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January 2010

Dear Friends,

We are pleased to present the 2010-2011 City of Chicago Comprehensive HIV Prevention Plan. This document was developed by the HIV Prevention Planning Group (HPPG) in partnership with the Chicago Department of Public Health (CDPH). Guided by the Centers for Disease Control and Prevention (CDC), HIV prevention planning for the City of Chicago is an ever evolving process built on the strength of collaboration and the spirit of cooperation.

Creating the prevention plan is one of the primary milestones in the work of community planners in Chicago. It represents many months of research, analysis and prioritizing on the part of both HPPG members and CDPH staff. This plan represents continuous improvement in the quality of the community planning process. The gap analysis was more extensive with more data sources. For the first time, HPPG was able to compare current data with data from the previous priority setting cycle. This plan also names more specific priority populations than in previous plans. We invite you to explore these differences in more depth by reading the plan.

The partnership between HPPG and CDPH represents a long-standing commitment to excellence and community service. We continually strive to refine our efforts, expand our reach and, most importantly, prevent the spread of HIV in our most vulnerable communities.

It is our hope that this plan provides relevant and informative HIV community planning information to you. Thank you for your interest in the work of the Chicago HIV Prevention Planning Group.

Cynthia Tucker
Community Co-Chair

Peter McLoyd
Community Co-Chair
Elect

Lora Branch
Government Co-Chair

Introduction

CDC National HIV Prevention Mandate

The Centers for Disease Control and Prevention (CDC) has a national directive to slow the advancement of HIV disease and prevent new infections. CDC works with state and local municipalities through Community Planning Groups (CPGs) to support HIV prevention services, as well as to promote cooperation between health departments and community partners to identify priority HIV prevention needs.

In 2003, CDC released the *Advancing HIV Prevention* (AHP) initiative geared towards increasing HIV testing, improving medical care and treatment, and reducing barriers to early HIV diagnosis (http://www.cdc.gov/hiv/topics/prev_prog/AHP/default.htm). The CDC ensures that this initiative is achieved through the following four key strategies:

- Make HIV testing a routine part of medical care.
- Implement new models for diagnosing HIV infections outside medical settings.
- Prevent new infections by working with persons diagnosed with HIV and their partners.
- Further decrease perinatal HIV transmission.

In addition, CDC developed the *HIV Prevention Community Planning Guide* (Guidance), which defines CDC's expectations of health departments and CPGs in implementing HIV prevention community planning (<http://www.cdc.gov/hiv/pubs/hiv-cp.pdf>). Together, AHP and the Guidance provide the framework for health departments and CPGs to organize prevention efforts in their jurisdictions. Both documents assist the Chicago HIV Prevention Planning Group (HPPG) and the Chicago Department of Public Health (CDPH) with developing a strategy to decrease the number of persons in Chicago at high-risk for acquiring or transmitting HIV infection. This potential decline will come as a result of delivering scientifically proven prevention interventions to target high-risk populations.

Under CDC's 2004-2008 Program Announcement, local health departments had the responsibility of considering the jointly recommended priorities outlined in the local Comprehensive HIV Prevention Plan and implementing a full prevention program. CDPH implemented a robust HIV prevention program with the following major components:

- HIV Prevention Community Planning
- HIV Prevention Activities (Refer to Introduction: Attachment 1 for additional Projects)
 - HIV prevention counseling, testing, and referral services (CTR)
 - Partner counseling and referral service (PCRS) with strong linkages to prevention care services
 - Prevention for HIV-infected persons

- Health education and risk reduction (HE/RR) activities
- Public information programs
- Perinatal transmission prevention
- Quality Assurance
- Evaluation of major program activities, interventions, and services as well as collection of data on interventions and clients served
- Capacity-building activities
- STI preventions activities
- Collaboration and coordination with other related programs
- Laboratory support
- HIV/AIDS epidemiologic and behavioral surveillance

Both HPPG and CDPH have specific and shared roles and responsibilities that enhance the planning process. The Guidance outlines these shared roles and responsibilities.

HPPG

HPPG's role is to represent the HIV community and to lend its personal and professional expertise to the planning process. By monitoring epidemiologic trends, behavioral research, and shifts in community norms, the HPPG makes strategic prevention program recommendations. The HPPG's specific responsibilities include:

- Reviewing key epidemiological data and behavioral science research.
- Identifying unmet HIV prevention needs.
- Setting priorities for HIV prevention needs.
- Addressing the technical assistance needs of the membership.
- Reviewing the CDPH's Cooperative Agreement (COOP) to ensure the recommendations from the Plan are reflected in the broader prevention program.
- Concurrence, concurrence with reservations, or non-concurrence with the CDPH Cooperative Agreement application.

CDPH

CDPH's role is to support the community planning process by providing staff/consultant resources, epidemiological or behavioral data, and leadership. CDPH's responsibilities include:

- Preparing an Epidemiologic Profile.
- Allocating and distributing resources based on the *Chicago Comprehensive HIV Prevention Plan (Comprehensive Plan)*.
- Implementing the Comprehensive Plan's HIV prevention services.
- Monitoring and evaluating the effectiveness of HIV prevention services.
- Regularly updating HPPG on the successes/barriers encountered in implementing community planning recommendations.
- Appointing a Health Department Co-Chair to the HPPG.
- Distributing the Comprehensive Plan to various audiences.

Shared Roles and Responsibilities

Together, HPPG and CDPH work to analyze data and to make prevention recommendations. Their shared roles and responsibilities include:

- Identifying other non-epidemiologic data sources.
- Identifying the technical assistance needs of service providers.
- Recommending science-based interventions.
- Developing, updating, and disseminating the Comprehensive Plan.
- Fostering integration of HIV prevention community planning process with other relevant planning efforts.
- Identifying opportunities to develop service provider coalitions that support broad HIV prevention program goals.
- Evaluating the planning process.

Introduction to the Chicago Comprehensive HIV Prevention Plan

The 2010-2011 City of Chicago Comprehensive HIV Prevention Plan is a collaborative effort of individuals living with HIV/AIDS, community advocates, HIV service providers, substance abuse professionals, and STI/HIV/AIDS program administrators. The goal of the Comprehensive Plan is to prioritize HIV prevention services that reduce HIV infection in Chicago.

The Comprehensive Plan is a resource used to orient and provide guidance for community planning members, HIV prevention staff and other community stakeholders. In addition, the plan is a means to measure whether the jurisdiction achieves CDC's national prevention goals. Further, the Comprehensive Plan is an important advocacy tool, and provides a historical record of the current priority setting process.

The Comprehensive Plan is the culmination of the work produced by HPPG in the priority setting year.

Use of the Comprehensive Plan and Intended Audience

The Comprehensive Plan provides organizations with valuable information about the execution of the priority setting process, outcomes, challenges, and barriers, and is used by various entities in the following ways, among others, to assist:

Community Based Organizations to...

- Orient staff to participate in the planning process.
- Provide guidance in program development.
- Provide data and information for grant applications.

Legislators and Advocacy Groups to...

- Provide information about Chicago's HIV epidemic.
- Inform decision making regarding allocation and distribution of resources.

Community Planning Groups and Health Departments to...

- Document HIV prevention funding priority allocations.
- Track health department goals and objectives.
- Meet grantee requirements and contractual agreements between the health department and the CDC.
- Provide a historical record of priority-setting of HIV/AIDS initiatives.

Section 1: The Chicago HIV Prevention Planning Group

Mission Statement

HPPG is a diverse group of volunteers working collaboratively with CDPH for the purpose of developing and overseeing the implementation of a comprehensive HIV prevention plan to reduce or stop the spread of HIV disease among the people of Chicago.

HPPG's goal is to improve the effectiveness of the City of Chicago's HIV prevention programs by strengthening the scientific basis, relevance, and focus of prevention interventions.

Overview

HPPG is a community planning group comprised of volunteers who work in collaboration with CDPH to set HIV prevention priorities for the City of Chicago. HPPG members consist of individuals who have personally been impacted by HIV/AIDS, experts in public health and the behavioral sciences, and governmental representatives. HPPG, in collaboration with CDPH, set resource allocation priorities for high-risk populations and support the delivery of effective prevention services.

HPPG follows the three *CDC community planning guiding principles* of fostering parity, inclusion and representation (PIR) when recruiting volunteers to serve on HPPG, to assure:

- *Parity* - All members of the group have an opportunity for orientation, training, and developing skills to participate fully in the community planning process, to have equal opportunity to vote, and to make relevant decisions.
- *Inclusion* - The sharing of all professional or personal perspectives and that affected groups' prevention needs and communities receive consideration in a productive and meaningful way.
- *Representation* - Planning group membership is reflective of the HIV epidemic across ethnic groups, high-risk modes of transmission, gender, age, and other specially affected groups.

Membership and Structure

The 2008 HPPG membership had thirty-four members. Figures 1 – 2 represent the 2008 priority setting membership by race/ethnicity and by risk behavior.

Figure 1

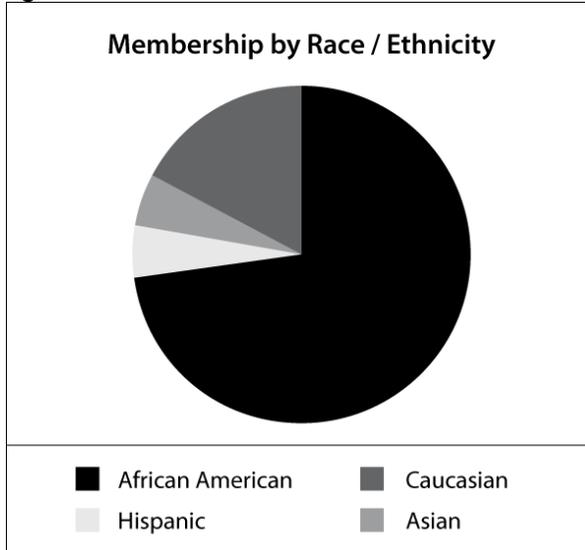
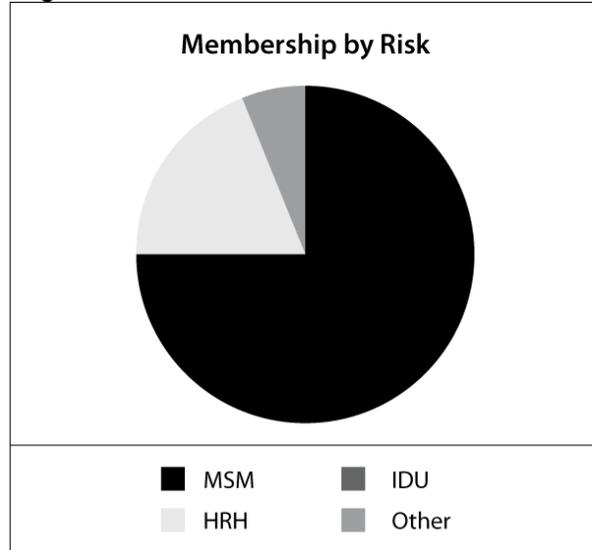


Figure 2



HPPG is comprised of the Executive Committee, as well as several subcommittees. The Executive Committee consists of two elected community co-chairs, one appointed governmental co-chair, subcommittee co-chairs (two per committee), and appointed chairs (representing various entities such as the Ryan White Planning Council).

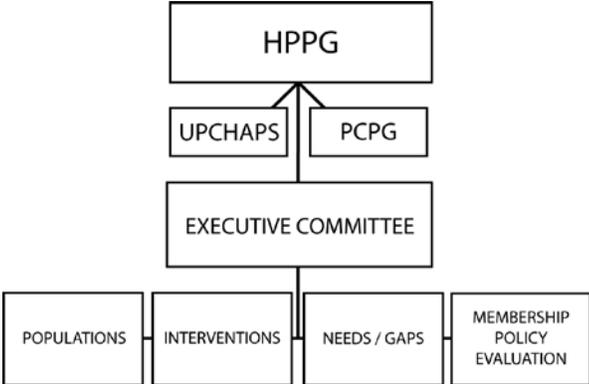
For the subcommittees, one subcommittee co-chair is appointed by the governmental and community co-chairs, and the other subcommittee co-chair is elected by subcommittee members. The appointed chairs are selected by the entities they represent.

Also represented on HPPG are liaisons to the Illinois Prevention Community Planning Group (PCPG) and Urban Coalition on HIV/AIDS Prevention Services (UCHAPS). The PCPG liaison is elected; the HPPG co-chairs serve as liaisons to UCHAPS.

The "full-body," or membership, divides into planning committees that support the overarching goals of the HPPG. In a priority setting year this consists of four committees dedicated to priority setting: Populations, Interventions, Needs Assessment/Gap Analysis, and Finishing. A fifth committee, Membership/Policy/Evaluation, conducts routine functions, but committee activities do not involve the priority setting process.

The HPPG full body and subcommittees meet monthly to share planning decisions and outcomes with the CPG membership and the community-at-large. The HPPG committee structure is shown in Figure 3.

Figure 3



Section 2: The Priority Setting Process

The Key Priority Setting Deliverable

The primary outcome of the priority setting process is a Comprehensive HIV Prevention Plan, which includes high priority HIV prevention strategies and interventions targeted to prioritized high-risk populations.

Overview

Priority Setting is one of the nine required components of the Comprehensive HIV Prevention Program as mandated by CDC. The state/local health department has the responsibility for implementing the Comprehensive HIV Prevention Program throughout the jurisdiction. Through the priority setting process, CDC expects the CPG to accomplish four community planning goals. Figure 4 below highlights these goals, and Figure 5 describes the five corresponding objectives.

Figures 4 & 5

Priority Setting Goals
<ol style="list-style-type: none">1. Increase meaningful community involvement in prevention planning.2. Maximize limited HIV prevention resources.3. Reduce HIV incidence.4. Develop a Comprehensive HIV Prevention Plan.
Priority Setting Objectives
<ol style="list-style-type: none">1. Engage in a participatory process to allocate HIV prevention resources.2. Identify & prioritize high-risk populations.3. Identify & prioritize interventions that are most appropriate for high-risk populations.4. Assess the HIV prevention needs of high risk populations.5. Assess gaps in available HIV prevention services.

A Comprehensive HIV Prevention Plan must contain an epidemiologic profile, a community services assessment, and a set of prioritized populations and interventions. Data outlined in the STI/HIV/AIDS Surveillance Report, published by CDPH, highlights the effect of STI/HIV/AIDS across the city (rates, incidence, and prevalence data for high-risk populations). These data identify high-risk populations and regionalize the epidemic by community area or zip code.

HPPG analyzes behavioral research, such as: investigating condom use efficacy; reduction in needle sharing practices; knowledge, attitudes, and beliefs of HIV; and other actions that influence high-risk behaviors. Furthermore, HPPG reviews relevant outcomes in which theoretical-based interventions target specific high-risk groups to reduce risk behaviors that may be unique to that group.

The third component of the plan, the community services assessment, describes the availability of HIV prevention services (interventions) targeted to prioritized populations in specific geographic areas. As stated previously, this area definition comes from community boundaries, census tract information, or zip code data. The intent of compiling this information is to allocate prevention funds to geographic regions where STI/HIV/AIDS are most prevalent.

In Chicago, HPPG refers to the community services assessment as a needs assessment. HPPG develops methods to collect information from local STI/HIV/AIDS and other relevant service providers to assess the number and types of prevention services that exist for each population. Additionally, HPPG identifies social determinants of health, and then considers in which geographic areas these determinants act in combination to create an environment for increased risk. The body of literature, combined with epidemiological and other data, enables HPPG to make the required population and intervention recommendations.

Getting Ready to Set Priorities

HPPG hosts an annual membership retreat for the full body to introduce and orientate new members, outline federal planning guidelines, discuss the previous planning year's accomplishments and challenges, and discuss the priority setting process.

During the retreat, membership breaks into the priority setting committees to develop their respective committee's work plan, which includes reviewing updated epidemiological data, and creating a foundation to analyze a needs assessment and other types of behavioral research data. The work plan enables each committee to define their deliverables.

Implementing the Priority Setting Process

The priority setting process lasts between eight to eleven months from the first meeting through to the final vote. During the priority setting process, committees meet and use their work plans to guide meeting topics and make decisions. Decision-making justification for each member is important and final recommendations necessitate citing scientific research or other supporting anecdotal data.

Each committee develops a final set of recommendations that inform the work of the other committees. These recommendations contain preliminary findings related to each committee's primary goal and work plan. Committees make regular presentations to the full-body to obtain feedback and build "buy-in" for their efforts.

Each priority setting committee has a specific role to play and key recommendations to deliver, as described below:

Populations Committee

The Populations Committee identifies the populations most at risk for HIV transmission. The committee uses epidemiological data such as HIV incidence data to access high risk populations and community areas. Based on their analysis of surveillance data sources, population research, and behavioral health models, the committee identifies a list of priority target populations that are at most risk for HIV and in most need of prevention services. Their recommendations are presented to the other committees for their use in the priority setting process.

Interventions Committee

The Interventions Committee is responsible for recommending HIV prevention interventions appropriate for each high-risk population prioritized by the Populations Committee. The committee reviews national science-based interventions as well as “home-grown” interventions that are most effective at reducing HIV transmission among high-risk HIV-negative and HIV-positive populations.

Needs Assessment/Gap Analysis Committee

The Needs Assessment/Gap Analysis Committee (NA/GA) is responsible for identifying available HIV resources as well as gaps in HIV prevention services. The committee reviews relevant epidemiological data, the resource inventory survey, social determinants and work from other committees to determine where gaps exist. The committee makes recommendations for allocation of resources based on this work.

Finishing Committee

The Finishing Committee (comprised of the Executive Committee), along with CDPH staff, reviews all the recommendations made by each of the three priority setting committees. The Finishing Committee compiles the recommendations for presentation to the HPPG full body for final approval.

Section 3: Populations Committee Process and Recommendations

COMMITTEE GOAL: To geographically identify and prioritize a list of at-risk populations that are in most need of HIV prevention services.

Overview

The Populations Committee identifies and prioritizes target populations. Limited HIV prevention resources require health departments to strategically direct resources to HIV at-risk populations, known as “target populations.” The Populations Committee reviews various data sources to accurately describe the demographics of these populations according to age, gender, race/ethnicity, and mode of transmission. The prioritized population list includes both HIV negative and HIV positive populations. Working with those who are HIV positive is a strategic way to reduce the potential to transmit HIV to persons who are HIV negative.

The *Guidance* requires CPGs to consider the following types of evidence, if available, as they develop their priority populations list:

- Size of at-risk populations
- Percentage of HIV morbidity (incidence and prevalence)
- Prevalence of risky behaviors in the populations
- Target populations defined by transmission risk, gender, age, race/ethnicity, HIV status and geographic area
- Rank order populations according to their contribution to new HIV infections

Populations Committee Priority Setting Methods

The Populations Committee considered both quantitative (e.g., epidemiological and behavioral research data) and qualitative (e.g., experience and anecdotal data) research to identify priority high-risk populations. The committee collaborated with CDPH STI/HIV/AIDS Division to develop a list of prioritized populations using epidemiological data as its primary source of data. Qualitative data sources used to confirm high-risk behavior and other characteristics of these populations included literature reviews, National Behavioral Surveillance Research data, and past priority setting outcomes.

