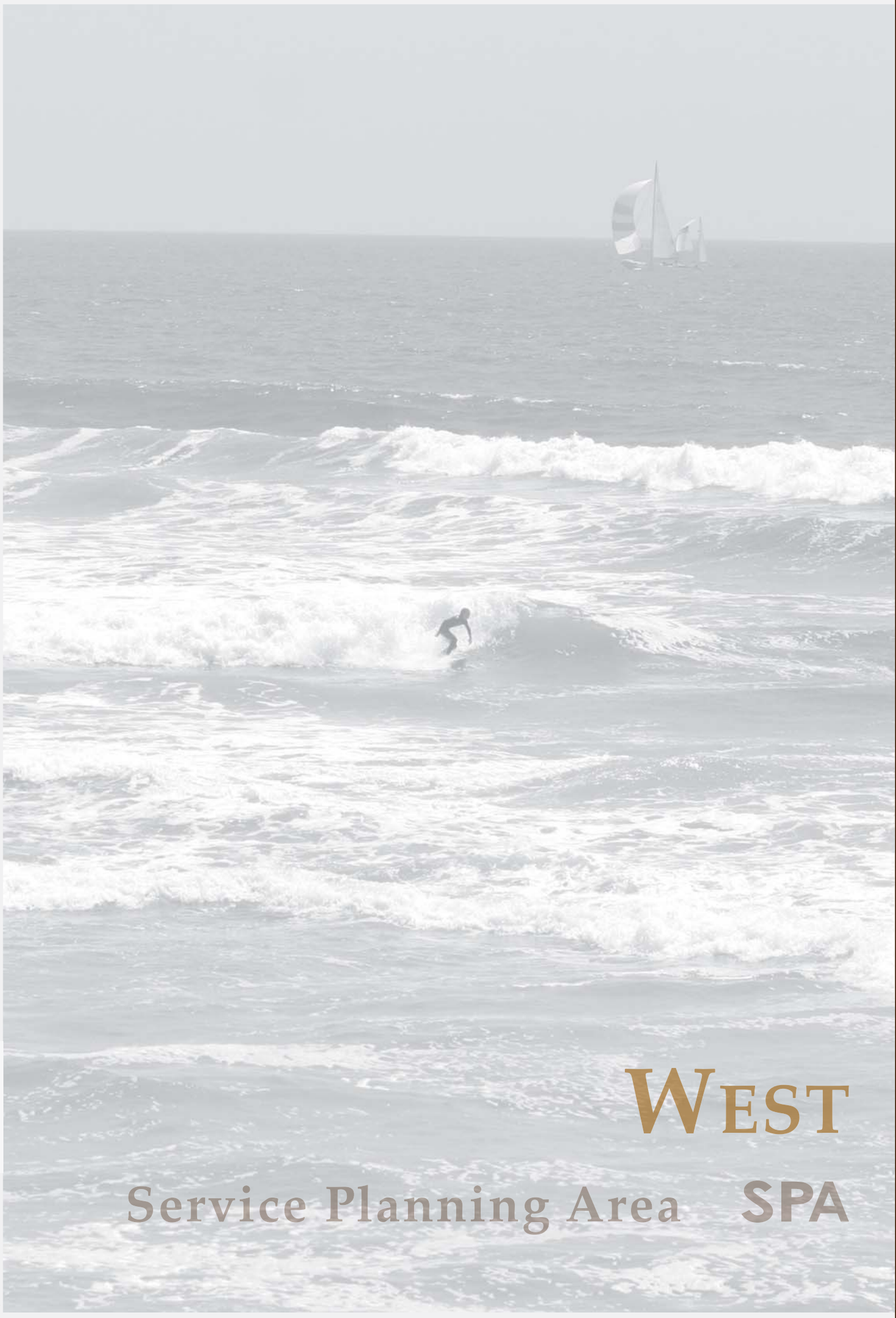


West

Service Planning Area SPA 5

Chapter 5: Interventions

Overview

This chapter:

- Will assist organizations in selecting appropriate interventions for their respective target population(s). It will do this by:
    - Presenting Los Angeles County's priority intervention strategies;
    - Clarifying the meaning of "evidence based" and what Los Angeles County deems as appropriate evidence when designing or selecting an intervention;
    - Describing relevant behavioral theories that may be useful when creating "locally developed interventions" (LDIs);
    - Reviewing the Centers for Disease Control and Prevention (CDC) evidence based interventions (EBIs) as well as other published interventions from the Substance Abuse and Mental Health Services Administration (SAMHSA);
    - Offering information on how to select and adapt (if needed) an existing intervention, or design a new locally developed intervention (LDI) for use with a specific target population; and
    - Providing additional resources for agencies to assist in designing programs.

A primary responsibility of local community planning groups is to ensure that HIV prevention interventions are identified for priority populations and that these interventions are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with the intended target populations for cultural appropriateness, relevance, and acceptability [1]. With the growing number of interventions, it is increasingly difficult for organizations to sift through the abundance of available information. This chapter will provide a practical toolkit for selecting and/or developing interventions to reach their intended target population(s), including an understanding of relevant behavioral theories. The information presented is not an exhaustive review of all published interventions, adaptations of interventions, or locally developed interventions (LDIs). It provides a foundation for agencies when designing and/or selecting, effective, evidence based interventions to reach an extremely diverse population at risk for HIV. It is therefore a starting point to stem the HIV epidemic in Los Angeles County among disproportionately impacted and other high-risk communities.

Priority HIV Prevention Efforts

The Los Angeles County HIV Prevention Planning Committee (PPC) supports the following key prevention intervention strategies and activities to meet the needs of priority populations at greatest risk for acquiring or transmitting HIV. These intervention strategies and activities provide the overarching framework for the County's HIV prevention efforts. However, the success of Los Angeles County's HIV prevention efforts is in the hands of the dedicated persons who work and have continued to work in the field over the past few decades. To aid their workforce development as well as guide agencies in the hiring of new staff, the Standards and

Best Practices Subcommittee of the PPC has outlined basic job competencies (see *Attachment A: Job Competencies* at the end of this chapter) for frontline staff who deliver these services targeting high-risk populations. Los Angeles County's priority efforts include:

■ Outreach (also referred to as Targeted Prevention Activities)

The primary goal of outreach is recruitment of targeted individuals into a more intensive service, such as HIV counseling and testing (HCT), interventions delivered to individuals and/or groups, and/or comprehensive risk counseling and services (CRCS). Outreach can be internal or external to an agency. Internal outreach occurs when an agency taps into its existing client or participant base to market to and recruit participants for a new HIV prevention program. For example, the agency may recruit into prevention programs for existing psychosocial support groups for high-risk HIV positive clients. External outreach occurs when the agency recruits individuals who are not existing clients or program participants. This type of outreach is often street-based and conducted by peer or paraprofessional educators. It involves face-to-face contact with high-risk individuals in neighborhoods or other areas where the target population gathers. Sites may include streets, bars, parks, bathhouses, shooting galleries, etc.

An outreach encounter is at least five minutes in length and is educational in nature. The outreach worker often conducts a brief risk assessment, provides brief HIV and risk reduction information, and provides referrals for HIV counseling and testing (HCT) and other services that are available through the agency he or she represents. The outreach worker emphasizes the potential benefit of these services for the individual. If the individual expresses interest in other services, the outreach worker collects the individual's contact information. At a later time, the outreach worker can set up an appointment for intake or a linked referral to another program or service. In addition to sharing information about HIV/AIDS, an outreach worker may distribute other promotional and educational materials, condoms, bleach, safer sex kits (e.g., condoms/latex barriers with instructions, lubricants), etc (see *Attachment A: Job Competencies*).

Outreach is considered successful when individuals are recruited into other HIV prevention programs and/or HCT. Documenting outreach is critical. An agency needs to track the number of individuals reached within a target population, as well as those individuals who are successfully linked to another service. An outreach worker must also document how many outreach contacts it takes to get one person into another service.

PROGRAM PERFORMANCE INDICATOR:	The mean number of outreach encounters required to get one person to access any of the following services: HIV counseling and testing; sexually transmitted disease screening and testing; interventions delivered to individuals; interventions delivered to groups; comprehensive risk counseling & services. *Target: 3.0 encounters per linked referral maximum*

■ HIV Counseling, Testing, and Referral Services

HIV counseling and testing (HCT) and referral services provide individuals at risk for HIV the opportunity to learn their HIV status. The PPC's HCT Work Group supports varied HIV testing modalities, including routine testing and counseling and testing, that are based on the needs of Los Angeles County. Although the PPC supports broad HIV testing, the committee has highlighted that public funds through OAPP support testing models that yield higher positivity

rates, thus diagnosing individuals with undiagnosed infection at a higher rate. Including counseling and testing in an HIV testing episode is strongly supported by the PPC. In addition, routine HIV testing in health-care settings, multiple morbidity testing with limited counseling, and other models are also recommended as a compliment to traditional HIV counseling and testing programs. The PPC supports the State of California's new HIV Counseling and Testing client flow, referred to as the "Two-Tier Model." In this model, a person seeking HCT services will be asked to complete a self-assessment questionnaire. Depending on the individual's answers to the questionnaire, HCT counselors will be able to determine if he or she falls under a "high-risk level" or "low-risk level" intervention category.

❖ *HIGH-RISK LEVEL INTERVENTION*

A client will receive a high-risk level intervention if in the self-administered Client Assessment Questionnaire, he or she answers yes to any one of the following:

a) they identify their gender as transgender (male to female or female to male), or Other
b) they are female AND they had anal sex
c) they are male AND they had anal sex
d) they had sex in the last year with someone that they knew injected drugs
e) they had sex in the last year with someone that they knew had HIV/AIDS
f) (for women only) they had sex in the last year with a man that she knew was having sex with other men
g) they used needles to inject drugs during the last year
h) they used meth, speed, crank, crystal, cocaine, or crack in the last year
i) they received drugs, money, or other items or services for sex in the last year
j) a medical or service provider told them they had gonorrhea or syphilis in the last year
k) a medical or service provider told them they had Hepatitis C

The high-risk level intervention consists of completing signed consents, a face-to-face pre-test counseling session, and disclosure of test results.

❖ *LOW-RISK LEVEL INTERVENTION*

A client will receive a low-risk level intervention if none of the answers listed above were identified in the Client Assessment Questionnaire.

The low-risk intervention consists of completing signed consents, administering the test, and providing the client with either an informational brochure or watching a video while the test is being processed, and disclosure of results. If a person receiving a low-risk intervention receives a preliminary positive on their HIV rapid test, the individual is switched to a high-level intervention.

PROGRAM PERFORMANCE INDICATORS:	Percent of newly identified, confirmed HIV-positive test results among all tests reported by CDC funded HIV counseling, testing and referral sites. *Target: 2.0%*
	Percent of newly identified, confirmed HIV-positive test results returned to clients. *Target: 95%*

❖ *HIV COUNSELING AND TESTING (HCT) WORK GROUP RECOMMENDATIONS*

The PPC's HCT Work Group has developed key recommendations to guide Los Angeles County's efforts to identify high risk individuals and encourage them to get tested for HIV (see *Attachment B: HCT Work Group Recommendations* at the end of this chapter for their complete list of recommendations). The following is an abbreviated list of recommendations:

- Recommend that targeted testing of high risk individuals remains a priority;
- Support targeting testing within highly impacted areas with HIV/AIDS;
- Allow for new HIV testing technologies and algorithms, when possible;
- Support counseling and testing models that consider repeat and low risk testers and allow for self-assessed risk assessments;
- Support Multiple Morbidity testing in appropriate settings;
- Recommend that testing occur in high-risk venues such as bathhouses and sex clubs;
- Support that all clients in health education/risk reduction (HE/RR) programs know their HIV status;
- Recommend that HE/RR programs, where appropriate, provide access either directly or through partner relationships w/other organizations to also provide HIV testing;
- Recommend that HIV/AIDS social marketing efforts encourage HIV testing; and
- Recommend HIV testing efforts in incarcerated settings.

In addition, the PPC wholly supports the Centers for Disease Control and Prevention (CDC) HIV Testing Guidelines in Health Care Settings as described in the Urban Coalition for HIV/AIDS Prevention Services' (UCHAPS) paper: *Positions and Recommendations on HIV Counseling and Testing* (see *Attachment C* at the end of this chapter).

■ Perinatal Transmission Prevention

Routine screening and testing for HIV in pregnant women can dramatically reduce the transmission of HIV from mother to child when an HIV infected woman initiates Highly Active Anti-retroviral Treatment (HAART) during pregnancy. The CDC's revised 2006 HIV testing recommendations support the universal screening of pregnant women for HIV [2]. For pregnant women, the recommendations state:

- *HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women.*
- *HIV screening is recommended after the patient is notified that testing will be performed unless the patient declines (opt-out screening).*
- *Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.*
- *Repeat screening in the third trimester is recommended in certain jurisdictions with elevated rates of HIV infection among pregnant women.*

Initiation of HAART after a confirmed HIV test is the best method for preventing perinatal transmission of HIV.

PROGRAM PERFORMANCE INDICATORS:	Proportion of women who receive an HIV test during pregnancy. *Target: .92*

■ Partner Counseling and Referral Services (PCRS)

Partner Counseling and Referral Services (PCRS) refers to a systematic approach to notifying sexual and needle-sharing partners of HIV-positive persons of their possible exposure to HIV. The purpose of this notification is to encourage partners of HIV-positive individuals to be tested for HIV so that they can learn their HIV status, provide them with information to avoid infection, or if infected, prevent HIV transmission to others. PCRS helps partners gain timely access to individualized counseling, HIV testing, medical evaluation, treatment, and other HIV and related prevention services. There are two primary components of PCRS:

1. Partner Elicitation is the process of eliciting or obtaining names of sexual and/or needle-sharing partners of an HIV-positive individual. Due to the very sensitive nature of PCRS, CBO staff must be well trained in order to conduct partner elicitation (see *Attachment A: Job Competencies*).

2. Partner Notification involves informing an HIV-positive individual's sexual or needle sharing partner of his or her possible exposure to HIV. Partner notification is traditionally a function of the public health department and its staff or agents must be certified in order to deliver Partner Notification services.

PCRS is frequently conducted within HIV counseling and testing interventions delivered to individuals (IDI), or Comprehensive Risk Counseling and Services (CRCS) session. PCRS services can also be coordination with anonymous third-party notification delivered by trained health department staff. Services offered to partners include counseling, testing and education about the exposure as well as services to prevent infection or, if infected, linkages to care. PCRS is successful when a sex or needle sharing partner who is notified of a possible exposure to HIV gets tested for HIV.

PROGRAM PERFORMANCE INDICATORS:	Percent of contacts with unknown or negative serostatus who receive an HIV test after PCRS notification. *Target: 80%*
	Percent of contacts with a newly identified, confirmed HIV-positive test among contacts who are tested. *Target: 17%*
	Percent of contacts with a known, confirmed HIV-positive test among all contacts. *Target: 39%*

■ Health Education and Risk Reduction (HE/RR)

Health education is a powerful tool in the prevention of HIV. Health education and risk reduction (HE/RR) services include outreach for high-risk for HIV-negative and HIV-positive persons (described earlier), interventions delivered to individuals and/or groups, community-level interventions, structural interventions, and comprehensive risk counseling and services (CRCS). HE/RR also includes health communication and public information programs for targeted at-risk populations and the general public. For minimum HE/RR staff competencies see *Attachment A: Job Competencies*.

Prevention efforts for high-risk populations, including HIV positive individuals, are critical for reducing the spread of HIV. These efforts ensure that individuals at highest risk for acquiring or transmitting HIV are given the tools necessary to protect themselves and others. Examples of prevention efforts include: (1) interventions delivered to individuals (formerly referred to as individual-level interventions); (2) interventions delivered to groups (formerly referred to as group-level interventions); (3) community level interventions, which includes structural interventions (e.g., sterile syringe access or decreasing discrimination); and (4) comprehensive risk and counseling services (CRCS). Providing information about and/or establishing linkages to STD, substance abuse, mental health, hepatitis, and social services is a component of all interventions.

❖ *INTERVENTION DELIVERED TO INDIVIDUALS*

Interventions delivered to individuals (IDIs) consist of health education and risk-reduction counseling provided to one individual at a time, either face-to-face, on the phone, or via the internet, by a peer or paraprofessionals (see *Attachment A: Job Competencies* at the end of this chapter). IDIs help individuals assess their risk behavior, make plans for changing behavior, develop risk reduction skills (e.g., safer sex practices, proper condom/latex barrier use and demonstration, needle cleaning techniques) to sustain healthy behaviors, and monitor their behavior change over time. IDIs facilitate linkages to additional services such as HIV testing, substance abuse prevention and/or treatment and other services needed to support behaviors and practices that prevent the transmission of HIV.

1. **Risk-reduction counseling** consists of one-on-one counseling sessions that focus on understanding human behavior (i.e., why people do what they do), identifying the personal factors that affect actions (e.g., self-efficacy, social situations, and cultural norms), increasing knowledge, skills building, and behavior change (e.g., safer sex practices, proper condom/latex barrier use and demonstration, needle cleaning techniques). Trained program staff generally conduct counseling sessions (see *Attachment A: Job Competencies*).

2. **Internet risk-reduction counseling** consists of HIV risk reduction counseling activities conducted over the internet. These activities often target gay men, non-gay identified men who have sex with men, and men who have sex with with men and multiple genders (i.e., female and/or transgender individuals). This type of intervention has a clear engagement and screening process in order to determine client eligibility (e.g., risk group, zip code, etc.) and ability to document participant demographics as well as ongoing participation.

IDI shall consist of a minimum of three sessions per participant. Each session should be a minimum of 20 minutes, delivered on three different days to increase the probability of risk reduction maintenance. Repeated exposures to an intervention has shown to be effective. IDI has a follow-up component at thirty (30), sixty (60) and ninety (90) days to assess adoption of risk reduction behaviors over a period of time and allow for additional intervention. Follow-up sessions may be conducted face-to-face, on the telephone, or via the internet.

An IDI is successful when it helps an individual change behavior that puts him/her at risk for HIV infection or at risk for transmitting HIV. Thus, to measure success, ensuring and documenting that individuals complete the required number of sessions is an important component of IDIs. This can be very challenging with some target populations, particularly those who may be more transient in nature or who wish to remain hidden. Another measure of success is the ability of an

IDI to get a person to access other needed services, particularly HIV counseling and testing for those with unknown HIV serostatus and partner counseling and referral services for HIV positive individuals.

PROGRAM PERFORMANCE INDICATORS:	Proportion of persons that completed the intended number of sessions. *Target: .90*
	Proportion of the intended number of the target population(s) to be reached who were actually reached. *Target: .90*

❖ *INTERVENTION DELIVERED TO GROUPS*

Interventions delivered to groups (IDGs) are health education risk-reduction counseling activities that shift the delivery of service from the individual to groups of varying size. IDGs may be facilitated by trained peers or other staff (see *Appendix A: Job Competencies* at the end of this chapter). IDGs involve a wide range of skills-building, information, education, and support for participants. In general, IDGs have multiple sessions and include a follow-up component. The number of sessions for IDGs varies depending upon the specific intervention and curriculum. The purpose of IDGs is to change and sustain positive, health promoting behaviors that reduce the risk of infection or transmission of HIV. They also seek to link participants to other needed services (e.g., HIV counseling and testing, comprehensive risk and counseling services, etc.). Although some evidence based IDGs are designed as a single session, PPC supports IDGs that have a minimum of three sessions (and a maximum of six sessions) that are conducted on different days to increase the probability of risk reduction maintenance and repeated exposure to an intervention.

1. **Group risk reduction counseling** generally occurs in small group sessions that focus on behavior change activities (e.g., safer sex practices, proper condom/latex barrier use and demonstration, and needle cleaning techniques). Trained program staff conduct (see *Appendix A: Job Competencies)* these sessions. Because behavior change occurs over time, sessions need to also occur over time.

   Group risk reduction counseling sessions follow a closed group model as opposed to an open group model. Closed groups are structured, have a defined lifespan, and have set participant limits. The closed group allows for important continuity, which fosters trust among members as they get to know each other over time. With a closed group model, an agency is able to establish client-specific outcome objectives that can be monitored over time (e.g., self-reported increased condom use with sexual partners at the end of four weeks of group attendance). Open-ended support group sessions that are less structured, informal, and are geared to risk reduction behavior maintenance are not conducive to this type of goal-setting. Closed groups are usually finite and open-ended groups are usually ongoing.

2. **Support group counseling** sessions are informal groups that provide a supportive environment for participants to discuss openly the challenges and successes they have achieved in maintaining their newly acquired risk reduction behaviors. Support groups are usually open-ended with open enrollment. Potential participants are able to "drop in" when they need to and thus avoid the wait for new groups to form. This type of group may appeal to individuals whose commitment to the group's process is initially limited. Due to their less structured, more fluid nature, support groups may be more appropriate to

process evaluation (e.g., percentage of agency's clients attending a determined number of sessions). To be an effective intervention that supports sustained behavior change, participants attending multiple sessions will likely have a greater benefit.

Although support group counseling sessions are less structured than group risk reduction counseling interventions, they are not psychotherapy groups. Very often support groups are facilitated by trained, self-identified members of the targeted risk group, population, or community (i.e., peer-based model). Trained professionals or paraprofessionals may also conduct these sessions.

3. **Peer Health Education** describes a role-model method of education in which trained, self-identified members of the target population provide HIV/AIDS education to their behavioral peers. Once Peer Health Educators are successfully trained (they are usually required to complete and pass an internal agency certification course), they assume clearly defined roles and responsibilities. They do not replace an agency's professional health educators, but they can augment the intervention team and enhance intervention efforts.

   Individuals who become Peer Health Educators often feel empowered as they help persons in their communities and social networks adopt healthy behaviors. This work strengthens and supports their personal behavior change efforts. Peer Health Educators often serve as community change agents as they are able to sustain intervention efforts in the community long after professional educators are gone.

Like IDIs, IDGs are successful when they help small group participants create and sustain positive behavior change over time. Thus, tracking participation and attendance is a core element of the intervention. Whether groups are peer-led or professionally-led, agencies need to develop rigorous tracking mechanisms to document participation. Follow-up is also a core element to be able to assess longer-term change. However, enticing participants to return for follow up sessions can be particularly challenging for agencies. They need to identify follow up mechanisms that work with their specific target population.

PROGRAM PERFORMANCE INDICATORS:	Proportion of persons that completed the intended number of sessions. *Target: .90*
	Proportion of the intended number of the target population(s) to be reached who were actually reached. *Target: .90*

❖ *COMMUNITY LEVEL INTERVENTIONS (CLI)*

Community-level interventions (CLIs) seek to reduce risk conditions and promote healthy behaviors in the broader community as a whole. CLIs attempt to alter social norms, policies, and the environment. CLIs include community mobilization efforts, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

1. **Community Mobilization** is a process by which community citizens take an active role in defining, prioritizing, and addressing issues in their community. This process focuses on identifying and activating the skills and resources of residents and organizations while developing linkages and relationships within and beyond the community for the purpose of expanding the current scope and effectiveness of HIV/STD prevention.

2. **Social Marketing Campaigns** apply marketing principles to affect knowledge, attitudes, behaviors, and beliefs regarding HIV/AIDS risk, associated behavior change and risk reduction, access to services, and treatment education. Social marketing is not simply advertising a service or hotline number but is action oriented. As required by OAPP's Materials Review Protocol, social marketing activities include a planning, development, and distribution phase.

3. **Community-Wide Events** may include the following:

   a) Community Forums provide and elicit information to and from a community.

   b) Health Fairs/Community Events include special events such as street fairs, job fairs, health fairs, World AIDS Day activities, and local celebrations in communities that deliver public information to large numbers of people.

4. **Structural Interventions** seek to modify the social, environmental, and political structures/systems that influence the delivery of HIV prevention services. Structural interventions may impact legislation, technology, and health care standards, among others to improve the delivery and/or effectiveness of HIV prevention efforts. They remove barriers and incorporate facilitators of an individual's HIV prevention behaviors. These barriers or facilitators include physical, social, cultural, organizational, community, economic, legal, or policy circumstances or actions that directly or indirectly affect an individual's ability to avoid exposure to HIV.

   Structural interventions may impact legislation, technology, and health care standards, among others, to improve the delivery and/or effectiveness of HIV prevention efforts. Structural interventions may include, but are not limited to: (1) integrating HIV/AIDS ministries into faith-based activities, (2) mandating HIV-antibody testing for specific offenders, (3) modifying a standard of care to include mandatory offering of HIV-antibody testing to pregnant women, or (4) legislative responses (e.g., opt-out legislation for testing, syringe exchange legislation, standards for the operation of commercial sex venues, etc.).

   Although OAPP and the PPC support a variety of structural interventions, including those mentioned above, the PPC recommends the following structural interventions that are also currently funded by OAPP:

   a) School-Based HIV Prevention. Schools have a critical role to play in promoting the health and safety of young people and helping them establish lifelong health behavior patterns. They achieve this by educating students about HIV, teaching skills on health communication, and providing age-appropriate individual counseling sessions.

   b) Faith-Based HIV Prevention. Faith communities play an important role in changing community norms and offering support to individuals in need. Many faith institutions have AIDS-Ministries that promote compassion and support for individuals to choose and maintain healthy behaviors, others offer HIV testing at their sites to increase awareness and encourage people to know their HIV status.

