and 3%, respectively. If the woman scores positive with mental health symptoms of substance use symptoms she is referred to the Comprehensive Risk Counselor who will provide a specific psychiatric diagnosis and provide individualized treatment based on the Strengths-Based Case Management.

Comprehensive Risk Counseling and Services (CRCS) is a service provided by the Bureau of Disease Control and Prevention HIV/AIDS Section division of the Kansas Department of Health and Environment. CRCS is defined as a time-limited and client-centered HIV prevention activity for individuals who are HIV positive. Key to providing direct services to individuals who are HIV positive and receiving CRCS include incorporating harm-reduction strategies, looking at motivation of self or other, recognition of responsibility to not transmit HIV, recognition of oppression and sociocultural factors and the importance of client engagement in the process of recovery.

Eligibility for CRCS is based on the following criteria: (1) Completion of SAMISS, (2) biopsychosocial assessment, and (3) diagnosis of HIV positive. The individual providing CRCS is a Licensed Specialist Clinical Social Worker (LSCSW). The LSCSW utilizes a wide spectrum of theories in order to provide individualized services which include the following: social (cognitive) learning theory, systems theory, empowerment theory, transtheoretical model (Stages of Change), motivational theory, harm-reduction theory, and personality theories.

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