The committee work plan outlines four major goals and corresponding objectives. Important findings follow each goal area that helped the committee make priority population recommendations.

The first step in setting priorities for the Populations Committee is to generate a list of high-risk target populations. The basis of this list is epidemiologic data and other behavioral risk trends not typically captured in surveillance data collection. Figure 6 lists “un-prioritized” populations that fall under high-risk modes of transmission or special concerns categories. Special concerns populations are groups of individuals who may be at increased risk for HIV due to unique circumstances.

Figure 6

Un-prioritized Population Categories	
High-Risk Modes of Transmission	Special Concerns
Injection Drug Use (IDU)	Homeless
Men who have Sex with Men (MSM)	Individuals involved in Sex Trade
Heterosexuals	Transgender
	Post Incarcerated Individuals
	Non-English / Non-Spanish Speaking Individuals
	Individuals with Physical and Developmental Disabilities
	High-risk Youth
	Individuals who are 50+

Typically, population priority setting involves efforts that score, weight, and rank populations according to the referenced qualitative and quantitative data. HPPG determined that the Chicago HIV/AIDS surveillance data between years 2006-2007 was reliable in identifying high-risk populations according to gender, age, mode of transmission/risk, HIV status, and geographic area. Therefore, the greatest at-risk populations were those with the highest HIV incidence rates. HPPG used qualitative data to supplement surveillance data in prioritizing target populations.

Executing the Work Plan: Analyzing Scientific Data & Findings

The following sections list each of the committee’s four goal areas and the findings for each goal area that influenced the committee’s final priority decisions (refer to Section 3: Attachment 10 for “High-Risk” and “Special Concerns” populations definitions).

Goal Area 1

Goal 1: Identify high-risk populations at-most-risk for acquiring and transmitting HIV infection by mode of transmission.
Objective: Review and discuss epidemiological data from CDPH between 2006-2007 and validated for reporting in 2008.

Tasks:

1. Use HIV/AIDS epidemiologic data to create maps illustrating the geographic distribution of HIV/AIDS in Chicago.
2. Review and consider cases of “unknown mode of transmission” and the redistribution of these cases into “known” modes of transmission groups.

Goal Area Findings

The Populations Committee identified high-risk HIV-negative individuals by HIV incidence data such as: gender, race/ethnicity, age, and mode of transmission (refer to Section 3: Attachments 1-6 for epidemiological data compiled for 2000-2006; mapped data are found in Section 3: Attachments 7-9). This data analysis revealed the following major trends in HIV diagnosis data:

Mode of Transmission

- MSM continues to be the leading mode of transmission (62%).
- Heterosexual contact is the second leading mode of transmission (22%).
- IDU has steadily declined since 2000 representing 13% of diagnoses in 2006.
- Both Non-Hispanic Black and White MSM ages 30-39 accounted for the largest proportion of HIV diagnoses.

Ethnicity

- Non-Hispanic Blacks comprise the majority of HIV diagnosis (56%).
- Non-Hispanic Black males and females have significantly higher numbers of HIV diagnoses than any other racial/ethnic group.

Gender & Age

- Males account for 80% of HIV diagnoses.
- Heterosexual females had higher numbers of HIV diagnosis than women who injected drugs.
- Males and females ages 30-39 had higher numbers of HIV than other age groups followed by (from highest to lowest): 40-49, 20-29, 50+, and under 19.

The category of “unknown risk” often emerges when individuals tested for HIV do not provide this important piece of data. Based on the age, gender, race, and ethnicity of known cases, new analytical methods “redistribute” cases of unknown mode of transmission into one of the four modes of transmission groups (MSM, IDU, MSM/IDU, or Heterosexual). In this priority setting scenario, “unknown risk” responses were redistributed using this methodology.

Goal Area 2

Goal 2: Identify Special Concerns Populations at-most-risk for acquiring and transmitting HIV infection but that are not captured by STI/HIV/AIDS surveillance efforts.

Objective: Review and discuss relevant data on Special Concerns Populations.

Tasks:

1. Review 2005 PSP Special Concerns Populations recommendations and rationale.
2. Review and discuss literature for evidence that these populations are at risk and have a need for HIV prevention services.

Goal Area Findings

The 2001 and 2005 Priority Setting Processes (PSP) identified Special Concerns Populations as important groups in need of HIV prevention services. A Special Concerns Population is a classification of populations that are at high-risk for HIV infection/transmission and are not covered by other priority setting recommendations. These populations fall through the “safety net” of traditional prevention services and do not appear in HIV/AIDS surveillance efforts (Refer to Section 3: Attachment 10 for a description of these populations).

The following criteria identify and prioritize Special Concerns Populations:

- Inadequately addressed in other Priority Populations recommendations
- Marginalized
- Engaged in high-risk sexual or drug using behaviors
- Disproportionately represented in other health categories
- Has known HIV risk co-factors
- Requires specialized HIV prevention services (e.g., translation, sign language, etc.)
- Possesses low levels of HIV risk knowledge

Goal Area 3

Goal 3: Identify in which Chicago geographic regions high-risk populations with the highest incidence and prevalence occurs.

Objective: Review and discuss epidemiological data and other historical PSP recommendations and other data sources.

Tasks:

1. Review the 2005 PSP Cluster model recommendations and rationale.
2. Analyze epidemiological data by zip code.
3. Create maps that illustrate high HIV incidence areas by zip code.

Goal Area Findings

Geographic maps were created using data on high-risk HIV-positive individuals. Mapping incidence and prevalence data illustrated that the HIV/AIDS epidemic continues to be “clustered” in distinct geographic regions. During the 2005 Priority Setting Process, the Populations Committee, in collaboration with the NA/GA Committee, concluded that the epidemic had higher concentrations of incidence in three key regions. They then modified the geographic regions to three “cluster areas” (i.e., North, West and South). These cluster areas included zip codes/community areas having HIV incidence rates above 50 per 100,000 cases.

The 2008 PSP continued using the HIV incidence rate of 50 per 100,000 as a baseline. Of the 77 Chicago community areas, the committee identified zip code areas with HIV incidence rates higher than the baseline HIV incidence rate in Chicago (refer to Section 3: Attachments 3 and 5). Cluster C zip codes of 60609, 60617, 60619, 60637, and 60649 experienced a greater than 25% increase in HIV diagnosis rates from 2005 to 2007. These same zip codes, with the exception of 60609, also had higher than average incidence in the 2005 Priority Setting Process.

In addition, HIV diagnoses for regional Cluster B declined, but increased in Cluster C (refer to Section 3: Attachments 8 and 9 and Section 5: Attachment 6). The Needs Assessment/Gap Analysis Committee, through its priority setting process, attempted to explain potential factors that influenced these changes. These changes are discussed in more detail in Section 5.

Overall, the average incidence rate declined from 79.8 per 100,000 for 2003-2004, to 69.1 per 100,000 in the 2006-2007 data analysis period. This decline demonstrates the effectiveness of prevention programs, particularly among IDU and mother-to-child transmission groups.

Final Priority Population Recommendations

Based on these findings, the Populations Committee made the following recommendations:

Recommendation #1: Cluster & Citywide Service Delivery

Cluster - Community based organizations are funded to provide prevention services within a specific geographic area according to Clusters A, B, and C.

Citywide - Community based organizations are funded to provide prevention services across two or more cluster regions.

Recommendation #2: Priority Populations - Adult & Youth

Target HIV prevention services to:

- Adults ages 25 + years.
- Youth ages 13-24 years.

Recommendations #3 – 5: Cluster “A, B, C” Target Populations

Figures 9 through 11 identify and describe “high-risk” populations in each cluster by age, race/ethnicity, and mode of transmission. The committee set priorities based on mode of transmission, and then considered age, gender, and race/ethnicity for each mode of transmission.

Figure 7 - Priority Populations for Cluster “A” Target Populations / North Region

High-Incidence Zip Codes	
60613, 60626, 60640, 60657, 60660	
Age by Mode of Transmission	
Adult	Youth
<ul style="list-style-type: none"> • White MSM • African-American MSM • Hispanic MSM 	<ul style="list-style-type: none"> • MSM (all ethnic groups)
HIV Positive Status: All Persons Living w HIV/AIDS	
HIV Negative Priorities by Mode of Transmission	
<ol style="list-style-type: none"> 1. White MSM, ages 25+ 2. African-American MSM, ages 25+ 3. Hispanic MSM, ages 25+ 4. MSM age <25, all ethnic groups 	

Figure 8 - Priority Populations for Cluster “B” Target Populations / West Region

High-Incidence Zip Codes	
60605, 60607, 60608, 60610, 60612, 60622, 60624, 60644, 60647, 60651	
Age by Mode of Transmission	
Adult	Youth
<ul style="list-style-type: none"> • African American MSM • AA High-Risk Heterosexuals • White MSM 	<ul style="list-style-type: none"> • AA MSM • AA High-Risk Heterosexual Females
HIV Positive Status: All Persons Living w HIV/AIDS	
HIV Negative Priorities by Mode of Transmission	
<ol style="list-style-type: none"> 1. African-American MSM, ages 25+ 2. African-American MSM, <25 years 3. African American High-Risk Heterosexual Females, ages 25+ 4. White MSM, ages 25+ 	

Figure 9 - Priority Populations for Cluster “C” Target Populations / South Region

High-Incidence Zip Codes	
60609, 60615, 60617, 60619, 60620, 60621, 60628, 60636, 60637, 60649, 60653	
Age by Mode of Transmission	
Adult	Youth
<ul style="list-style-type: none"> • African American MSM • AA High-Risk Heterosexuals • Non-Hispanic White MSM 	<ul style="list-style-type: none"> • AA MSM • AA High-Risk Heterosexual Females
HIV Positive Status: All Persons Living w HIV/AIDS	
HIV Negative Priorities by Mode of Transmission	
<ol style="list-style-type: none"> 1. African-American MSM, ages 25+ 2. African-American High-Risk Heterosexual Females, ages 25+ 3. African-American MSM, ages < 25 4. African-American High-Risk Heterosexual Females, ages <25 	

Recommendation #6: Citywide Service Delivery: Projects for IDU and Special Concerns Populations

Community based organizations intending to provide prevention services to IDU and Special Concerns Populations are required to provide services under the Citywide model and provide services in two or more Cluster regions.

Recommendation #7: Priority Special Concerns Populations

Community based organizations are encouraged to direct HIV prevention services to any number of the following populations.

- Transgender
- Individuals involved in Sex Trade
- Individuals with Physical and Developmental Disabilities
- Non-English / Non-Spanish Speaking Individuals
- Homeless Individuals
- Post Incarcerated Individuals

Recommendation #8: Transgender Prevention Services

Prevention services targeted to the transgender community must include syringe access and other needle/injection harm reduction education, as well as a mechanism for making referrals to other services.

Recommendation #9: On-Going Data Collection

CDPH will address improved methods to collect and redistribute cases of “unknown/unidentified” risk.

Section 4: Interventions Committee Process and Recommendations

COMMITTEE GOAL: To identify, evaluate and prioritize science-based, evidence-based and home-grown interventions that are the most effective at reducing HIV transmission among high-risk HIV negative and HIV positive populations.

Overview

CDC's *Compendium of Effective Interventions* documents interventions targeting high-risk sexual behavior, such as delaying the onset of sexual activity, decreasing the number of sex partners, and increasing the use of condoms. The *Compendium* also addresses risky drug use behavior (e.g., harm reduction programs that provide sterile injection equipment to drug users) and the use of therapeutic or other biomedical agents to reduce the risk of infection (e.g., administering AZT or nevirapine to prevent mother to child transmission). Data supports the effectiveness of these interventions with the target population. CDC Tier I best-evidence interventions and Tier II promising-evidence interventions have the highest level of effectiveness. The most common set of Tier I and II interventions are Diffusion of Effective Behavioral Interventions (DEBIs).

Based on the recommendations of the *Compendium*, CBOs implement scientifically proven interventions targeting priority populations. These types of interventions reduce HIV infection among HIV-negative individuals, and decrease the likelihood of HIV transmission by HIV-positive individuals. CBOs may also develop and implement homegrown interventions that meet the minimum requirements for addressing high-risk behaviors, but lack rigorous outcome evaluation to demonstrate effectiveness with changing high-risk behaviors.

Interventions Committee Priority Setting Methods

The Interventions Committee looked at various sources of data to gain a better understanding of the recommended interventions proposed under the 2005 priority setting process, which were implemented starting in FY 2007. The committee met with CDC's DEBI Program Monitor to learn more about best practices and challenges experienced by Chicago CBOs managing DEBI prevention interventions. In addition to this critical evidence, several local CBOs made monthly presentations to discuss the effectiveness of their chosen interventions in reducing HIV among high-risk populations. Lastly, the committee analyzed data collected by CDPH STI/HIV/AIDS Behavioral Surveillance team (2004 to 2007), locally known as Project CHAT

(Chicago’s Health Assessment Team). The ongoing behavioral system provides HIV prevalence estimates and monitors STD/HIV risk behaviors, HIV testing behaviors, and exposure to HIV prevention services among MSM, IDU, and heterosexual populations. These sources of data allowed the Interventions Committee to make informed and strategic interventions recommendations. (Refer to Section 4: Attachment 1 for an abbreviated Project CHAT methodology. For more detailed Project CHAT study methodology and findings, contact the CDPH STI/HIV/AIDS Division.)

Executing the Work Plan: Analyzing Scientific Evidence & Findings

The Interventions Committee developed a plan to analyze various data sources and to identify the most effective interventions aimed at reducing high-risk behaviors and HIV incidence. Goal Areas 1-3 detail the Intervention Committee’s process for understanding social behavioral health models and factors that influence the design of effective interventions.

Goal Area 1

Goal 1: Identify, evaluate and prioritize science-based interventions.
Objective: Review relevant literature to develop a priority list of interventions.
Tasks:

1. Collect & read literature, research and anecdotal information on science-based interventions.
2. Collect & review information and best-practices on science-based interventions being used in Chicago.
3. Present theoretical foundation for prevention interventions.
4. Summarize and prioritize science-based interventions.

Goal Area Findings

National HIV Behavioral Surveillance (NHBS)

Local NHBS Project CHAT data was collected in various Chicago neighborhoods and surveyed MSM, IDU and high-risk heterosexual populations. The Interventions Committee analyzed data from specific questions to determine which Compendium Tier I, Tier II and home-grown interventions address high-risk behaviors identified by Project CHAT respondents (refer to Section 4: Attachment 2 for the NHBS Project CHAT Survey Questions & Findings).

Overall, findings revealed that there is an increased need for STI/HIV testing opportunities targeted to all high-risk populations, as well as the increased need for free condom distribution. For heterosexual women, intervention components must address condom negotiation skills building along with the disclosure of serostatus of their sex partners. Priority interventions targeted to MSM groups must address the issue of “condom fatigue,” as well as the relationship between drug use and high-risk behaviors.

To create a more effective HIV prevention service “package,” the Committee recommended that all DEBI interventions be coupled with recruitment interventions as a means to continuously connect high-risk populations services. Refer to Goal Area 3 for an explanation of recruitment and focused interventions.

Health Model Theories

The committee explored the social and behavioral health theories listed below in order to better understand factors that influence high-risk behaviors and prevention behavior change. Interventions grounded in these scientific theories produce behavior changes in high-risk populations when implemented consistently. CDC Tier I & II interventions are based on these health model theories. HIV prevention intervention research has demonstrated that interventions based on these models are effective in changing poor health behaviors among individuals and groups. Refer to Section 4: Attachment 3 for a description of each of the following theories:

- Health Belief Model
- Social Cognitive (Learning) Theory
- Theory of Reasoned Action
- Theory of Planned Behavior
- Transtheoretical Model (i.e. Stages of Change Model)
- Information-Motivation-Behavioral

Crack Cocaine Use and Sexual Risk Study

As a result of the 2005 Priority Setting Process, HPPG initiated a study on the connection between crack cocaine use and sexual risk in Chicago. In 2007, CDPH selected the University of Illinois at Chicago School of Public Health Community Outreach Intervention Project (COIP) to collect and analyze the data obtain from 100 study participants. The project aimed to:

- Describe individual, social and environmental contexts of crack use among African-American and Latino high risk heterosexual individuals and men who have sex with men.
- Understand the decision-making processes within the context of crack cocaine use that shape HIV risk reduction methods including condom usage.
- Explore an individual’s relative concern about HIV infection.
- Identify personal, social and structural barriers to sexual risk reduction in the context of crack use and trading sex.
- Explore perceptions of, use of, and barriers to STI/HIV testing and care, substance abuse treatment, and other health, social, and economic resources.

The preliminary findings were presented to HPPG during the priority setting process. A final report of this study will be available in late 2009.

Best-Fit & Culturally Appropriate Interventions

Using a solid theoretical foundation, the committee discussed the relevance, appropriateness and the cultural responsiveness of interventions for specific high-risk populations. Each high-risk population has unique characteristics based on race/ethnicity, gender, age, or type of risk behavior. Prevention interventions cannot have a “one size fits all” approach. Interventions are intentionally designed to meet the unique “cultural” (ethnic, risk, gender/age group) needs of the target population. Some interventions can be used across multiple populations where there is evidence of intervention effectiveness.

Variables that are considered when developing “culturally” appropriate and effective interventions include:

- Risk group (Hetero/Bi/Gay, IDUs, etc)
- Rates and modes of transmission
- Serostatus of the target population
- Population type: non-primary partners of unknown or discordant serostatus
- Limitations (cost, access to personnel, population, site, etc)
- Socio-demographic info: education, age, gender, sexuality, etc
- Individual: intention, attitude, self-efficacy, social normative influences, risk appraisal (i.e., feelings of threat)
- Ethical considerations (best practices, do no harm, and best fit, etc)
 - Principles of scientific integrity and ethics in conducting preventive research
 - Life-span developmental and ecological theoretical orientations, including biological, cognitive, and social influences on development
 - Developmental epidemiology in the community as an opportunity for scientific integration
 - Culturally appropriate assessment and intervention approaches
 - Multi-component prevention programs in natural settings
 - Research designs and data analytic techniques for longitudinal preventive interventions
 - Cost-benefit analysis of preventive interventions
 - Strategies to disseminate effective prevention practices

Goal Area 2

Goal 2: Identify, evaluate and prioritize DEBI interventions

Objective: Review relevant literature to develop a priority list of DEBI interventions.