Measuring the success of CLIs offers unique challenges as large-scale impact or change may not be evident for years. Thus, although long-term outcome-oriented evaluation is needed to measure the success of CLI, in the immediate-term, process measures lend themselves to CLI. Agencies may be able to utilize more outcome-oriented measures for specific CLIs, such as structural interventions that produce concrete outcomes (e.g., legislative changes).

■ Health Communications/Public Information (HCPI)

Health communications/public information (HC/PI) efforts deliver HIV/AIDS prevention messages through one or more channels. Their purpose is to target specific audiences to build general support for safer behavior, personal risk-reduction efforts, and/or inform persons at risk for infection or transmission how to obtain specific services. HC/PI interventions do not include a skills building component.

1. **Group Presentations** are the most common form of HCPI activity. These are informational, "one-shot" education interventions (e.g., HIV 101 class) that target small or large groups. Group presentations differ from group risk reduction counseling in that group presentations lack a skills building component.

■ Comprehensive Risk Counseling & Services (CRCS)

CRCS, previously called Prevention Case Management (PCM), is intensive, individualized client-centered counseling for high-risk individuals to adopt and maintain HIV risk-reduction behaviors. In November 2005, the CDC renamed the intervention to clarify differences between Ryan White and other case management programs. CRCS is designed for HIV-positive and HIV-negative individuals who are at high risk for acquiring or transmitting HIV, and who struggle with multiple complex issues such as substance abuse, mental health, and/or other social and cultural factors that affect HIV risk. CRCS is a hybrid of HIV risk-reduction counseling and traditional case management, which provides intensive, ongoing, and individualized prevention counseling, support, and links to other vital services. The CRCS prevention counselor (see *Attachment A: Job Competencies*) can provide case management services, but only if traditional case management services are not otherwise available for clients. CRCS consists of a minimum of five sessions per person.

PROGRAM PERFORMANCE INDICATORS:	Proportion of persons that completed the intended number of sessions. *Target: .90*
	Proportion of the intended number of the target population(s) to be reached who were actually reached. *Target: .90*

Understanding Evidence Based Interventions

In 2003, the Institute of Medicine (IOM) called for "evidenced based" decision making across all public health sectors [3]. The IOM further recommended that HIV prevention efforts utilize interventions of proven efficacy to avert as many new infections as possible. In response to the IOM, several federal agencies, including the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Service Administration (SAMHSA), and the National Institute on Drug Abuse (NIDA) among others, have emphasized evidenced based interventions as part of their national HIV prevention strategic plans.

Although this formal emphasis on evidence based interventions originated with the federal government, HIV program developers strive to create interventions that are effective, i.e., positively impact a person's behavior in order to reduce the risk for acquiring or transmitting HIV. In developing a shared understanding of what constitutes appropriate evidence for designing new interventions, selecting and/or adapting existing interventions, it is critical to have a basic understanding of behavioral theory.

■ Behavioral Theories

Having a theoretical basis is a core component of an evidence based intervention. This foundation contributes to the success of locally developed interventions (LDIs) as well as those interventions designed by others, including the effective behavioral interventions (EBIs) and best evidence interventions promoted by the Centers for Disease Control and Prevention (CDC). Behavioral theory provides HIV program developers with a framework within which to design an intervention. It helps to explain aspects of risk-taking behavior when working with a target population. By understanding the main components of a behavioral theory, an agency may then be able to match up the needs of its target population with the theory that is most likely to address that need. Thus, whether the agency creates its own LDI, or selects/adapts an existing intervention, the intervention's foundation will be rooted in a theoretical base.

There are a multitude of behavioral theories that can be used when designing or selecting an intervention. What follows is a brief description of commonly used behavioral theories in the current HIV/AIDS literature, as well as the *Community Intuitive Theory* based on the work of Alice Gandelman, and *Empowerment Education Principles* based on the work of Paulo Freire. Additional web resources are provided at the end of this chapter to assist organizations in learning more about these behavioral theories as well as others that are not listed here. The theories presented below are in alphabetical order and provide a starting point for the design, selection, and/or adaptation of an evidence based intervention.

❖ *AIDS RISK REDUCTION MODEL (ARRM)*

The ARRM is based on the work of Catania (1990) [4]. The ARRM combines aspects of the Health Belief Model, the Diffusion of Innovation Theory, and Social Cognitive Theory. ARMM theory considers behavior change as a process that individuals move through from one step to the next. The three stages a person goes through are: (1) labeling the behavior, (2) making a commitment to change the behavior, and (3) taking action to change the behavior [5].

For example:

1. A non-gay identified Latino man recognizes that his unprotected sexual behavior with multiple men of unknown HIV status puts him at high risk for acquiring HIV (labeling a behavior as a problem).
2. The non-gay identified Latino man makes a decision to reduce his number of high risk sexual partners and increase low risk activities (committing to changing a behavior).
3. The non-gay identified Latino man begins to use condoms more consistently and reduces his sexual partners to one. He also finds a support group with whom he can talk about the stigma and discrimination he feels when labeled as "gay" (taking action).

❖ *COMMUNITY INTUITIVE THEORY*

Community Intuitive Theory is based on the recent work of Gandelman, et al [6]. Their formative research suggests that the translation of an intervention from research to practice is not always smooth. Gandelman, et al propose that frontline HIV prevention staff have an intuitive knowledge and common sense about what influences the behavior of the communities they serve. This intuitive knowledge can be used in designing HIV interventions that effectively change behavior. These staff are often peers and members of the communities served. As a result they often have tremendous insight into "the factors and behavioral determinants" affecting risky behaviors as well as barriers to reducing their risk. Agencies are able to leverage this expertise and match the intuitive knowledge/experience of staff with behavioral concepts in order to design evidence based interventions.

❖ *DIFFUSION OF INNOVATION THEORY*

The Diffusion of Innovation Theory is based on the work of Rogers (2000) [7]. The theory focuses on how a new idea or concept (e.g., consistent condom use) is communicated through channels over time among the members of a social system (e.g., young gay men of color). The four main elements in the diffusion (spread) of new ideas are: (1) the Innovation, (2) Communication Channels, (3) Time, and (4) the Social System.

1. Characteristics which determine an innovation's rate of adoption are:

    a. The *relative advantage* is the degree to which an innovation is perceived as better than the idea it supersedes. The advantage may be measured in economic terms, social prestige, convenience or satisfaction.
    b. *Compatibility* is the degree to which the innovation is perceived as being consistent with the existing values, past experiences, and needs of the potential adopters.
    c. *Complexity* is the degree to which the innovation is perceived as difficult to understand or use.
    d. *Trialability* is the degree to which the innovation may be experimented with on a limited basis. New ideas that can be tried through a series of steps are more quickly adopted.
    e. *Observability* is the degree to which the results of an innovation are visible by others. Visibility stimulates peer discussion of new ideas by friends and neighbors.

2. Communication is the process by which participants create and share information with one another in order to reach a mutual understanding. A communication channel is the means by which messages get from one person to another. Mass media channels are more effective in creating knowledge of innovations. Interpersonal channels are more

effective in forming and changed attitudes toward a new idea and thus influencing the decision to adopt or reject a new idea.

3. The time dimension influences diffusion in three ways. First, time is involved in the innovation-decision process of an individual. For example a person hears about the innovation and then decides on accepting or rejecting the new idea. Second, time is in the innovativeness [creativity] of the message provider. Third, time is the rate of adoption [speed] in which a new idea is embraced by a social system.

4. The fourth element of diffusion is the social system, which may be made up by individuals, informal groups, organizations and/or subsystem(s) [8].

Expanding on the earlier example: If enough young gay men of color who are key leaders in their peer social networks adopt a desired behavior (e.g., using condoms consistently), a new norm can be established. Once established, the new norm can then be disseminated widely through social networks and thereby have a better chance of being adopted by the community. Diffusion of Innovation is often used when developing mass media social marketing campaigns [8].

❖ *EMPOWERMENT THEORY*

Empowerment Theory is based on the work of Paulo Freire [9]. His popular education model engages groups to identify and discuss problems. Both students and teachers learn together [10]. Empowerment is both a means and an outcome of the educational process. Once an issue is fully understood by community members, solutions are jointly proposed, agreed, and acted upon. This seeks to promote health by increasing people's feelings of power and control over their lives. Using this theory, a program may select a format that fosters working together as a community (e.g., discussion group versus a lecture). Such a format can strengthen the intervention by empowering people to engage in meaningful dialogue and develop their own solutions to change their environment.

❖ *HEALTH BELIEF MODEL*

The Health Belief Model is based on the work of Rosenstock (1950) [11]. The theory stresses that people will change their behavior according to their knowledge and attitudes. The Health Belief Model has evolved over time and now has six key components:

Table 5.1 Components of the Health Belief Model

CONCEPT	DEFINITION	APPLICATION
1. **Perceived Susceptibility**	One's opinion of chances of getting a condition	Define population(s) at risk, risk levels; personalize risk based on a person's features or behavior; heighten perceived susceptibility if too low.
2. **Perceived Severity**	One's opinion of how serious a condition and its consequences are	Specify consequences of the risk and the condition
3. **Perceived Benefits**	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take; how, where, when; clarify the positive effects to be expected.
4. **Perceived Barriers**	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance.
5. **Cues to Action**	Strategies to activate "readiness"	Provide how-to information, promote awareness, reminders.
6. **Self-Efficacy**	Confidence in one's ability to take action	Provide training, guidance in performing action.

Source: Table from "Theory at a Glance: A Guide for Health Promotion Practice" (1997) [12].

❖ *SOCIAL LEARNING THEORY*

Social Learning Theory is based on Bandura's (1986) theory of observational learning [13]. At the core of Social Learning Theory is an understanding that learning is more than just receiving information. People learn by observing others and then replicating what they see. This involves receiving information about what needs to change, watching someone model the change, having opportunities to practice what is being taught, and having positive reinforcement when participating in the newly learned behavior. The four conditions needed for effective modeling are: Attention, Retention, Reproduction, and Motivation.

1. Attention: A person must pay attention to the model.
2. Retention: A person must remember what they observed.
3. Reproduction: A person must be able to reproduce or repeat the behavior that was demonstrated (e.g., how to negotiate safer sex).
4. Motivation: A person *wants* to demonstrate what he or she has learned. Motivation increases as a person builds social support for the new behaviors [14].

❖ *SOCIAL NETWORK THEORY*

Social Network Theory looks at social behavior through relationships. With respect to sexual relationships, social networks focus on the impact of selective mixing (i.e., how different people choose partners, acquaintances, and friends), and the variations in partnership patterns (e.g., length of partnership). When applied to HIV prevention, social network theory suggests that individuals function within social networks that establish norms for behavior, including safer sexual behavior, and that these social networks enforce adherence to these norms [15]. Thus, interventions grounded in this theory would seek to change attitudes and norms regarding safer sexual behaviors through the natural opinion leaders (i.e., social network members who are widely respected within the community and have the power to create and influence social norms) within a specific social network. Thus, successful HIV interventions utilizing this theory would target these community leaders as a means to change social norms that influence safer and/or risky sexual behavior within a target population.

❖ *STAGES OF CHANGE MODEL*

The Stages of Change Model is based on the work of Prochaska, DiClemente and colleagues (1990) and was originally designed for use in drug recovery [5, 16]. The theory proposes six stages of change that an individual must go through to change behavior. The six stages are: (1) pre-contemplation, (2) contemplation, (3) preparation, (4) action, (5) maintenance, and (6) relapse. The AIDS Risk Reduction Model utilizes components of the Stages of Change Model. An example, condom use:

1. Not considering using condoms (pre-contemplation)
2. Recognizing the need to use condoms (contemplation)
3. Thinking about using condoms in the next six months (preparation)
4. Using condoms consistently for less than six months (action)
5. Using condoms consistently for six months or more (maintenance)
6. No longer using condoms consistently (relapse)

❖ *THEORY OF GENDER AND POWER*

The Theory of Gender and Power is based on Conell's (1987) work [17]. The Theory of Gender and Power views the wider social and environmental issues relating to gender-based power imbalances. It emphasizes the power dynamic between men and women, and also between different groups of men. Applying this theory to HIV risk suggests that an imbalance of power can be reflected in one's sexual relationships. For example, a woman's ability to practice safer sex and other protective behaviors may be limited by her inability to communicate openly about sex with her partner who has the power in the relationship.

■ Types of Evidence

In terms of HIV prevention, evidence based interventions typically refer to approaches in prevention that have been proven effective in well-designed, and preferably randomized controlled trials [18]. However, in Los Angeles County, OAPP and the PPC recognize there are various types of evidence, which agencies may use when designing their own locally developed intervention (LDI) or selecting/adapting an existing intervention. Both LDIs and interventions designed by other entities (e.g., University of California at Los Angeles, Yale University, University of Connecticut) may be proven effective but have not gone through or completed the rigorous evaluation process required to be considered "evidence based" by the CDC, SAMHSA, NIDA, or other institutions.

Whatever evidence base drives the program design, grounding an HIV prevention intervention in a behavioral or other theory is an essential ingredient to program success. The following section describes four types of evidence, which agencies may use in designing, or selecting/adapting interventions to meet the needs of a specific target population.

❖ *INFORMAL THEORY ("PRACTICE WISDOM")*

With this type of evidence, an agency designs an LDI based on a theory that is not described in academic language or published in the scientific literature. Informal theory describes an HIV prevention provider's "practice wisdom" (i.e., knowledge that comes from working with or being a member of a population) and is explained in lay terms. For example, the concept of "self-efficacy" referenced in behavioral science literature is a component of Social Learning Theory that may be described as the "confidence to use condoms" by someone not familiar with the formal language of behavioral science. Informal theory provides a logical explanation of why the

population is at risk and then integrates this information into the content, format, and delivery of the intervention being designed to address that risk.

> *Example: An organization working with African American gay men develops the "baby steps" theory [6]. This theory acknowledges that change happens in small, incremental steps and that each step is significant. The intervention plan describes the "baby steps" that African American gay men need to take in order to create positive behavior change.*

❖ *THEORY FROM THE SCIENTIFIC LITERATURE*

With this type of evidence, an agency selects a formal behavioral science or other theory that is published in the scientific literature as the foundation for its LDI. An agency may also choose an existing, evaluated intervention (e.g., CDC EBI) that is based upon formal behavioral theory. For LDIs, the agency then develops the elements of the intervention (e.g., activities to develop condom use skills and increase self-efficacy to use condoms) to address the specific component parts of the theory (e.g., skills, self-efficacy). The intervention plan will explain how the theory is integrated into the content, format, and delivery of the intervention.

> *Example: An agency designs a CRCS intervention based on the Stages of Change theory targeting HIV-positive Latino men who use crystal methamphetamines and do not identify as gay. The intervention plan summarizes the theory, explains how it will be used to assess the individual's readiness for behavior change, and describes how counseling strategies will address the individual's readiness to move along the Stages of Change. The plan also includes an example of a risk assessment tool based on the Stages of Change theory.*

❖ *EVALUATION OF THE SAME INTERVENTION*

With this type of evidence, an agency may select an intervention that may or may not be published in the scientific literature. This may include an LDI that has been implemented and evaluated by another agency; a published intervention such as those developed by the CDC, SAMHSA, NIDA or other entity; or it may be an intervention that has been designed and evaluated, but not yet published.

To use this as evidence, there must be congruence between the agency's proposed intervention and the evaluated intervention with regard to the (1) population served, (2) intervention setting, and (3) core elements of the intervention. Thus, for two interventions to be considered the same, the intervention must use the same content, format, and method of delivering the intervention, as well as the same number and length of intervention sessions.

> *Example: An agency designs an IDG for Native American Two-Spirited men living in the City of Los Angeles. The intervention was previously conducted and evaluated in New York City with the same population. The agency replicates the core elements of the intervention using the same curriculum and materials, focusing on the same content, conducting the same number of group sessions, and utilizing peer educators who have been trained to deliver the intervention.*

❖ ***EVALUATION OF A SIMILAR INTERVENTION***

With this type of evidence, an organization adapts an existing intervention that may or may not be in the published literature. The intervention being developed is similar, though not identical, to an intervention that has already been evaluated. Generally, "evaluation of a similar intervention" means that there are differences between the proposed intervention and the previously evaluated intervention in one or more of the following areas: (1) population served; (2) intervention setting, content, and format; (3) method of delivering the intervention; and (4) the number and length of sessions. If differences are too significant between the proposed and the previously evaluated intervention, the prior evaluation may no longer provide sufficient evidence to support the proposed intervention.

> *Example: An agency adapts an IDI for Asian/Pacific Islander transgender individuals who engage in sex exchange. A similar intervention has been evaluated with commercial sex workers of all races/ethnicities but not evaluated with transgender individuals. The intervention plan explains how the risk assessment protocol and educational materials used in the evaluated intervention have been adapted to be culturally and linguistically appropriate for Asian/Pacific Islander transgender individuals. The number and length of intervention sessions and the risk reduction skills addressed in each session remain the same.*

■ PPC's Standards and Best Practices Subcommittee: Menu of Interventions

In 2006, the PPC's *Standards and Best Practices Subcommittee* (SBP) began a comprehensive search for evidence-based or promising interventions for the County's priority populations. The SBP Subcommittee implemented a process to research interventions and periodically reviewed the following websites for updates and listings:

1. CDC: www.effectiveinterventions.org;
2. HIV/AIDS Prevention Program Archive of Effective Programs: http://www.socio.com/pasha/haprogms.htm;
3. HIV Prevention Research Centers at Columbia University HIV Center for Clinical and Behavioral Studies: www.hivcenternyc.org;
4. Yale University Center for Interdisciplinary Research on AIDS: http://cira.med.yale.edu;
5. Medical College of Wisconsin Center for AIDS Intervention Research: www.mcw.edu;
6. UCLA Center for HIV Identification, Prevention and Treatment Services: http://chipts.ucla.edu/;
7. UCSD HIV Neurobehavioral Research Center: http://www.hnrc.ucsd.edu/;
8. State of California University wide AIDS Research Program: http://chrp.ucop.edu/;
9. UCSF Center for AIDS Prevention Studies: http://www.caps.ucsf.edu/;
10. University of Texas Southwestern Prevention Toolbox: http://www.utsouthwestern.edu/utsw/cda/dept156726/files/181124.html; and
11. University of Connecticut Center for Health, Intervention and Prevention: http://www.chip.uconn.edu/.

The search resulted in a list of 138 interventions (see *Attachment D: PPC's Menu of Interventions by Target Population* at the end of this chapter for the complete list*)*. The PPC's Standards and Best Practices (SBP) Subcommittee entered the information into a database consisting of the intervention name, contact information, source recommending the intervention, and information gathered from the contact sheet. Out of the 138 interventions:

- 29 of the interventions are listed in the CDC published interventions;
- 29 of the interventions listed are SAMHSA published interventions;
- 4 interventions are from the University of California at San Francisco's (UCSF) Center for AIDS Prevention Studies (CAPS) published programs;
- 7 interventions are from the University of California at Los Angeles' (UCLA) Center for HIV Identification, Prevention and Treatment Services (CHIPTS) published programs;
- 14 intervention studies are from Yale University Center for Interdisciplinary Research on AIDS' (CIRA) listed projects;
- 5 intervention studies are from the Center for Health, Intervention and Prevention (CHIP) at the University of Connecticut's listed projects;
- 8 intervention studies are from the HIV/AIDS Prevention Program Archive of Effective listed programs; and
- 30 additional studies and interventions are listed as "Other Programs."

Table 5.2 summarizes the results of the efforts made to obtain program materials as well as information on technical assistance, training and intervention manuals.

Table 5.2 Interventions Identified by the PPC Standards & Best Practices Subcommittee

INTERVENTIONS LOCATED, AND THEIR AVAILABILITY AND ACCESSIBILITY				
	Can provide short description?	Can provide technical assistance?	Can provide training?	Can provide manual?
Yes	82	42	45	51
No	11	24	30	25
Not Applicable*	10	22	13	14
Missing*	35	50	50	48
Total	**138**	**138**	**138**	**138**

Note. * "Not applicable" refers to no replies received from intervention contact, or no replies received after multiple attempts made to contact. "Missing" refers to interventions which were not contacted by the volunteers.

As a result of this comprehensive identification and review process, the SBP Subcommittee made two key recommendations for agencies as they review, select or implement the interventions identified. The recommendations are:

1. Strongly encourage applicant organizations to consider the availability and accessibility of intervention manuals, technical assistance and training when selecting an intervention to implement; and
2. Locate resources to be able to continue to identify EBIs suitable for use in Los Angeles (e.g., solicit more homegrown interventions training, including how to develop locally effective interventions; and training on how to adapt CDC EBIs).

Many of the interventions identified are not focused on HIV prevention but address other life issues such as drug abuse which is a co-factor that heightens an individual's risk for HIV. A sample of the programs that specifically address HIV are presented below. The PPC's SBP Subcommittee has also organized this information by target population (see *Attachment D* at the end of this chapter). The information will help guide HIV prevention program designers select and create effective interventions for their priority populations in targeted communities.

❖ *UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO'S (UCSF) CENTER FOR AIDS PREVENTION STUDIES (CAPS) PUBLISHED PROGRAMS*

Detailed information about each of these programs may be obtained at UCSF Center for AIDS Prevention Studies' website at: http://www.caps.ucsf.edu/.

1. *African American Men's Health Study:* The intervention consists of three, 3-hour weekly group meetings. All training materials are culturally relevant for African-American gay and bisexual men. The three sessions are grouped around the following themes: Self-identity and development of social support.

2. *Draw the Line/Respect the Line:* Is a 20-session youth focused (6^{th}-8^{th} grade) intervention that focuses on the postponement of sexual activity by developing a range of skills.

3. *The CHANGES:* This is a 6-session *Coping Effectiveness Training* (CET) intervention, designed to assist HIV positive gay men in sustaining psychological health despite the ongoing stress associated with HIV infection.

4. *Mid-Peninsula YWCA AIDS Prevention Program:* This is a 5-hour, prevention intervention that targets 9th graders. The focus of the intervention is enhancing resistance to peer pressure around sexual risk-taking.

❖ *UNIVERSITY OF CALIFORNIA AT LOS ANGELES' (UCLA) CENTER FOR HIV IDENTIFICATION, PREVENTION AND TREATMENT SERVICES (CHIPTS) PUBLISHED PROGRAMS*

Detailed information about each of the seven intervention studies may be obtained at UCLA CHIPTS website at http://chipts.ucla.edu/.

1. Six of the seven interventions focus on Youth. CHIPTS developed *CLEAR,* which is one of the CDC's "Best Evidence" interventions.

2. The 7^{th} program, *Getting Off is* a 24-session behavioral treatment intervention targeting male gay and bisexual methamphetamine users.

❖ *YALE UNIVERSITY CENTER FOR INTERDISCIPLINARY RESEARCH ON AIDS (CIRA) LISTED PROJECTS*

Detailed information about each of the 14 intervention studies and projects may be obtained at CIRAs website http://cira.med.yale.edu. The website provides information on whether the study is active (current) or completed.

❖ *CENTER FOR HEALTH, INTERVENTION AND PREVENTION (CHIP) AT THE UNIVERSITY OF CONNECTICUT'S LISTED PROJECTS*

Detailed information about each of these programs may be obtained at the University of Connecticut's Center for Health, Intervention, and Prevention Studies' website at http://www.chip.uconn.edu/int_res_int.htm.

1. *Just Like Me:* This is a video intervention that addresses the motivational component of the HIV prevention information-motivation-skills model. The intervention targets high school athletes.

2. *Just Like Us:* This is video intervention for high school students designed to motivate them to change HIV risk behavior. It features interviews with young people who are HIV-positive.

3. *Knowing the Facts:* This is a video intervention for high school and college students. It provides information about HIV prevention that prior research has found commonly lacking in this population.

4. *AIDS Risk Reduction for College Students:* This is a 3-session intervention focusing on HIV 101 information, and has a motivational component that addresses students' attitudes and perceptions towards prevention.

5. *Options/Opciones:* This intervention targets clinicians who work with HIV positive persons in a medical setting. The intervention teaches clinicians and medical providers on how to effectively provide HIV/AIDS prevention and intervention skills within 5-10 minutes during regular medical appointments.

❖ *HIV/AIDS PREVENTION PROGRAM ARCHIVE OF EFFECTIVE LISTED PROGRAMS*

Detailed information about each of these programs may be obtained at http://www.socio.com/pasha/haprogms.htm. [Note: Each of the intervention evaluations has been analyzed using different methods and evaluation resources.]

1. *Turning Point* includes two separate interventions (5 total sessions) designed to reduce the frequency and probability of injection-risk behavior among IDUs not participating in drug abuse treatment programs.

2. *Sniffer* is a 4-session intervention designed to prevent intranasal heroin users from making the transition to injection drug use, and to prevent those who have used injection drugs in the past from returning to that mode of use.

3. *Safety Point* is a 9-session community-based intervention that seeks to reduce sex- and drug-related HIV risk factors in populations of injection drug and crack cocaine users.

4. *Point for Point* is a needle exchange intervention designed for implementation in street settings.

5. *Let's Chat* is a 4-session intervention designed for use with same-gender groups of adults with chronic mental illness.