Tasks:

1. Research and coordinate CBO presentations of effective DEBI for agencies directly and indirectly funded by CDC.
2. Summarize CDPH funded agencies.
3. Collect and review existing CDC research and body of knowledge related to DEBI interventions.
4. Summarize and prioritize DEBI interventions.

Goal Area Findings

To maintain prevention program continuity, the Committee determined that DEBI interventions should be limited to those that are currently implemented under the FY2007-2010 CDPH funding cycle. CBOs selecting DEBI interventions under the next funding cycle must already have training in the proposed intervention. This measure is a cost-efficient way to decrease implementation costs and support successfully implemented DEBI interventions.

Goal Area 3

Goal 3: Identify, evaluate and prioritize “home-grown” interventions.

Objective: Review relevant literature to develop a priority list of home-grown interventions.

Tasks:

1. Research and coordinate CBO presentations of effective home-grown interventions by agencies directly and indirectly funded by CDC.
2. Identify interventions used with Special Concerns populations.
3. Summarize and prioritize home-grown interventions.

Goal Area Findings

During the 2005 priority setting process, HPPG prioritized and reclassified home-grown interventions into either recruitment or focused interventions. CDC notes effective interventions must:

- Be feasible, practical, cost-effective, and have good potential for sustainability.
- Have a low potential for adverse short- and long-term, individual-level and community-level outcomes that could be attributed to the implementation of the intervention.
- Be acceptable and relevant to the target population.
- Have sufficient time to allow for the collection of data demonstrating the degree to which the intervention works, as well as the impact the intervention has on broader community health.
- Have the potential for additional health or social benefits that could result from its implementation.

The Interventions Committee listed all known non-DEBI interventions (home-grown) with a determination of whether the intervention met the effectiveness criteria (refer to Section 4: Attachment 4). The group determined that homegrown interventions continued to meet the minimum criteria of effectiveness set forth in the first *Compendium*. There is also tangible evidence from Chicago CBOs supporting the effectiveness of home-grown interventions.

Based on a thorough examination of the health behavioral model literature, the CDC's *Compendium of Effective Interventions*, and the Tiers of Evidence Models, the Committee recommended that Chicago CBOs combine a mix of both homegrown and DEBI (Tier I and II) interventions that best fit its operations and target populations.

As mentioned, recruitment interventions recruit members of high-risk populations to participate in more intense focused interventions. Focused Interventions incorporate risk-behavior counseling, risk reduction education, skills building practices, and increased opportunity for STI/HIV knowledge acquisition. The committee theorized that they required both types of interventions to maintain adequate service delivery to populations while actively reducing HIV incidence. The committee members recommended that at least one focused intervention be coupled with at least one homegrown or DEBI intervention. The Interventions Committee reviewed this practice and adopted this intervention matrix (Refer to Section 4: Attachment 4 for detailed intervention descriptions).

Final Priority Interventions Recommendations

Recommendation #1: Prioritized Recruitment & Focused Interventions

All HIV prevention programs must include at least one focused intervention coupled with at least one recruitment intervention.

Recruitment Interventions:

- Outreach
- Health Communication/Public Information (HC/PI)
- Community Level Intervention (CLI)
- Social Marketing
- Internet Based Intervention

Focused Interventions:

- Individual Level Interventions (ILI)
- Group Level Intervention (GLI)
- Comprehensive Risk Counseling and Services (CRCS)
- Comprehensive Syringe Access and Exchange Programs

Recommendation #2: DEBI & “Home-grown” Intervention Implementation

- DEBI and home-grown interventions are equally acceptable approaches to implement as recruitment and focused interventions.
- DEBI interventions are considered to be focused interventions and should be coupled with at least one recruitment intervention.

Recommendation #3: Culturally Relevant DEBIs

- Organizations are encouraged to select culturally relevant interventions that are most appropriate for the ethnic characteristics of the high-risk populations. For example, select *Many Men Many Voices* or *D-Up* as interventions for use with African-American MSM.

Recommendation #4: Address Risk Behaviors of Target Populations

- Interventions proposed by organizations must be targeted to specific priority populations and must address the unique issues and high-risk behaviors associated with those populations.

Recommendation #5: Prevention Services for High-Risk Heterosexuals (HRH)

Prevention interventions targeted to HRH must:

- Increase HIV Counseling, STI testing.
- Include some level of Hepatitis integration including basic education, referral, screening, counseling, and treatment and /or vaccination for Hepatitis A/B.
- Increase Health Communication/Public Information services.
- Expand access to free condoms.
- Focus on HIV prevention skills-building for women including condom negotiation skills and discussion of serostatus.

Recommendation #6: Prevention Services for Men who have Sex with Men (MSM)

Prevention interventions targeted to MSM must:

- Increase HIV and STI testing opportunities.
- Expand access to free condoms.
- Address and incorporate the concept of “condom fatigue” in interventions.
- Explore and document the relationship between drug use and casual sex in this population.

Recommendation #7: Prevention Services for Injection Drug Users

Prevention interventions targeted to IDU must:

- Increase HIV and STI testing opportunities.
- Expand access to free condoms.
- Expand access to Needle Exchange Programs (NEP).
- Focus risk reduction curriculum on the risks of sharing injection equipment (i.e., cookers, cotton, rinse water, etc.).

Recommendation #8: Prevention Services for Youth

Prevention interventions targeted to high-risk youth must:

- Increase HIV testing opportunities to MSM under age 25.
- Increase HIV testing opportunities to Non-Hispanic Black young females under 25.

- Increase condom distribution and risk reduction counseling to Non-Hispanic Black young females under 25 (who have unprotected sex with their casual non-primary sex partners).

Recommendation #9: Minimum Intervention Standards

All interventions must address the following HIV-related services:

- HIV Counseling, Testing & Referral (HIV CTR)
- STI and Hepatitis Integration that includes basic education, referral, screening, counseling, and treatment and /or vaccination for Hepatitis A/B

Section 5: Needs Assessment/Gap Analysis Committee Process and Recommendations

COMMITTEE GOAL: To identify gaps in HIV prevention services, and to develop a prevention portfolio that addresses the needs of high-risk populations and considers social barriers that influence access to services.

Overview

HIV prevention service needs are either “met” or “unmet.” Prevention needs are met when targeted services reach priority high-risk populations in high-incidence areas. Needs are unmet when expressed epidemiological data reveals increases in STI/HIV/AIDS incidences for specific high-risk populations or geographic regions.

Needs Assessment/Gap Analysis (NA/GA) Committee Methods

The NA/GA Committee summarized prevention service needs by analyzing:

- Existing HIV prevention services targeted to priority high-risk populations.
- Geographic areas where HIV diagnosis rates are the highest.
- Factors that contribute to HIV.
- Past funding amounts of HIV prevention programs.

In 2008, the NA/GA Committee adopted the 2005 PSP gap analysis methodology. The Committee analyzed four distinct sets of data: Populations Committee epidemiological findings of priority populations, social barriers data, resource inventory, and CDPH-funded HIV prevention services. Goal Areas 1-4 document the goals and major goal area findings from the Committee’s priority setting process.

Goal Area 1

Goal 1: Identify the distribution of HIV prevention services across Chicago.

Objective: Conduct a needs assessment and gap analysis.

Tasks:

1. Review and modify, if necessary, the 2005 PSP gap analysis model.
2. Modify and distribute a resource inventory survey assessing prevention services under CDPH funding under the HIV Prevention Program Announcement 2006-2009.
3. Review resource inventory data analysis from the 2005 PSP.

Goal Area Findings

The NA/GA Committee conducted a resource inventory of HIV prevention services. However, the findings were inconclusive because of the low response rate from local HIV prevention agencies. To compensate, the NA/GA Committee relied on basic funding and other (report data etc.) information supplied by CDPH in order to gain greater insight into service needs and gaps (refer to Section 5: Attachment 1).

The NA/GA committee reviewed epidemiological data compiled for the Populations Committee and confirmed major changes in the epidemic. The Committee compared and mapped the HIV incidence rates of the 2005 and 2008 priority setting cycles. This is an addition made by the NA/GA Committee to capture a different perspective of HIV disease, as illustrated by comparing the 2006-2007 HIV incidence rate map to the changes in HIV incidence rates map (refer to Section 5: Attachments 5 and 6).

Clusters A and B experienced a decrease in the change in HIV diagnosis rate between 2002-2003 and 2006-2007 (refer to Section 5: Attachment 6), while Cluster C experienced an increase in the change in HIV diagnosis rate between the two time periods. Factors for these changes are unknown.

Goal Area 2

Goal 2: Identify gaps in HIV prevention services through a comparison of community needs vs. services offered.

Objective: Conduct a needs assessment and gap analysis.

Tasks:

1. Analyze CDPH delegate agency HIV prevention programs funded under CDPH funding under the HIV Prevention Program Announcement 2007-2009.
2. Review and consider interventions best-practice literature, science-based theories, etc.
3. Review and consider prioritized populations recommendations.
4. Review and consider prioritized intervention recommendations.
5. Compare existing prevention interventions in the cluster regions by high-risk population to HIV incidence data.

Goal Area Findings

The committee analyzed interventions delivered to target populations by CBOs funded between FY 2007 to 2010. CBOs had the option to provide prevention interventions in one or more Cluster Regions (A, B, C) to prioritized populations. This service “utilization” data confirms epidemiological data, which expresses an HIV prevention need.

The committee also compared funding strategies from the 2003 and 2005 Priority Setting Process. Full health department prevention funding combines both CDC, state, and local sources. Funding allocation determination occurs first by the geographic Cluster, or Citywide Models, and then to target populations.

For FY 2005-2006 (PSP, 2003) and FY 2007-2010 (PSP 2005), 70% of prevention funding was allocated to programs whose efforts were directed within a single cluster, while the other 30% funded city-wide programs. Funding allocations for non-priority populations, such as Special Concerns Populations and special initiatives, were increased for FY 2007-2010, which decreased overall funding to the previously prioritized populations (refer to Section 5: Attachments 2 and 3).

Goal Area 3

Goal 3: Using a public health framework, identify and weigh contextual factors (social barriers) that increase risk for HIV transmission.
Objective: Conduct a needs assessment and gap analysis.
Tasks:

1. Review and discuss 2008 PSP Social Determinants of Health recommendations.
2. Conduct social determinants of health indexing analysis to determine where barriers exist in geographic areas.
3. Create social determinants of health maps to geographically illustrate where social barriers to HIV prevention exist.

Goal Area Findings

The 2008 Priority Setting Process NA/GA Committee explored various social factors that influence HIV risk behaviors and developed a framework to identify and to weight these factors. CDC and other research groups concluded that, when multiple economic, social, and health conditions occur simultaneously in an environment (community or geographic region), they amplify the potential for the occurrence of high-risk sex and drug using behaviors. Factors, such as poverty, substance abuse, crime/violence, availability of health care facilities, and other socioeconomic factors present in communities with high HIV incidence, or experienced by high-risk populations, increase the likelihood of risk behaviors as illustrated in Figure 10.

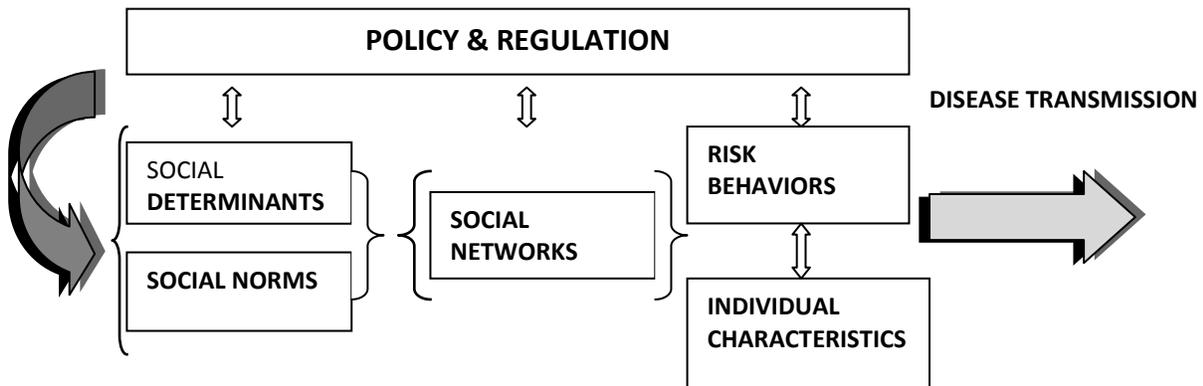
Figure 10



Figure adapted from Anderson et al, 2003; Marmoraetal, 1999; and Wilkinson et al, 2003 39-41

The committee used a Contextual Model of Health to describe the influence of social norms and the presence of a syndemic environment on disease transmission. Figure 11 traces the bi-directional and lateral relationship between policy and regulations on social determinants (social barriers), social networks, and risk behaviors, with each influencing the other and ultimately leading to increase disease transmission.

Figure 11



Goal Area 4

Goal 4: Develop a set of identified needs, social barriers and gaps to support targeting resources to the Populations and Interventions priority recommendations.

Objective: Create suggestions to fill in gaps in prevention services.

Tasks:

1. Review and synthesized research findings and outcomes from discussions.
2. Create a list of final Gap Analysis findings and Prioritized recommendations for each for presentation to HPPG.

Goal Area Findings

Built on this theoretical foundation, the committee created a list of social determinants of health, particularly as they affect HIV/AIDS.

The NA/GA Committee reviewed the 2005 list of social determinants. The committee attempted to incorporate as many social determinants of health and of HIV/AIDS as possible. The committee reviewed each social determinant based on the following factors: direct relationship to HIV transmission, direct relationship to health, literature reviews, and field experience. The NA/GA Committee decided to combine the variables into factors when appropriate. With the factors, the committee reviewed available data sources and eliminated factors with unavailable data sources (refer to Section 5: Attachment 4 for the full list of social barriers used).

The NA/GA Committee combined variables into factors using a basic linear model to place each variable on the same scale. The committee voted on the weight of each variable. All variables were combined to calculate the presence of social barriers in each zip code across the city. The Committee employed the use of geographic information systems (GIS) to create maps identifying the areas of city with higher social barriers.

The NA/GA Committee created maps of the weighted variables and compared them to epidemiological incidence maps to better understand the full HIV picture. An analysis of the social determinants data revealed that overall Cluster A experienced fewer social barriers when compared to Clusters B and C. Within Clusters B and C, there were zip codes with higher numbers of barriers than other zip codes within the region, including socioeconomic status and total crime. In analyzing STIs, Cluster A (among white MSM) experienced higher rates of syphilis infections than in all areas. However, Clusters B and C experienced higher rates of gonorrhea and chlamydia than in Cluster A, with African American youth experiencing the highest rates in Chicago (refer to Section 5: Attachments 6-9).

Social barriers data, compared against the existing HIV prevention program, confirmed that resources set by the 2005 Priority Setting Process were targeted adequately. Social barriers data revealed other unmet, non-HIV prevention needs services. Therefore, the creation of a multi-pronged prevention approach should decrease barriers to access services and other types of chronic illnesses that influence HIV risk. The committee mapped and compared barriers to epidemiological incidence maps to understand the full HIV picture (refer to Section 5: Attachments 7 and 9 for a map of these social barriers in each high incidence Cluster area). Based on these findings the committee developed the following final priority recommendations.

Furthermore, the NA/GA Committee reviewed gaps and needs, not only based on gaps in services, but based on priority setting process gaps and needs. The committee understood the many limitations of the process and of the data available and decided to document the limitations with some recommendations. With enhanced reporting systems, NA/GA Committee, along with the other committees, can capture populations more accurately, specifically the special concerns populations that fall under the radar of epidemiology.

Final Priority NA/GA Recommendations

Recommendation #1: Geographic Recommendations

The results of the gap analysis process confirmed the recommendations set forth by the Populations and Interventions Committees.

Recommendation #2: Regional HIV Prevention Allocations: Cluster Model

Confirm that the cluster models (A, B, and C) encompass zip code areas where both HIV incidence and social determinants are the highest. Refer to Section 5 Attachment 3-5.

Recommendation #3: Gap Analysis Methodology

Revise the methodology for Resource Inventory to improve the existing methodology to distribute an annual Resource Inventory at the local, county, and state levels to ensure that agencies only complete one inventory per year.

Recommendation #4: Reduce HIV rates in Injection Drug User

Maintain current levels of IDU prevention services in an effort to affect consistent decreases in HIV prevention rates for this population.

Recommendation #5: Post-Incarceration Services

- Continue post-incarceration HIV prevention work, including prevention with currently incarcerated individuals.
- Establish communication and collaboration with the Cook County system to ensure access to HIV testing/counseling and access to condoms and to incorporate HIV prevention work with the juvenile detention center.

Recommendation #6: Expand HIV Prevention in Non-Traditional Settings

Expand HIV prevention efforts at non-traditional venues such as internet, etc.

Recommendation #7: Standardize and Include New Variables in CDPH Data Collection

- Include youth (13 to 24 years of age) as a variable in CDPH data collection (i.e., surveillance and research).
- Include transgender variable in CDPH data collection (i.e., surveillance and research).
- Standardize transgender variables into Male-to-Female (MTF) and Female-to-Male (FTM).
- Include Asian/Pacific Islanders, American Indian, and Alaskan Native ethnic groups as standard variables in all data collection activities and reports.

The Illinois Department of Public Health is responsible for the development and modification of state surveillance forms. The Chicago Department of Public Health is working with both CDC and IDPH to alleviate barriers in data collection. HPPG will also continue to prioritize data collection issues. It is important to note that CDC does not include youth under the age of 18 in behavioral research activities due to child protection laws.

Section 6: Finishing Committee Process and Final Recommendations

COMMITTEE GOAL: To develop a set of recommendations that confirms the work of the Populations, Interventions and NA/GA Committees, and results in a prevention portfolio that documents the percentage of resources to be allocated by cluster, priority population and special projects.

Overview

The Executive Committee, serving in their role as the Finishing Committee, met monthly during the priority setting process. The committee discussed work plan progress and refined recommendations prior to presenting them to the full body and to the community at large. The committee reviewed, revised, and approved the prevention priority recommendations developed by each committee. The committee then presented the final committee recommendations, along with the recommended HIV prevention resource allocations, to the HPPG full body for final approval. CDPH then used these recommendations to guide resource allocations for HIV prevention activities. CDPH is responsible for allocating resources as it sees fit to best meet the needs of HIV prevention programming in Chicago.

Final Priority Recommendations

Recommendation #1: Percentage Resource Allocations

Population Allocation

88% = Prioritized High-Risk Populations

12% = Special Concerns Populations

Cluster Allocation for Populations

83% = Cluster-specific High-Risk Populations

16.5% = IDU Populations

Serostatus Allocation

90% = High-Risk Negative Population Programs

10% = Prevention with Positives Programs

Age Allocation

75% = Adults

25% = Youth

Cluster Region Allocation

31.64% = Cluster A

28.08% = Cluster B

40.34% = Cluster C

Recommendation #2: Effective HIV Prevention Interventions

The Finishing Committee reviewed the Interventions Committee's Recommendation #2, which was:

“DEBI and home-grown interventions are equally acceptable approaches to implement as recruitment and focused interventions. DEBI interventions are considered to be focused interventions and should be coupled with at least one recruitment intervention.”

To ensure the effectiveness of HIV prevention services, the Finishing Committee decided to include the following as an expansion of this recommendation:

“Through a competitive RFP, organizations will demonstrate their capacity to implement DEBI and home-grown interventions under the Focused & Recruitment Intervention model.”

Recommendation 3: Other Allowable Infectious Disease Prevention Activities

The Finishing Committee clarified the Interventions Committee's Recommendation #9 of Minimum Intervention Standards, which states that:

“All interventions must address the following HIV-related services: HIV Counseling, Testing & Referral (HIV CTR) as well as STI and Hepatitis Integration (which may include basic education, referral, screening, counseling, and treatment and /or vaccination for Hepatitis A/B)”

With the following provision:

“The allowable HIV prevention program costs may include Hepatitis vaccines, STD medications, and related medical supplies.”

Section 7: Attachments

Introduction: Attachment 1 – Special Projects

Prevention with Positives

The committee acknowledged the importance of retaining existing prevention for HIV-positive programming. The key factor in reducing HIV incidence is to make known an individual's positive serostatus and to change high-risk behaviors among persons infected with HIV. The committee recommended that CBOs target appropriate evidenced-based prevention interventions to HIV positive MSM, IDU, and high-risk heterosexuals.

Partner Counseling and Referral Services (PCRS)

Partner Counseling and Referral Services is intended to provide intensive and supportive counseling services to persons who are newly diagnosed with HIV. CDPH made these funds available to CBOs to support the third goal in CDC's "Advancing HIV Prevention," which states, "Prevent new infections by working with persons diagnosed with HIV and their partners." This mirrors CDPH's intent to directly impact its strategic goal of reducing new HIV infections in Chicago.

The goals of community-based PCRS are to:

- Reduce HIV transmission by working closely with newly diagnosed HIV-positive individuals.
- Reduce barriers to early diagnosis of HIV infection.
- Increase the proportion of individuals at high risk for HIV infection who become aware of their status.
- Increase access to quality HIV medical care and ongoing prevention services for individuals living with HIV.
- Complement other activities and interventions supported by CDPH.

Social Networks

According to CDC, HIVCTR programs that integrate social networks have been shown to be highly effective at identifying HIV-positive individuals who are unaware of their status. In CDC's *Social Networks Demonstration Program (2003-2005)*, the prevalence rate was significantly higher (six times) than the average of most HIVCTR programs. Social Networks HIVCTR programs presume that individuals who are HIV-positive or who are at high-risk for becoming HIV-positive will know other individuals who are also positive or at high-risk for becoming infected with HIV. Social Networks HIVCTR programs also recognize that peers may have a better ability to educate high-risk individuals in their social network about HIV than do traditional agency outreach workers.

2007–2012 Special Projects of Innovative Significance (SPInS)

In 2005, CDPH developed special funding for a five year program to create innovative HIV prevention program models that:

- Explore the links between HIV risk and other issues that increase the likelihood of HIV infection/transmission in specific target populations, like substance use, incarceration and poverty.
- Explore links between healthy decision-making and community assets that increase the likelihood of reducing HIV infection/transmission in specific target populations, like kinship, economics, education and faith.
- Identify new HIV infections.
- Reduce HIV infection in the identified populations/settings.

Corrections

The Corrections SPInS project explores the link between incarceration, MSM high-risk behavior, and the use of crack and other substances.

This project seeks to reduce HIV infection/transmission among high-risk men who:

- Engage in high-risk unprotected anal intercourse with other men.
- Are currently incarcerated, recently released from a correctional facility or at risk for future incarceration.
- Currently use/formerly used crack and other substance.

Crystal Methamphetamine Prevention

The Prevention of Crystal Methamphetamine Use and HIV Infection/Transmission SPInS project explores the link between the presence of crystal methamphetamine use in MSM communities and the use of Internet websites for sexual encounters in HIV infection/transmission.

This project seeks to reduce HIV infection/transmission among high-risk MSM who:

- Engage in high-risk unprotected anal intercourse with other men.
- Are at risk for using crystal methamphetamine.
- Use the Internet to facilitate high-risk sexual encounters.

Female Empowerment

The Female Empowerment SPInS explores the link between incarceration, high-risk behavior among women, and gender inequality and associated vulnerabilities.

This project seeks to reduce HIV infection among high-risk women who:

- Engage in unprotected vaginal and/or anal intercourse with HIV+ men or high-risk men of unknown HIV status (i.e., men who engage in unprotected anal intercourse with other men and needle/syringe sharing).
- Are currently incarcerated, recently released from a correctional facility or at risk for future incarceration.
- Experience vulnerabilities associated with gender inequality.

STD Clinic Waiting Room

The STD Clinic Waiting Room SPInS enhances the delivery of HIV prevention interventions to clients receiving CDPH STD clinic services. The project will incorporate Voices/VOCES, a CDC-DEBI behavioral intervention.

This project seeks to reduce HIV infection/transmission among high-risk STD clients who:

- Engage in high-risk vaginal and/or anal intercourse.
- Visit CDPH STD clinics to be screened, tested and/or treated for an STI.

Section 3: Attachment 1 – Epidemiological Data (prepared by SER for Populations Committee)

Table 1 - HIV Diagnoses vs. Concurrent by Selected Characteristics Chicago, 2006, as of 6/30/2008

Characteristic	HIV Diagnoses		Concurrent [§]		Percent Late Testers
	No.	%	No.	%	
Sex					
Male	1,241	80	366	79	29%
Female	316	20	97	21	31%
Race/Ethnicity					
Non-Hispanic Black	865	56	272	59	31%
Non-Hispanic White	396	25	88	19	22%
Hispanic	242	16	88	19	36%
Non-Hispanic Other	54	3	15	3	28%
Transmission Group[#]					
Male Sex w/Male	968	62	252	54	26%
Injection Drug Use	198	13	68	15	34%
MSM and IDU [¶]	38	2	18	4	47%
Heterosexual	337	22	114	25	34%
Other ^{**}	18	1	8	2	44%
Age Group					
<19	74	5	13	3	18%
20-29	401	26	78	17	19%
30-39	428	27	128	28	30%
40-49	432	28	151	33	35%
50+	222	14	93	20	42%
Total	1,557	100	463	100	30%

Note: Groups may not total 100% due to rounding. Cells representing 1-4 person(s) are marked with a dash (-).

*Data for 2006 are not complete due to delays in reporting.

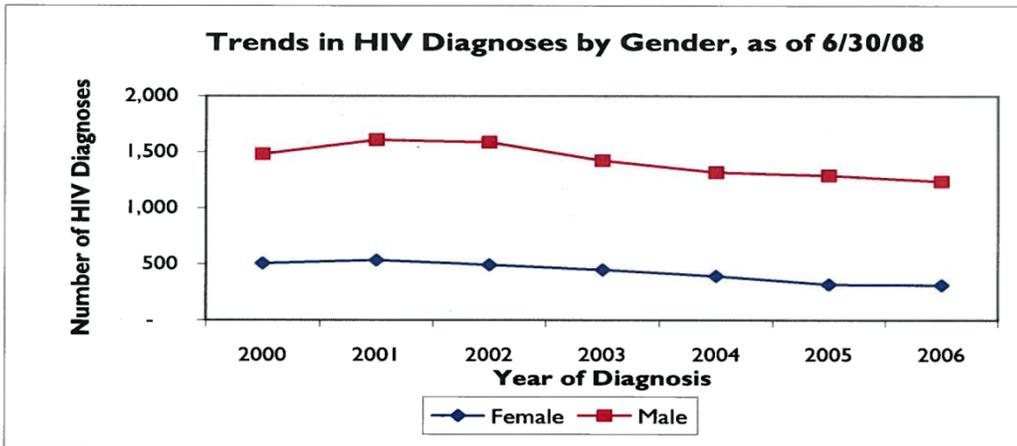
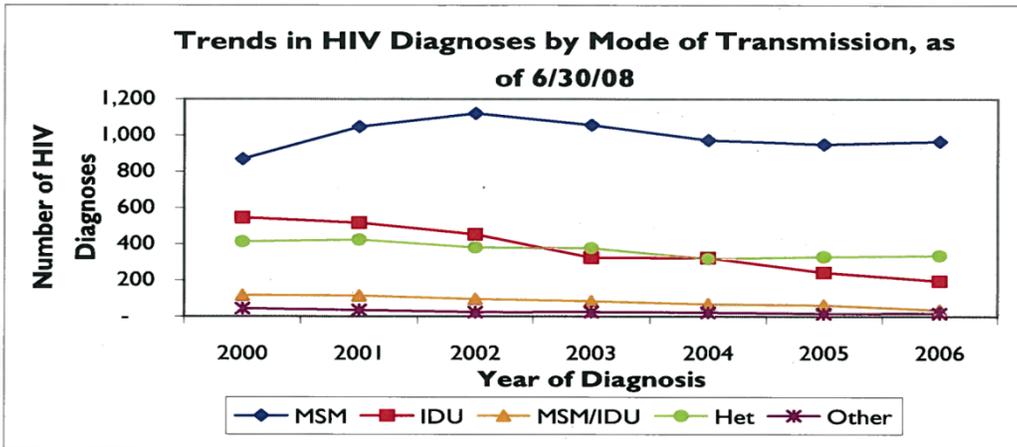
§Concurrent HIV diagnoses are those people receiving a new diagnoses of HIV and AIDS during the same calendar year.

¶Men who have sex with men and inject drugs.

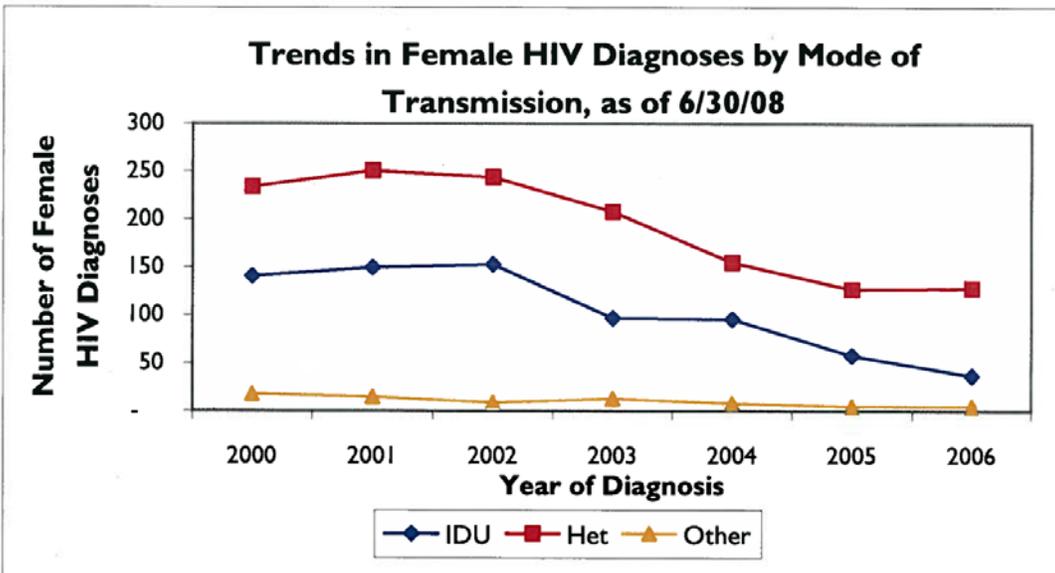
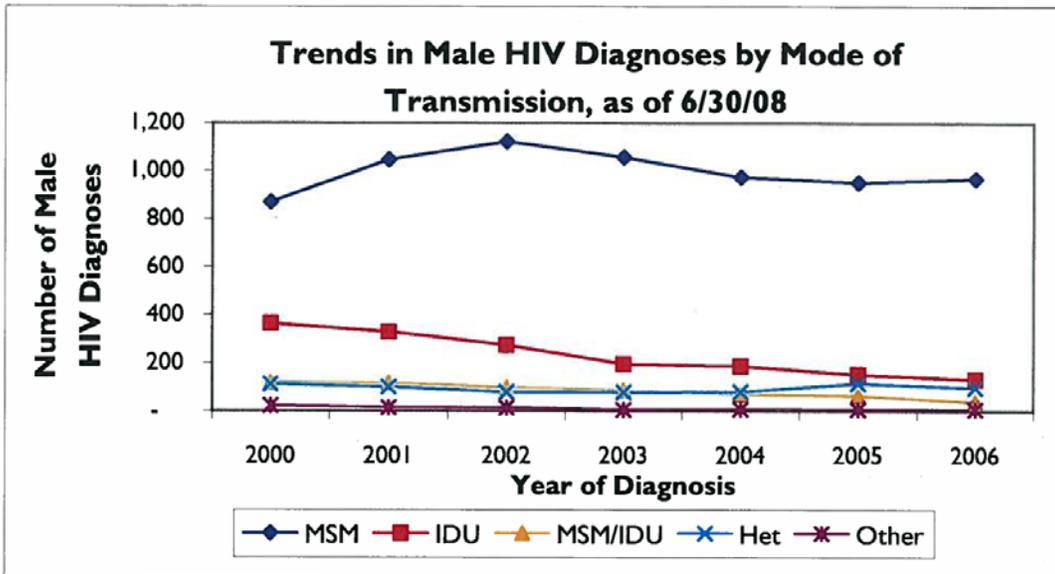
**Includes perinatal transmission, blood transfusion and hemophilia.

#Cases with unknown risk have been re-distributed based on age/gender/race/ethnicity distribution of known cases.

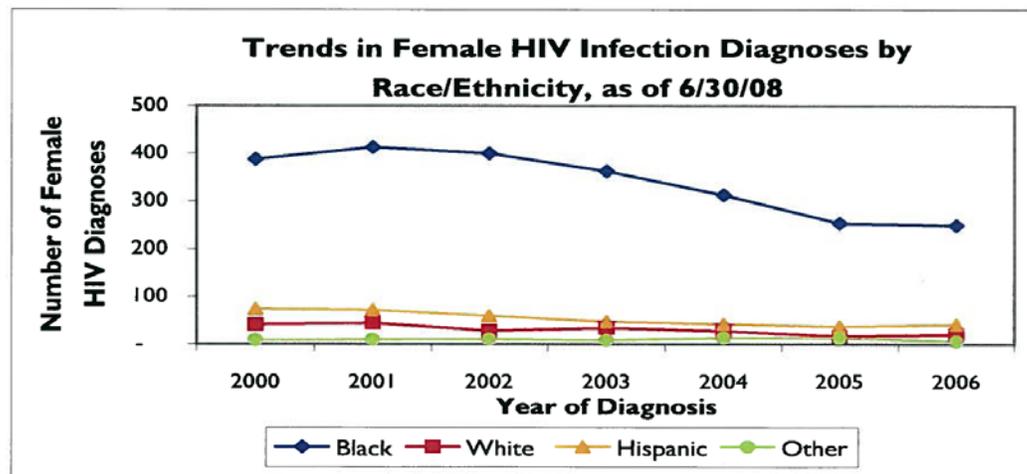
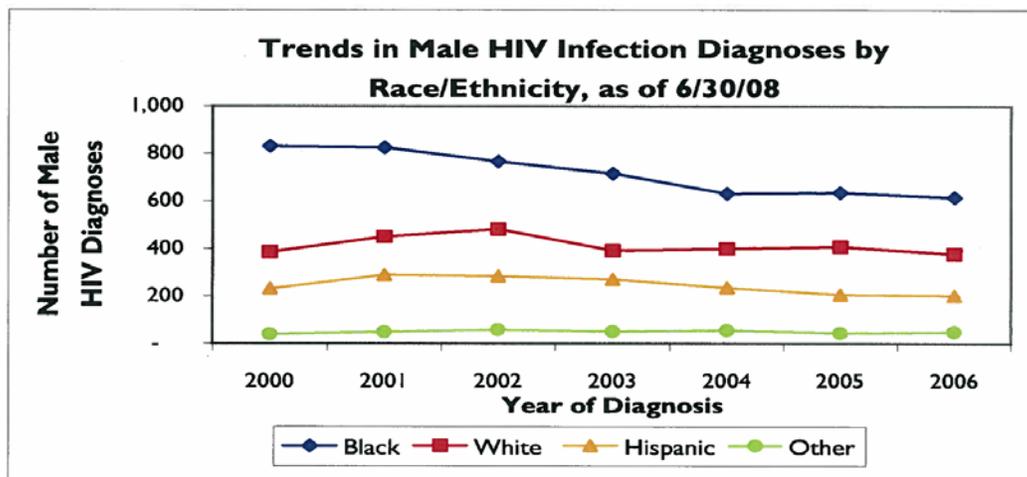
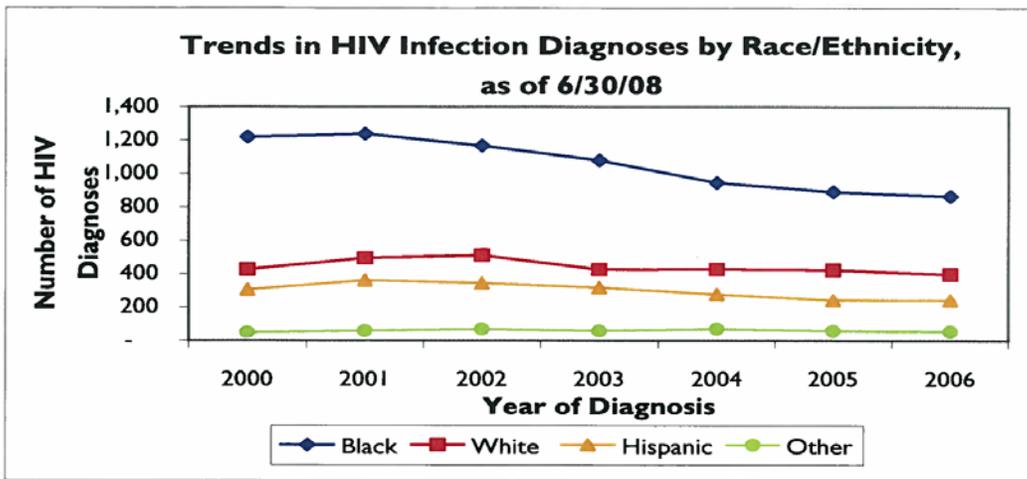
Section 3: Attachment 2 – Epidemiological Data (prepared by SER for Populations Committee)