6. *Hot, Healthy, and Keeping it Up* is a three-hour, single session, culturally appropriate intervention for use with homosexual Pacific Islander and/or Asian men. The intervention is designed to increase positive ethnic and sexual identity in order to help participants acknowledge HIV risk behaviors by discussing negative experiences of being both Asian or Pacific Islander and homosexual (e.g., lack of social support, racism, and homophobia).

7. *Doing Something Different* is a single-session, one-hour intervention, initially designed for use in an inner-city public health clinic, but is appropriate for use in any community setting that provides education or services to at-risk populations.

8. *Brother to Brother* is a 3-session intervention aimed at reducing HIV infection among African-American gay and bisexual men. Sessions are designed to foster positive identity development, educate participants about HIV/AIDS risk, teach assertiveness, and encourage the sharing of commitments and strategies for risk reduction among group members.

In addition to those listed above, the PPC SBP Subcommittee identified 30 additional studies and interventions that are included in the appendix in the Other Programs section. These do not have any training resources available and so are not included here.

■ Promising Interventions

The Prevention Plan Work Group has compiled a list of interventions that may serve as an adjunct to interventions already referenced in this current prevention plan. These interventions exhibit promise even though they are not considered evidence based. As several may still be in trial or early phases of research, the strength of evidence is being evaluated for feasibility and effectiveness. The PPC and OAPP acknowledge and mention these interventions not as an endorsement, but because they are becoming a part of the landscape of prevention efforts being examined across the country. Thus, the purpose here is to bring awareness of these interventions to the Los Angeles County prevention community. They include:

1. Post Exposure Prophylaxis (PEP),
2. Pre-exposure Prophylaxis (PrEP),
3. Male circumcision, and
4. Biomedical interventions.

Published Interventions

There are a multitude of interventions that have been disseminated by the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute on Drug Abuse (NIDA) and other federal agencies that have been deemed effective and evidence based. The PPC's SBP Subcommittee included many of these interventions in their review process. As an organization thinks about what intervention to use and/or develop for a specific high risk population, it is important to have an understanding of the interventions that currently exist and are available for use. The following section presents

detailed information on CDC and SAMHSA interventions. Information on NIDA studies and interventions is available through their website at http://www.nida.nih.gov/.

OAPP and the PPC do not endorse any one specific intervention over another intervention. Instead, organizations must consider the different factors involved when selecting an intervention to use with a specific target population.

■ CDC Interventions

The CDC began the Diffusion of Effective Behavioral Interventions (DEBIs) project in 1999. Its purpose was to bring science-based, community- and group-level HIV prevention interventions to local organizations as well as state and local health departments. The Center on AIDS & Community Health (COACH) at the Academy for Educational Development (AED) collaborates with the CDC's Division of HIV/AIDS Prevention, to offer training and coordinate technical assistance for these interventions. Detailed descriptions of the CDC's effective behavioral interventions (EBIs) may be found at www.effectiveinterventions.org. In 2005, the CDC identified over 100 new studies that were eligible for efficacy review. Of the 100 studies, 18 behavioral interventions were identified as "Best Evidence" and 18 were identified as "Promising Evidence" interventions for use by organizations [19]. Additional information for both is available at http://www.cdc.gov/hiv/topics/research/prs/best-evidence-intervention.htm and http://www.cdc.gov/hiv/topics/research/prs/promising-evidence-interventions.htm. The CDC's EBIs are also an important resource when selecting interventions to target priority populations. They complement interventions developed by other organizations around the nation and serve as one guide for Los Angeles based agencies in creating LDIs. To assist agencies in reviewing this information, the EBIs are categorized into three main types: Community, Group, and Individual level interventions.

The CDC criteria for Best-Evidence include:

1. HIV action (behavioral) oriented;
2. Has been thoroughly tested (evaluated);
3. Has shown to have significant and positive evidence of effectiveness (i.e., eliminate or reduce sex- or drug-risk behaviors, reduce the rate of new HIV/STD infections, or increase HIV-protective behaviors); and
4. Are scientifically meticulous and provide the strongest evidence of usefulness.

❖ *CDC "BEST EVIDENCE" INTERVENTIONS AND EBIS AT-A-GLANCE*

All of the CDC's effective behavioral interventions (EBIs) (e.g., Mpowerment, Safety Counts, Popular Opinion Leader, and Community PROMISE) and other "Best Evidence" interventions share these elements. The following series of tables provides a brief picture of the CDC's "Best Evidence" interventions as well as interventions from the original DEBI project, organized by priority population (see *Attachment E: Description of CDC's Best Evidence Interventions & EBIs* at the end of this chapter for a brief description of these interventions).

Table 5.3 CDC's EBIs/Best Evidence Interventions by Type of Intervention and Priority Population

TYPE	BEST EVIDENCE INTERVENTIONS	HIV POSITIVE	MEN	WOMEN	YOUTH	TRANSGENDER	SHARING INJECTION PARAPHERNALIA	OTHER
Community Level Interventions	Community PROMISE		X	X	X		X	
	Mpowerment		X		X			
	Popular Opinion Leader (POL)	X	X	X	X	X	X	
	Real AIDS Prevention Program (RAPP)			X				
Individual Level Interventions	CLEAR	X			X			
	EXPLORE		X					
	Female and Culturally Specific Intervention			X			X	
	Modelo de Intervención Psicomedica (MIP)							X
	Personalized Cognitive Risk Reduction Counseling		X					
	Project Connect		X	X				
	Project S.A.F.E.			X				
	RESPECT (brief & enhanced counseling)		X	X				
	RESPECT (brief + booster)		X	X				
	Sister to Sister: One-on-One skills building			X				
	START		X					
	Women's Co-Op			X				
Group Level Interventions	BART		X	X	X			
	Be Proud! Be Responsible!		X		X			
	Brief Group Counseling		X					
	CHOICES			X				
	Communally Effectance-AIDS Prevention			X				
	¡Cuídate!		X	X	X			
	FOK + ImPACT		X	X	X			
	Healthy Relationships	X						
	HIP							X
	Holistic Health Recovery Programs (HHRP)	X						
	"light"		X	X				
	Many Men, Many Voices (3MV)		X					
	Project Connect		X	X				
	Project FIO			X				
	Project S.A.F.E.			X				
	Safety Counts						X	X
	SHIELD							X
	SiHLE			X	X			
	Sisters Informing Sisters on Topics About AIDS (SISTA)			X		X		
	Sister-to-Sister: Group Skills-building			X				
	Sisters Saving Sisters			X				
	Street Smart				X			
	SUMIT Enhanced Peer-led	X						
	Together Learning Choices (TLC)		X	X	X			
	VOICES/VOCES		X	X				
	WHP			X				
	WiLLOW	X						
	Women's Co-Op			X				

❖ *CDC'S BEST EVIDENCE INTERVENTIONS AND EBIS BY TYPE OF INTERVENTION*

The following series of tables presents the CDC's best evidence interventions and EBIs by intervention type (e.g., community level, individual level, group level) and target population. The percentages present the proportion of the population by race/ethnicity that received the intervention and participated in the original evaluation study.

Table 5.4 CDC's Community Level Interventions by Target Population

COMMUNITY-LEVEL INTERVENTIONS	TARGET POPULATION(S)	Percent of Original Evaluation Population					
		White	African American	Latino	Asian/Pacific Islander	Native American	Other
Community PROMISE	IDUs and their sex partners, non-gay identified MSM, high risk youth, female sex workers, high risk heterosexuals	22%	54%	19%			5%
Mpowerment	Young gay and bisexual men	81%	4%	6%	7%		2%
Popular Opinion Leader (POL)	Men who frequent bars, male sex workers, adolescents, and business owners who cater to gay men	86%	14%				
Real AIDS Prevention Program (RAPP)	Sexually active women and their male partners		73%				27%

Table 5.5 CDC's Individual Level Interventions by Target Population

INDIVIDUAL-LEVEL INTERVENTIONS	TARGET POPULATION	Percent of Original Evaluation Population					
		White	African American	Latino	Asian/Pacific Islander	Native American	Other
1. CLEAR	Young HIV positive substance users	23%	26%	42%			8%
2. EXPLORE	MSM	72%	7%	15%			6%
3. Female and Culturally Specific Intervention	Women who are IDU and/or smoke crack		100%				
4. Modelo de Intervención Psicomedica (MIP)	Drug users			100%			
5. Personalized Cognitive Risk Reduction Counseling	MSM	74%	3%	11%	6%		6%
6. Project Connect	Heterosexual couples or woman alone		55%	39%			6%
7. Project S.A.F.E.	Women with STDs		77%	23%			
8. RESPECT (brief)	Heterosexual men and women in STD clinic	16%	59%	19%			6%
9. RESPECT (brief + booster)	Men and women in STD clinic	18%	51%	22%			9%
10. Sister to Sister: One-on-One	Women		100%				
11. START	Young men soon to be released from prison	23%	52%	14%			12%
12. Women's Co-Op	Women who use crack		100%				

Table 5.6 CDC's Group Level Interventions by Target Population

GROUP-LEVEL INTERVENTIONS	TARGET POPULATION	Percent of Original Evaluation Population					
		White	African American	Latino	Asian/Pacific Islander	Native American	Other
BART (Becoming a Responsible Teen)	Adolescents (male/ female)		100%				
Be Proud! Be Responsible!	Adolescents (male)		100%				
Brief Group Counseling	Gay men				100%		
CHOICES	Women (low-income)	54%	29%	3%	3%	5%	6%
Communally Effectance-AIDS Prevention	Women (low-income)	42%	55%				3%
¡Cuídate!	Youth (male/female)			100%			
FOK + ImPACT	Youth (male/female) and parents		100%				
Healthy Relationships	HIV positive people	74%	22%				4%
Holistic Health Recovery Programs	HIV positive; HIV negative; drug users	35%	49%	16%			
HIP	Psychiatric outpatients	67%	21%				12%
"light"	High-risk clinic patients		74%	25%			1%
Many Men, Many Voices	Gay men of color	87%	13%				
Project Connect	Heterosexual couples		55%	39%			6%
Project FIO	Women in family planning clinics	10%	73%	17%			.3%
Project S.A.F.E.	Women with STDs		23%	77%			
Safety Counts	Injecting Drug Users; other drug users	28%	47%	20%	1%	4%	
SHIELD	Drug users		94%				6%
SiHLE	Youth (female)		100%				
SISTA	Women		100%				
Sisters Saving Sisters	Women		68%	32%			
Sister-to-Sister: Group Skills-building	Women		100%				
Street Smart	Homeless and runaway youth (11-18 years)	17%*	53%	29%			
SUMIT Enhanced Peer-led	HIV positive gay and bisexual men	51%	23%	17%	1%	1%	7%
Together Learning Choices	Young people (up to 29 years old)	19%	27%	37%			17%
VOICES/VOCES	STD clinic patients (male/female)		62%	38%			
WHP	Women			100%			
WiLLOW	HIV positive Women	15%	84%				1%
Women's Co-Op	Women who use crack		100%				

*Street Smart: The study population included 17% White or Other race/ethnicity.

■ SAMHSA Interventions

In 1997, SAMHSA's Center for Substance Abuse Prevention (CSAP) developed a process, in which substance abuse and mental health interventions were reviewed, rated and designated as model, effective or promising programs [20]. The agency reviewed over 1,100 substance abuse programs and interventions; more than 150 received a designation. This review process was part of the Model Programs Initiative and later became the National Registry of Evidenced-Based Programs and Practices (NREPP). Based on extensive input from scientific communities, service providers, expert panels and the public, SAMHSA revised the procedures, resulting in the launch of the new NREPP and its website (www.nrepp.samhsa.gov) in March 2007 (see *Attachment F: Navigating SAMHSA's NREPP Website* at the end of this chapter) [21].

At SAMHSA, evidence based interventions refer to approaches in prevention or treatment that are well developed and tested multiple times in different settings. The intervention must demonstrate practical use for the area that it is targeting (e.g., HIV AIDS, Substance Abuse or Mental Health). The NREPP uses very specific criteria to rate interventions and the evidence supporting their outcomes. They first look into how strong is the evidence (i.e., has the intervention proven to be consistently effective). Second, they look into whether the intervention material is ready for wider use by community based organizations.

NREPP uses very specific standardized criteria to rate interventions and the evidence supporting their outcomes. NREPP uses two ratings: Quality of Research and Readiness for Dissemination. Both ratings are on a scale of 0.0 to 4.0. A higher rating means stronger, more compelling evidence.

❖ *NATIONAL REGISTRY OF EVIDENCE-BASED PROGRAMS AND PRACTICES (NREPP)*

The NREPP website is a searchable database designed to serve as a more comprehensive and interactive source of information. The site provides descriptive information on interventions, ratings for individual outcomes targeted by the intervention. The summaries synthesize and evaluate the research on specific interventions and in this way can help potential users of these interventions more effectively understand the impact on target populations [21]. Attachment B at the end of this chapter provides a step-by-step description on how to navigate the NREPP website.

Key features: The online database has several key features, including:

1. Custom searches based upon desired outcomes, target populations and service settings;
2. Access to 69 evidence-based interventions;
3. Details on each intervention including: (a) a brief descriptive summary, (b) the types of outcomes achieved, (c) the costs of implementing the intervention, and (d) the complete contact information for the intervention developer; and
4. Two independent expert ratings for each intervention – the first assesses the quality of research supporting specific intervention outcomes, and the second assesses the availability of implementation and training materials to support adoption of the intervention in routine service settings.

Determining the Best Intervention

When an agency gets to the point of designing, selecting or adapting an intervention for a target population, theory becomes practice and it is where the rubber hits the road. At this point, an agency must ask itself two key questions [22]:

1. What is the best intervention for the target population?
2. Does the agency have the resources to implement and maintain a particular intervention, whether it is an LDI or already developed intervention?

Determining the best intervention requires an in depth understanding of the target population, their HIV risk behaviors, the co-factors that heighten their risk for HIV, and the protective factors that will support risk reduction. It is also imperative that an agency understand how behavioral interventions work and how they impact behavior change. Lastly, as behavior does not occur in a vacuum, agencies must recognize that the behavioral intervention is, in fact, only one essential piece of a total HIV prevention program.

■ Understanding Behavioral Interventions

Before assessing the needs and risks of a particular community or target population, an agency needs to understand the purpose of behavioral interventions and how they work. In its training, *Selecting Effective Behavioral* Interventions, the California STD/HIV Training Center defines a behavioral intervention as "an activity or group of activities based on behavioral theory, intended to change the knowledge, attitudes and beliefs, behaviors, or practices of individuals and/or their immediate small social group to reduce their health risk [22]. Thus, behavioral interventions target the *internal factors* that influence behavior versus *external factors*, which can include environmental factors or structural factors. Behavioral interventions are rooted in behavior change theory and address *behavioral determinants* of risk, those internal thought processes that can change behavior, such as:

- Knowledge
- Attitudes and beliefs
- Intentions
- Perceptions
- Self-efficacy
- Skills
- Values
- Perceived norms
- Social norms

Some HIV risk factors increase the chance that an HIV risk behavior (e.g., unprotected sex with multiple partners, sharing injection paraphernalia) will occur. Some risk factors are behavioral determinants (e.g., poor condom negotiation skills); while other risk factors have to do with religious, cultural, or social norms; or are structural or environmental in nature (e.g., poverty, economic dependency). OAPP and the PPC refer to risk factors that are not behavioral determinants as *co-factors* that heighten an individual's risk for HIV. The PPC has identified key co-factors that are shared by all priority populations, as well as co-factors that cause concern within a specific priority population. Table 5.7 lists the co-factors that the PPC has identified for all priority populations; and Table 2.8 depicts those specific to each priority population.

Table 5.7 Common Co-Factors that Contribute to a Person's Risk for Acquiring or Transmitting HIV Shared by All Priority Populations

CO-FACTORS IMPACTING ALL PRIORITY POPULATIONS		
▪ Poverty	▪ STDs	▪ Homelessness
▪ Stigma	▪ Mental Health Issues	▪ Immigration Status
▪ Discrimination	▪ Violence	▪ Language
▪ Racism	▪ Sexual Assault	▪ Sex Work
▪ Limited educational Level	▪ Incarceration	▪ Other Substance Use

Table 5.8 Co-Factors that Contribute to a Person's Risk for Acquiring or Transmitting HIV by Priority Populations Who Engage in Sexual Risk Behavior and People Who Share Needles and/or Works.

HIV POSITIVE INDIVIDUALS *(sexual risk)*	YOUTH *(sexual risk)*	MEN *(sexual risk)*
▪ Methamphetamine use ▪ Undiagnosed HIV ▪ Homophobia ▪ Transphobia ▪ Age	▪ Developmental Issues ▪ Legal ▪ Homelessness/ Runaway Status ▪ Methamphetamine use ▪ Transphobia ▪ Homophobia	▪ Individuals who engage in Day Labor ▪ Methamphetamine use ▪ Internet use for Anonymous Sex ▪ Homophobia
WOMEN *(sexual risk)*	**TRANSGENDER INDIVIDUALS *(sexual risk)***	**PEOPLE WHO SHARE NEEDLES / WORKS**
▪ Sexism ▪ Crack Cocaine use	▪ Methamphetamine and Other Substance Use ▪ Lack of Employment ▪ Transphobia	▪ Methamphetamine use ▪ Transphobia ▪ Homophobia

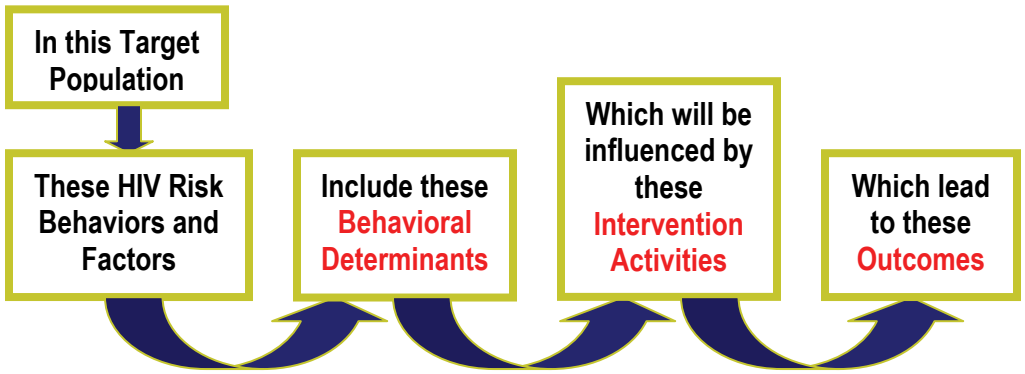
For HIV transmission to occur, an individual has to engage in an HIV risk behavior with an HIV positive individual. Co-factors by themselves do not constitute risk for HIV but they may heighten one's risk for acquiring or transmitting HIV. For example, a gay man who uses methamphetamine is only at risk for HIV if he has unprotected sex with an HIV positive individual or injects methamphetamines or another substance and shares injection paraphernalia with an HIV-positive person. Multiple studies have shown that the presence of syphilis will increase the likelihood of HIV transmission if an individual engages in unprotected sex with an HIV positive person. Understanding co-factors within a target population are an important component of the community assessment, which is one of the first steps an organization needs to take in order to determine the best intervention for the population.

❖ *HOW BEHAVIORAL INTERVENTIONS WORK*

All behavioral interventions are designed to achieve specific immediate outcomes (i.e., changes in behavioral determinants such as knowledge about HIV transmission), intermediate outcomes (i.e., changes in HIV risk behaviors), and long term outcomes such as decreases in new cases of HIV (see Figure 5.1). Agencies are able to measure immediate and intermediate outcomes by collecting specific outcome monitoring data. For example, an agency may use a pre- and post-intervention assessment to identify immediate changes in participants' self-reported knowledge about HIV transmission, safer sex negotiation skills, or skills needed for properly cleaning injection paraphernalia. During a 30 day follow-up assessment, the agency can assess intermediate outcomes and learn about the individual's actual HIV risk behavior during the time from the intervention to the 30 day follow-up. For example, if the participant reports having sex

during the past 30 days, a follow-up question might include assessing whether or not the participant used condoms with his or her sexual partner. An intervention targeting people who share injection paraphernalia might ask the individual if he/she shared needles during the past 30 days without cleaning them or if that person accessed a needle exchange program so that he/she did not have to share needles.

Figure 5.1 How Behavioral Interventions Work



Source: California STD/HIV Prevention Training Center

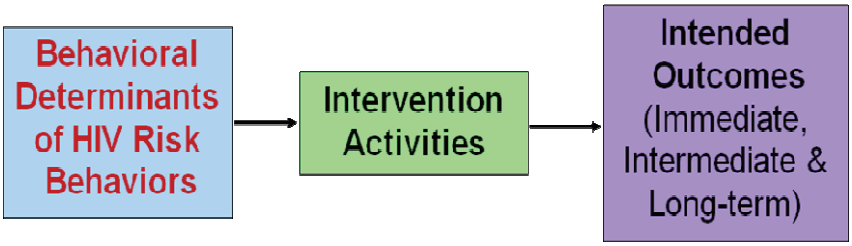
When designing LDIs, this type of outcome monitoring data is extremely important to include when describing the effectiveness of an agency's LDI. Reporting relevant outcome data is important for organizations that may seek funding from public or private entities to support the ongoing implementation of an LDI. Relevant outcome data includes [23]:

- *Behaviors* directly impacting HIV risk:
  - Sexual risk behaviors (e.g., abstinence, mutual monogamy, number of sex partners, negotiating safer sex, condom use, refusal to have unsafe sex)
  - Drug injection behaviors (e.g., frequency of use, sharing injection paraphernalia)
  - HIV testing behavior

- *Biologic* measures of HIV or other STD infections (e.g., prevalence or incidence measures of Hepatitis, HIV, or other STDs)

Creating a logic model can help agencies depict the relationship between specific behavioral determinants addressed through the intervention and intended outcomes (see Figures 5.2 and 5.3).

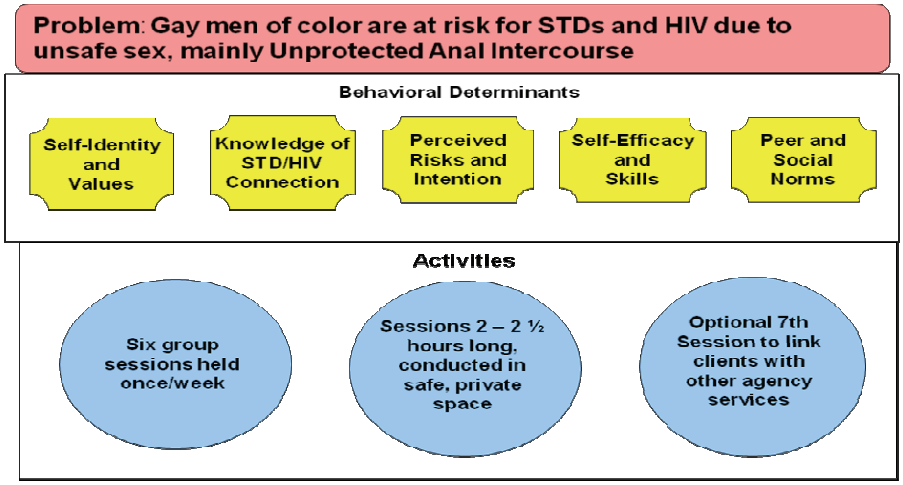
Figure 5.2 Behavior Change Logic Model



Source: California STD/HIV Prevention Training Center

Logic models clearly identify which behavioral determinants are addressed through a specific intervention. Figure 5.3 depicts a sample logic model for the CDC's Many Men Many Voices (3MV) EBI.

Figure 5.3 Many Men Many Voices (3MV) Logic Model



Source: California STD/HIV Prevention Training Center

The purpose of 3MV is to impact specific HIV risk behavior among gay men of color who may or may not identify as gay. These outcomes include (1) increasing condom use and (2) decreasing the frequency of unprotected anal intercourse.

■ Steps Needed to Select the Best Intervention

There are several important steps that an agency can take to guide their process in selecting the best intervention for a target population. The California STD/HIV Prevention Center outlines the four basic steps that an agency can take when selecting an effective intervention for a target population [22]. These steps include:

1. Assess the HIV prevention needs of your community;
2. Examine available behavioral interventions and match them;
3. Assess the agency's capacity to deliver the intervention; and
4. Final match of the intervention with agency capacity and community needs.

These steps can be applied to the full range of available interventions, including among others: LDIs, interventions designed by a variety of organizations but that may or may not be published in the HIV/AIDS literature, CDC EBIs and Best Evidence Interventions, and SAMHSA interventions found through the NREPP website. The PPC's Standards and Best Practices Subcommittee has organized many of these interventions by target population (see *Attachment D: PPC's Menu of Interventions by Target Population* at the end of this chapter). Even this extensive list is not exhaustive as new interventions are being created and evaluated; existing interventions are being adapted and evaluated for new populations that were not part of the original research (e.g., a local Los Angeles organization worked with the CDC to adapt *SISTA*, originally designed for African American women, for use with Latina transgender individuals).

Following this four-step process provides agencies with a guide in selecting an intervention for its intended target population. The information may also inform decisions around adapting an intervention or even designing a new intervention from scratch if that is the agency's inclination. The following is excerpted from the California STD/HIV Prevention Training Center's training and describes each of the four steps in detail [22].

STEP 1: Assess the HIV prevention needs of the community.