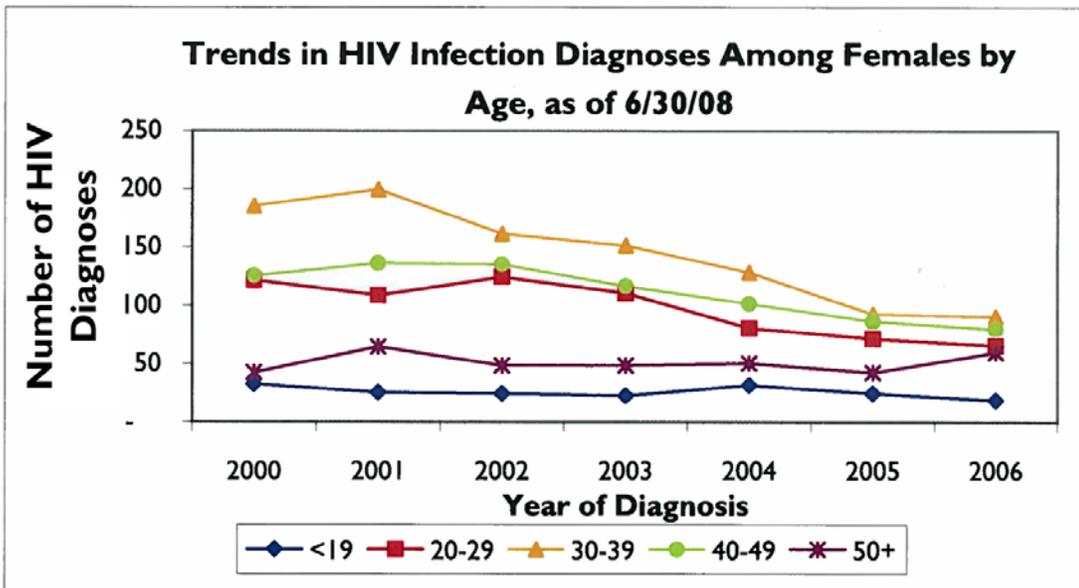
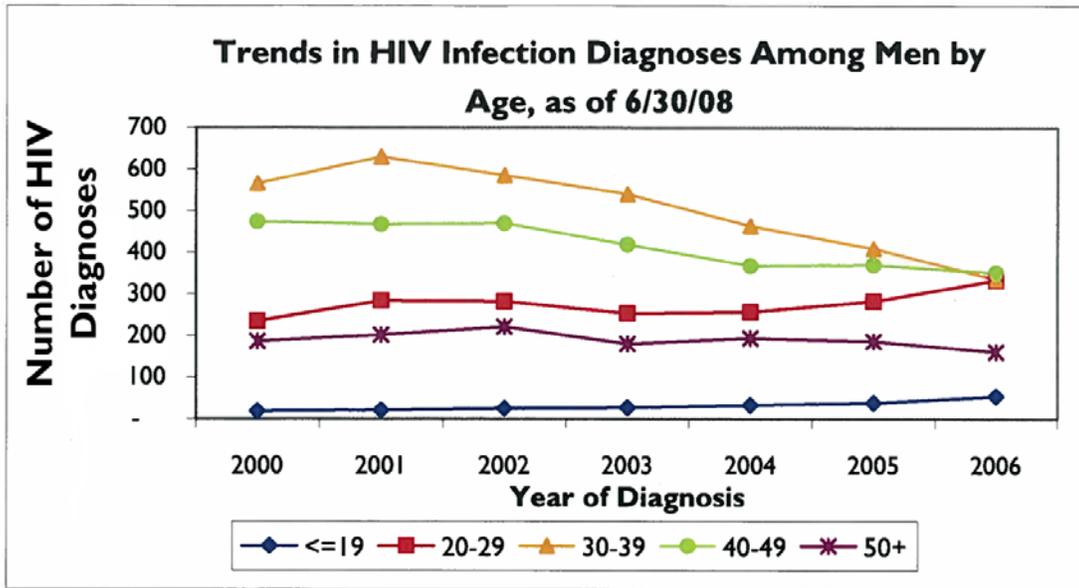
Section 3: Attachment 2 – Epidemiological Data (prepared by SER for Populations Committee)



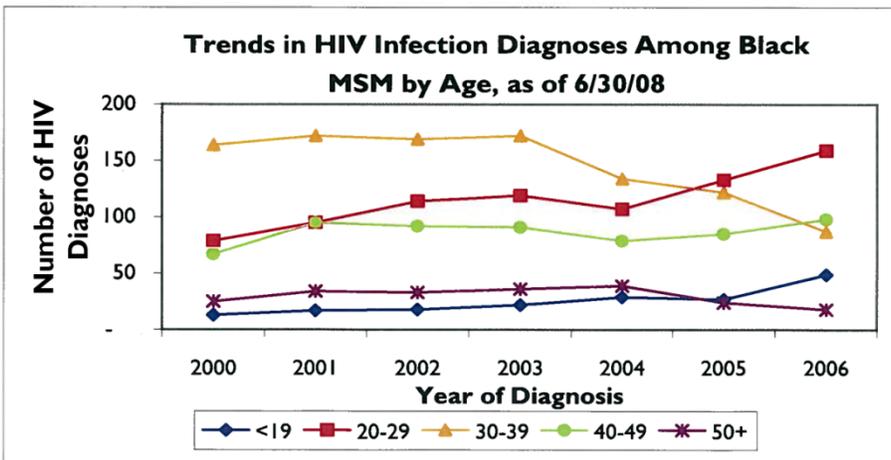
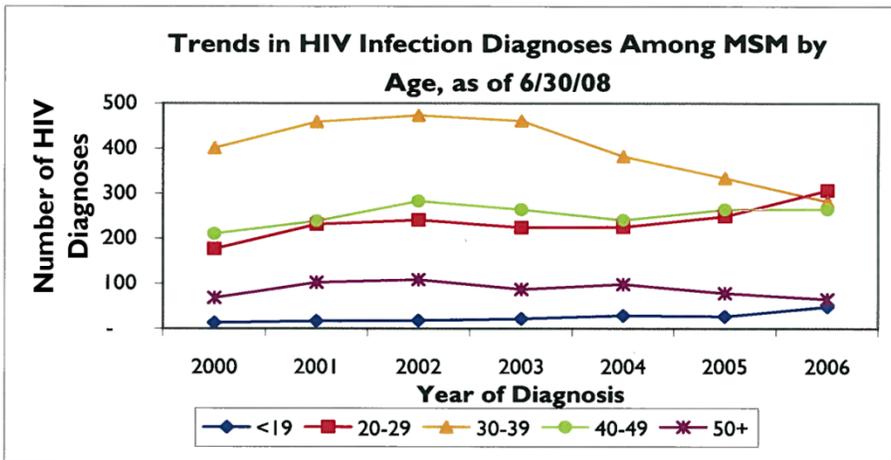
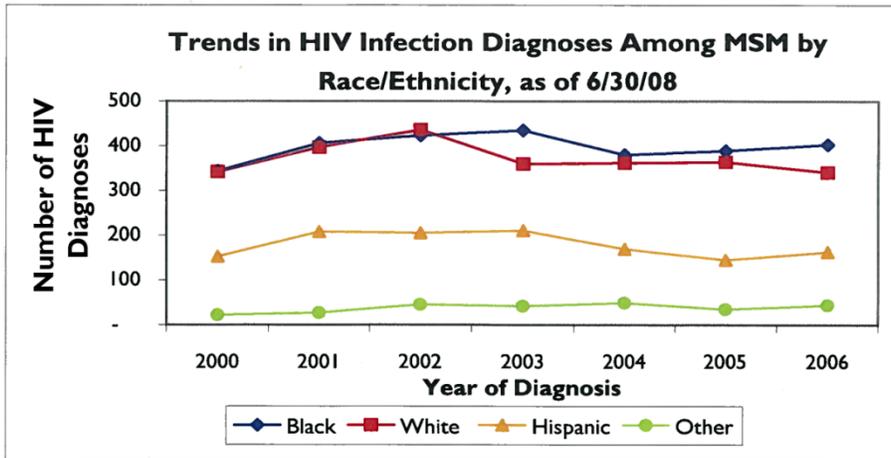
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Section 3: Attachment 2 – Epidemiological Data (prepared by SER for Populations Committee)



Section 3: Attachment 3 – Epidemiological Data (prepared by SER for Populations Committee)

Average Annual HIV (not AIDS) Diagnosis Rate, 2006-2007

Rank	Population	Age Group	Rate	N
1	NHB Male	25-34	171.4	97
2	NHB Male	35-44	159.5	98
3	NHB Male	15-24	151.2	101
4	NHB Male	45-54	144.7	68
5	NHW Male	35-44	126.6	98
6	NHW Male	25-34	94.6	79
7	NHW Male	45-54	81.6	49
8	Hisp Male	35-44	62.9	38
9	NHB Female	25-34	60.7	44
10	Hisp Male	25-34	53.3	44
11	NHB Female	45-54	51.6	32
12	NHW Male	15-24	50.6	21
13	NHO Male	25-34	-	-
14	NHB Female	15-24	44.9	33
15	NHB Male	55+	41.0	28
16	NHO Male	35-44	-	-
17	Hisp Male	45-54	-	-
18	NHO Male	45-54	-	-
19	Hisp Male	15-24	29.4	21
20	NHO Male	15-24	-	-
21	Hisp Female	45-54	-	-
22	NHB Female	55+	-	-
23	Hisp Male	55+	-	-
24	NHO Female	15-24	-	-
25	NHW Male	55+	-	-
25	NHW Female	25-34	-	-
26	NHW Female	15-24	-	-
27	NHW Female	45-54	-	-
28	NHO Female	45-54	-	-
29	Hisp Female	35-44	-	-
30	Hisp Female	25-34	-	-
31	NHO Male	55+	-	-
32	NHW Female	35-44	-	-
33	NHB Female	35-44	-	-
34	Hisp Female	15-24	-	-
35	Hisp Female	55+	-	-
36	NHO Female	25-34	-	-
37	NHW Female	55+	-	-
38	NHO Female	35-44	-	-
39	NHO Female	55+	-	-
			37.4	1,010

830 Diagnoses:
82% of City Diagnoses

Data as of 6/30/08.

Note: Rates are not calculated if numerator or denominator is less than 20.

Case counts are not displayed if there are less than 5 cases.

Source: Chicago Department of Public Health, 7/08/08

STD/HIV/AIDS Division - Surveillance, Epidemiology and Research Section

Section 3: Attachment 3 – Epidemiological Data (prepared by SER for Populations Committee)

Change in HIV (not AIDS) Diagnosis Rates by Zipcode, 2002-2003 to 2006-2007

Zip Code*	2002-2003		2006-2007		% change
	N	2-Year Rate	N	2-Year Rate	
60657	161	241.1	139	208.1	-13.7%
60640	197	266.1	149	201.3	-24.4%
60613	131	259.2	99	195.9	-24.4%
60660	91	190.7	79	165.5	-13.2%
60605	16	128.8	20	161.0	25.0%
60626	92	155.3	84	141.8	-8.7%
60607	21	135.0	20	128.6	-4.8%
60649	51	93.0	66	120.4	29.4%
60653	36	104.3	40	115.9	11.1%
60619	55	73.4	78	104.1	41.8%
60637	37	64.8	57	99.8	54.1%
60644	48	81.3	57	96.5	18.8%
60624	69	151.2	44	96.4	-36.2%
60621	55	115.8	45	94.7	-18.2%
60612	70	184.3	35	92.1	-50.0%
60615	37	82.0	41	90.9	10.8%
60636	54	105.0	45	87.5	-16.7%
60608	125	135.2	77	83.3	-38.4%
60628	66	75.1	66	75.1	0.0%
60622	64	84.2	50	65.8	-21.9%
60610	50	105.2	31	65.2	-38.0%
60620	55	64.1	52	60.6	-5.5%
60651	51	65.7	47	60.6	-7.8%
60647	67	67.8	59	59.7	-11.9%
60609	35	44.0	45	56.6	28.6%
60617	32	33.2	48	49.9	50.0%
60616	33	70.1	22	46.7	-33.3%
60643	26	49.5	23	43.8	-11.5%
60623	72	66.6	42	38.8	-41.7%
60614	38	58.0	25	38.2	-34.2%
60618	43	43.8	36	36.7	-16.3%
60625	48	52.5	32	35.0	-33.3%
60629	32	28.1	38	33.3	18.8%
60639	42	45.2	29	31.2	-31.0%
60641	22	29.8	15	20.3	-31.8%
City Total	2,313	79.8	1,999	69.1	

Data as of 6/30/08.

Note: Rates are not calculated if numerator or denominator is less than 20 and hence zipcodes are not presented.

Source: Chicago Department of Public Health, 7/30/08

STD/HIV/AIDS Division - Surveillance, Epidemiology and Research Section

Section 3: Attachment 4 – Epidemiological Data (prepared by SER for Populations Committee)

HIV (not AIDS) Diagnoses and Prevalence Among Asian and Hawaiian/Pacific Islanders, Chicago, as of 6/30/08

Characteristic	2001-2007 Diagnoses	2007 Prevalence
Gender		
Male	92%	89%
Female	8%	11%
Race/Ethnicity		
NH Asian	71%	55%
NA Native Hawaiian/PI	15%	9%
Legacy Asian/PI	14%	37%
Age at Diagnosis		
<15	-	2.0%
15-24	11%	8%
25-34	51%	47%
35-44	22%	29%
45-54	14%	10%
55+	2%	4%
Mode		
MSM	69%	61%
IDU	4%	4%
MSM/IDU	4%	4%
Hetero	8%	12%
Other/Unidentified	15%	19%
Total Cases	100	241

*Rate represents a selection of populations with an HIV incidence rate greater than the city average. Geography represents a selection of zipcodes with an HIV incidence rate greater than the city average.

Section 3: Attachment 4 – Epidemiological Data (prepared by SER for Populations Committee)

Comparison of Priority Populations Obtained Using Different Ranking Methods based on HIV Incidence Rates, Chicago, 2002-2003

Characteristic	Distribution of Cases		Total
	Ranking Method*		
	Rate	Geography	
Gender			
Male	80%	78%	75%
Female	20%	22%	25%
Race/Ethnicity			
NHW	21%	30%	25%
NHB	65%	56%	56%
Hispanic	14%	10%	15%
NHO	0.7%	2%	2%
Age			
<13	0%	0.3%	0.4%
13-24	11%	11%	13%
25-34	34%	31%	29%
35-44	40%	35%	35%
45+	15%	23%	23%
Mode			
MSM	49%	51%	46%
IDU	15%	15%	16%
MSM/IDU	3%	2%	3%
Hetero	12%	12%	14%
Other	0.5%	0.6%	1%
NIR	20%	19%	20%
Total Cases	976	700	1,224

*Rate represents a selection of populations with an HIV incidence rate greater than the city average. Geography represents a selection of zipcodes with an HIV incidence rate greater than the city average.

Section 3: Attachment 4 – Epidemiological Data (prepared by SER for Populations Committee)

**Comparison of Priority Populations Obtained Using
Different Ranking Methods based on HIV
Incidence Rates, Chicago, 2006-2007**

Characteristic	Distribution of Cases		
	Ranking Method*		Total
	Rate	Geography	
Gender			
Male	87%	81%	79%
Female	13%	19%	21%
Race/Ethnicity			
NHW	29%	29%	27%
NHB	59%	59%	55%
Hispanic	12%	9%	14%
NHO	0%	2%	2%
Age			
<15	0%	0.5%	0.5%
15-24	21%	19%	18%
25-34	31%	28%	29%
35-44	28%	30%	29%
45-54	18%	18%	18%
55+	3%	6%	6%
Mode			
MSM	58%	54%	51%
IDU	7%	8%	8%
MSM/IDU	2%	1%	1%
Hetero	8%	9%	10%
Other	0.5%	0.3%	0.4%
NIR	25%	27%	29%
Total Cases	1,697 (84%)	1,240 (61%)	2,020

*Rate represents a selection of populations with an HIV incidence rate greater than the city average (37.4 per 100,000). Geography represents a selection of zipcodes with an HIV incidence rate greater than the city 2-year annual average (70.0 per 100,000).

Section 3: Attachment 5 – Epidemiological Data (prepared by SER for Populations Committee)

2002-2003 Groups with Diagnoses Rates Greater than City Average

NH Black	Males	13-24	Hispanic	13-24
		25-34		25-34
	Females	35-44	Females	35-44
		45+		45+
		13-24		
		25-34		
		35-44		
		45+		
NH White	Males	13-24	Hispanic	13-24
		25-34		25-34
	Females	35-44	Females	35-44
		45+		45+
		13-24		
		25-34		
		35-44		
		45+		
NH Other	Males	13-24	Hispanic	13-24
		25-34		25-34
	Females	35-44	Females	35-44
		45+		45+
		13-24		
		25-34		
		35-44		
		45+		

2006-2007 Groups with Diagnoses Rates Greater than City Average

NH Black	Males	15-24	Hispanic	15-24
		25-34		25-34
	Females	35-44	Females	35-44
		45-54		45-54
		55+		
		15-24		
		25-34		
		35-44		
		45-54		
		55+		
NH White	Males	15-24	Hispanic	15-24
		25-34		25-34
	Females	35-44	Females	35-44
		45-54		45-54
		55+		
		15-24		
		25-34		
		35-44		
		45-54		
		55+		

Section 3: Attachment 6 – Epidemiological Data (prepared by SER for Populations Committee)

2006-07 HIV (not AIDS) Diagnoses by Cluster, Select Demographics and					
North					
		MSM	IDU and IDU/MSM	Heterosexual	Total*
NHW Male	<25	25	2	1	28
NHW Male	25+	265	12	3	280
Hispanic Female	<25	0	0	0	0
Hispanic Female	25+	0	1	1	2
NHO Male	<25	3	0	0	3
NHO Male	25+	12	0	1	13
NHO Female	<25	0	0	0	0
NHO Female	25+	0	0	0	0
NHB Male	<25	18	2	1	21
NHB Male	25+	74	12	3	89
NHW Female	<25	0	0	0	0
NHW Female	25+	0	0	1	1
Hispanic Male	<25	12	0	0	12
Hispanic Male	25+	58	3	1	62
NHB Female	<25	0	0	5	5
NHB Female	25+	0	3	17	20
Total		467	35	34	536
South					
NHW Male	<25	2	0	0	2
NHW Male	25+	5	1	0	6
Hispanic Female	<25	0	0	1	1
Hispanic Female	25+	0	2	5	7
NHO Male	<25	2	0	0	2
NHO Male	25+	0	0	0	0
NHO Female	<25	0	0	1	1
NHO Female	25+	0	0	0	0
NHB Male	<25	95	1	0	96
NHB Male	25+	177	55	16	248
NHW Female	<25	0	0	3	3
NHW Female	25+	0	0	4	4
Hispanic Male	<25	5	1	0	6
Hispanic Male	25+	19	1	2	22
NHB Female	<25	0	1	37	38
NHB Female	25+	0	23	85	108
Total		310	85	154	544
West					
NHW Male	<25	2	0	0	2
NHW Male	25+	25	1	1	27
Hispanic Female	<25	0	0	1	1
Hispanic Female	25+	0	4	1	5
NHO Male	<25	0	0	0	0
NHO Male	25+	0	0	1	1
NHO Female	<25	0	0	1	1
NHO Female	25+	0	0	0	0
NHB Male	<25	28	0	2	30
NHB Male	25+	52	34	8	94
NHW Female	<25	0	0	0	0
NHW Female	25+	0	2	4	6
Hispanic Male	<25	5	0	0	5
Hispanic Male	25+	9	2	1	12
NHB Female	<25	0	1	12	13
NHB Female	25+	0	13	35	48
Total		121	57	67	245

Note: Numbers that are greater than 10% of the column total are in bold and their respective population is highlighted.

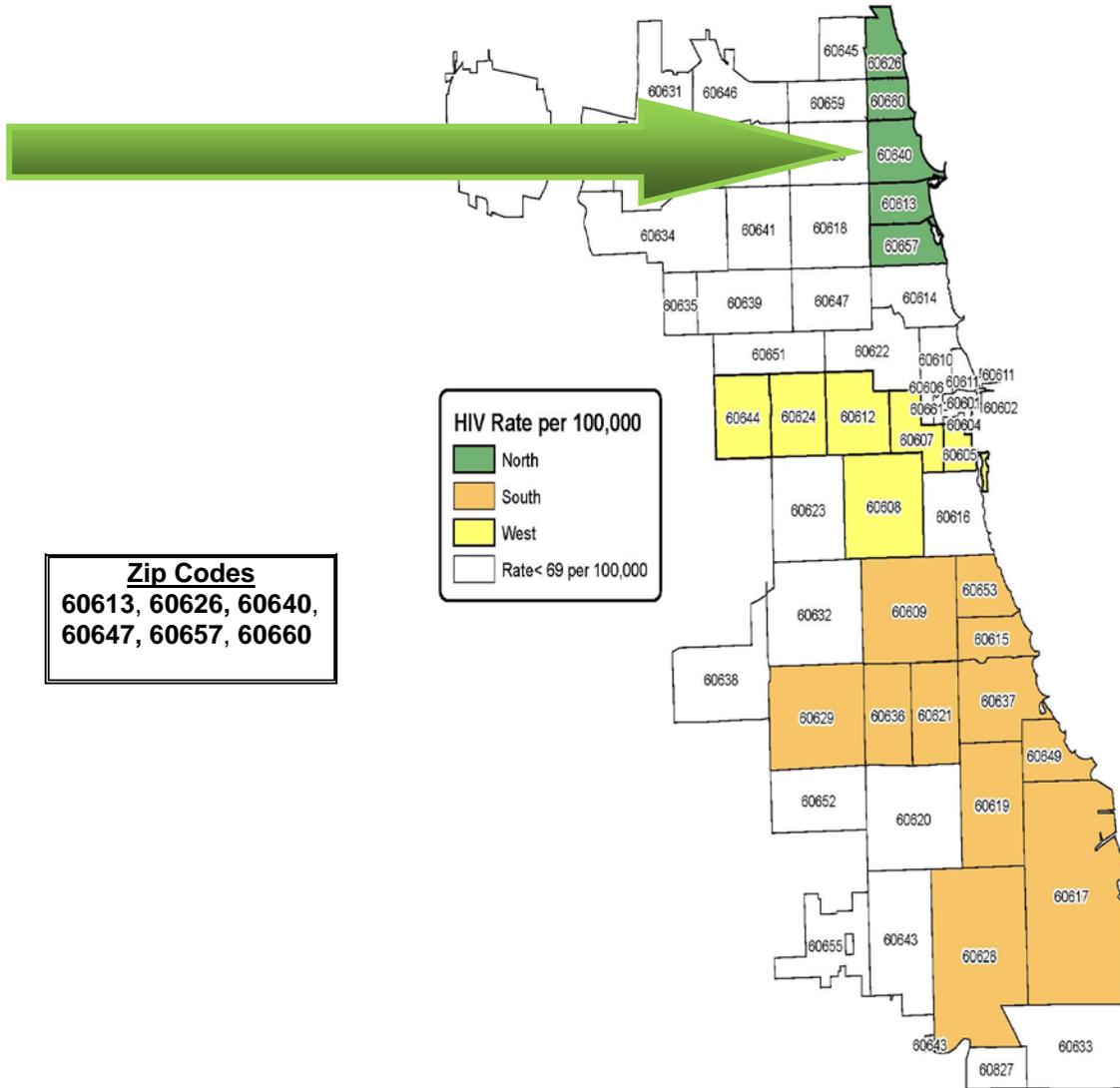
* = Less than 5 observations.

*Total does not include cases with a risk factor other than that presented and excludes cases with unknown race/ethnicity.

Source: Chicago Department of Public Health - STD/HIV/AIDS Division's SER Section, 10/27/08.

Section 3: Attachment 7 – HIV Diagnosis Rates 2006-2007 for Geographic Cluster “A”

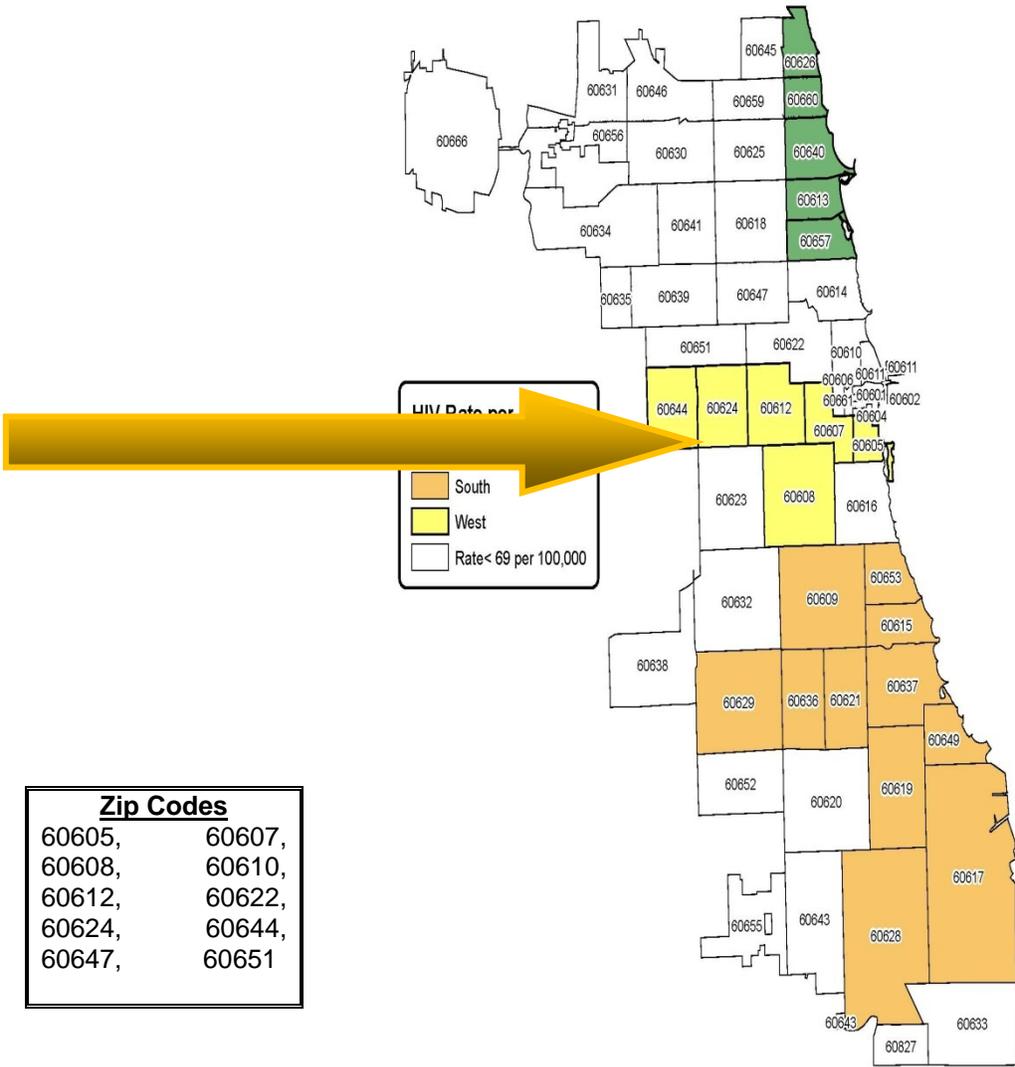
Average Annual HIV(not AIDS) Rate >69.1 per 100,000*
by Zipcode, Chicago 2006-2007, as of 6/08



*Includes 3 zipcodes with rate <69.1 that had a significant rate increase from 2002-2003
Chicago Department of Public Health
Office of HIV/AIDS Surveillance, September 2008

Section 3: Attachment 8 – HIV Diagnosis Rates 2006-2007 for Geographic Cluster “B”

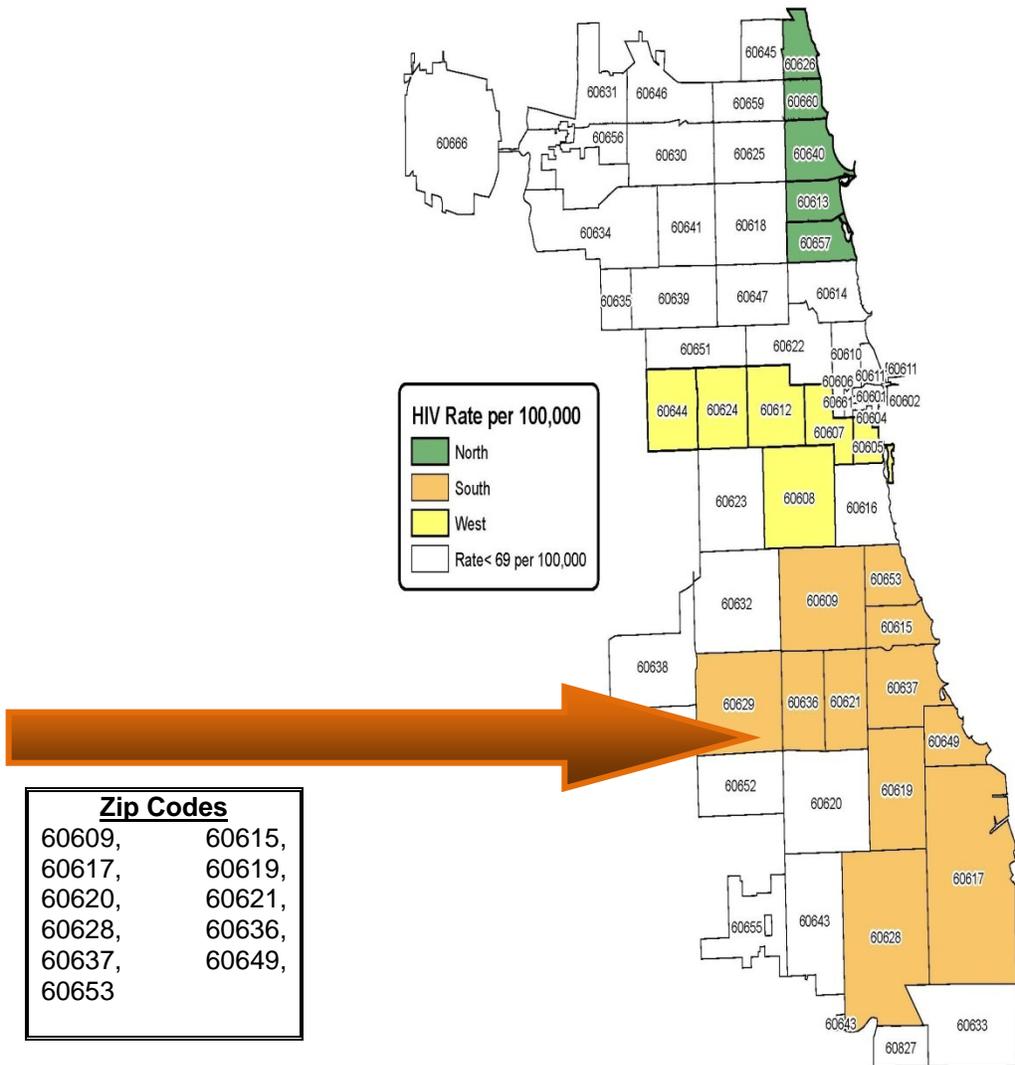
Average Annual HIV(not AIDS) Rate >69.1 per 100,000*
by Zipcode, Chicago 2006-2007, as of 6/08



*Includes 3 zipcodes with rate <69.1 that had a significant rate increase from 2002-2003
Chicago Department of Public Health
Office of HIV/AIDS Surveillance, September 2008

Section 3: Attachment 9 – HIV Diagnosis Rates 2006-2007 for Geographic Cluster “C”

Average Annual HIV(not AIDS) Rate >69.1 per 100,000*
by Zipcode, Chicago 2006-2007, as of 6/08



*Includes 3 zipcodes with rate <69.1 that had a significant rate increase from 2002-2003
Chicago Department of Public Health
Office of HIV/AIDS Surveillance, September 2008

Section 3: Attachment 10 – Descriptions of Prioritized High-Risk and Special Concerns Populations

Mode of Transmission

- *Men who have Sex with Men*
- *High-Risk Heterosexuals (males and females)*
- *Injection Drug Users*

Age

High-Risk Adults (25+ years)- Adults engaged in unprotected high-risk sexual behaviors with multiple partners or injection drug use behaviors, and or have steady sex partners who engage in high-risk behaviors. These individuals may have a history of STD infection or other co-occurring factors like substance abuse, mental health disorders, or involvement in sex trade.

High-Risk Youth (<25 years)- Youth that are disadvantaged, at risk, high risk, vulnerable, and disconnected because they are: from poor families and communities, (usually) high school dropouts, homeless or young parents, unemployed or underemployed, and/or often involved with or are transitioning from the child welfare or juvenile justice systems. These youth often engage in high-risk sex or drug using behaviors and generally lack access to critical prevention education and other health care access. These youth are historically from minority racial/ethnic groups and are disproportionately represented in these categories.

Special Concerns Populations

The Special Concerns Populations category captures populations at high-risk for HIV infection/transmission that are not covered by other priority setting recommendations. Additionally, there is no national surveillance data that are currently available on the incidence or prevalence of HIV/AIDS for these populations.

- *Transgender*- "Transgender" is an umbrella term that includes persons whose gender identity, expression, or behavior does not conform to societal gender norms associated with sex at birth (Center for AIDS Prevention Studies 2001). Transgender people (male-to-female (MTF) transgender women or female-to-male (FTM) transgender men) experience a gender identity that is different than their anatomic sex. They may seek to alter their physical appearance by undergoing cosmetic procedures, using hormones, or having sex reassignment surgery. Other persons do not choose a physical transition, but rather express their gender identity through varied presentations and behaviors. Different labels have been used to describe gender-variant persons, including MTF, FTM, transsexual, cross-dresser, transvestite, drag queen/king, gender queer, and others. Transgender persons often engage in numerous risky sex behaviors, such as having multiple sex partners or unprotected sex, frequently within the context of commercial sex work. Needle injection practices may also increase risk for HIV through unsafe injection of recreational drugs or substances to alter gender presentation (Jeffrey H. Herbst, et. al., (2008)

Estimating HIV Prevalence and Risk Behaviors of Transgender Persons in the United States: A Systematic Review, *AIDS Behavior*, 12(1):1-17).

- *Individuals Involved in Sex Trade* – Individuals who trade sex for money, drugs, or for other daily living needs including food, housing or clothes. These “trade” negotiations can place both individuals in circumstances where condoms are not used upon request or in situations where sex with no condom is forced. Methamphetamine, crack use, and greater lengths of homelessness are associated with a history of sex trade among women, while heroin use, recent mental health treatment, and homosexual or bisexual orientation were significantly associated with sex trade for men (Sheri D. Weiser, et. al., (2006). Gender-specific correlates of sex trade among homeless and marginally housed individuals in San Francisco, *Journal of Urban Health*, 83 (4) 736-740).
- *Individuals with Physical and Developmental Disabilities*- Individuals who live with a permanent physical, sensory (deafness, blindness), intellectual, or mental health disability. Social marginalization and physical vulnerability has been shown to result in situations of pressured or forced-into sex. These factors, combined with lack of access to health care, poverty, social iniquity, low literacy rates and few opportunities for HIV education or prevention, increase risk for HIV acquisition (Groce Nora Ellen, (2005) HIV/AIDS and Individuals with Disability Disabled Peoples International).
- *Homeless Individuals* - Homeless individuals with co-occurring mental health and substance use disorders. The instability of their living arrangements coupled with other chronic diseases or disorders place these individuals at increased risk for acquiring HIV and other infectious diseases like Hepatitis C, tuberculosis or STDs. Housing status may also propel homeless individuals to engage in sex trade and other survival behaviors that place them at increased risk for HIV. Additionally, these individuals typically lack adequate access to HIV prevention health care and treatment services, or other co-occurring disorders significantly impact the delivery of targeted HIV prevention education and testing opportunities. (Implementing Interventions for Homeless Individuals with Co- Occurring Mental Health and Substance Use Disorders A PATH Technical Assistance Package. Center for Mental Health Services Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services, 1998).
- *Non-English / Non-Spanish Speaking Individuals* - Immigrant groups with deficiencies in HIV/AIDS knowledge, lack of access to health care, and delays in accessing HIV-related testing and care due to foreign-born status, language barriers, or cultural/religious customs that hinder access to health care or HIV testing and treatment (Nina T. Harawa, et. al., (2002) HIV Prevalence Among Foreign- and US-Born Clients of Public STD Clinics, *American Journal of Public Health*. 92(12): 1958–1963).

- *Post Incarcerated Individuals*- Individuals who acquired HIV either prior to or during incarceration, who are socially marginalized, and who experience barriers to adequate access to health care, prevention and other types of services as a result of their incarceration.

Section 4: Attachment 1- NHBS Project CHAT Abbreviated Methodology

Study Background

CDPH is one of 21 health departments funded by CDC to conduct National HIV Behavioral Surveillance, known locally as Project CHAT. Project CHAT collects cross-sectional data among populations that are at high risk for acquiring HIV, specifically MSM, IDU and HRH. Variables include, but are not limited to: patterns in HIV testing, knowledge of casual partner's serostatus, engagement in unprotected sex with casual partners, STI testing, and access to free condoms.

Methods

CHAT data is collected through face-to-face surveys in the community with members of each at-risk population.

- MSM, IDU and HRH are interviewed in 3-year cycles, one population a year. The data examined looked at MSM in 2004, IDU in 2005, and HRH in 2007.
- The second 3-year cycle began in 2008 with MSM, and will look at IDU in 2009 and HRH in 2010.