- *Start with a broad population (e.g., Youth).*
- *Look at the epidemiologic data (e.g., HIV/AIDS and STD) for this population. Identify the patterns and trends to see where the epidemic is increasing.*
- *Assess the community's needs and identify the HIV risk factors and co-factors (i.e., the circumstances in which HIV risk happens such as poverty, stigma, homophobia, etc.).*
- *Identify the risk factors that are also behavioral determinants (e.g., low level communication skills to effectively negotiate safer sex) so that you end up with a list of behavioral determinants.*
- *Narrow and select your target population (e.g., African American gay youth (18-24 years old) who live in South Los Angeles, or runaway youth (12-17 years old) who are involved in survival sex in the Metro area of Los Angeles.*

Although this step begins with identifying a broad target population and then the population narrows through the community assessment process, the reverse is also possible. An agency may have expertise working with a specific critical target population, e.g., African American gay youth between the ages of 18 to 24 years old. In this case, the agency already has a clearly defined target population. When an agency knows its target population in advance, the agency will use the community assessment step to understand the very specific HIV prevention needs of the target population. The agency will have very specific information regarding the HIV risk behaviors of the population as well as the HIV risk factors, including those that are behavioral determinants that need to be addressed through a behavioral intervention. During this community assessment process, the agency can find out how issues of identity impact a person's access to services or even serve as a *protective factor,* i.e., those factors that promote health and well being and reduce the likelihood that an individual will engage in HIV risk behavior. Protective factors might include cultural pride, sense of empowerment, embracing a gay identity, treatment for substance use, and linkage to primary medical care and ongoing treatment, a unique factor for HIV positive individuals.

STEP 2: Examine available behavioral interventions and match them.

- *Review available interventions, including an agency's LDI and other published or not published interventions from the CDC, SAMHSA, NIDA, Yale University, CHIPTS, or any other source (see Tables 5.4-5.6, as well as Attachment D: PPC's Menu of Interventions by Target Population at the end of this chapter for additional information).*
- *Select a few interventions that have the best match for your target population. There should be a match between: (1) your target population and the intervention's target population; (2) the risk factors of your target population and the risk factors addressed by the intervention; and (3) the behavioral determinants of your target population and the behavioral determinants addressed by the intervention.*

Although a great deal of information has been provided to help agencies begin this process, it is not exhaustive. The most information available is regarding the CDC's EBIs and Best Evidence Interventions. As a result, there may be a tendency for an agency to select a CDC intervention versus doing a little research to find out more about other developed interventions or to shy away from implementing an LDI developed by an agency in Los Angeles. Again, neither OAPP nor the PPC are endorsing one intervention over another. They do support the development of interventions that are grounded in behavioral theory and seek to impact HIV risk behavior.

That said, it is also important to understand that an evidence based intervention that has been implemented as part of academic research does not always translate into an effective real-world/practical program. There are several factors to consider when selecting any intervention, including: (1) quality of program implementation, (2) availability, and (3) acceptance of the intervention [24, 25, 26]. Quality refers to how the intervention is implemented in the real world. Are the health educators delivering the intervention faithful to the intervention design? For example, if different sections of the intervention are running overtime, do the health educators cut off parts of the intervention to make up for running late? Availability refers to the community of potential participants. Are there enough participants to go through the intervention? Acceptance refers to the acceptance of the intervention by the target population. Does the community being targeted accept the intervention? For example, if an intervention was originally designed and tested for African American gay men, will Latino gay men accept the intervention for their community? If not, can the intervention be adapted in a way that will be acceptable to Latino gay men? In addition, most interventions have been designed for use with a specific target population and evaluated with specific racial/ethnic communities. As seen in Tables 5.4-5.6, there are very few CDC interventions that have been evaluated with Native Americans or Asians and Pacific Islanders. Thus, any agency that selects a CDC intervention to target these populations will likely have to adapt the intervention to address the specific language, cultural, and other needs that are specific to these communities.

STEP 3: Assess the agency's capacity to deliver the intervention.

- *After identifying a few interventions for the target population, conduct an internal assessment of the agency's capacity to deliver the intervention.*
- *The agency needs to assess four factors: (1) ability to recruit, retain, and work with the target population; (2) capacity to implement the intervention; (3) skill level and training needs of staff that will implement the intervention; and (4) other resources needed such as space, materials, incentives, equipment, etc.*

When seeking funding for an intervention, Step 3 is extremely important. An agency has to be very realistic about what resources it has to implement a specific intervention and what resources it does not have and needs to secure. This will help an agency when developing a budget. For example, the agency may have a large meeting room that can accommodate small group interventions. However, the agency's building does not have smaller office spaces that can be used for individual sessions or vice versa. The agency may have a current health educator who can deliver the intervention but it really needs to hire a dedicated outreach coordinator in order to successfully recruit participants for the intervention. This realistic assessment regarding the agency's capacity to deliver an intervention, whether it is

the agency's own LDI or another behavioral intervention, is critical to the success of the intervention. An agency should not choose to implement an intervention that it does not have the capacity to deliver.

STEP 4: Final match of the intervention with agency capacity and community needs.

- *Once this assessment is done, an agency can then complete the final selection process by answering the following two questions: (1) is this the best intervention for the target population? and (2) does the agency have the resources to implement the intervention?*

If the answer to both of these questions is yes, the agency has then successfully completed the selection process. However, as noted earlier, not every intervention has been implemented with every population. Thus, although it is a good match in terms of the behavioral determinants that it targets and the outcomes it hopes to achieve, the intervention may still require adaptation to meet the needs of a specific target population as identified through the community assessment process.

■ The Decision to Modify or Change an Intervention

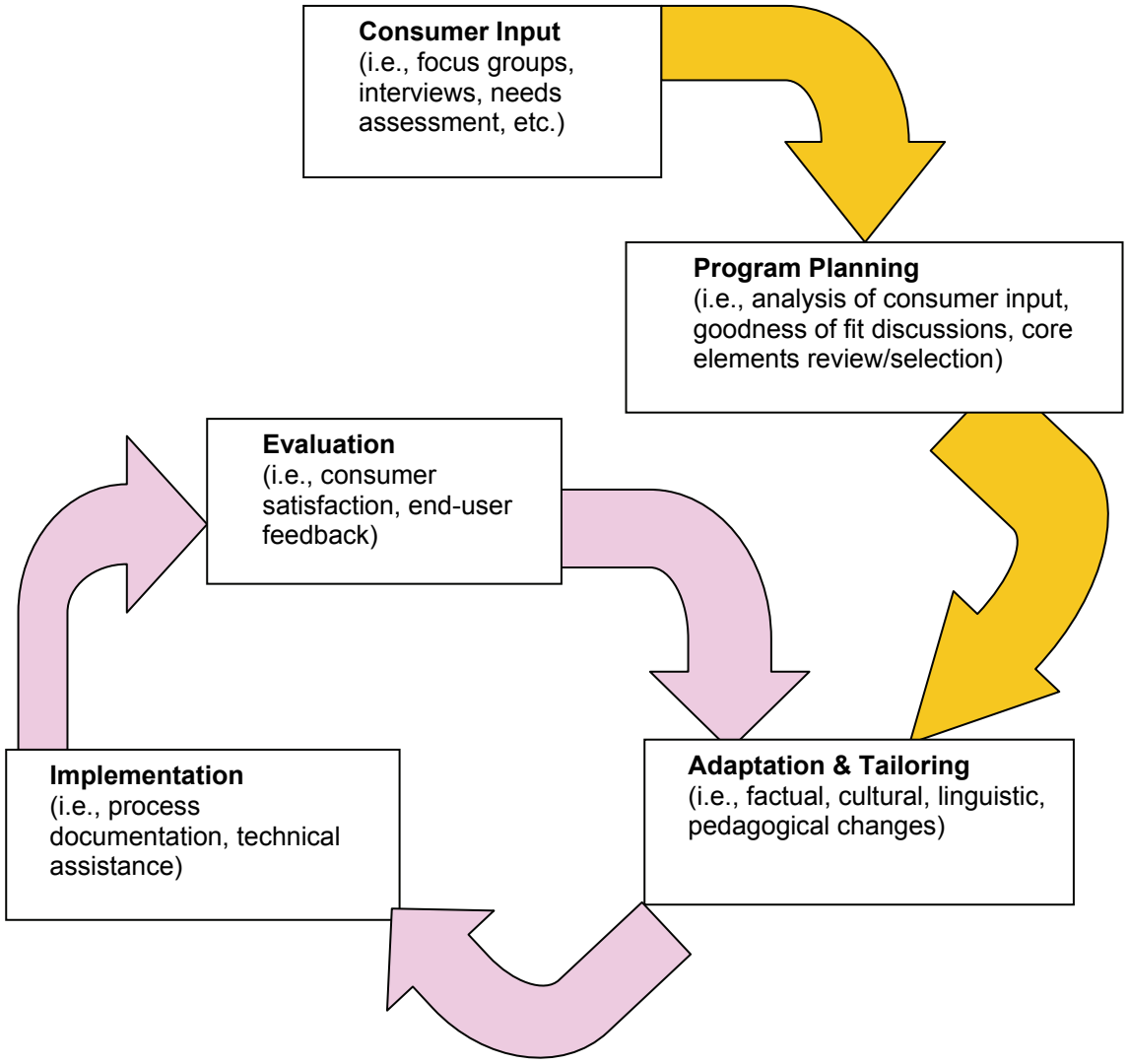
If the intervention is an "almost" best fit for the target population an agency might consider adapting and/or tailoring the intervention. The CDC defines adaptation as *"changes in the audience or venue in which an intervention takes place [27]."* It is about changing the "who" and "where" of the intervention. Tailoring can be about changing the health message (the "what"), the timing of the intervention (the "when"), and/or how the intervention is delivered or by whom (the "how"). Gandelman refines the definition of adaptation as the *process of modifying key characteristics of an intervention without competing with or contradicting the core elements [27]*. The purpose of adapting is *to fit the risk behaviors and influencing factors of the target population and the unique circumstances of the agency and other stakeholders [28]*. When an agency makes changes that contradict the core elements of an intervention, these modifications fundamentally reinvent the intervention. At this point, the intervention is no longer the original intervention but something new and should be given a new name [28].

Gandelman presents a three-phase, five-step process for adapting evidence based interventions. The phases include assessment, preparation, and implementation. The assessment phase includes two steps: (1) the community assessment already described, as well as (2) selection of the specific intervention to be adapted and implemented. The preparation phase also has two steps, which include: (1) preparation, adaptation, and pre-testing the adaptation with the target population, and (2) developing the implementation plan for the adapted intervention and completing a successful pilot test. The final step and last phase of the process, is the implementation of the adapted intervention. Additional information is available at http://www.caps.ucsf.edu/conference/2005/.

The CDC and other organizations recognize that behavioral interventions do not always smoothly transition into real world practical programs [29, 30, 31]. Translation research, (i.e., building the bridge between research and practice, is growing. In search of a methodology to effectively adapt evidence based interventions, a group of local researchers and organizations designed a multi-method approach for adapting interventions. They applied this approach to adapt the CDC's *Street Smart* EBI for young Latino gay men. As seen in Table 5.6, *Street Smart* originally targeted runaway youth, ages 11 to 18 years old of whom only 29% were Latino (see *Attachment*

G: Model for Adapting an Evidence Based Intervention at the end of this chapter for the complete description). Figure 5.4 depicts the components implemented for adapting *Street Smart* [32]. As seen, the process begins with consumer input, which includes the input an agency receives through the community assessment process described earlier.

Figure 5.4 A Locally Developed Model for Adapting Evidence-Based HIV Prevention Interventions



Source: Ayala, G. et al. A Poster Presentation. *Adapting Street Smart in Partnership with its Consumers and End-users.*

Additional Resources

The following resources and their websites may be pursued for additional information about HIV/AIDS, Prevention Interventions, and capacity building opportunities. The list is not exhaustive as more agencies may exist.

	RESOURCE / DESCRIPTION	WEBSITE
BEHAVIORAL THEORY	The Population Council *This organization conducts research worldwide to improve policies, programs, and products in three areas: HIV and AIDS; poverty, gender, and youth; and reproductive health.*	http://www.popcouncil.org/horizons/aidsquest/cmnbehvrtheo/index.html
	American Psychological Association	www.apa.org
INTERVENTIONS	Academy for Educational Development	interventions@aed.org
	California STD/HIV Prevention Training Center	http://www.stdhivtraining.org/
	Center for Health, Intervention and Prevention (CHIP) at the University of Connecticut's	http://www.chip.uconn.edu/int_res_int.htm.
	Center for HIV Identification, Prevention, and Treatment Services	http://chipts.ucla.edu/
	CDC's Diffusion of Effective Behavioral Interventions (DEBI) project	http://effectiveinterventions.org/
	CDC's Best Evidence Interventions	http://www.cdc.gov/hiv/topics/research/prs/best-evidence-intervention.htm
	CDC's Promising Evidence Interventions	http://www.cdc.gov/hiv/topics/research/prs/promising-evidence-interventions.htm
	SAMHSA's National Registry of Evidence Based Programs and Practices	www.nrepp.samhsa.gov
OTHER RESOURCES	Chestnut Health Systems, Research and Training Lighthouse Institute *Information and widely used measures, including the Global Appraisal of Individual Needs (GAIN) for a variety of large projects examining the drug abuse treatment service delivery.*	http://www.chestnut.org/LI/index.html
	The Treatment Research Institute (TRI) *Home of the Addiction Severity Index (ASI) and Drug Evaluation Network System (DENS), this site providers information, measures, and data archives for a variety of large projects examining the drug abuse treatment service delivery.*	http://www.tresearch.org/
	Institute of Behavioral Research at Texas Christian University *Information, measures, and data archives for a variety of large projects examining the drug abuse treatment service delivery.*	http://www.ibr.tcu.edu/
	University of Kentucky Center for Drug and Alcohol Research *Information, measures, and data archives for a variety of large projects examining the drug and alcohol abuse treatment service delivery.*	http://cdar.uky.edu/

RESOURCE / DESCRIPTION		WEBSITE
	Drug Abuse Treatment Outcomes Study (DATOS) *Information, measures, and data archives for this national study examining the effectiveness of drug abuse treatment.*	http://www.datos.org/
	Comorbidity and Addictions Center (CAC) *Frequently-used measures and summaries of various projects examining the drug abuse treatment service delivery at the Washington University School of Social Work.*	http://gwbweb.wustl.edu/users/cac/
	The Center for Education and Drug Abuse Research (CEDAR)	http://www.pitt.edu/~cedar/index.html
	Inter-University Consortium for Political and Social Research (ICPSR) *Provides a large searchable archive of data bases, codebooks, reports, etc. most of it downloadable.*	http://www.icpsr.umich.edu/index.html
	The National Center on Addiction and Substance Abuse at Columbia University (CASA) *Contains some downloadable reports on national surveys.*	http://www.casacolumbia.org/
	The Web of Addictions *Provides linkages to a broad variety of websites addressing substance use and abuse that can be helpful for orienting researchers new to the field - lots of annotated links.*	http://www.well.com/user/woa/index.html

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Attachment A: Standards and Best Practices - Job Competencies

STANDARDS AND BEST PRACTICES: JOB COMPETENCIES

Health Education Risk Reduction (HERR) – Outreach Worker

BASIC: Achieved within 6 months of hire	PREFERRED: In addition to Basic Competencies
Demonstrate ability to build rapport with clients (i.e. customer service skills, outreach, and open ended questions) and talk openly about sex and sexual risk taking behaviors.	Two years experience conducting outreach, group facilitation and/or individual risk reduction counseling.
Basic Knowledge of STD's, Hepatitis and Tuberculoses transmission and treatment.	Trained in co-morbidities: HIV, STD's, Hepatitis and Tuberculoses transmission and treatment.
Knowledge of substance abuse issues and treatment, and related sexual risks.	Cross trained in drug and alcohol assessment/risk behaviors: harm reduction and risk reduction.
Knowledge of target population, inclusive of cultural competency and sensitivity, including that of persons living with HIV.	Extensive knowledge and experience working with behavioral risk groups, including, Injection Drug Users, Youth and the LGBT Community.
Understanding of confidentiality and (legal) consequences of failure to abide.	HIPPA certified and knowledge of informed consent.
High School Diploma and/or successful completion of GED.	Bachelor's degree or two years experience in a human services related field.
Basic computer skills, knowledge of word processing, data entry, and use of internet and internet research.	Experience with one or more of the following Excel, Access, Internet Explorer, Outlook or Client Level Data Systems.
Ability to manage time efficiently, meet deadlines and adapt to fast pace environments.	Demonstrate ability to manage time efficiently, meet deadlines, multi-task and adapt to fast-paced environments.
Ability to research, identify and access community referrals.	Working knowledge of community services and resources.
Demonstrate proficient written-documentation and verbal-communication skills.	Experience in data collection and reporting.
General understanding and awareness of professional boundaries.	Understanding of dual relationships with staff and clients, internal and external customers, and off site work environments.
Ability to apply skills that motivate clients to modify HIV risk taking behaviors and substance use behaviors.	Understanding of the various effects of individual drugs, knowledge of substance related risk behaviors and corresponding treatment and services
Valid California Drivers License and proof of insurance and/or ability to access reliable transportation.(Applicable to program need)	
Bilingual/Multilingual speaking and understanding of multicultural issues.(Applicable to program need)	Bilingual/Multilingual – Ability to speak and write proficiently.(Applicable to program need)

STANDARDS AND BEST PRACTICES: JOB COMPETENCIES

HIV Counseling and Testing - Counselor

BASIC: Achieved within 6 months of hire	PREFERRED: In addition to Basic Competencies
Certified HIV Counselor	Certified in HIV Rapid Testing and Phlebotomy or certified Phlebotomist.
Excellent oral communication skills, ability to build rapport with clients (i.e. customer service skills, outreach, open ended questions) and talk openly about sex and sexual risk taking behaviors.	Two years experience working in HIV prevention services, working with HIV Positive individuals and/or have disclosed an HIV positive test result.
Basic Knowledge of STI's, HIV, Hepatitis and Tuberculoses transmission and treatment.	Trained in co-morbidities: HIV, STD's, Hepatitis and Tuberculoses transmission and treatment.
Knowledge of substance abuse issues and treatment, and related sexual risks.	Cross trained in drug and alcohol assessment/risk behaviors: harm reduction and risk reduction.
Knowledge of target population, inclusive of cultural competency and sensitivity, including that of persons living with HIV.	Extensive knowledge and experience working with behavioral risk groups, including Injection Drug Users, Youth and the LGBT Community.
Understanding of confidentiality and (legal) consequences of failure to abide.	HIPPA certified and knowledge of informed consent.
High School Diploma and/or successful completion of GED.	Bachelor's degree or two years experience in a human services related field.
Basic computer skills, knowledge of word processing, data entry, and use of internet and internet research.	Experience with one or more of the following HCT data base programs: HIV 5-6, HIRS or ELI.
Ability to manage time efficiently, meet deadlines and adapt to fast pace environments.	Demonstrate ability to manage time efficiently, meet deadlines, multi-task and adapt to fast-paced environments.
Ability to research, identify and access community referrals.	Working knowledge of community services and resources.
Demonstrate proficient written-documentation skills: notes, written terminology, process, short/long term goals, follow-up, and referrals.	Experience in creating client service plan. Experience in data collection and reporting.
General understanding and awareness of professional boundaries.	Understanding of dual relationships with staff and clients, internal and external customers, and off site work environments.
Ability to demonstrate basic skills of risk behavior assessment. Motivate clients to modify HIV risk taking behaviors and substance use behaviors.	Understanding of the various effects of individual drugs, knowledge of substance related risk behaviors and corresponding treatment and services
Valid California Drivers License and proof of insurance and/or ability to access reliable transportation.(Applicable to program need)	Clean driving record, ability/experience in driving a Mobile Unit/RV and/or possess a class B driver's license.(Applicable to program need)
Bilingual/Multilingual speaking and understanding of multicultural issues.(Applicable to program need	Bilingual/Multilingual – Ability to speak and write proficiently.(Applicable to program need)
Organized, able to maintain client files, charts and test results.	Knowledge of current HIV treatment modalities.
Ability or experience in the disclosure of life altering conditions.	Experience in extensive methods of follow-up and linked access to services.
Knowledge of HIV prevention and care services and/or ability to research and identify accessible services.	Experience in conducting a psychosocial assessment and/or working individually with clients in a counseling capacity.
Knowledge of HIV case reporting.	Experience in HIV case reporting.

STANDARDS AND BEST PRACTICES: JOB COMPETENCIES

Partner Counseling and Referral Services – Service Provider/Community Liaison/Counselor

BASIC: Achieved within 6 months of hire	PREFERRED: In addition to Basic Competencies
Completed PCRS training.	Certified HIV Test Counselor.
Excellent oral communication skills, ability to build rapport with clients (i.e. customer service skills, outreach, open ended questions) and talk openly about sex and sexual risk taking behaviors.	Two years experience working in HIV prevention services, working with HIV Positive individuals and/or have disclosed an HIV positive test result.
Basic Knowledge of STD's, Hepatitis and Tuberculoses transmission and treatment.	Trained in co-morbidities: HIV, STD's, Hepatitis and Tuberculoses transmission and treatment.
Knowledge of substance abuse issues and treatment, and related sexual risks.	Cross trained in drug and alcohol assessment/risk behaviors: harm reduction and risk reduction.
Knowledge of target population, inclusive of cultural competency and sensitivity, including that of persons living with HIV.	Extensive knowledge and experience working with behavioral risk groups, including Injection Drug Users, Youth and the LGBT Community.
Understanding of confidentiality and (legal) consequences of failure to abide.	HIPPA certified and knowledge of informed consent.
High School Diploma and/or successful completion of GED.	Bachelor's degree or two years experience in a human services related field.
Basic computer skills, knowledge of word processing, data entry, and use of internet and internet research.	Experience with data base reporting and HIV case reporting.
Ability to manage time efficiently, meet deadlines and adapt to fast pace environments.	Demonstrate ability to manage time efficiently, meet deadlines, multi-task and adapt to fast-paced environments.
Ability to research, access and disseminate community referrals.	Working knowledge of community services and resources.
Demonstrate proficient written-documentation skills: notes, written terminology, process, short/long term goals, follow-up, and referrals.	Experience in creating client services plan. Experience in data collection and reporting.
General understanding and awareness of professional boundaries.	Understanding of dual relationships with staff and clients, internal and external customers, and off site work environments.
Ability to demonstrate basic skills of risk behavior assessment. Motivate clients to modify HIV risk taking behaviors and substance use behaviors.	Understanding of the various effects of individual drugs, knowledge of substance related risk behaviors and corresponding treatment and services
Valid California Drivers License and proof of insurance and/or ability to access reliable transportation.(Applicable to program need)	Clean driving record, ability/experience in driving a Mobile Unit/RV and/or possess a class B driver's license.(Applicable to program need)
Bilingual/Multilingual speaking and understanding (Applicable to program need) of multicultural issues.	Bilingual/Multilingual – Ability to speak and write proficiently.(Applicable to program need)
Organized, able to maintain client files, charts and test results.	Knowledge of current HIV treatment modalities.
Ability or experience in the disclosure of life altering conditions.	Experience in extensive methods of follow-up and linked access to services.
Knowledge of HIV prevention and care services and/or ability to research and identify accessible services.	Experience in conducting a psychosocial assessment and/or working with clients in a counseling capacity individually, in a group (couple) or family setting.
Competent experience with solicitation of vital information.	Experience in conducting field partner notification. Proven skills of tracking clients.
Knowledge and understanding of the Los Angeles Community Planning Process.	Two years of experience as a member or participant of the Los Angeles Community Planning Process.

STANDARDS AND BEST PRACTICES: JOB COMPETENCIES

Health Education Risk Reduction (HE/RR) –Interventions Delivered to Individuals (IDI) Health Educator

BASIC: Achieved within 6 months of hire	PREFERRED: In addition to Basic Competencies
Excellent oral communication skills, ability to build rapport with clients (i.e. customer service skills, outreach, open ended questions) and talk openly about sex and sexual risk taking behaviors.	Two years experience conducting outreach, group facilitation and/or individual risk reduction counseling.
Basic Knowledge of STD's, Hepatitis and Tuberculosis transmission and treatment.	Trained in co-morbidities: HIV, STD's, Hepatitis and Tuberculosis transmission and treatment.
Knowledge of substance abuse issues and treatment, and related sexual risks.	Cross trained in drug and alcohol assessment/risk behaviors: harm reduction and risk reduction.
Knowledge of target population, inclusive of cultural competency and sensitivity, including that of persons living with HIV.	Extensive knowledge and experience working with behavioral risk groups, including, Injection Drug Users, Youth and the LGBT Community.
Understanding of confidentiality and (legal) consequences of failure to abide.	HIPPA certified and knowledge of informed consent.
High School Diploma and/or successful completion of GED.	Bachelor's degree or two years experience in a human services related field.
Basic computer skills, knowledge of word processing, data entry, and use of internet and internet research.	Experience with one or more of the following Excel, Access, Internet Explorer, Outlook or Client Level Data Systems.
Ability to manage time efficiently, meet deadlines and adapt to fast pace environments.	Demonstrate ability to manage time efficiently, meet deadlines, multi-task and adapt to fast-paced environments.
Ability to research, identify and access community referrals.	Working knowledge of community services and resources.
Demonstrate proficient written-documentation skills: notes, written terminology, follow-up, process and goals.	Experience maintaining client caseload and participating in case study/review. Experience in data collection and reporting.
General understanding and awareness of professional boundaries.	Understanding of dual relationships with staff and clients, internal and external customers, and off site work environments.
Ability to demonstrate basic skills of risk behavior assessment. Motivate clients to modify HIV risk taking behaviors and substance use behaviors.	Understanding of the various effects of individual drugs, knowledge of substance related risk behaviors and corresponding treatment and services
Valid California Drivers License and proof of insurance and/or ability to access reliable transportation.(Applicable to program need)	Experience in conducting a psychosocial assessment.
Bilingual/Multilingual speaking and understanding of multicultural issues.(Applicable to program need)	Bilingual/Multilingual – Ability to speak and write proficiently.(Applicable to program need)
Knowledge of DEBI Interventions.	Trained in DEBI Intervention(s)
Able to learn and implement program module.	Experience adapting and implementing program modules.

STANDARDS AND BEST PRACTICES: JOB COMPETENCIES

Health Education Risk Reduction (HE/RR) –Interventions Delivered to Groups (IDG) Health Educator

BASIC: Achieved within 6 months of hire	PREFERRED: In addition to Basic Competencies
Excellent oral communication skills, ability to build rapport with clients (i.e. customer service skills, outreach, open ended questions) and talk openly about sex and sexual risk taking behaviors.	Two years experience conducting outreach, group facilitation and/or individual risk reduction counseling. *Proficient public speaking skills*.
Basic Knowledge of STD's, Hepatitis and Tuberculoses transmission and treatment.	Trained in co-morbidities: HIV, STD's, Hepatitis and Tuberculoses transmission and treatment.
Knowledge of substance abuse issues and treatment, and related sexual risks.	Cross trained in drug and alcohol assessment/risk behaviors: harm reduction and risk reduction.
Knowledge of target population, inclusive of cultural competency and sensitivity, including that of persons living with HIV.	Extensive knowledge and experience working with behavioral risk groups, including, Injection Drug Users, Youth and the LGBT Community.
Understanding of confidentiality and (legal) consequences of failure to abide.	HIPPA certified and knowledge of informed consent.
High School Diploma and/or successful completion of GED.	Bachelor's degree or two years experience in a human services related field.
Basic computer skills, knowledge of word processing, data entry, and use of internet and internet research.	Experience with one or more of the following Excel, Access, Internet Explorer, Outlook or Client Level Data Systems.
Ability to manage time efficiently, meet deadlines and adapt to fast pace environments.	Demonstrate ability to manage time efficiently, meet deadlines, multi-task and adapt to fast-paced environments.
Ability to research, identify and access community referrals.	Working knowledge of community services and resources.
Demonstrate proficient written-documentation skills: notes, written terminology, follow-up, process, goals, sign-in-sheets and logs.	Experience in creating client service plans. Experience in data collection and reporting.
General understanding and awareness of professional boundaries.	Understanding of dual relationships with staff and clients, internal and external customers, and off site work environments.
Ability to demonstrate basic skills of risk behavior assessment. Motivate clients to modify HIV risk taking behaviors and substance use behaviors.	Understanding of the various effects of individual drugs, knowledge of substance related risk behaviors and corresponding treatment and services
Valid California Drivers License and proof of insurance and/or ability to access reliable transportation.(Applicable to program need	Experience in conducting a psychosocial assessment.
Bilingual/Multilingual speaking and understanding of multicultural issues.(Applicable to program need)	Bilingual/Multilingual – Ability to speak and write proficiently.(Applicable to program need)
Knowledge of DEBI Interventions.	Trained in DEBI Intervention(s)
Knowledge and understanding of curriculum principles.	Experience in curricula development and adaptation.
Understanding of Group Dynamics (differentiate process, outcome, curricula, and learning groups).	Two years experience and knowledge conducting process, didactic, open groups.
General understanding of life-long learning.	Completed advanced/supplemental education/training, able to demonstrate skills and present certificates/CEU.

STANDARDS AND BEST PRACTICES: JOB COMPETENCIES

Comprehensive Risk Counseling and Services - Counselor

BASIC: Achieved within 6 months of hire	PREFERRED: In addition to Basic Competencies
Excellent oral communication skills, ability to build rapport with clients (i.e. customer service skills, outreach, open ended questions, engagement attending, paraphrasing, reflecting, goal setting/planning) and talk openly about sex and sexual risk taking behaviors.	Two years experience conducting outreach, group facilitation and/or individual risk reduction counseling.
Basic Knowledge of STD's, Hepatitis and Tuberculoses transmission and treatment.	Trained in co-morbidities: HIV, STD's, Hepatitis and Tuberculoses transmission and treatment.
Knowledge of substance abuse issues and treatment, and related sexual risks.	Cross trained in drug and alcohol assessment/risk behaviors: harm reduction and risk reduction.
Knowledge of target population, inclusive of cultural competency and sensitivity, including that of persons living with HIV.	Extensive knowledge and experience working with behavioral risk groups, including Transgenders, Injection Drug Users, Youth and the LGBT Community.
Understanding of confidentiality and (legal) consequences of failure to abide.	HIPPA certified and knowledge of informed consent.
High School Diploma and/or successful completion of GED.	Bachelors degree or two years experience in a human services related field.
Basic computer skills, knowledge of word processing, data entry, and use of internet and internet research.	Experience with one or more of the following Excel, Access, Internet Explorer, Outlook or Client Level Data Systems.
Ability to manage time efficiently, meet deadlines and adapt to fast pace environments.	Demonstrate ability to manage time efficiently, meet deadlines, multi-task and adapt to fast-paced environments.
Ability to research, identify and access community referrals.	Working knowledge of community services and resources.
Demonstrate proficient written-documentation skills: progress notes, written terminology, follow-up, process and goals.	Experience maintaining client caseload and participating in case study/review. Experience in data collection and demonstrated congruency of documentation and make appropriate connection between assessment, plan and follow-up documentation..
General understanding and awareness of professional boundaries.	Understanding of dual relationships with staff and clients, internal and external customers, and off site work environments.
Ability to demonstrate basic skills of risk behavior assessment. Motivate clients to modify HIV risk taking behaviors and substance use behaviors.	Understanding of the various effects of individual drugs, knowledge of substance related risk behaviors and corresponding treatment and services
Valid California Drivers License and proof of insurance and/or ability to access reliable transportation.(Applicable to agency need)	Experience in conducting a psychosocial assessment.
Bilingual/Multilingual speaking and understanding of multicultural issues.(Applicable to agency need)	Bilingual/Multilingual – Ability to speak and write proficiently.(Applicable to agency need)
Knowledge of DEBI Interventions.	Trained in DEBI Intervention(s)
Able to learn and implement program module.	Experience adapting and implementing program modules.
	Knowledge of Transtheoretical Model or Stage of Change Theory

Attachment B: HIV Counseling & Testing Work Group Recommendations

Introduction

The HIV Counseling and Testing Work Group is committed to developing strategies for strengthening Los Angeles County's HIV prevention response and, in particular, HIV counseling and testing programs. This document outlines the HCT Work Group's positions and recommendations for HIV testing in Los Angeles County for the Prevention Planning Committee's consideration.

The following recommendations summarize discussions held between December 21, 2006 and September 20, 2007 regarding HIV counseling and testing guidelines.

Background

The HCT Work Group, a subcommittee of the Standards and Best Practices Subcommittee of the Los Angeles County Prevention Planning Committee (PPC) was charged with:

- Review, update and respond to HCT guidelines and practices
- Review and address legislation issues and identifying recommendations to forward to the Los Angeles County HIV Prevention Planning Committee (PPC).
- Present and provide a forum to train on new HIV testing technologies, programs and strategies.
- Identify training needs and opportunities
- Actively collaborate and provide input to the Commission on HIV (COH) regarding HCT standards.

Additionally, the HCT Work Group will assist in HCT community planning; identify collaboration opportunities and coordination of services.

Recommendations

HCT Work Group Recommendations

The members of the HCT Work Group recommend that the Los Angeles County HIV Prevention Planning Committee (PPC) in conjunction with the County of Los Angeles Department of Public Health consider the below recommendations.

- Increase the percentage of allocation of the HIV Testing service category
- Recommend that targeted testing of high risk individuals remain a priority
- Support targeting testing within highly impacted areas with HIV/AIDS
- Allow for new HIV testing technologies and algorithms, when possible (e.g. support multiple rapid testing products, support Nucleic Acid Amplification Testing [NAAT] testing)
- Support counseling and testing models that consider repeat and low risk testers and allow for self-assessed risk assessments
- Support Multiple Morbidity testing in appropriate settings
- Recommend that testing occur in high-risk venues such as bathhouse and sex clubs
- Support that all clients in health education/risk reduction (HE/RR) programs know their HIV status

- Recommend that HE/RR programs, where appropriate, provide access either directly or through partner relationships w/other organizations to also provide HIV testing
- Recommend that HIV/AIDS social marketing efforts encourage HIV testing
- Recommend that all counselors are cross-trained in substance use (e.g., crystal meth, party drugs, and other drugs), STDs and Hepatitis.
- Incorporate and Increase collaboration and referrals with Partner Counseling and Referral Services (PCRS) in care settings as well as prevention settings. PCRS should be continually introduced and offered in care (e.g., case management, medical outpatient, treatment adherence etc.) and prevention settings at multiple points of service
- Recommend HIV testing efforts in incarcerated settings
- All HCT data collection instruments and efforts will be reviewed and updated to reflect the new planning model, critical populations, and sub-populations
- Recommend that trainings are available to ensure capacity of providers to implement HCT services, and to ensure capacity of agencies to serve critical target populations at highest risk for HIV

Urban Coalition of HIV/AIDS Prevention Services (UCHAPS)

In addition to the above recommendations, the HCT Work Group voted to adopt the UCHAPS recommendations (see *Attachment C* that follows).

The HCT Work Group supports broad and varied HIV testing modalities that are based on the needs of Los Angeles County, HIV prevention and care planning processes, and prevention response. Different models of testing provide for different ranges or level of intensity of the provision of information, risk reduction counseling, and/or education. The issues covered in the UCHAPS recommendations also cover the HCT Work Group's perspective regarding HIV testing models, structural or policy issues, and coordination and referral issues.

It is important to note that although the HCT Work Group supports the Centers for Disease Control and Prevention (CDC) HIV Testing Guidelines in Health Care Settings as described in the UCHAPS position paper, the Group recommends that the priority for testing services should focus on high risk individuals and follow the HIV Counseling and Testing Guidelines. However, the HCT Work Group also recommends that the Department of Public Health support demonstration projects, policy development, and provide guidance to entities (private and public) that are implementing routine testing guidelines.

Review of Available Data and Guidelines

The HCT Work Group reviewed the following documents to formulate the above recommendations:

Guidelines/Recommendations

State of California, Department of Health Services, Office of AIDS Programs and Policy, HIV Counseling and Testing Guidelines: Policies and recommendations 1997 and Rapid HIV Testing Supplement.

CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, MMWR, September 22, 2006, Vol. 55, No. RR-14

Centers for Disease Control and Prevention, 2001, Revised Guidelines for HIV Counseling, testing and Referral Urban Coalition for HIV/AIDS Prevention Services (UCHAPS) Positions and Recommendations on HIV Counseling and Testing, February 24, 2007

Data

Holtgrave, DR (2007), Costs and Consequences of the US Centers for Disease Control and Prevention's Recommendations for Opt-Out HIV Testing, PloS Med 4 (6):e194. doi:10.1371/journal.pmed. 0040194

Holtgrave, D, and McGuire, J., Impact of counseling in Voluntary Counseling and Testing Programs, "Opportunities for Improving Diagnosis, Prevention & Access to Care in the US" conference, sponsored by Centers for Disease Control and Prevention, The Forum for Collaborative HIV Research, the HIV Medicine Association of the Infectious Diseases Society of America, and the National Institute of Allergy and Infectious Diseases.

HIV Counseling and Testing Models Presentation, S. Rumanes, Standards and Best Practices Meeting, HCT Work Group Meeting, July 19, 2007

HIV Counseling and Testing Services: A brief review of the Service and HCT Week Initiative Presentation, S.Rumanes, P.Zamudio, HIV Prevention Planning Meeting, June 7, 2007

HIV Counseling and Testing Services: A Brief Review of the service and HCT Preliminary Data, S. Rumanes, C. Chavers, Commission on HIV, June 14, 2007 meeting.

Advancing HIV Prevention Initiative: Evaluation Results for Projects 1 and 3, N. Osorio, Standards and Best Practices Meeting, HCT Work Group Meeting, August 16, 2007.

Conclusion

Community members of the HCT Work Group in conjunction with members of the Los Angeles County HIV Prevention Planning Committee are in agreement that the fore stated recommendations are of utmost importance in effectively addressing the HIV Counseling and Testing needs in Los Angeles County.

Attachment C: Urban Coalition for HIV/AIDS Prevention Services (UCHAPS): Position and Recommendations on HIV Counseling and Testing

UCHAPS is committed to developing strategies for strengthening the nation's HIV prevention response and, in particular, HIV counseling and testing programs. UCHAPS' member jurisdictions work with local, state, and federal partners to provide an average of 300,000 HIV tests each year. These jurisdictions have been on the forefront of providing HIV testing services to those at highest risk for HIV.

UCHAPS presents a unique perspective given that it encompasses both health department and community perspectives. This document outlines the UCHAPS' positions on HIV testing in both health care and non-traditional settings[1]. It is important to note that although UCHAPS supports client-centered prevention counseling, education, risk assessments and health information as a critical component of HIV testing, the degree to which these services are provided vary according to program model and jurisdiction need. **Although this document serves to summarize the perspective of seven UCHAPS member jurisdictions, UCHAPS understands that these positions provide a general perspective and each individual jurisdiction may have more in-depth positions that tackle jurisdiction-specific issues.**

UCHAPS welcomes the opportunity to share its perspective to enhance the continued improvement of HIV counseling and testing and referral services in the nation.

About UCHAPS

The Urban Coalition for HIV/AIDS Prevention Services [UCHAPS] is a partnership of community members and health department representatives from urban areas highly impacted by HIV/AIDS. The current member jurisdictions are Chicago, Houston, Los Angeles, Miami, New York, Philadelphia, San Francisco, and Washington, DC. Combined, these jurisdictions are home to more than one-third of the nation's AIDS epidemic. UCHAPS member jurisdictions are responsible for coordinating care and treatment services for an estimated 150,000 people living with AIDS and for ensuring effective and ongoing HIV prevention, counseling and testing.

UCHAPS jurisdictions are dedicated to reducing mortality and morbidity, reducing disparities in health outcomes and reducing the incidence of new HIV infections. UCHAPS continually explores ways to improve the delivery of services and ensuring the full complement of services is provided to those in greatest need. UCHAPS uses a peer technical assistance model to exchange expertise, strategies and solutions to common challenges.

HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings

UCHAPS acknowledges that routine HIV testing is an aggressive case finding activity and existing federal, state, and local support is needed for the successful outcome of these efforts. To support these efforts, UCHAPS also supports the expansion of care and treatment programs to respond to these testing activities, which will result in a potentially large number of newly diagnosed HIV-positive individuals. The following describes UCHAPS' positions on routine screening efforts.

[1] This paper reflects the position of the seven jurisdictions that are full UCHAPS members: Chicago, Houston, Los Angeles, New York, Philadelphia, San Francisco, and Washington, DC. UCHAPS also has other jurisdictions that are affiliate members.

UCHAPS Supports:

- Routine screening in health care settings as a strong strategy in identifying and counseling individuals with unrecognized HIV infection and linking individuals to clinical and prevention services.

- Routine screening in high prevalence areas.

- Voluntary screening with the patient's full knowledge and understanding that testing is planned. The provision of a patient opting-out of testing should be a part of a screening program and include provisions for individuals who have low-literacy levels, are limited English proficient, illiterate, or are otherwise less likely to read consent forms and fully understand that they will be tested unless they decline.

- Prevention counseling for patients at high risk for HIV and those who request such counseling. In appropriate instances, prevention counseling is not necessary; however, the provision of HIV education and the ongoing provision of brief risk assessments to ascertain risk behavior are recommended.

- Ongoing risk assessments for patients to ensure that clinicians are able to assess a person's risk profile as it may change over time. UCHAPS acknowledges that individuals at high risk for HIV may not perceive themselves at risk.

- A comprehensive strategy to bolster these resources to support the existing health care system to develop the capacity to implement the recommendations. Developing the "necessary expertise" in health care facilities implementing HIV screening to provide sensitive, competent, appropriate, and up-to date information regarding HIV risk behaviors, prevention, and treatment. This is a shared responsibility between service and governmental organizations. Relying on existing expertise and resources within health departments, AIDS service organizations and community-based organizations to assist the health care system to implement the full scope of the CDC recommendations and dealing with the number of individuals who are unaware of their status is insufficient.

Publicly-Funded HIV Counseling, Testing, and Referral Programs

UCHAPS supports broad and varied HIV testing modalities that are based on a jurisdiction's needs, HIV prevention and care planning processes, and prevention response. As stated earlier, different models of testing provide for different ranges or level of intensity of the provision of information, risk reduction counseling, and/or education. The issues below cover UCHAPS' perspective regarding HIV testing models, structural or policy issues, and coordination and referral issues.

HIV Testing Models

UCHAPS Supports:

- A full complement of HIV testing modalities within different settings including:
  - targeted HIV counseling and testing to individuals at high risk for HIV within community-based settings;
  - in appropriate instances, testing without client-centered prevention counseling be considered; and
  - multiple morbidity screening (i.e., HIV, syphilis, gonorrhea, chlamydia, hepatitis A, B, and C).

- Client-centered prevention counseling for individuals at high risk for HIV. In appropriate instances (e.g., HIV/STD clinics, jail settings, commercial sex venues, etc.), prevention counseling may be not necessary; however, the provision of HIV education and the ongoing provision of brief risk assessments to ascertain risk behavior are recommended. Although education and HIV information are necessary components of HIV testing, the degree to which client-centered prevention counseling is offered may differ depending on the program model's intent. UCHAPS supports various counseling and testing models to educate and diagnose those individuals who are unaware of their HIV-positive status.

- Maintaining HIV counseling and testing efforts that focus on individuals and communities at high risk for HIV. In addition to focusing or targeting programs to those with a high behavioral risk for HIV, UCHAPS supports targeting programs based on geography and race/ethnicity in high prevalence areas and zip codes.

- Focusing HIV counseling and testing programs towards individuals in high prevalence areas with no other reportable risk. Evidence has shown that some groups, such as African American men or women, who test HIV positive do not identify with any behavioral risk and, thus, do not test or test late in their disease progression. Targeting programs in a way that will maximize the opportunity of those individuals to test for HIV will help to diagnose those who may not perceive themselves to be at risk for HIV.

- Targeting or focusing HIV testing strategies by geography in addition to behavioral risk group models (e.g., geo-coding communities).

- Creating a separate testing model for high-risk habitual testers that have a high level of education for HIV given that prevention counseling may serve as a barrier to testing in light of the clients' goal to learn their HIV status regardless of counseling.

Structural or Policy Issues

UCHAPS Supports:

- Confidential testing as the preferred testing option in order to facilitate client follow-up and increase opportunities for linkages to care for HIV-positive individuals. Although anonymous testing is a valued service, UCHAPS encourages confidential testing.

- Aggressive case finding to ensure that as many of the approximately 285,000 undiagnosed individuals in the United States living with HIV are diagnosed.

- Decreasing the data burden in certain settings by developing a condensed client information form for certain venues and/or populations (e.g., habitual repeat testers).

- Campaigns or activities addressing co-factors including HIV/AIDS-related stigma, homophobia, racism, immigration status, etc. that impact an individual's choice to test for HIV.

Coordination and Referral Issues

UCHAPS Supports:

- Strong linkages and referrals between HIV counseling and testing, prevention services, mental health, partner counseling and referral services, and care and treatment.

- Coordination and collaboration between prevention providers so that individuals are offered, linked to, or provided with prevention education, risk-reduction counseling, interventions addressing high-risk behavior, disclosure counseling, partner counseling and referral services, mental health, and/or substance use services as appropriate when they receive HIV testing. Providers with specific areas of expertise should collaborate so that prevention and testing resources within a community are accessible to clients regardless of where they seek services.

We believe that these positions enhance the national discussion on routine HIV testing and HIV counseling and testing and referral services. UCHAPS acknowledges that HIV testing in correctional settings and partner counseling and referral services are activities that jurisdictions are reviewing and in some cases implementing. Given the complexity of the state and federal laws associated with these topics, UCHAPS will provide its perspective in additional documents. UCHAPS continues to be a strong partner in the provision of sound and effective HIV counseling and testing services.

Approved February 24, 2007

UCHAPS♦*Urban Coalition for HIV/AIDS Prevention Services*
Positions and Recommendations on HIV Counseling and Testing

Glossary of Terms

Anonymous: In anonymous testing, client-identifying information is not linked to testing information, including the request for tests or test results.

Client-centered HIV prevention counseling: An interactive risk-reduction counseling model usually conducted with HIV testing, in which the counselor helps the client identify and acknowledge personal HIV risk behaviors and commit to a single, achievable behavior change step that could reduce the client's HIV risk

Collaboration: Working with another person, organization, or group for mutual benefit by exchanging information, sharing resources, or enhancing the other's capacity, often to achieve a common goal or purpose.

Confidentiality: Pertains to the disclosure of personal information in a relationship of trust and with the expectation that it will not be divulged to others in ways that are inconsistent with the original disclosure. Confidentiality must be maintained for persons who are recommended and/or who receive HIV counseling, testing, and referral (CTR) services.

Confidential HIV test: An HIV test for which a record of the test and the test results are recorded in the client's chart.

Health Care settings: Health care settings are facilities in the public and private sector, which include hospital emergency departments, urgent care clinics, inpatient services, substance abuse treatment clinics, public health clinics, community clinics, correctional health-care facilities, and primary care settings.

Opt-out testing approach: Individuals are notified that an HIV testing will be included in the standard battery of tests and procedures and that the individual may decline testing. In the more commonly used opt-in approach, individuals are given pretest counseling and must specifically consent, usually in writing, to an HIV test.

Prevalence: The number or percentage of persons in a given population with a disease or condition at a given point in time.

Rapid HIV test: A test to detect antibodies to HIV that can be collected and processed within a short interval of time [e.g., approximately 10-60 minutes].

Risk assessment: Risk assessment is a fundamental part of a client-centered HIV prevention counseling session in which the client is encouraged to identify, acknowledge, and discuss in detail his or her personal risk for acquiring or transmitting HIV.

Screening: Performing a test for all persons in a defined population, is a basic, effective public health tool used to identify an unrecognized condition so that treatment can be offered before symptoms develop.

Voluntary HIV testing: HIV testing that is offered free of coercion. With voluntary HIV testing, participants have the opportunity to accept or refuse HIV testing.