Men Who Have Sex with Men 2004

- MSM were selected at random and interviewed in places in Chicago where MSM congregate. These could be nightclubs, gyms, social organizations, churches, festivals, parks, bathhouses, etc.
- Survey was mostly conducted during evenings, late nights and weekends.
- Recruitment took place between December 2003 and October 2004.
- Over 120 different venues were included.
- A total of 1,158 MSM were interviewed.

IDU Recruitment in 2005

- IDUs in 15 city neighborhoods told each other about the survey and gave study coupons to people they knew who were also IDUs.
 - All IDUs that came to the survey sites with a coupon were interviewed.
- Over 1500 coupons were distributed throughout Chicago.
- Interviews took place in 6 different CBO storefronts or CDPH clinics six days a week.
- Recruitment took place between June 2005 and December 2005.
- A total of 525 IDU were surveyed.

Heterosexual Recruitment in 2007

- 15 neighborhoods with the highest rates of living heterosexual AIDS cases and the highest rates of household poverty were selected for the survey.
- People were selected at random from those neighborhoods and were interviewed in various locations including corner stores, on street corners or bus stops, currency exchanges, liquor stores, churches, laundromats, grocery stores, fast-food restaurants, beauty salons and barbershops.
- Recruitment took place between March 2007 and October 2007. Survey was largely limited to daytime hours.
- Interviews were conducted in 74 different venues in those 15 neighborhoods.
- A total of 858 people were interviewed.

Project CHAT limitations

- Findings for one population cannot be applied to other high-risk populations. Data must be interpreted with caution particularly when attempting to compare findings between high-risk groups. These comparison group differences have not been statistically analyzed.
- The minimum age for survey recruitment is 18 years. Therefore, high-risk behaviors and practices of youth under 18 are not captured.
- The maximum age is 50 years for heterosexuals. Studies show that many over 50 years engage in sex and may need HIV prevention services.
- Data is self-reported and biased.
- Sub-groups like young Black IDU are under-represented.

Section 4: Attachment 2 - NHBS Project CHAT Survey Questions & Findings

Survey Area	Survey Questions
HIV & STD Testing	<p>When did you have your most recent HIV test?</p> <p>In the past 12 months, have you had a test for any of the following STDs? (syphilis, gonorrhea, Chlamydia, genital herpes, genital warts, any other _____)</p>
Sexual Behaviors	<p>When you had (oral, anal or vaginal) sex that last time (with casual ptr), did you (or your partner) use a condom <u>the whole time</u>?</p> <p>When you had (oral, anal or vaginal) sex that last time (with casual ptr), did you know his (or her) HIV status?</p> <p>Before or during the last time you had sex with this partner, did you use (alcohol, drugs, both alcohol and drugs, neither one)?</p>
IDU Needle Access & Safer Drug Use Behaviors	<p>In the past 12 months when you injected, did you get you needles at any of the following places? (pharmacy, doctor, friend, relative, sex partner, drug dealer, off the street, needle exchange program)</p> <p>In the past 12 months when you injected, how often did you use a new, sterile needle? By a new, sterile needle, I mean a needle never used before by anyone, even you.</p> <p>In the past 12 months when you injected, how often did you use a cooker that someone else had already used?</p> <p>In the past 12 months when you injected, how often did you use a cotton that someone else had already used?</p> <p>In the past 12 months when you injected, how often did you use water that someone else had already used?</p>
Access to and utilization of ILI & GLI services.	<p>In the past 12 months, have you had a one-on-one conversation with an outreach worker, counselor, or prevention program worker about ways to prevent HIV? (Don't count the times when you had a conversation as part of an HIV test.)</p> <p>In the past 12 months, not including discussions with friends, have you been a participant in any organized session(s) involving a small group of people to discuss ways to prevent HIV?</p>

Survey Area	Findings for High-Risk Heterosexual
HIV Testing	Nearly 60% of all HRH have not had a HIV test in the last 12 months compared to 22% among MSM and 12% among IDU.
STD Testing	65% of all HRH have not been tested for Sexually Transmitted Diseases in the last 12 months.
Condom Usage & Access	Only 43% of all HRH accessed free condoms, of those, 74% used the free condoms they received.
Knowledge of Serostatus	91% of HRH women did not know the serostatus of their most recent casual sex partner.
Unprotected Sex for Women	Among HRH women, 60% reported having unprotected sex with their most recent casual sex partner.

Survey Area	Findings for Men who have Sex with Men
HIV Testing	22% of MSM have not had an HIV test in the last 12 months.
STD Testing	52% of MSM have not been tested for Sexually Transmitted Infection (STI) in the last 12 months.
Condom Usage & Access	82% of all MSM accessed free condoms, but only 42% used the free condoms they received.
Use of Drugs	63% of MSM used drugs with sex with their most recent casual sex partner.
Sex with Women	NHB/Hispanic MSM are more likely to have female sex partners than White MSM.

Survey Area	Findings for Injection Drug Use
HIV Testing	12% of all IDUs have not been tested for HIV in the last 12 months.
STD Testing	54% of all IDUs have not been tested for Sexually Transmitted Infections (STI) in the last 12 months.
Condom Usage & Access	62% of IDUs have accessed free condoms in the last 12 months and of those, 77% have used free condoms.
Knowledge of Serostatus	70% of IDUs did not know the serostatus of their most recent casual sex partner
Unprotected Sex	42% of IDUs had unprotected sex with their most recent casual sex partner.
Needle Exchange Service Use	77% use Needle Exchange Programs regularly.
Sharing Injection Paraphernalia	64% regularly share injection paraphernalia (cookers, cotton, rinse water. Compared to 39% that regularly share needles.

Survey Area	Findings for Youth
HIV Testing	92% of MSM under 25 have been tested for HIV in the past 12 months. This is consistent across race & ethnicity
Unprotected Sex	58% of NHB HRH women under 25 had unprotected sex with their most recent casual partner.
MSM sex with Women	Young minority MSM are much more likely to have female sex partners than older MSM (all races).
Knowledge of Serostatus	95% of NHB HRH women under 25 did not know the serostatus of their most recent casual sex partner.

Section 4: Attachment 3 – Social & Behavioral Theories

Health Belief Model

- The Health Belief Model maintains that health related behaviors depend on the following four key beliefs that must be operating for a behavior change to occur: (A) perceived susceptibility – personally vulnerable to the condition, (B) perceived severity – belief that harm can be done by the condition, (C) perceived benefits of performing a behavior – what they are going to get out of the change, and (D) perceived barriers of performing the behavior – what keeps them from changing.

Redding, C. A. et. al., (2000) Health Behavior Models. *The International Electronic Journal of Health Education*, 3, (Special Issue): 180-193.

Social Cognitive (Learning) Theory

- The Social Cognitive Theory maintains that behavior changes are dynamic and influenced by personal and environmental factors. People learn new behaviors through direct experience or modeling after others by observation.
 - Outcome expectations - the extent the person values the expected outcome of a specific behavior. Will it lead to a positive or negative outcome?
 - Self efficacy – a person’s belief about his/her ability and confidence in performing behaviors.
- People ‘learn’ new behaviors best when trusted sources such as their peers practice this behavior and when people have the opportunity to increase both knowledge and skills related to the behavior.
- Involves social modeling, social support, etc.

Redding, C. A. et. al., (2000) Health Behavior Models. *The International Electronic Journal of Health Education*, 3, (Special Issue): 180-193.

Theory of Reasoned Action

- The Theory of Reasoned Action maintains a person must have an intention to change. Intentions are influenced by two major factors.
 - Attitudes towards the behavior
 - Belief in performing the behavior is based on positive or negative outcomes.
 - Evaluation of consequences to performing behavior
 - Subjective norms about the behavior
 - What significant other thinks about performing the behavior
 - Motivation to perform behavior based on subjective norms

Redding, C. A. et. al., (2000) Health Behavior Models. *The International Electronic Journal of Health Education*, 3, (Special Issue): 180-193.

Theory of Planned Behavior

- Emphasizes the intersection of normative beliefs, behavioral beliefs and control beliefs as factors that influence ‘intention’ and ultimately future behavior. Here normative beliefs are based on social norms and influence the individuals ‘attitude’ and ‘behavioral’ control or control belief.

Redding, C. A. et. al., (2000) Health Behavior Models. *The International Electronic Journal of Health Education*, 3, (Special Issue): 180-193.

Transtheoretical Model (i.e. Stages of Change Model)

- According to Prochaska and DiClemente cognitive/behavioral change progresses as the individual moves through the following stages: precontemplation (benefits of lifestyle change are not being considered); contemplation (starting to consider change but not yet begun to act on this intention); preparation (ready to change the behavior and preparing to act); action (making the initial steps toward behavior change); and maintenance (maintaining behavior change while often experiencing relapses).
 - Persons in the precontemplation stage should be made aware of consequences for not engaging in health-behavior change, be provided the opportunity to share their feelings about their condition and discuss how their behavior affects their family.
 - People who are contemplators should be taught to closely monitor their motivations for engaging in the health behavior change and explore their ambivalence and reasons they think change might be beneficial.
 - Individuals in the preparation stage should be asked to verbalize a commitment to change both to themselves and to their family.
 - Action-stage individuals and those in the maintenance stage should work with the clinician to set up rewards for appropriate behavior and stress-management techniques and establish supportive relationships.

Prochaska JO, DiClemente CC. *The Transtheoretical Approach: Crossing the Traditional Boundaries of Therapy*. Homewood, IL: Dow Jones/Irwin; 1984

Redding, C. A. et. al., (2000) Health Behavior Models. *The International Electronic Journal of Health Education*, 3, (Special Issue): 180-193.

Information-Motivation-Behavioral

According to this model, there are 3 steps to changing HIV prevention high-risk behavior:

- Receipt and application of HIV prevention information
- Motivation (personal or social) to engage in HIV prevention risk-reduction behaviors. Motivations determine whether well-informed individuals will act on what they know about prevention.
- Opportunities to practice specific behavior skills (HIV prevention activities). Determines whether well-informed and motivated individuals will be capable of enacting HIV prevention behaviors effectively.

Fisher, J. D., & Fisher, W. A. (1992). Changing AIDS-risk behavior. *Psychological Bulletin*, 111, 455–474.

Fisher, J. D., & Fisher, W. A. (2000). Theoretical approaches to individual level change in HIV-risk behavior. In J. Peterson & R. J. DiClemente (Eds.), *HIV prevention handbook* (pp. 3–55). New York: Kluwer Academic/Plenum Press.

Fisher, J. D., Fisher, W. A., Misovich, S. J., Kimble, D. L., & Malloy, T. E. (1996). Changing AIDS risk behavior: Effects of an intervention emphasizing AIDS risk reduction information, motivation, and behavioral skills in a college student population. *Health Psychology*, 15, 114–123.

Redding, C. A. et. al., (2000) Health Behavior Models. *The International Electronic Journal of Health Education*, 3, (Special Issue): 180-193.

Section 4: Attachment 4 - Priority Intervention Descriptions

Recruitment Interventions	Description and/or Minimum Criteria
Outreach	HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face “encounters” with high-risk individuals in the neighborhoods or other areas where they typically congregate. Outreach usually includes a combined distribution of condoms, bleach and other HIV and infectious disease prevention educational materials or health care access brochures. This intervention is typically used to increase HIV testing opportunities. NOT: Condom drop offs, materials distribution, and other outreach activities that lack face-to-face contact
Health Communication / Public Information (HC/PI)	Delivery of planned HIV/AIDS prevention informational messages through one or more channels to target audiences to increase adoption of safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. Includes: electronic media, print media, hotlines, clearinghouses, presentations and lectures. Forums in which this intervention is delivered are used to increase HIV testing opportunities. NOT: Group interventions with a skills-building component.
Community Level Intervention (CLI)	Delivery of planned HIV/AIDS prevention informational messages to the community as a whole focusing on broad community-wide behavioral change by altering social norms, increasing HIV knowledge acquisition, or impacting policy. Forums in which this intervention is delivered are used to increase HIV testing opportunities. NOT: any intervention that can be described by one of the existing categories.
Internet-Based Intervention	Use of the Internet as a tool for the control and prevention of HIV and other STIs. Interventions focus on three distinct types of Internet activities: Internet-based Partner Services, Outreach, and Health Communications.
Social Marketing	Social marketing is the application of commercial technologies to the planning and implementation of prevention programs. Social marketing is not social advertising, social education, attitude change, or socially responsible marketing of HIV prevention messages. Examples of social marketing programs at CDC include the "America Responds to AIDS" campaign and the "5-A-Day Nutrition" campaign.

Focused Interventions	Description and/or Minimum Criteria
Individual Level Intervention (ILI)	Mainly focused on health education and risk-reduction counseling one-on-one. The goal is to assist in making plans for pro-health behavior and ongoing self-appraisal for making corrective actions when needed. Also includes linking individuals to clinical and community services that promote healthy behaviors that include both risk-reduction and prevent the transmission of HIV. NOT: Outreach, CRCS, or HIV Counseling & Testing
Group Level Intervention (GLI)	Usually face-face, peer or paraprofessional educators (like Peer Opinion Leaders) embedded in communities of high-risk individuals. The outreach includes the face-face distribution of transmission impediments like condoms, bleach, materials, etc. NOT: group education that lacks skills component

Comprehensive Risk Counseling & Services (CRCS)	Formerly known as Prevention Case Management, this intervention is a hybrid of HIV Risk-Reduction Counseling and traditional Case Management. Individualized client-centered counseling for adopting and maintaining HIV risk-reduction behaviors. CRCS is designed for HIV-positive and HIV-negative individuals who are at high risk for acquiring or transmitting HIV and STDs and struggle with issues such as substance use and abuse, physical and mental health, and social and cultural factors that affect HIV risk. CRCS implementation manual hyperlink . NOT: the more simple one-on-one risk assessment counseling lacking ongoing and individualized prevention counseling, and support.
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Focused Interventions	Description and/or Minimum Criteria
Comprehensive Needle Exchange	Similar to Outreach intervention in offering HIV prevention education materials in face-to-face non-counseling encounters. This Harm Reductions strategy provides sterile syringes in exchange for used and potentially contaminated ones. NOT: typically funded with direct CDC HIV prevention resources but is supported by non-CDC health department grant funds.

Additional Required Interventions	Description and/or Minimum Criteria
HIV Counseling, Testing and Referral (HIV CTR)	Typically a two-session intervention: pre/post test designed to learn about one's current serostatus; increased education about transmission; negotiating behavior change to reduce risk of acquiring or transmitting HIV; and providing referrals for additional medical, preventive and psychosocial needs. NOT: therapy.
Partner Services (PS)	Also known as Partner Counseling Referral Services (PCRS) PS is a systemic approach to notifying the sex and needle-sharing partners of HIV-infected persons of possible exposure to HIV to avoid infection or, if already infected, can prevent transmission to others. NOT: HIV Counseling and Testing

*Category to be used for those interventions funded with CDC Program Announcement 99004 funds that cannot be described by the definitions provided for the other six types of interventions

Section 5: Attachment 1 – 2008 HIV Prevention Resource Inventory

2008 HIV Prevention Resource Inventory Survey General Directions

Online submission: This is *highly encouraged* over the paper version. For the link to SurveyMonkey, please email David Amarathithada at amarathithada_david@cdph.org or type the following link:
http://www.surveymonkey.com/s.aspx?sm=ILTMbHAvsAg7Cioh9uxg7g_3d_3d

Paper submission:

- Fill out only one (1) Agency Profile
- Fill out a Resource Inventory Form for **each** HIV Prevention project that is **not funded** by the Chicago Department of Public Health (CDPH).
- Please make additional copies of the Resource Inventory Forms for all of your funded HIV prevention projects or high-risk populations, not CDPH funded

Below are instructions to assist you in completing the Resource Inventory Forms. **Please complete the worksheets in a way that accurately describes your HIV project or program.**

Resource Inventory Form Instructions

What are the top funding sources of this Project?

1. Write the name of the funding source. (i.e. Donations, Robert Wood Foundation, CDC, etc.
2. Please round the dollar amount to the nearest dollar.
3. Month and Date of the funding source's expiration

After each funding source expires, indicate how future funding will be pursued, if at all.

How many clients were served in 2007? What is the Project's client capacity to serve in 2008?

Indicate approximately how many clients were served in 2007. Indicate approximately the number of clients this Project can serve in 2008.

What is the primary population's profile that the Project serves?

Circle only one (1) choice under each column. The profile of the Project's population is to be examined by HIV status, Risk factor, Gender, Sexual orientation, Race/ethnicity, Language clients speak in, and Age. For definition of acronyms, please refer to the box to the right. If you cannot assign your high-risk population to one of these categories, please describe your population as best you can in the space allotted.

What are the zip codes of this Project's client service sites?

Indicate where this Project's client services are being delivered in order of capacity.

What type of activities does this Project administer?

Please indicate which activities or intervention this Project delivers to its clients. Most of the activities fall in one of the following categories. If your intervention does not fall into any of the listed categories, briefly describe the intervention in the space provided. The categories are as follows:

Outreach

Face-to-face interactions with high-risk individuals in their neighborhood or areas where the population congregates (i.e., street corners, from mobile vans, clubs, parks, etc.). Typically includes distribution of risk reduction supplies (i.e., condoms, bleach kits, lubricant, literature, etc.).

Testing and Counseling

Helps clients identify their risk(s) for acquiring HIV. Offers HIV testing through standard blood draw, oral swab, or rapid testing. Assists in preparing a client to receive, understand, and manage the test result. Makes appropriate referrals to other prevention interventions (i.e., partner notification, etc.).

Needle Exchange Program (NEP)

Designed to reduce the transmission of HIV by providing sterile syringes in exchange for used or contaminated ones.

Group Level (GLI)

A planned series of educational/supportive sessions (two or more persons but no more than 12 persons) intended to reduce high-risk behaviors through skills building and other supportive activities. Curriculums or session outlines intend to reinforce positive behavior change and focus on specific topics.

Individual Level (ILI)

Health Education/Risk Reduction counseling conducted one-on-one to assist the individual in making plans to change risky behavior. Sessions may be sporadic but are part of an on-going relationship.

Prevention Case Management (PCM)

A client-centered individual intervention intended to promote the adoption of risk-reduction behaviors. Intended for persons with multiple, complex problems and risk reduction needs (e.g., substance abuse, financial, medical, psychological, etc.) having or likely to have difficulty initiating, or sustaining behaviors that reduce or prevent HIV transmission.

Community Level/Social Marketing (CL/SM)

Seeks to reduce high-risk behaviors by targeting social networks and communities, rather than by intervening with the individual or smaller groups (i.e., social marketing campaigns, community wide events).