Attachment D: PPC's Menu of Interventions by Target Population

■ People Living With HIV and AIDS (HIV+)

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
Intervention for Coping with AIDS Related Bereavement	Yale University Center for Interdisciplinary Research on AIDS	HIV+	Kathleen J. Sikkema, Ph.D. Associate Professor Epidemiology & Public Health Yale Center for Interdisciplinary Research on AIDS 40 Temple St. Suite 1B New Haven, CT 06510 E-mail: kathleen.sikkema@yale.edu Phone: (203) 785-7298
Intervention for Coping with HIV and Trauma	Yale University Center for Interdisciplinary Research on AIDS	HIV+	Kathleen J. Sikkema, Ph.D. Associate Professor Epidemiology & Public Health Yale Center for Interdisciplinary Research on AIDS 40 Temple St. Suite 1B New Haven, CT 06510 E-mail: kathleen.sikkema@yale.edu Phone: (203) 785-7298
Meditation and Massage in End of Life (aka MIEL)	Yale University Center for Interdisciplinary Research on AIDS	HIV+	David L. Katz, M.D.,M.P.H Associate Clinical Professor Division of Health Policy and Administration Epidemiology & Public Health Yale Center for Interdisciplinary Research on AIDS 40 Temple St. Suite 1B New Haven, CT 06510 E-mail: david.katz@yale.edu Phone: (203) 785-62
Physician Delivered Intervention with HIV+ Individuals	Yale University Center for Interdisciplinary Research on AIDS	HIV+	Jeffrey D. Fisher, Ph.D. Professor, University of Connecticut Director, Center for Health/HIV Intervention & Prevention Yale Center for Interdisciplinary Research on AIDS 40 Temple St. Suite 1B New Haven, CT 06510 E-mail: jeffrey.fisher@uconn.edu Phone: (860) 486-4529
Clinician-Initiated Prevention for HIV Positives (aka Options/Opciones Project)	Center for Health, Intervention and Prevention	HIV+ persons 18 years and older	Center for Health, Intervention, and Prevention (CHIP) University of Connecticut 2006 Hillside Road, Unit 1248 Storrs, CT 06269 Phone: 860 486-5917 Fax: 860 486-4876

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
Healthy Relationships	UT Southwestern Prevention Toolbox, AED DEBI	HIV+ Women HIV+ Gay Men and Non-Gay Identified MSM	Anne Freeman, MS Division of Community Outreach Department of Health Care Science School of Allied Health Sciences UT Southwestern Medical Center at Dallas 400 S. Zang, Suite 520 Dallas, TX 75208 305 E-mail: anne.freeman@utsouthwestern.edu Phone: (214) 645-7305
Increasing Drug Users' Adherence to HIV Therapeutics	Yale University Center for Interdisciplinary Research on AIDS	HIV+ drug users	Robert S. Broadhead, Ph.D., Professor Department of Sociology University of Connecticut Unit 2068 344 Mansfield Road Storrs, CT 06269 New Haven, CT 06510 E-mail: robert.broadhead@uconn.edu Phone: (860) 486-4184
Optimizing Auricular Accupuncture for HIV+ Drug Users	Yale University Center for Interdisciplinary Research on AIDS	HIV+ drug users	Arthur Margolin, Ph.D. Research Scientist, Division of Substance Abuse, Department of Psychiatry Yale Center for Interdisciplinary Research on AIDS 40 Temple St. Suite 1B New Haven, CT 06510 E-mail: arthur.margolin@yale.edu Phone: (203) 974-7358
Reducing HIV Risk Behavior in HIV+ Drug Abusers	Yale University Center for Interdisciplinary Research on AIDS	HIV+ drug users	S. Kelly Avants, Ph.D. Associate Professor, Psychiatry Yale Center for Interdisciplinary Research on AIDS 40 Temple St. Suite 1B New Haven, CT 06510 E-mail: kelly.avants@yale.edu Phone: (203) 974-7357
Holistic Health Recovery Program (HHRP) (formerly Holistic Harm Reduction Program)	UT Southwestern Prevention Toolbox, AED DEBI	HIV+ People who share injection paraphernalia (SIP)	Center on AIDS and Community Health (AED) E-mail: interventions@aed.org Phone: (800) 462-9521 or (202) 884-8712 TTY: 800-434-3652
Partnership for Health	UT Southwestern Prevention Toolbox	HIV+ men HIV+ women	Maggie Hawkins Partnership for Health Program Pacific AIDS Education & Training Center 1441 Eastlake Avenue, Suite 3412 Keck School of Medicine University of Southern California Los Angeles, CA 90089-9175 E-mail: margareh@usc.edu Phone: (323) 865-0343 (323) 865-0134
CHANGES	UCSF Center for AIDS Prevention Studies	HIV+ Gay men and non-gay identified MSM	Joey Taylor CAPS 74 New Montgomery San Francisco, CA 94105 E-mail: JTaylor@psg.ucsf.edu Phone: (415) 597- 9189 Fax: (415) 597-9213

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
RISE (Rewriting Inner Scripts)	Homegrown Interventions Work Group	HIV+ African American gay men and non-gay identified MSM	Kip Castner, MPP Act Deputy Chief, Center for Prevention Maryland AIDS Administration 500 North Calvert St. 5th floor Baltimore, MD 21202 Phone: (410) 767-5290 Fax: (410) 333-6333
Nursing Intervention to Improve Antiviral Adherence	Yale University Center for Interdisciplinary Research on AIDS	HIV+ women	Ann B. Williams, R.N.C., Ed.D. Professor Yale School of Nursing Yale Center for Interdisciplinary Research on AIDS 40 Temple St. Suite 1B New Haven, CT 06510 E-mail: ann.williams@yale.edu Phone: (203) 737-2350 phone
Together Learning Choices (formerly Teens Linked to Care)	UT Southwestern Prevention Toolbox, AED DEBI	HIV+ Youth, aged 13-29 years	Center on AIDS and Community Health (AED) E-mail: interventions@aed.org Phone: (800) 462-9521 or (202) 884-8712 TTY: 800-434-3652
Seropositive Urban Men's Intervention Trial (SUMIT) Enhanced Peer-Led Intervention	CDC Best-Evidence Interventions	HIV+ gay men and non-gay identified MSM	Dr. Richard Wilitski Prevention Research Branch Division of HIV/AIDS Prevention NCHHSTP, CDC 1600 Clifton Rd (M/S E-37) Atlanta, GA 30333 E-mail: rwolitski@cdc.gov
Safety Counts	UT Southwestern Prevention Toolbox, AED DEBI	HIV+ SIPs	Center on AIDS and Community Health (AED) E-mail: interventions@aed.org Phone: (800) 462-9521 or (202) 884-8712 TTY: 800-434-3652
Women Involved in Life Learning from Other Women (WiLLOW)	CDC Best-Evidence Interventions	Sexually-active, female clinic patients living with HIV	Dr. Gina M. Wingood Rollins School of Public Health Emory University 1518 Clifton Road, NE, BSHE/Room 556 Atlanta, GA 30322 E-mail: gwingoo@sph.emory.edu DEBI Technical Monitor Cynthia Prather Phone: (404) 639 5234 E-mail: CPrather@cdc.gov

■ Men: Gay Men and Non-Gay Identified MSM

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
The NIA Outreach	Homegrown Interventions Work Group	African American gay men and non-gay identified MSM	In The Meantime Men's Group, Inc. PO Box 29861 Los Angeles, Ca 90029-0861
Healthy Relationships	UT Southwestern Prevention Toolbox, AED DEBI	HIV+ women, HIV+ gay men and non-gay identified MSM	Anne Freeman, MS Division of Community Outreach Department of Health Care Science School of Allied Health Sciences UT Southwestern Medical Center at Dallas 400 S. Zang, Suite 520 Dallas, TX 75208 305 E-mail: anne.freeman@utsouthwestern.edu Phone: (214) 645-7305
CHANGES	UCSF Center for AIDS Prevention Studies	HIV+, gay men and non-gay identified MSM	Joey Taylor CAPS 74 New Montgomery San Francisco, CA 94105 E-mail: JTaylor@psg.ucsf.edu Phone: (415) 597- 9189 Fax: (415) 597-9213
RISE (Rewriting Inner Scripts)	Homegrown Interventions Work Group	HIV+, Gay men and non-gay-identified MSM, African American	Kip Castner, MPP Act Deputy Chief, Center for Prevention Maryland AIDS Administration 500 North Calvert St. 5th floor Baltimore, MD 21202 Phone: (410) 767-5290 Fax: (410) 333-6333
Seropositive Urban Men's Intervention Trial (SUMIT) Enhanced Peer-Led Intervention	CDC Best-Evidence Interventions	HIV-seropositive gay men and non-gay-identified MSM	Dr. Richard Wolitski Prevention Research Branch Division of HIV/AIDS Prevention NCHHSTP, CDC 1600 Clifton Rd (M/S E-37) Atlanta, GA 30333 E-mail: rwolitski@cdc.gov
Peer-based HIV Prevention Among Injection Drug Users and Satellite Syringe Exchangers in California	Universitywide AIDS Research Program	SIPs	Tom Stopka, Research Scientist HIV Prevention Research and Evaluation Section California Department of Health Services Office of AIDS 611 North 7th Street, Suite A Sacramento, CA 95814 Email: tstopka@dhs.ca.gov Phone: 916-323-7419 Fax: 916-322-2206
A Web-Based Structural HIV Prevention Intervention in MSM Networks	Universitywide AIDS Research Program	gay men and non-gay-identified MSM	Deb Levine, ISIS, Inc. 436 14th Street, Suite 1511 Oakland, CA 94612 Phone: 510-835-9400 Fax: 510-835-9402
Faith-Based HIV Prevention for African American MSM	Universitywide AIDS Research Program	gay men and non-gay-identified MSM	Susan Kegeles, Ph.D. UCSF Email: susan.kegeles@ucsf.edu Phone: 415-597-9159
Increasing Testing Through a Health Promotion Focus	Universitywide AIDS Research Program	gay men and non-gay-identified MSM	Frank Galvan, Ph.D., L.C.S.W, Charles Drew University Phone: (323) 357-3452

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
Multi-level Prevention in Culture and Context with Latino MSM	Universitywide AIDS Research Program	gay men and non-gay-identified MSM	LeRoy Blea, City of Berkeley Public Health Department HIV Education & Prevention Program 830 University AvenueBerkeley, CA 94710 Email: lblea@ci.berkeley.ca.us Phone: (510) 981-5383 Fax: (510) 981-5385
Popular Opinion Leader (POL)	UT Southwestern Prevention Toolbox, AED DEBI	gay men and non-gay-identified MSM	Center on AIDS and Community Health (AED) E-mail: interventions@aed.org Phone: (800) 462-9521 (202) 884-8712 TTY: 800-434-3652
Project EXPLORE	UCSF Center for AIDS Prevention Studies	gay men and non-gay-identified MSM	Explore San Francisco AIDS Office, Dept. of Public Health Phone: (415) 554-9000
Social Marketing to Reduce HIV Risk Among Non-Gay Identified Men Who Have Sex with Men	Universitywide AIDS Research Program	gay men and non-gay-identified MSM	Ana Martinez Donate, Ph.D. SDSU Phone: (619) 594-8085
Translating Street Smart in Partnership with Its Consumers and End-users: Technology Exchange as an Iterative Process	Universitywide AIDS Research Program	gay men and non-gay-identified MSM	George Ayala, Psy.D. APLA and GMHC Email: gayala@apla.org
Crystal Methamphetamine Program	Homegrown Interventions Work Group	gay men and non-gay-identified MSM	Phil Hendricks AIDS Project Los Angeles 3550 Wilshire Boulevard, Suite 300 Los Angeles, CA 90010 E-mail: phendricks@apla.org Phone: (213) 201-1308
The G.U.Y.S. (Guys Understanding Your Situation) Program	Homegrown Interventions Work Group	gay men and non-gay-identified MSM, men who have sex with multiple genders	Cathy J. Reback, Ph.D (323) 463-1601 E-mail: Rebackcj@aol.com Catherine Branson, MPH E-mail: katie@vnpd.org Phone: (323) 463-1601
Personalized Cognitive Risk-Reduction Counseling (with optional sex diary)	CDC Best-Evidence Interventions	Gay men and non-gay-identified MSM who are HIV seronegative and have undergone repeat HIV testing	Dr. James W. Dilley, Executive Director AIDS Health Project University of California, San Francisco' PO Box 0884 San Francisco, CA 94143-0884 E-mail: jdilley@itsa.ucsf.edu
HIV Outreach and Testing with Non-gay Identified African American MSM	Universitywide AIDS Research Program	Gay men and non-gay-identified MSM, African American	Edward Mamary, Ph.D. San Jose State University Phone: 408-924-2986
HIV Prevention for Men on the Down Low	Universitywide AIDS Research Program	Gay men and non-gay-identified MSM, African American	Carla Dillard Smith CAL-PEP 1755 Broadway 5th Floor Oakland, CA 94612 Phone: 510.874.7850 Fax: 510.839.6775
HIV Translation Research for Young African American MSM	Universitywide AIDS Research Program	Gay men and non-gay-identified MSM, African American	Susan Kegeles, Ph.D. UCSF E-mail: susan.kegeles@ucsf.edu Phone: 415-597-9159

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
Network to Reduce Negative Impact of Methamphetamine Use in Latino MSM	Universitywide AIDS Research Program	Gay men and non-gay-identified MSM, meth users	Rafael Diaz, Ph.D. Center for Community ResearchSan Francisco State University 3004 16th St., Suite 301 San Francisco, CA 94103 Phone: 415-522-5808 Fax: 415-522-5899 E-mail: rmdiaz@sfsu.edu
Getting Off: A behavioral treatment intervention for gay and bisexual male methamphetamine users	UCLA Integrated Substance Abuse Programs	Gay men and non-gay-identified MSM, methamphetamine users	Cathy J. Reback, Ph.D. 1419 North La Brea Blvd. Los Angeles, CA 90028 E-mail: rebackcj@aol.com
Many Men Many Voices	UT Southwestern Prevention Toolbox, AED DEBI	Gay men and non-gay-identified MSM of Color, men of Color who have sex with multiple genders	The Center for Health and Behavioral Training 691 St. Paul St., 4th floor Rochester, New York 14605 E-mail: www.urmc.rochester.edu/chb Phone: 585-530-4382
Mpowerment	UT Southwestern Prevention Toolbox, AED DEBI	Gay men and non-gay-identified MSM, men who have sex with multiple genders Youth, 18-29yr	Ben Zovod Project Assistant Center of AIDS Prevention Studies University of California, San Francisco 74 New Montgomery, Suite 600 San Francisco, CA 94105 E-mail bzovod@psg.ucsf.edu
Bathhouse-based Voluntary Counseling and Testing	Universitywide AIDS Research Program	Gay men and non-gay-identified MSM, men who have sex with multiple genders	David Huebner, Ph.D., M.P.H., UCSF Phone: 415-597-8122 E-mail: david.huebner@ucsf.edu
African American Men's Health Study	UCSF Center for AIDS Prevention Studies	Gay men and non-gay-identified MSM, men who have sex with multiple genders African American	Order Intervention Kits at http://www.socio.com/pasha/haprogms.htm
Brother to Brother - Hot, Healthy and Safe	HIV/AIDS Prevention Program Archive	Gay men and non-gay-identified MSM, men who have sex with multiple genders African American	Order Intervention Kits at http://www.socio.com/pasha/haprogms.htm
Hot, Healthy and Keeping It Up	HIV/AIDS Prevention Program Archive	Gay men and non-gay-identified MSM, men who have sex with multiple genders Asian/Pacific Islander	Order Intervention Kits at http://www.socio.com/pasha/haprogms.htm
PROMISE	UT Southwestern Prevention Toolbox, AED DEBI	Gay men and non-gay-identified MSM, men who have sex with multiple genders, SIP, women, Youth, African American	Center on AIDS and Community Health (AED) E-mail: interventions@aed.org Phone: (800) 462-9521 (202) 884-8712 TTY: 800-434-3652

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
Adapting Evidence-Based Drug Treatment Interventions for Use as HIV Prevention with Gay and Bisexual Male Methamphetamine Users	Universitywide AIDS Research Program	Gay men and non-gay-identified MSM, men who have sex with multiple genders Meth users	Cathy J. Reback, Ph.D (323) 463-1601 E-mail: Rebackcj@aol.com
Partners in Prevention	UT Southwestern Prevention Toolbox	Gay men and non-gay-identified MSM, women	Medical College of Wisconsin Center for AIDS Intervention Research (CAIR) Department of Psychiatry and Behavioral Medicine Medical College of Wisconsin 1204 North Prospect Avenue Milwaukee, Wisconsin 53202 Phone: 414.456.7700
Strengthening the Circle	Homegrown Interventions Work Group	Native American Gay Men	Elton Naswood, Project Coordinator The Red Circle Project AIDS Project Los Angeles 3550 Wilshire Blvd. Ste. #300 Los Angeles, Ca 90010 Phone: (213) 201-1598 Fax: (213) 201-1598 E-mail: enaswood@apla.org

■ Men: African American Gay Men and Non-Gay Identified MSM

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
The NIA Outreach	Homegrown Interventions Work Group	African American Gay men and non-gay identified MSM	In The Meantime Men's Group, Inc. PO Box 29861 Los Angeles, Ca 90029-0861
RISE (Rewriting Inner Scripts)	Homegrown Interventions Work Group	HIV+, Gay men and non-gay identified MSM, African American	Kip Castner, MPP Act Deputy Chief, Center for Prevention Maryland AIDS Administration 500 North Calvert St. 5th floor, Baltimore, MD 21202 Phone: (410) 767-5290 Fax: (410) 333-6333
Faith-Based HIV Prevention for African American MSM	Universitywide AIDS Research Program	Gay men and non-gay identified MSM, African American	Susan Kegeles, Ph.D. UCSF Email: susan.kegeles@ucsf.edu Phone: 415-597-9159
HIV Outreach and Testing with Non-gay Identified African American MSM	Universitywide AIDS Research Program	Gay men and non-gay identified MSM, African American	Edward Mamary, Ph.D. San Jose State University Phone: 408-924-2986
HIV Prevention for Men on the Down Low	Universitywide AIDS Research Program	Gay men and non-gay identified MSM, African American	Carla Dillard Smith CAL-PEP 1755 Broadway 5th Floor Oakland, CA 94612 Phone: 510.874.7850 Fax: 510.839.6775
HIV Translation Research for Young African American MSM	Universitywide AIDS Research Program	Gay men and non-gay identified MSM, African American	Susan Kegeles, Ph.D. UCSF Email: susan.kegeles@ucsf.edu Phone: 415-597-9159
African American Men's Health Study	UCSF Center for AIDS Prevention Studies	Gay men and non-gay-identified MSM, men who have sex with multiple genders African American	Order Intervention Kits at http://www.socio.com/pasha/haprogms.htm
Brother to Brother - Hot, Healthy and Safe	HIV/AIDS Prevention Program Archive	Gay men and non-gay-identified MSM, men who have sex with multiple genders African American	Order Intervention Kits at http://www.socio.com/pasha/haprogms.htm
PROMISE	UT Southwestern Prevention Toolbox, AED DEBI	Gay men and non-gay identified MSM, men who have sex with multiple genders, SIP, women, Youth, African American	Center on AIDS and Community Health (AED) E-mail: interventions@aed.org Phone: (800) 462-9521 (202) 884-8712 TTY: 800-434-3652

■ Men: Men who have Sex with Men and Multiple Genders

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
The G.U.Y.S. (Guys Understanding Your Situation) Program	Homegrown Interventions Work Group	Gay men and non-gay identified MSM, Men who have sex with multiple genders	Cathy J. Reback, Ph.D Phone: (323) 463-1601 E-mail: Rebackcj@aol.com Catherine Branson, MPH E-mail: katie@vnpd.org Phone: (323) 463-1601
Many Men Many Voices	UT Southwestern Prevention Toolbox, AED DEBI	Gay men and non-gay identified MSM of Color, Men who have sex with multiple genders	The Center for Health and Behavioral Training 691 St. Paul St., 4th floor Rochester, New York 14605 Email: www.urmc.rochester.edu/chb Phone: 585-530-4382
Mpowerment	UT Southwestern Prevention Toolbox, AED DEBI	Gay men and non-gay identified MSM, Youth, 18-29yr, Men who have sex with multiple genders	Ben Zovod Project Assistant Center of AIDS Prevention Studies University of California, San Francisco 74 New Montgomery, Suite 600 San Francisco, CA 94105 E-mail: bzovod@psg.ucsf.edu
Bathhouse-based Voluntary Counseling and Testing	Universitywide AIDS Research Program	Gay men and non-gay identified MSM, Men who have sex with multiple genders	David Huebner,, Ph.D., M.P.H. UCSF E-mail: david.huebner@ucsf.edu Phone: 415-597-8122
African American Men's Health Study	UCSF Center for AIDS Prevention Studies	Gay men and non-gay identified MSM, African American, Men who have sex with multiple genders	Order Intervention Kits at http://www.socio.com/pasha/haprogms.htm
Brother to Brother - Hot, Healthy and Safe	HIV/AIDS Prevention Program Archive	Gay men and non-gay identified MSM, African American, Men who have sex with multiple genders	Order Intervention Kits at http://www.socio.com/pasha/haprogms.htm
Hot, Healthy and Keeping It Up	HIV/AIDS Prevention Program Archive	Gay men and non-gay identified MSM, Asian/Pacific Islander, Men who have sex with multiple genders	Order Intervention Kits at http://www.socio.com/pasha/haprogms.htm
PROMISE	UT Southwestern Prevention Toolbox, AED DEBI	Gay men and non-gay identified MSM, IDU, WSR, Youth, African American, Men who have sex with multiple genders	Center on AIDS and Community Health (AED) E-mail: interventions@aed Phone: (800) 462-9521 (202) 884-8712 TTY: 800-434-3652
Adapting Evidence-Based Drug Treatment Interventions for Use as HIV Prevention with Gay and Bisexual Male Methamphetamine Users	Universitywide AIDS Research Program	Gay men and non-gay identified MSM, Meth users, Men who have sex with multiple genders	Cathy J. Reback, Ph.D (323) 463-1601 E-mail: Rebackcj@aol.com

■ Women

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
Project FIO (The Future Is Ours)	CDC Best-Evidence Interventions	Heterosexual women in family planning clinics	Dr. Anke A. Ehrhard HIV Center for Clinical and Behavioral Studies 1051 Riverside Drive New York State Psychiatric Institute Unit 15 New York, NY 10032 E-mail: ehrharda@child.cpmc.columbia.edu
Focus on Kids (FOK) and Informed Parents and Children Together (ImPACT)	CDC Best-Evidence Interventions ETR Associates, 4 Carbonero Way, Scotts Valley CA 95066-4200 (http://pub.etr.org/ProductDetails.aspx?prodid=R565).	High-risk African American youth living in low-income urban community sites	Dr. Bonita F. Stanton Department of Pediatrics Children's Hospital of Michigan Suite 1k40 Wayne State University 3901 Beaubien St. Detroit, MI 48201 E-mail: bstanton@dmc.org or Dr. Jennifer Galbraith Centers for Disease Control and Prevention 1600 Clifton Road Mailstop E-37 Atlanta, GA 30333 E-mail: jgalbraith@cdc.gov DEBI Technical Monitor Winifred King Phone: (404) 639 0892 E-mail: WKing@cdc.gov
Healthy Relationships	UT Southwestern Prevention Toolbox, AED DEBI	HIV+ women , HIV+ Gay men and non-gay identified MSM	Anne Freeman, MS Division of Community Outreach Department of Health Care Science School of Allied Health Sciences UT Southwestern Medical Center at Dallas 400 S. Zang, Suite 520 Dallas, TX 75208 305 E-mail: anne.freeman@utsouthwestern.edu Phone: (214) 645-7305
Partnership for Health	UT Southwestern Prevention Toolbox	HIV+, men, women	Maggie Hawkins Partnership for Health Program Pacific AIDS Education & Training Center 1441 Eastlake Avenue, Suite 3412 Keck School of Medicine University of Southern California Los Angeles, CA 90089-9175 E-mail: margareh@usc.edu Phone: (323) 865-0343 (323) 865-0134
Nursing Intervention to Improve Antiviral Adherence	Yale University Center for Interdisciplinary Research on AIDS	HIV+, women	Ann B. Williams, R.N.C., Ed.D. Professor Yale School of Nursing Yale Center for Interdisciplinary Research on AIDS 40 Temple St. Suite 1B New Haven, CT 06510 E-mail: ann.williams@yale.edu Phone: (203) 737-2350

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
Female- & Culturally-Specific Negotiation	CDC Best-Evidence Interventions	Inner city, HIV-negative, heterosexually active, African-American female drug injectors and crack cocaine smokers	Dr. Claire Sterk Emory University Rollins School of Public Health Department of Behavior Sciences and Health Education 1518 Clifton Road N.E. Atlanta, GA 30322 Email: csterk@esph.emory.edu
Communal Effectance-AIDS Prevention	CDC Best-Evidence Interventions	Low income, single, inner-city females attending urban clinics	Dr. Steven E. Hobfoll Applied Psychology Center Kent State University Kent, OH 44242 E-mail: shobfoll@kent.edu
CHOICES	CDC Best-Evidence Interventions	Low-income heterosexually-active women	Dr. Blair Beadnell University of Washington School of Social Work 4101 15th Avenue, NE Seattle, WA 98105 E-mail: blairb@u.washington.edu
Project SAFE (Standard Version)	CDC Best-Evidence Interventions	Mexican-American and African-American women diagnosed with gonorrhea, chlamydia, syphilis, or trichomonas in public health clinics	Dr. Rochelle Shain Department of OB/GYN, University of Texas Health Science Center at San Antonio 7703 Floyd Curl Drive San Antonio, TX 78229 E-mail: shain@uthscsa.edu
Project Connect (Couple or Woman-alone)	CDC Best-Evidence Interventions	Minority, inner-city heterosexual couples	Dr. Nabila El-Bassel Social Intervention Group Columbia University School of Social Work 622 West 113th Street Box 713 New York, NY 10025 E-mail: ne5@columbia.edu
PROMISE	UT Southwestern Prevention Toolbox, AED DEBI	Gay men and non-gay identified MSM, men who have sex with multiple genders, SIP, women, Youth, African American	Center on AIDS and Community Health (AED) E-mail: interventions@aed.org Phone: (800) 462-9521 or (202) 884-8712 TTY: 800-434-3652
Partners in Prevention	UT Southwestern Prevention Toolbox	Gay men and non-gay identified MSM, women	Medical College of Wisconsin Center for AIDS Intervention Research (CAIR) Department of Psychiatry and Behavioral Medicine Medical College of Wisconsin 1204 North Prospect Avenue Milwaukee, Wisconsin 53202 Phone: (414) 456-7700
Sistering, Informing, Healing, Living, and Empowering (SiHLE)	CDC Best-Evidence Interventions	Sexually experienced African American adolescent girls	Dr. Ralph J. DiClemente Rollins School of Public Health Department of Behavioral Sciences and Health Education 1518 Clifton Road NE, Room 554 Atlanta, GA 30322 E-mail: rdiclem@sph.emory.edu DEBI Technical Monitor Cynthia Prather Phone: (404) 639-5234 E-mail: CPrather@cdc.gov

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
Women Involved in Life Learning from Other Women (WiLLOW)	CDC Best-Evidence Interventions	Sexually-active, female clinic patients living with HIV	Dr. Gina M. Wingood Rollins School of Public Health Emory University 1518 Clifton Road, NE, BSHE/Room 556 Atlanta, GA 30322 E-mail: gwingoo@sph.emory.edu DEBI Technical Monitor Cynthia Prather Phone: (404) 639 5234 E-mail: CPrather@cdc.gov
Real AIDS Prevention Project (RAPP)	UT Southwestern Prevention Toolbox, AED DEBI	Women	Center on AIDS and Community Health (AED) E-mail: interventions@aed.org Phone: (800) 462-9521 or (202) 884-8712 TTY: 800-434-3652
Enhancing Motivation	UT Southwestern Prevention Toolbox	Women, African American	Michael P. Carey Department of Psychology 430 Huntington Hall Syracuse University Syracuse, NY 13244-2340 E-mail: mpcarey@syr.edu
SISTA Project	UT Southwestern Prevention Toolbox, AED DEBI	Women, African American	Center on AIDS and Community Health (AED) E-mail: interventions@aed.org Phone: (800) 462-9521 or (202) 884-8712 TTY: 800-434-3652
Voices/Voces	UT Southwestern Prevention Toolbox, AED DEBI	Women, African American, Latinas, Heterosexual Men	Center on AIDS and Community Health (AED) E-mail: interventions@aed.org Phone: (800) 462-9521 or (202) 884-8712 TTY: 800-434-3652
Project SAFE (Sexual Awareness for Everyone)	UT Southwestern Prevention Toolbox	Women, Latinas and African American Women	Dallas STD/HIV Behavioral Intervention Training Center UT Southwestern Medical Center at Dallas 400 S. Zang, Suite 520 Dallas, Texas 5208 Phone: 214.645.7353 Fax: 214.645.7303

■ Transgender Individuals

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
Peer-based HIV Prevention Among Injection Drug Users and Satellite Syringe Exchangers in California	Universitywide AIDS Research Program	SIP, men, women, gay men and non-gay identified MSM, transgenders	Tom Stopka, Research Scientist HIV Prevention Research and Evaluation Section California Department of Health Services Office of AIDS 611 North 7th Street, Suite A Sacramento, CA 95814 Phone: 916-323-7419 Fax: 916-322-2206 Email: tstopka@dhs.ca.gov
Asian Pacific AIDS Intervention Team	Homegrown Interventions Work Group	Transgender Women	n/a
HIV Prevention Case Management for High-Risk Transgender Women	Universitywide AIDS Research Program	Transgender Women	Cathy J. Reback, Ph.D (323) 463-1601 E-mail: Rebackcj@aol.com

■ Youth (12-24 years)

INTERVENTION NAME	LISTED IN OR RECOMMENDED BY	POPULATION(S)	CONTACT INFORMATION
Clinician-Initiated Prevention for HIV Positives (aka Options/Opciones Project)	Center for Health, Intervention and Prevention	HIV+ persons 18 years and older	Center for Health, Intervention, and Prevention (CHIP) University of Connecticut 2006 Hillside Road, Unit 1248 Storrs, CT 06269 Phone: 860 486-5917 Fax: 860 486-4876
Together Learning Choices (formerly Teens Linked to Care)	UT Southwestern Prevention Toolbox, AED DEBI	HIV+ Youth, aged 13-29 years	Center on AIDS and Community Health (AED) E-mail: interventions@aed.org Phone: (800) 462-9521 or (202) 884-8712 TTY: 800-434-3652
Mpowerment	UT Southwestern Prevention Toolbox, AED DEBI	Gay and Non-gay identified MSM Youth, 18-29yr	Ben Zovod Project Assistant Center of AIDS Prevention Studies University of California, San Francisco 74 New Montgomery, Suite 600 San Francisco, CA 94105 E-mail: bzovod@psg.ucsf.edu
PROMISE	UT Southwestern Prevention Toolbox, AED DEBI	Gay and non-gay identified MSM, SIP, women, Youth, African American	Center on AIDS and Community Health (AED) E-mail: interventions@aed.org Phone: (800) 462-9521 or (202) 884-8712 TTY: 800-434-3652
Sistering, Informing, Healing, Living, and Empowering (SiHLE)	CDC Best-Evidence Interventions	Sexually experienced African American adolescent girls	Dr. Ralph J. DiClemente Rollins School of Public Health Department of Behavioral Sciences and Health Education 1518 Clifton Road NE, Room 554 Atlanta, GA 30322 E-mail: rdiclem@sph.emory.edu DEBI Technical Monitor Cynthia Prather Phone: (404) 639-5234 E-mail: CPrather@cdc.gov
Rikers Health Advocacy Program (RHAP)	UT Southwestern Prevention Toolbox	Incarcerated populations, IDU male, 16-19yrs	Program Archive on Sexuality, Health, and Adolescents (PASHA) Sociometrics Corporation 170 State Street, Suite 260 Los Altos, CA 94022-2812

Attachment E: Description of CDC's Best Evidence Interventions & EBIs

❖ CDC'S COMMUNITY-LEVEL INTERVENTIONS (EBIs)

Community-level interventions seek to alter attitudes, norms, and values of an entire community and/or target population as well as their social and environmental context of risk behaviors.

1. ***Community Peers Reaching Out and Modeling Intervention Strategies (PROMISE)***
   Community PROMISE is a community level HIV/STD prevention intervention that relies on role model stories and peer advocates from the community. Community PROMISE begins with a community identification process to collect and analyze information about the community, including HIV/STD risk behaviors and influencing factors, to help agencies identify target populations and appropriately tailor the intervention. Members of the target population who have made positive HIV/STD behavior change are interviewed and role models stories are written based upon the interviews. The stories are personal accounts about how and why they took steps to practice HIV/STD prevention behaviors and the resulting positive effects on their lives. Peers advocates from the target populations are recruited and trained to distribute the role model stories and prevention materials within their social networks.

THEORETIC BASIS	• Stages of Change

2. ***Popular Opinion Leader (POL)***
   POL is a community-level intervention designed to identify, enlist, and train opinion leaders to encourage safer sexual norms and behaviors within their peer social networks through risk reduction conversations. The program teaches skills for initiating HIV risk reduction messages to friends and acquaintances. It also teaches POLs characteristics of effective behavior change communication messages targeting risk-related attitudes, norms, intentions, and self-efficacy. In conversations, POLs personally endorse the benefits of safer behavior and recommend practical steps needed to implement change.

THEORETIC BASIS	• Diffusion of Innovation

3. ***Real AIDS Prevention Program (RAPP)***
   RAPP was developed to help women and their partners reduce their risk for HIV infection. The intervention objectives are to increase consistent condom use by women and their partners, to change community norms so that practicing safer sex is seen as the acceptable norm, and to involve as many people in the community as possible. The program has two phases: (1) community assessment, which involves finding out about the community and how to talk to women and their partners about their risk for HIV infection, and (2) getting the community involved in a combination of risk reduction activities directed toward these women and their partners.

THEORETIC BASIS	• Stages of Change • Diffusion of Innovation • Social Learning Theory

4. MPowerment

The Mpowerment Project was developed by and for young gay man ages 18-29. The intervention is run by a core group of 10-15 paid and volunteer young gay men from the community. The young gay men, along with other volunteers, design and carry out all project activities. Ideally, the project has its own physical space where most social events and meetings are held and which serves as a drop-in center where young men can meet and socialize during specified hours. The program relies on a set of four integrated activities: (1) formal outreach, (2) M-groups, (3) informal outreach, and (4) ongoing publicity campaign.

THEORETIC BASIS	• Diffusion of Innovation • Empowerment Theory

❖ *CDC INDIVIDUAL-LEVEL INTERVENTIONS (BEST-EVIDENCE)*

1. Choosing Life: Empowerment, Actions, Results (CLEAR)

CLEAR is a 3-module intervention focusing on different target behaviors. Module 1 focuses on improving youths' physical health, including the use of and adherence to antiretroviral medication, implementing new daily routines to stay healthy, and coping with their serostatus. Module 2 aims to reduce unprotected sex acts and substance use through the identification of situations that elicit risky behavior. In this module, youth build skills in condom use self-efficacy and negotiation of safer sex. Module 3 aims to reduce emotional distress and to increase quality of life of participants. Each participant is taught relaxation, self-instruction and meditation techniques in order to control negative emotional states. Participants also identify long-term life goals in this module.

THEORETIC BASIS	• Cognitive Behavior Therapy • Social Action Theory
SESSIONS	• 18 sessions total (6 sessions per module) • Each session lasts 1.5 hours

2. EXPLORE

Explore is a ten session intervention. The first 3 core counseling sessions are intended to establish rapport between the counselor and the participant, and to provide personalized risk assessments. The remaining 7 sessions cover topics such as sexual communication, knowledge of personal and others' HIV serostatus when making sexual decisions, and the role of alcohol and drug use in risk behavior. Sessions also address coping with triggers of unsafe sex and skills needed to modify risky behavior. Motivational interviewing is used to help participants make and sustain knowledge, attitude, belief and behavior changes. Maintenance counseling booster sessions are delivered every 3 months after the initial 10 sessions.

THEORETIC BASIS	• Information-Motivation-Behavior Skill model • Motivational Enhancement • Social Learning Theory
SESSIONS	• 10 core counseling sessions; 7 booster sessions • Each core counseling session lasts 1 hour

3. Female and Culturally Specific Negotiation

The *Enhanced Negotiation* intervention focuses on the social context of women's daily lives. The intervention explores the meaning of gender-specific behaviors and social interactions, norms and values, and power and control. The intervention emphasizes the local HIV epidemic, sex- and drug-related risk behaviors, HIV risk reduction strategies, and the impact of race and gender on HIV risk and protective behaviors. Intervention sessions teach women correct condom use, safer injection, and communication and assertiveness skills. Women develop and evaluate their short-term goals for communication, gaining control, and developing assertiveness. Women learn to identify unhealthy triggers that can lead them to deviate from their goals and to develop a tailored negotiation and conflict resolution style.

THEORETIC BASIS	• Theory of Gender and Power • Theory of Planned Behavior • Theory of Reasoned Actions • Social Cognitive Theory • Transtheoretical Model of Change
SESSIONS	• 4 sessions • 20-40 minutes each

4. Modelo de Intervención Psicomedica (MIP)

MIP is an intervention designed to support risk reduction behaviors by increasing the participant's perception of his/her personal risks and by emphasizing incremental risk reduction strategies. The intervention is done on a one-on-one approach using teachable moments to motivate participants to change risk-taking behaviors.

THEORETIC BASIS	• Miller's Motivational Interviewing Model
SESSIONS	• 6 weekly sessions with ongoing case management

5. Personalized Cognitive Risk Reduction Counseling

This intervention involves a single counseling session delivered to clients during the 1- to 2-week period between standard "pre-test" (risk-assessment) and "post-test" (results disclosure) HIV counseling. During the session, counselors ask the client to recall a recent encounter of unprotected anal sex with another man of unknown or serodiscordant HIV status. The client describes the encounter with as much detail as possible. The client is then encouraged to identify and express the thoughts, feelings, or attitudes that might have led to the high-risk behavior. Together, the client and the counselor examine the encounter to identify any thoughts that may have led the client to make a decision to engage in high transmission risk sex. Finally, the client and the counselor agree on strategies that can be used to deal with similar situations in the future.

THEORETIC BASIS	• Gold's model of "on-line" vs. "off-line" self-appraisal of risk behavior • Model of Relapse Prevention
SESSIONS	• 1 session • 1 hour

6. Project Connect

An initial orientation session is delivered one-on-one to each woman and her partner. The orientation session increases participants' motivation for attendance, heightens risk awareness, and prepares participants for the intervention. The 5 relationship-based sessions are delivered to intact intimate couples (i.e., a woman and her regular male sex partner). These sessions emphasize the importance of relationship communication, safer sex negotiation and problem solving skills. The sessions also highlight how relationship dynamics are affected by gender roles and how social supports can help maintain safer sex behavior.

THEORETIC BASIS	• AIDS Risk Reduction Model • Bronfenbrenner's Ecological Perspective
SESSIONS	• 6 sessions over 2 weeks • 2 hours

7. Project S.A.F.E.

Project S.A.F.E. is an STD counseling and treatment with repeated HIV testing sessions. The intervention may be done at an individual or group level. The intervention teaches participants risk reduction skills and enhances skill development and skill application by providing a social support group.

THEORETIC BASIS	• AIDS Risk Reduction Model
SESSIONS	• 3 sessions over 3 weeks • 3 hours each session

8. RESPECT (Brief)

There are two *RESPECT* interventions – *Brief Counseling* (Best-evidence) and *Enhanced Counseling* (Promising-evidence). Both are one-on-one, client-focused HIV/STD prevention counseling interventions, consisting of either 2 (*Brief*) or 4 (*Enhanced*) interactive counseling sessions. In the first of both *Brief* and *Enhanced Counseling* interventions, HIV counselors help STD clinic patients to identify personal risk factors and barriers to risk reduction and work with patients to develop an achievable personalized risk-reduction plan. HIV-antibody testing is offered at the end of the first session. The second session of the *Brief Counseling* intervention includes a discussion of the HIV test result and additional counseling to support patient-initiated behavior change and help patients develop a longer-term risk-reduction plan. Patients in the *Enhanced Counseling* intervention receive three weekly 60-minutes counseling sessions in addition to the first session. The additional sessions address condom use attitudes, social norms and support for condom use, build condom use self-efficacy, discuss prior week's behavior change success and barriers, and develop a strategy for taking a risk-reduction step before the next session. HIV test result is given at the end of the third session and a longer-term personalized risk reduction plan is developed at the last session.

THEORETIC BASIS	• Social Cognitive Theory • Theory of Reasoned Action
SESSIONS	• Brief: 2 sessions • 20 minutes each over 7-10 days

9. RESPECT (Brief + booster session)

RESPECT is an intervention designed to support risk reduction behaviors by increasing the participant's perception of his/her personal risks and by emphasizing incremental risk reduction strategies. The intervention is done on a one-on-one approach using teachable moments to motivate participants to change risk-taking behaviors.

THEORETIC BASIS	• Cognitive Behavior Therapy • Social Action Theory • Motivational interviewing principles
SESSIONS	• 2 sessions of 20 minutes one week apart • 1 booster session of 20 minutes after 6 months

10. Sister to Sister: One on One Skills Building Format

Sister-to-Sister has two formats – group and One-on one. These Skills-building interventions are culturally-sensitive, gender-appropriate, single-session interventions developed to increase self-efficacy and skills to use condoms correctly and to negotiate condom use with sex partners. The interventions encourage women to respect and protect themselves, not only for their own sake, but also for their family and community. The interventions are delivered by female African-American nurses. One-on-one format involves video viewing, condom demonstration, practice with an anatomical model, and role playing to increase self-efficacy and skills to negotiate condom use.

THEORETIC BASIS	• Social Cognitive Theory
SESSIONS	• 1 session • 20 minutes

11. STD/AIDS Risk Reduction Trial (START)

In the first in-prison session, the educator assesses the participant's knowledge of HIV/AIDS, STD, and hepatitis, conducts a brief HIV-risk assessment, and helps the participant develop a personal risk-reduction plan. The educator also provides information, skills training, and referrals and helps to identify incremental steps towards risk reduction. The second in-prison session focuses on community reentry needs and referrals for housing, employment, finances, substance abuse, mental treatment, legal issues, and avoiding re-incarceration. The post-release sessions involve a review of the previous sessions and discussion of the facilitators and barriers to implementing the risk reduction plan.

THEORETIC BASIS	• Not explicitly stated
SESSIONS	• 2 sessions pre-release of 60-90 minutes each • 4 sessions post-release of 30-60 minutes

12. Women's Co-Op

The *Women's Co-Op* is a woman-focused intervention that incorporates gender- and culture-specific skills training for crack-using African American women. The first 2 sessions are delivered to women individually, and focus on pre- and post-test counseling for HIV. Session 1 includes a personal HIV risk assessment, and provides women with skills training on condom and dental dam use and syringe cleaning. Session 2 includes

receipt of HIV test results, the development of an individualized risk assessment plan, and a repeat of the skills training from Session 1. The final 2 sessions are delivered to small groups of 2 to 5 women, and use a support-based format to help women develop skills that can reduce their risk of HIV. These sessions include the development of communication and problem solving skills that increase women's sense of power and ability to cope with stress.

THEORETIC BASIS	• African American Feminism • Empowerment Theory
SESSIONS	• 4 sessions • First 2 individual sessions last 30-40 minutes; Last two group sessions last 60-90 minutes

❖ *CDC-VALIDATED GROUP-LEVEL INTERVENTIONS*

1. Becoming a Responsible Teen (BART)

Becoming a Responsible Teen (BART) is a group-level, education and behavior skills training intervention designed to reduce risky sexual behaviors and improve safer sex skills among African American adolescents. The 8 intervention sessions, delivered to groups of 5-15 youth, provide information on HIV and related risk behaviors and the importance of abstinence and risk reduction. The sessions were designed to help participants clarify their own values and teach technical, social, and cognitive skills. Through discussions, games, videos, presentations, demonstrations, role plays, and practice, adolescents learn problem solving, decision-making, communication, condom negotiation, behavioral self-management, and condom use skills. The participants also have a discussion with local, HIV-positive youth to promote risk recognition and improve their perception of vulnerability. In addition, the intervention encourages participants to share the information they learn with their friends and family and to provide support for their peers to reduce risky behaviors.

THEORETIC BASIS	• Information Motivation Behavior Model • Social Learning Theory
SESSIONS	• 8 sessions • 90-120 minutes over 8 weeks

2. Be Proud! Be Responsible!

Be Proud! Be Responsible! is a small group skills building and motivational intervention to increase knowledge of AIDS and sexually transmitted diseases (STDs) and to reduce positive attitudes and intentions toward risky sexual behaviors among African-American male adolescents. The intervention consists of one 5-hour session delivered to groups of 5-6 males. The intervention includes facts about HIV/AIDS and risks associated with intravenous drug use and sex behaviors; clarifies myths about HIV; and helps adolescents realize their vulnerability to AIDS and STDs. Videos, games, exercises, and other culturally and developmentally appropriate materials are used to reinforce learning and build a sense of pride and responsibility in reducing HIV risk. Adolescents also engage in role-playing situations to practice implementing abstinence and other safer sex practices, including practicing condom use skills.

THEORETIC BASIS	• Social Cognitive Theory • Theory of Reasoned Action • Theory of Planned Behavior
SESSIONS	• 1 session • 5 hours

3. Brief Group Counseling

The *Brief Group Counseling* intervention is a group-level counseling and skills training intervention for homosexual API men. The intervention, delivered to groups of approximately 8 men, consists of one 3-hour culturally tailored session with four key components: (1) development of positive self identity and social support; (2) safer sex education; (3) promoting positive attitudes toward safer sex; and (4) negotiating safer sex. HIV transmission facts and correct use of a condom are presented. An interactive game is used to discuss risks associated with different types of sexual partners. Participants also engage in group discussion about negative experiences associated with being API and with being homosexual, feelings toward safer sex, as well as ways to build support around their self image and personal strengths. The participants build safe-sex negotiation skills through role play and demonstrations.

THEORETIC BASIS	• Health Belief Model • Theory of Reasoned Action • Social Cognitive Theory
SESSIONS	• 1 session • 3 hours

4. CHOICES

Choices is a small-group (5-10 women), skills training intervention designed to reduce STD infections and risky sex behaviors of women at risk for STDs, including HIV. The intervention focuses on skills that emphasize initial behavior change as well as the maintenance of behavior change over time. Motivational and decision-making exercises help women choose safer sex strategies best suited to their circumstances; and skill building exercises, using role plays, teach how to implement these exercises successfully. Skills include using condoms correctly, negotiating safe sex with their partners, and creating lifestyle balance. The intervention also encourages women to evaluate their relationship choices, and explore how those choices affect their health and well being. The intervention involves identifying, enlisting, and training key opinion leaders to encourage safer sexual norms and behaviors within their social networks through risk-reduction behaviors.

THEORETIC BASIS	• Relapse Prevention Model
SESSIONS	• 16 sessions • 2 hours each; weekly

5. Communally Effectance-AIDS Prevention

The *Communal Effectance - AIDS Prevention* intervention is a small group (3-6 women) intervention that emphasizes negotiation skills training and the idea that women's sexual behavior not only affects themselves but also those around them. Women are taught to protect themselves from HIV infection through cognitive rehearsals, role plays,

discussions, and interactive videos. The intervention sessions provide women with general HIV and AIDS prevention information, and instructs women how drugs and alcohol can lead to risky sex behaviors. The sessions also teach condom use skills and how to take control of sexual encounters. Women are also taught skills on how to refuse unwanted sexual propositions and how to negotiate sexual safety with their partners. The final 3 sessions emphasize the maintenance of behavior change, review skills and techniques discussed in earlier sessions, and focus on relapse prevention.

THEORETIC BASIS	• Social Learning Theory • Theory of Gender and Power • Conservation of Resources Theory
SESSIONS	• 6 sessions • 1.5-2 hours; spread over 2-3 months

6. ¡Cuídate! (Take Care of Yourself)

¡Cuídate! is a small-group, culturally based intervention to reduce HIV sexual risk among Latino youth. The intervention consists of six 60-minute modules delivered to small, mixed-gender groups. *¡Cuídate!* incorporates salient aspects of Latino culture, including familialism (i.e., the importance of family) and gender-role expectations (i.e., *machismo, which is described as the man's responsibility in caring for and protecting one's partner and family*). These cultural beliefs are used to frame abstinence and condom use as culturally accepted and effective ways to prevent sexually transmitted diseases, including HIV. Through the use of role plays, videos, music, interactive games and hands-on practice, *¡Cuídate!* addresses the building of HIV knowledge, understanding vulnerability to HIV infection, identifying attitudes and beliefs about HIV and safe sex, and increasing self-efficacy and skills for correct condom use, negotiating abstinence, and negotiating safer sex practices. The intervention curriculum is available in English and Spanish.

THEORETIC BASIS	• Social Cognitive Theory • Theory of Planned Behavior • Theory of Reasoned Action
SESSIONS	• 6 sessions • 60 minutes each; over 2 consecutive Saturdays

7. FOK + ImPACT

FOK+ImPACT is a skill-building intervention to reduce substance and sex risk behaviors of high-risk youth. The first component, FOK, is an 8-session HIV risk reduction intervention delivered to small groups of 5-12 youth. The intervention emphasizes decision-making, goal setting, communication, negotiation, and consensual relationships. Through the use of games, discussions, homework, and videos, youth receive information on abstinence and safe sex, drugs, alcohol, drug selling, AIDS and STDs, contraception, and human development. ImPACT, the second component, is a single-session intervention delivered to each youth and his/her parent or guardian. ImPACT begins with a 20-minute video emphasizing parental monitoring and communication. After the video, the parent and youth role-play a vignette where the parent is confronted with evidence of a child's involvement in a sexual relationship. Finally, the youth and parent are taught and practice correct condom use.

THEORETIC BASIS	• Protection Motivation Theory
SESSIONS	• 8 FOK sessions to Youth; 1 ImPACT session to parents • 1.5 hour sessions; weekly

8. Healthy Relationships

Healthy Relationships is a small-group, skills-based behavioral intervention for men and women living with HIV. The intervention focuses on skills building, self-efficacy, and positive expectations about new behaviors. Through group discussions, role plays, videos and skill-building exercises, the intervention helps persons living with HIV develop skills to cope with HIV-related stressors and risky sexual situations. Intervention sessions also enhance decision-making skills for self-disclosing HIV-serostatus to sex partners, and help participants develop and maintain safer sex practices. Participants receive personalized feedback about their own risk practices, and with the help of the intervention group, develop strategies to maintain satisfying relationships while protecting both themselves and their partners. Intervention sessions are conducted separately for men and women in groups of 6-10 participants.

THEORETIC BASIS	• Social Cognitive Theory
SESSIONS	• 5 sessions • 2 hours each; over 2.5 weeks

9. HIP

The *Health Improvement Project (HIP)* intervention is a small group, skills training intervention to reduce risky sex behavior among persons with mental illness. Through interactive group discussions and motivational exercises, the first 4 sessions provide participants the facts about sexual behavior, HIV, and STDs; increase awareness of HIV risk; offer healthy alternatives to unsafe sex; discuss social norms concerning risky and safe sex; and address the benefits and costs of behavior change. Through the use of role plays, the remaining 6 sessions provide participants the skills necessary to use male and female condoms, develop coping strategies to deal with risky situations, and negotiate condom use with sex partners. Standard outpatient psychiatric care—including medication, psychotherapy and case management—is also provided on an ongoing basis.

THEORETIC BASIS	• Information-Motivation Behavioral Skills Model
SESSIONS	• 10 sessions • Over 5 weeks (duration not stated)

10. "light"

"light" is a 7-session, small-group HIV-risk reduction intervention to stimulate motivation for behavior change along with individualized skill building required to accomplish personal HIV-related goals. The intervention covers topics, including HIV/AIDS knowledge, identification and management of triggers for risk acts, problem-solving in risk situations, condom use, interpersonal assertiveness to negotiate safer sex, and maintenance of new behavioral routines. Each session has a focus, but skills are reinforced and practiced throughout the 7 sessions. Each participant practices skills

specific to his or her risk circumstances involving steady partners, casual partners, drug-using partners, and other personally relevant relationships. Goals to reduce risk are set every session and revised at the following session for feedback, review or problem-solving as appropriate. Each session contains scripted role plays and activities to facilitate group interaction and learning. The intervention is delivered to same-sex small groups of 5 to 15 persons twice weekly.

THEORETIC BASIS	• Social Cognitive Theory
SESSIONS	• 7 sessions • 90-120 minutes each; twice weekly

11. Project Connect

The *Project Connect* can be delivered to the couple or the woman alone. The Couples intervention consists of an orientation session and 5 relationship-based sessions delivered to each couple. An initial orientation session is delivered one-on-one to each woman and her partner. The orientation session increases participants' motivation for attendance, heightens risk awareness, and prepares participants for the intervention. The 5 relationship-based sessions are delivered to intact intimate couples (i.e., a woman and her regular male sex partner). These sessions emphasize the importance of relationship communication, safer sex negotiation and problem solving skills. The sessions also highlight how relationship dynamics are affected by gender roles and how social supports can help maintain safer sex behavior. The intervention delivered to each woman alone is identical in content and session format as the Couples intervention.

THEORETIC BASIS	• AIDS Risk Reduction Model • Bronfenbrenner's Ecological Perspective
SESSIONS	• 6 sessions • 2 hours each; over 6 weeks

12. Project FIO (the Future Is Ours)

The interactive sessions allow women to connect with each other by sharing their feelings about relationships with men, values and personal vulnerability. Women learn to understand and personalize their risk for HIV and other STDs, identify barriers to safer sex, and gain practical knowledge about a range of risk-reduction strategies, including male and female condoms and mutual HIV testing. The intervention provides women with the skills necessary to communicate and negotiate safer sex with their partners (including how to identify and respond to abuse in relationships), and how to solve problems to avoid relapses. A single booster session reviews progress and reinforces the skills learned in the intervention in the supportive group environment.

THEORETIC BASIS	• AIDS Risk Reduction Model • Social LearningTheory
SESSIONS	• 8 sessions; 1 booster session • 2 hour sessions over 8 weeks; 2 hour booster after 7 months

13. Project S.A.F.E.

The *Standard SAFE* intervention is a small group, motivational and skill building intervention to reduce risky sexual behaviors and STDs among minority women. The 3 intervention sessions, delivered to groups of 5-6 women, emphasize recognizing risk, increasing commitment to change behavior, and facilitating the acquisition of protective skills. Women participate in group discussions to increase awareness of AIDS and other STDs and prevention methods, address myths of HIV acquisition, increase awareness of personal risk, and discuss relationship issues and barriers to condom use. Women are taught how to ask partners about their current behaviors, apply condoms, and make safer decisions regarding sexual health. Preventive strategies discussed included abstinence, monogamy, correct condom use, and reducing the number of sex partners. Through videotapes, games, discussions and practice, women learn skills to facilitate communication and negotiation of safer sex, raise feelings of self-efficacy in partner selection and communication about condom use, identify triggers to unsafe sex, and encourage the sharing of information with others to build a support network. Standard STD counseling and testing is also provided to everyone by a nurse clinician.

THEORETIC BASIS	• AIDS Risk Reduction Model
SESSIONS	• 3 sessions • 3 hours each; over 3 weeks

14. SHIELD

SHIELD is a small-group, interactive intervention that relies on peer networks to reduce drug and sex risk behaviors. Participants are asked to make public commitments to increase their own health behaviors and to promote HIV prevention among their networks and community contacts. The intervention includes multiple training and skill building sessions that involve setting goals, role plays, demonstrations, and group discussions. In addition, one session occurred in the community and provided a "street outreach" practice session. These sessions teach participants techniques for personal risk reduction and the development of correct condom use and safer sex negotiation skills. The intervention also addresses injection drug use risk and the avoidance of risky situations. To present HIV risk within a broader community context, the intervention emphasizes the interrelatedness of HIV risk among individuals, their risk partners, and their community. Participants are also provided tools and strategies for effective community outreach, and are encouraged to conduct HIV education and become advocates of risk reduction among their sex and drug partners, family and friends, and other community members.

THEORETIC BASIS	• Active learning Theory • Cognitive Consistency Theory • Social Identity Theory • Social Influence Theory • Social Cognitive Theory
SESSIONS	• 10 sessions • 90 minutes each

15. SiHLE

The *SiHLE* intervention is a small group, skills training intervention to reduce risky sex behavior among African-American adolescent females. Through interactive discussions in groups of 10-12 girls, the intervention emphasizes ethnic and gender pride, and enhances awareness of HIV risk reduction strategies such as abstaining from sex, using condoms consistently, and having fewer sex partners. Through the use of role plays and cognitive rehearsal, the intervention enhances confidence in initiating safer-sex conversations, negotiating for safer sex, and refusing unsafe sex encounters. In addition, intervention deliverers model proper condom use skills and emphasize the importance of healthy relationships.

THEORETIC BASIS	• Social Cognitive Theory • Theory of Gender and Power
SESSIONS	• 4 sessions • 4 hours each; on consecutive Saturdays

16. Sisters Saving Sisters

The *Skill-Based HIV/STD Risk-Reduction* intervention is a single-session, small group intervention to reduce risky sexual behaviors and STDs among African American and Latina adolescent girls. This intervention is culturally and developmentally appropriate, and is delivered to groups of 2-10 participants. Through the use of group discussions, videotapes, games and exercises, the intervention addresses beliefs relevant to HIV/STD risk reduction, illustrates correct condom use, and depicts effective condom use negotiation. Participants handle condoms, practice correct use of condoms with anatomical models, and engage in role playing to increase condom use negotiation skills. Participants also learn about their personal vulnerability to HIV, and barriers to condom use including alcohol and drug use.

THEORETIC BASIS	• Theory of Reasoned Action • Theory of Planned Behavior • Social Cognitive Theory
SESSIONS	• 1 session • 250 minutes

17. Sister to Sister: Group Skills Building

Sister-to-Sister includes two skills-building interventions – *Group* (Best-evidence) or *One-on-one* (Best-evidence). These Skills-building interventions are culturally-sensitive, gender-appropriate, single-session interventions developed to increase self-efficacy and skills to use condoms correctly and to negotiate condom use with sex partners. The interventions encourage women to respect and protect themselves, not only for their own sake, but also for their family and community. The interventions are delivered by female African-American nurses and can be delivered to small groups of women (3-5 women) or individuals. Both group and one-on-one formats involve video viewing, condom demonstration, practice with an anatomical model, and role playing to increase self-efficacy and skills to negotiate condom use. The additional activities used in the group format include group discussions, brainstorming, and interactive exercises and games.

THEORETIC BASIS	• Social Cognitive Theory
SESSIONS	• 1 session • 200 minutes

18. SUMIT Enhanced Peer-led

The *SUMIT* enhanced peer-led intervention is delivered to groups of gay or bisexual men living with HIV in order to reduce risky sexual behavior. Led by HIV-seropositive gay or bisexual peer facilitators, structured group activities focus on sexual and romantic relationships, HIV and STD transmission, drug and alcohol use, assumptions about the HIV status of sex partners, disclosure of HIV status, and mental health. Intervention sessions seek to increase knowledge of sex risk practices, increase motivation to adopt reduced risk practices, encourage disclosure of HIV status to partners, promote personal responsibility to prevent HIV transmission, increase awareness of substance use and mental health issues, and encourage identification and management of personal risk triggers. These topics were delivered using audio and video tapes, didactic presentations, and group discussions.

THEORETIC BASIS	• Information-Motivational-Behavioral Skills Model • Social Cognitive Theory • Theory of Planned Behavior
SESSIONS	• 6 sessions • 3 hours each; weekly

19. Voices/VOCES

VOICES/VOCES is a single-session, culturally specific, video-based intervention for STD clinic patients. The small group session (3-8 patients) is gender and ethnic matched and is conducted by a gender-matched facilitator in either English or Spanish. Groups of participants first review one of the culturally appropriate STD prevention videos, "*Let's Do Something Different*" for African Americans and "*Porque Si*" for Latinos/Hispanics. Both videos provide accurate risk information and corrected misinformation, portray positive attitudes about condom use, and model gender- and culturally-specific strategies for encouraging condom use. Interactive group discussions following the video reinforce the STD and HIV prevention message. Participants are encouraged to talk about problems they have experienced when trying to use condoms and discuss strategies to increase condom use. All participants are offered a selection of free condoms at the clinic and a coupon for free condoms at an area pharmacy.

THEORETIC BASIS	• Health Belief Model • Theory of Reasoned Action
SESSIONS	• 1 session • 20 minute video followed by 25 minute discussion

20. WHP

The *Women's Health Promotion* (WHP) intervention includes twelve intensive 90- to -120-minute sessions delivered over 12 weeks. The WHP consists of four standard HIV education sessions (lasting about 6 to 9 hours) that address HIV transmission and prevention, sexually transmitted diseases, sexual and reproductive anatomy, condom practice, and condom negotiation skills. These sessions use lectures, group discussion, and skill-building exercises and games to teach participants. The eight additional sessions involve speakers on a variety of topics deemed relevant by participants, including general mental health, depression, cervical cancer, non-HIV-related partner communication, diabetes, nutrition, partner violence, oppression, and social justice. WHP is implemented

in small, closed groups comprised of 10 to 16 women, co-facilitated by two bilingual community health educators, and conducted in Spanish.

THEORETIC BASIS	• Social Cognitive Theory • Theory of Reasoned Action • Health Belief Model
SESSIONS	• 12 sessions • 90-120 minutes; weekly

21. WiLLOW

The *WiLLOW* intervention is a small group, skill-training intervention for women living with HIV. Through interactive discussions within groups of 8-10 women, the intervention emphasizes gender pride and informs women how to identify and maintain supportive people in their social networks. The intervention enhances awareness of HIV transmission risk behaviors, discredits myths regarding HIV prevention for people living with HIV, teaches communication skills for negotiating safer sex, and reinforces the benefits of consistent condom use. *WiLLOW* also teaches women how to distinguish between healthy and unhealthy relationships, discusses the impact of abusive partners on safer sex, and informs women of local shelters for women in abusive relationships.

THEORETIC BASIS	• Social Cognitive Theory • Theory of Gender and Power
SESSIONS	• 4 sessions • 4 hours each; weekly

22. Women's Co-Op

The *Women's Co-Op* is a woman-focused intervention that incorporates gender- and culture-specific skills training for crack-using African American women. The first 2 sessions are delivered to women individually, and focus on pre- and post-test counseling for HIV. Session 1 includes a personal HIV risk assessment, and provides women with skills training on condom and dental dam use and syringe cleaning. Session 2 includes receipt of HIV test results, the development of an individualized risk assessment plan, and a repeat of the skills training from Session 1. The final 2 sessions are delivered to small groups of 2 to 5 women, and use a support-based format to help women develop skills that can reduce their risk of HIV. These sessions include the development of communication and problem solving skills that increase women's sense of power and ability to cope with stress.

THEORETIC BASIS	• African American Feminism • Empowerment Theory
SESSIONS	• 4 sessions • First 2 individual sessions last 30-40 minutes; Last two group sessions last 60-90 minutes

❖ *CDC INDIVIDUAL-LEVEL INTERVENTIONS (EBIs)*

1. RESPECT

See description under "Best Evidence" Individual-Level Interventions.

❖ *CDC GROUP-LEVEL INTERVENTIONS (EBIs)*

1. Healthy Relationships

See description under "Best Evidence" Individual-Level Interventions.

2. Holistic Health Recovery Program (HHRP)

The primary goals of HHRP are health promotion and improved quality of life. More specific goals are abstinence from illicit drug use or from sexual risk behaviors; reduced drug use; reduced risk for HIV transmission; and improved medical, psychological, and social functioning. According to this model, there are three steps to changing behavior: Providing HIV prevention information, motivation to engage in HIV prevention and opportunities to practice behavior skills for HIV prevention.

HHRP takes a harm reduction approach to behavior change in which abstinence from drug use or sexual risk-taking behavior is one goal along a continuum of risk-reduction strategies. Clients are not assumed to be abstinent from either drug use or sexual risk behaviors. Risk behaviors are viewed as being sustained by hopelessness in the face of a life-threatening illness, high levels of stress, psychiatric disorders, and medical and social problems. In addition, the ability to acquire and retain the skills needed for change may be impeded by the impact of HIV status and/or drug-related cognitive deficits. HHRP allows clients to meet their own harm-reduction goals by presenting materials in a way to minimize the effects of cognitive difficulties, and providing clients with an empathic, directive, non-confrontational setting where structure and consistency are emphasized.

THEORETIC BASIS	• Information-Motivation-Behavioral Skills model
SESSIONS	• 12 sessions • Over 2.5 days

3. Many Men, Many Voices (3 MV)

The 3MV intervention targets gay men of color. The intervention also targets men of color who have sex with other men but do not identify as gay or bisexual with or without female partners. 3MV was not specifically designed for each racial/ethnic group who may identify as being "of color" including African American or Black, Asian/Pacific Islander, Latino or Hispanic, and Native American groups. 3MV, however, could be adapted and tailored to serve those at risk from other racial/ethnic backgrounds who identify as "being of color".

THEORETIC BASIS	• AIDS Risk Reduction Model
SESSIONS	• 7 sessions total; can be adapted to 12 sessions or condensed to a weekend retreat • Each session lasts 2-3 hours

4. Safety Counts

Safety Counts is an HIV prevention intervention for out-of-treatment active injection and non-injection drug users aimed at reducing both high-risk drug use and sexual behaviors. It is a behaviorally focused intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings.

THEORETIC BASIS	• Social Learning Theory
SESSIONS	• 7 sessions

5. Sisters Informing Sisters on Topics About AIDS (SISTA)

The SISTA project is a social-skills training intervention. It is aimed at reducing HIV sexual risk behavior and increase condom use. The sessions are delivered by peer facilitators in a community-based setting. The sessions are gender specific and culturally relevant and include behavioral skills practice, group discussions, lectures, role playing, prevention video viewing, and take-home exercises. The sessions focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk reduction behaviors and decision making.

THEORETIC BASIS	• Social Learning Theory • Theory of Gender and Power
SESSIONS	• 5 sessions • 2 hours each session

6. Street Smart

Street Smart is an HIV/AIDS and STD prevention program for runaway and homeless youth. This skills-building program may be used to help groups of young people reduce their unprotected sex acts, number of sex partners, and substance use. It is based on social learning theory, which links feelings, attitudes, and thoughts to behavior change. Each session has specific goals on HIV/AIDS, STDs, pregnancy prevention, coping and negotiation skills, personalized risk behaviors and reducing drug and alcohol use. Group members participate in scripted and non-scripted role plays, activities, and video production.

THEORETIC BASIS	• Social Learning Theory
SESSIONS	• 8 group sessions; 1 individual session; 1 visit to community organization that provides healthcare • 1.5-2 hours each session; over 6-8 weeks

7. Together Learning Choices (TLC)

Together Learning Choices (TLC), formerly Teens Linked to Care, is an effective intervention for young people, aged 13 to 29 living with HIV. This program helps young people living with HIV identify ways to increase use of health care, decrease risky sexual behavior and drug and alcohol use, and improve quality of life. It emphasizes how contextual factors influence ability to respond effectively to stressful situations, solve problems, and act effectively to reach goals. Delivering the TLC intervention involves delivering specific content for each session, determining a routine format for all sessions, and helping clients identify behavior-changing mechanisms for solving their problems.

Teens may be recruited or referred from HIV treatment programs. TLC was originally called Teens linked to Care because it was designed to target teens and youth (ages 13–24) enrolled in HIV treatment programs. However, the intervention was renamed Together Learning Choices because HIV positive young people could be linked to a broader range of care that includes emotional and social health as well as medical treatment. The age range was extended because the intervention addresses challenges faced not just by teens but also by young adults who are living with HIV.

THEORETIC BASIS	• Social Action Theory
SESSIONS	• 24 sessions (3 modules of 8 sessions each) • 1.5-2 hours each session; over 6-8 weeks

8. VOICES/VOCES

See description under "Best Evidence" Individual-Level Interventions.

Attachment F: Navigating SAMHSA's NREPP Website

SAMHSA launched its *National Registry of Evidenced-Based Programs and Practices* (NREPP) website (www.nrepp.samhsa.gov) in March 2007. The NREPP website is a searchable database designed to serve as a comprehensive and interactive source of information for organizations as they select appropriate interventions to reach their targeted communities. The site provides descriptive information on interventions as well as desired outcomes. Each intervention summary synthesizes and evaluates the research on specific interventions. This information can help organizations that are considering these interventions more effectively understand their impact on target populations.

❖ *USING THE DATABASE*

The database is a very user-friendly system once you understand how it works. The following is a step-by-step description on how to navigate the NREPP database.

STEP 1: Log onto www.nrepp.samhsa.gov. The web site will take you to the NREPP home page. At the top of the page there are seven tabs:

1. *About*: Provides general information about what is NREPP and how to use the database.
2. *Find Interventions*: Allows you to search the database using established criteria. **Select this tab http://www.nrepp.samhsa.gov/find.asp** . You will be guided to the image that follows after the description of the tabs. See image 1 of database.
3. *Review Process*: Provides information on how to submit an intervention to be considered as a potential NREPP program. You will be provided information about the application, pre-review, review, and reporting process. The information in this category is very useful if you are considering in establishing a "home grown" intervention as evidenced base.
4. *Submissions*: Provides information on how to submit an intervention to NREPP. It also gives guidelines in areas that are necessary for the intervention to be considered as evidenced based. For example, quality of research and readiness for dissemination – supporting documentation.
5. *Resources*: Provides NREPP published documents in Adobe format along with links to legacy programs that existed prior to NREPP.
6. *Help*: Provides a general description of how to use the database and a link to a glossary of terms used within the database.
7. *Contact*: Provides a source to ask questions.

STEP 2: Click on the "Find Interventions" tab to access the database.

An interactive form appears displaying the following categories: Topics, Areas of Interest, Evaluation/Study Design, Implementation History, Population, Settings, and Public/Proprietary.

STEP 3: Click on the checkboxes next to the categories of interest.

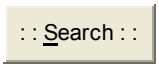
For example: Your agency is looking for a substance abuse intervention that also focuses on HIV and ethnic minorities. Click the following checkboxes:

TOPICS
- ☑ Substance Abuse Treatment

AREAS OF INTEREST
- ☑ HIV/AIDS

POPULATION
- ☑ Black or African American
- ☑ Hispanic or Latino

STEP 4: Click the "Search" button and wait for the results to appear on the screen.



STEP 5: Review results.

In this example, three different interventions appear:

1. Family Behavior Therapy
2. Living in Balance
3. Trauma Recovery and Empowerment Model.

Immediately, a brief listing of outcomes and a short abstract appear. By clicking on the name of the intervention, this takes you to an intervention-specific web page with detailed information about the program. The details include a brief descriptive summary of the intervention, the types of outcomes achieved, the costs of implementing the intervention, and the complete contact information for the intervention developer.

Attachment G: Model for Adapting an Evidence Based Intervention

Adapting Street Smart in Partnership with its Consumers and End-users

George Ayala[1], Rosemary Veniegas[2], Matt Mutchler[3], Monica Nuno[1], Oscar de la O[4]
Richard Zaldivar[5], Steve Shoptaw[2], Fernando Cadavid[2], Ani Chizobam[4], Carlos Peralta[6]
Emily Elman[1], Daniel Pearce,[7] Claudia Rodriguez[1], and Miguel Chion[1]

INTRODUCTION

To date relatively few research studies have been conducted on the process of adapting evidence-based interventions for implementation in community-based organizations (CBOs) that serve MSM, particularly MSM of color. This poster reports findings of a three-year, multi-method study that aimed to document the processes of adaptation and adoption of "Street Smart," an intervention originally designed for homeless and runaway youth. The intervention was adapted for use with young Latino MSM and delivered by staff from four Latino-run CBOs that vary along a specified set of organizational domains (size, age, staff characteristics, scope of prevention portfolios, and ideological commitment to both the target population and HIV prevention).

AIDS Project Los Angeles (APLA) utilized an iterative model of adaptation that sought ongoing consumer (members of the target population) and staff (end-users of the intervention) input. Street Smart was adapted in four-steps over a nine month period.

[1] AIDS Project Los Angeles
[2] University of California, Los Angeles
[3] California State University, Dominguez Hills
[4] Bienestar Human Services
[5] The Wall/Las Memorias Project
[6] El Proyecto del Bario
[7] Altamed Health Services

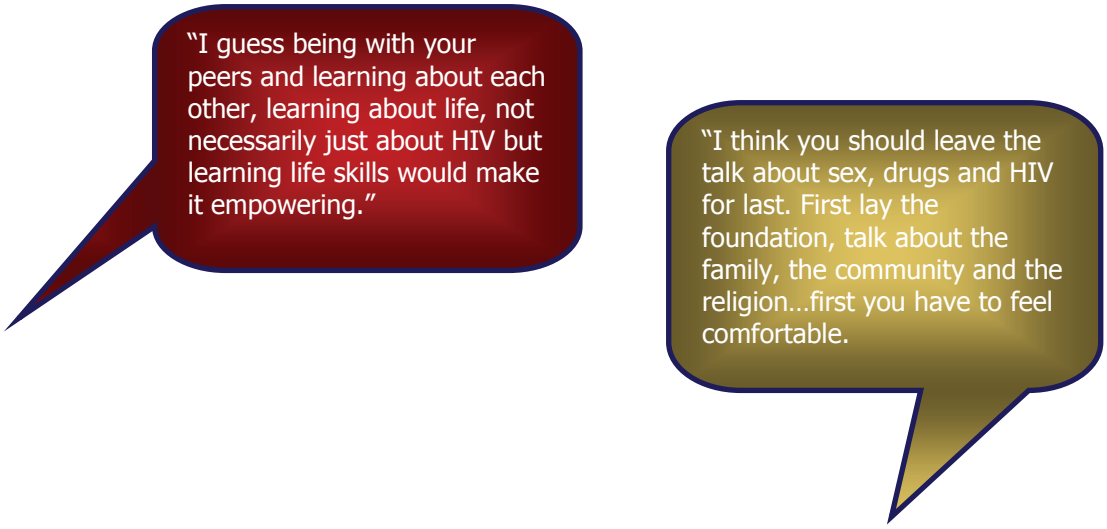
A MULTI-METHOD APPROACH TO ADAPTING EVIDENCE-BASED HIV PREVENTION INTERVENTIONS

Step 1: Systematic Solicitation Of Feedback From Potential Consumers (Clients)
Young Latino gay men were conveniently recruited by each of the adopting agencies from their respective client bases to participate in focus groups designed to solicit information for the purposes of adapting Street Smart. Trained research staff facilitated a total of 7 groups (5 in English, 2 in Spanish) on site at each of the adopting agencies (n=42).

- What has your experiences been with HIV prevention programs or group interventions?
- What do you think young Latino gay men need in order to help prevention HIV transmission?
- If you could create an HIV prevention program, what would it look like?
- How would you get guys to talk about HIV in your program?

Consumers wanted:

- **A safe space, family like environment, assistance with communicating with friends and family about their sexuality, opportunities to engage with peers and interactive ways of addressing sex and HIV.**



Step 2: Facilitated Program Planning And Adaptation Discussions With Staff
Meetings with staff members from each of the adopting agencies, characterized by in-depth discussions about consumer input, the importance of retaining the primary elements of the intervention, and goodness of fit issues regarding the intervention chosen, were conducted bi-weekly over a nine month period. These meetings helped to inform changes made to the intervention as follows:

Adaptations Made to Street Smart:

- *Factual:* Updated content information on HIV/AIDS, STI, risk reduction strategies, and coming out.
- *Linguistic/Cultural:* Added specific information about and made exercises salient to young Latino gay men; language adjustments; role plays were changed to reflect more contemporary and culturally relevant situations.
- *Pedagogical:* Popular Education Principles; feeling thermometer and tokens were substituted; shortened; re-sequenced sessions; included provider developed interactive exercises.
- *Usability:* Made curriculum fun and easier to use; trained staff and provided consultation on demand.

Step 3: Joint Training And Individualized Technical Assistance
Copies of the intervention's curriculum along with its core elements were distributed to all staff participating. Staff responsible for implementing the intervention received a 3-day training that included practice opportunities for facilitating specific intervention sessions. Ongoing technical assistance was made available to organizations adopting the adapted intervention on an as needed basis. The 3-day training session was digitally recorded and made available to each agency for use for new staff and staff requesting booster training.

Step 4: Process Evaluation With A Focus On Consumer Satisfaction And Staff Perspectives
Intervention participants were invited to complete a brief satisfaction survey at mid-point (after the fourth session) (n=38) and again immediately following the intervention (n=35). The survey was developed to obtain self-report ratings of:

- satisfaction with the intervention;
- cultural relevance;
- facilitator knowledge and helpfulness; and
- areas for improvement (i.e., what was the one thing you liked the most and least about the program").

LESSONS LEARNED:

- Organizational characteristics (mid-size, large prevention budgets, longer staff tenure, evaluation capacity, and historical commitment to target population) may play a role in determining successful adaptation and adoption of evidence-based interventions.
- Philosophical commitment to and implicit theories about the target population held by staff may at times compete with consumer needs and intervention core elements.
- The learning needs and expectations of consumers (clients) are important to integrate when adapting evidence-based HIV prevention interventions.
- Facilitated staff involvement, training and ongoing support are key to systematically adapting evidence-based HIV prevention interventions.
- The length, pliability, and pedagogical orientation of the intervention matter to consumers (clients) and end-users (staff), and should be taken into account when determining intervention 'goodness of fit'.