Health Communication / Public Information (HC/PI)

The delivery of single-session planned HIV/AIDS prevention messages to target audiences through electronic media, print media, hotlines, clearinghouses, and/or presentations/lectures for the purpose of building supporting safe behaviors, supporting personal risk reduction efforts, and/or informing persons at risk for infection how to obtain specific services.

Other STI/STD Services

This refers to services related to the prevention of STI/STDS, diagnosis, and treatment.

Drug Addiction Services

This refers to services related to the all forms of drug addiction prevention and treatment.

Home-Grown

A home grown activity/intervention is one that is locally developed by an organization based on the knowledge and experience of the community.¹ It includes grass roots effort by individuals and collectives. It also includes new (not based off established interventions) HIV prevention efforts uniquely developed by an agency to promote HIV prevention efforts for a specific population. Home grown activities typically have not been scientifically tested or rigorously evaluated for its efficacy.² Please briefly describe the activity in the space provided next to the choice.

Modified

Different from Home Grown activity, a Modified Activity is framed from a “widely used” activity (intervention) but largely modified to meet the needs of a current or new population. The modification can come in many forms to include, but not limited to, adjustments for unexpected: population access, unanticipated cultural rules, norms, values that require adaptation of the intervention, in-vivo methodology adjustments to meet unanticipated barriers, etc. in order to better effectively deliver the intervention. Please briefly describe the activity in the space provided next to the choice

If any which of the following Diffusion of Effective Behavioral Interventions (DEBI) does this Project deliver?

DEBIs are scientifically tested activities/interventions that have been shown that positive behavioral and/or health outcomes are a result of the intervention itself. Typically these interventions require special training and preparation in order to administer. *Your project may not be administering DEBI in which case please mark “No DEBIs administered in this Project”.* There are 16 official DEBIs. Please indicate which DEBIs this Project delivers to its clients. If your DEBI is not listed, briefly please indicate the DEBI in the space provided.

What barriers have you encountered while implementing this particular prevention Project? How did you overcome or attempt to overcome them (adapt)?

Please briefly describe your barriers and strategies you used to attempt to overcome the challenges in this Project in 25 words or less.

¹ DeSantis et. al. "Evidence-based and Homegrown Interventions -How do they fit together?" HPLS 2007 presentation. Slide #2. <http://www.cdcpin.org/2007_National_HIV_Prev_Conf/Public/ViewDocument.aspx?DocumentID=9f7bb61c-9b17-4e49-b7f7-30e926bfeeca>

² Ibid.

2008 HIV Prevention Resource Inventory

Agency/Organization Profile

Agency Name	
Street Address	
City, State, Zip Code	
Phone Number	
Fax Number	

Contact information of person completing this assessment.

Name	
Title	
Phone Number	
Email:	

General Agency Questions:

- 1) How many HIV prevention projects do you have? _____
- 2) Other than CDPH, where do you receive funding for your HIV projects? (Check all that apply.)

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Foundations | <input type="checkbox"/> IDPH | <input type="checkbox"/> CDC |
| <input type="checkbox"/> Universities | <input type="checkbox"/> Other State | <input type="checkbox"/> Other federal |
| <input type="checkbox"/> Other sources: <u>(please list sources)</u> _____ | | |

- 3) If the agency performs HIV testing and/or counseling, what method(s) does the agency use? (Check all that apply.)

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Blood based | <input type="checkbox"/> No testing and counseling provided |
| <input type="checkbox"/> Oral swab | <input type="checkbox"/> No HIV counseling provided |
| <input type="checkbox"/> Rapid test | <input type="checkbox"/> No testing provided |

2008 HIV Prevention Resource Inventory Form

Due: May 30, 2008

***Use a separate copy of this form for each HIV prevention project at your agency.**

(i.e. For 4 separate projects please fill out 4 resource inventory forms)

Please keep in mind HPPG is interested in projects NOT funded by CDPH.

Agency Name: _____

Official Name of the HIV prevention project: _____

1. What are the top funding sources of this Project? (NOT CDPH FUNDED)

(e.g.: Chicago Community Trust, NIH, Office of Minority Health, Donations)

Name of Funding Source	Funding Amount for HIV Prevention Activities	Expiration Date	How will this project be sustained? (Please choose one)
			<input type="checkbox"/> (a) Funding with new/ re-application <input type="checkbox"/> (b) Project will not continue <input type="checkbox"/> (c) Identify new source of funding
			<input type="checkbox"/> New/Re-application <input type="checkbox"/> Not continue <input type="checkbox"/> New source

			<input type="checkbox"/> New/Re-application	<input type="checkbox"/> Not continue	<input type="checkbox"/> New source
			<input type="checkbox"/> New/Re-application	<input type="checkbox"/> Not continue	<input type="checkbox"/> New source
			<input type="checkbox"/> New/Re-application	<input type="checkbox"/> Not continue	<input type="checkbox"/> New source

2. How many clients were served in 2007? What is the Project's client capacity to serve in 2008?

Number of clients served (2007): _____ Capacity (2008): _____

3. What is the primary population's profile that the Project serves?

Please circle one choice under each column.

HIV status	Risk Factor	Gender	Sexual Orientation	Race/Ethnicity	Language of Clients	Age
1) All	1) All	1) All	1) All	1) All	1) English	1) All
2) Positive	2) MSM	2) Male	2) Heterosexual	2) Black, not Hispanic	2) Spanish	2) 24 years old or less
3) Negative	3) HRH	3) Female	3) Homosexual	3) White, not Hispanic	3) English & Spanish	3) 25-49 years old
4) Unknown	4) IDU	4) Transgender	4) Bisexual	4) Hispanic/Latino		4) 50 and older
	5) Incarcerated		5) Homosexual & Bisexual	5) Asian		
	6) Homeless			6) Native American/ Alaskan Native		
	7) Sex workers			7) Native Hawaiian / Pacific Islander		
	8) People w/ disabilities			9) Other: _____	9) Other: _____	
	9) Other: _____					

2008 HIV Prevention Resource Inventory Form

Due: May 30, 2008

*** Use a separate copy of this form for each HIV prevention project at your agency.**
(i.e. For 4 separate projects please fill out 4 resource inventory forms)

4. What are the zip codes of this Project's client service sites? (Please list the top 4 locations in order of capacity)

Zip Code 1: _____
 Zip Code 2: _____
 Zip Code 3: _____ Zip Code 4: _____

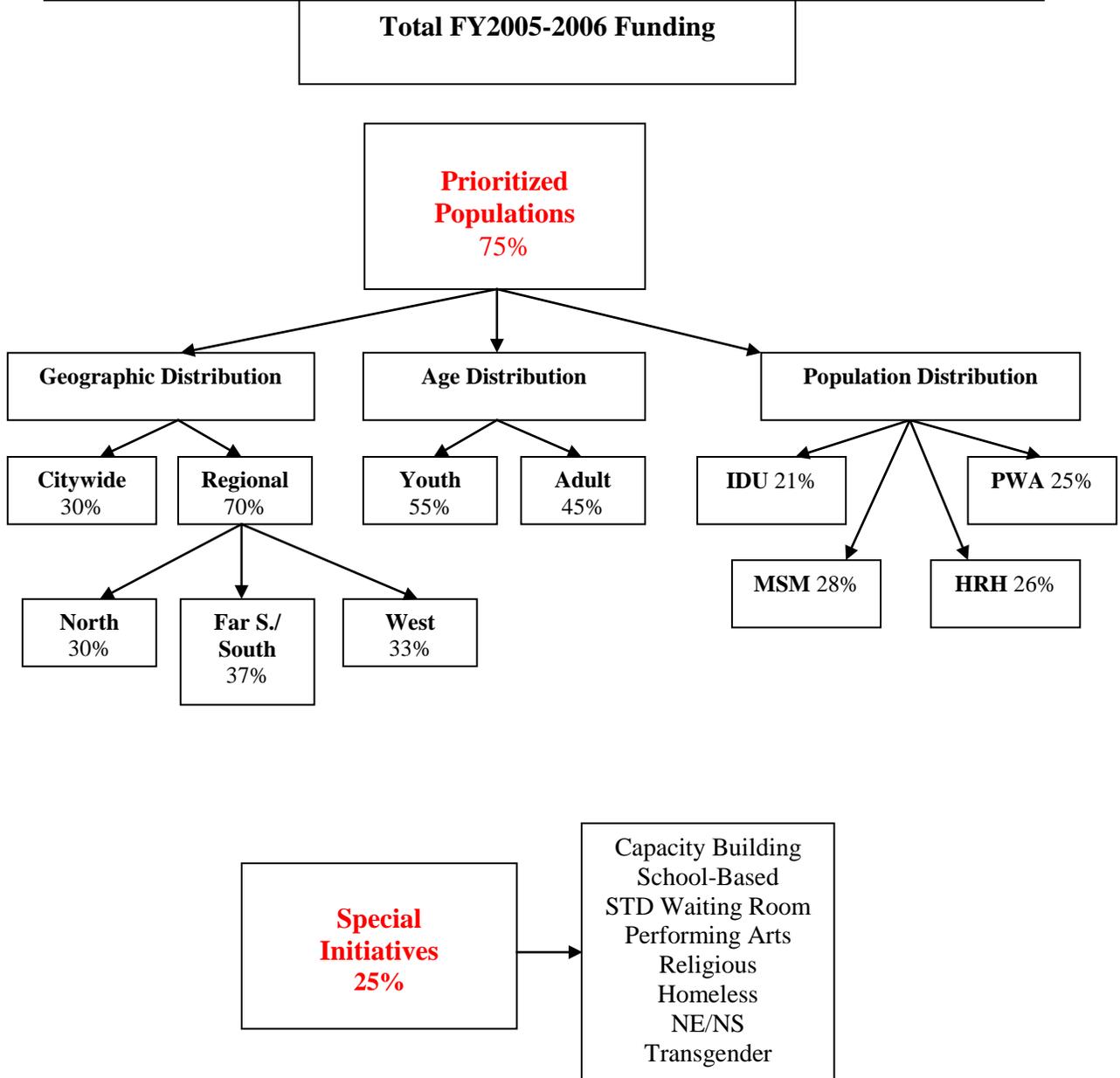
5. What type of activities does this Project administer? (Check all that apply)

- Outreach
- Testing and Counseling
- Needle Exchange
- Group Level
- Individual Level
- Prevention Case Management
- Community Level / Social Marketing
- Health Communication/Public Information
- Other STI/STD services
- Drug addiction services
- Home-Grown: (specify) _____
- Intervention Modifications: (specify) _____
- Other: (specify) _____

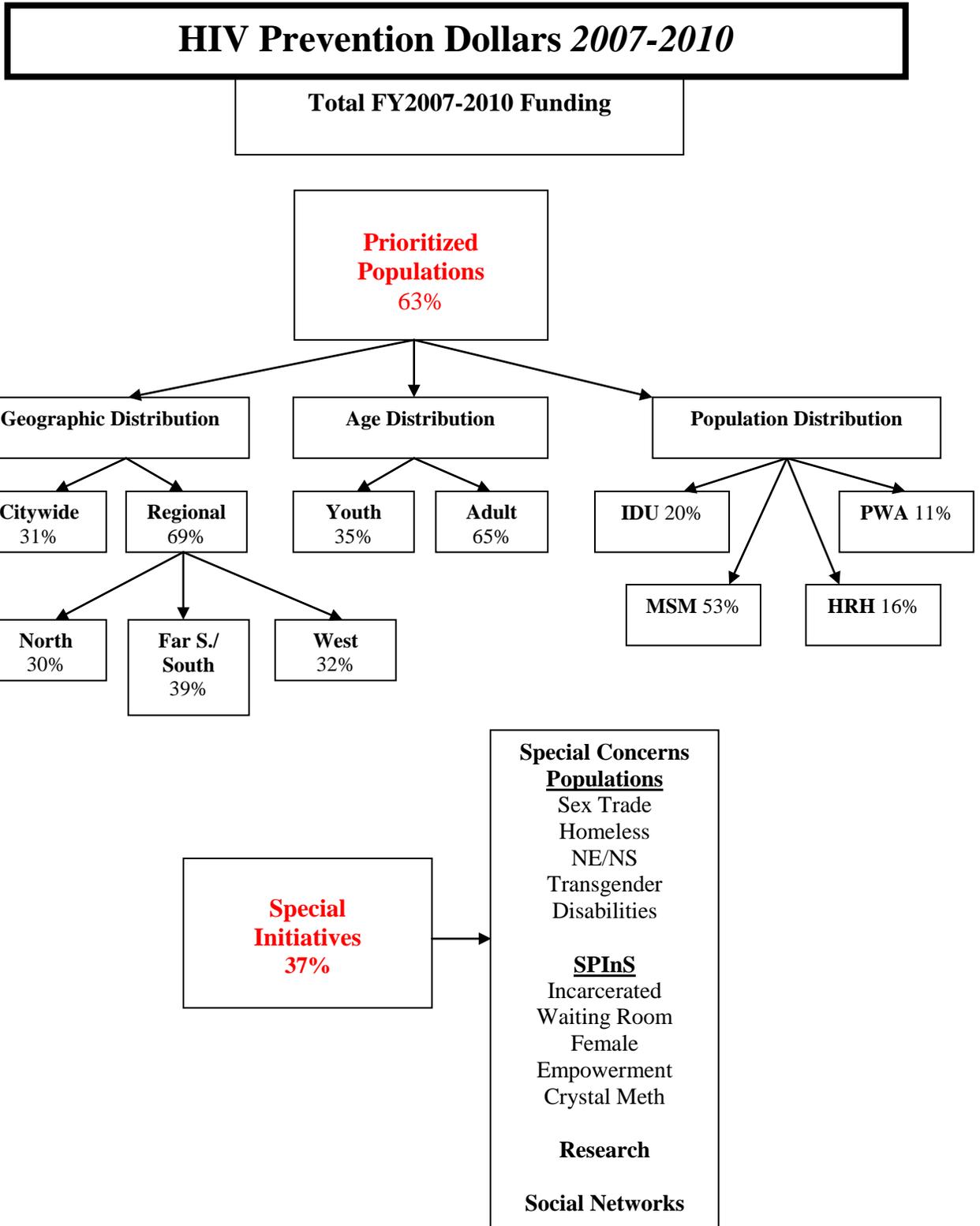
6. If any, which of the following Diffusion of Effective Behavioral Interventions (DEBI) does this Project deliver? (Check all that apply)

Section 5: Attachment 2 – FY2005-2006 CDPH HIV Prevention Portfolio

HIV Prevention Dollars 2005-2006



Section 5: Attachment 3 – FY2007- 2010 CDPH HIV Prevention Portfolio

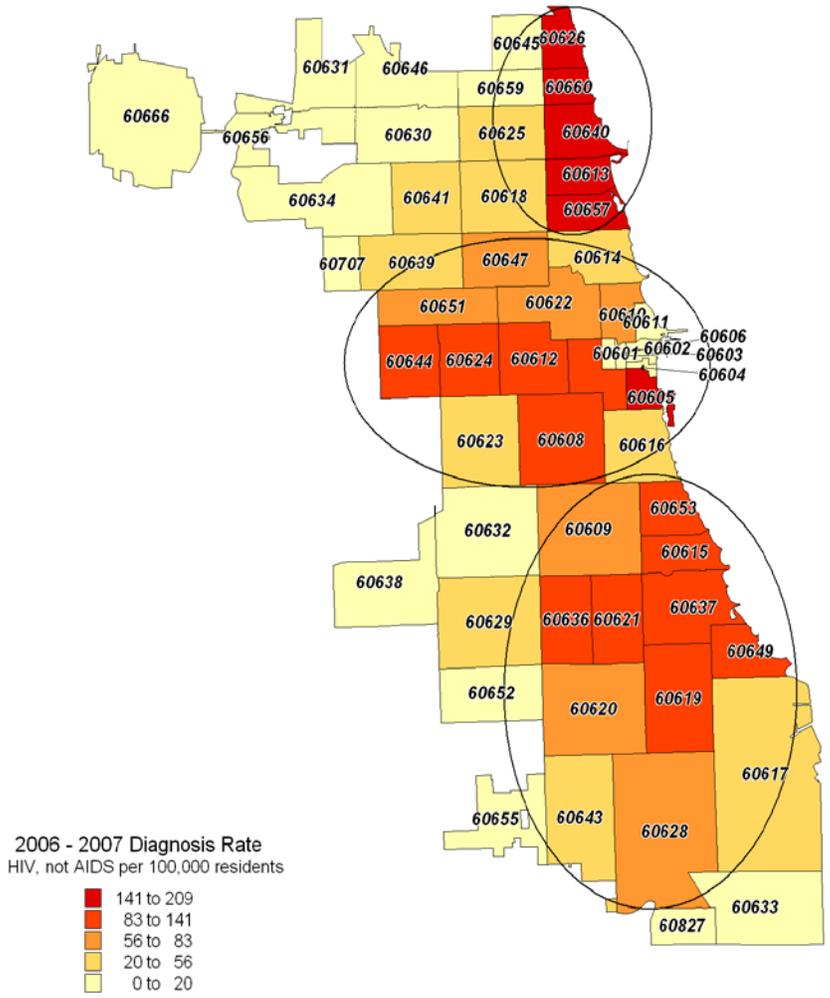


Section 5: Attachment 4 – Social Determinants of Health Descriptions

Social Determinant Variable	Direct or Indirect Relationship to HIV Transmission	Data Source
HIV Incidence / AIDS Prevalence	Direct: Incidence is the number of new infections in a population during a specific time period. Prevalence is the total number of persons with HIV/AIDS infection alive at any given moment in time	Number of new HIV cases, rate of HIV infection, numbers living with AIDS/HIV; Office of HIV/AIDS Surveillance Summer 2008
STD	Direct: Individuals exposed to Gonorrhea, Chlamydia, and particularly Syphilis are at more risk to acquire HIV due to the presence of an STD. Individuals with an HIV diagnosis and an STD increase the likelihood of transmitting both HIV and the STD.	Cases, CDPH, 2007
Poverty	Direct: Poverty indicators include status of income level, housing, employment/unemployment, and insurance eligibility. Poverty is associated with other Social Determinant factors and is a correlate of HIV particularly in communities with a high incidence/prevalence of HIV.	People with income below the Federal Poverty Level, Census, 2000 (i.e., Adults over 25 years with less than a high school diploma/GED; Housing expenses are 30% more than annual household income; Over 16 years & able work but unemployed).
Crime / Violence	Indirect: May exist inside the HIV environment like substance abuse but does not contribute directly to HIV incidence. However, crimes related to drug use, prostitution or sexual crimes may create an opportunity for transmission of HIV or stimulate other high-risk behaviors that can increase HIV risk.	Drug Crimes Arrests, CPD, 2000; Index Crime Reports, CPD, 2003; Ex-Offenders relocation after release, Illinois Department of Corrections, 2003; Prostitution Arrests, CPD, 2004; Domestic Violence Reports, CPD, 2003

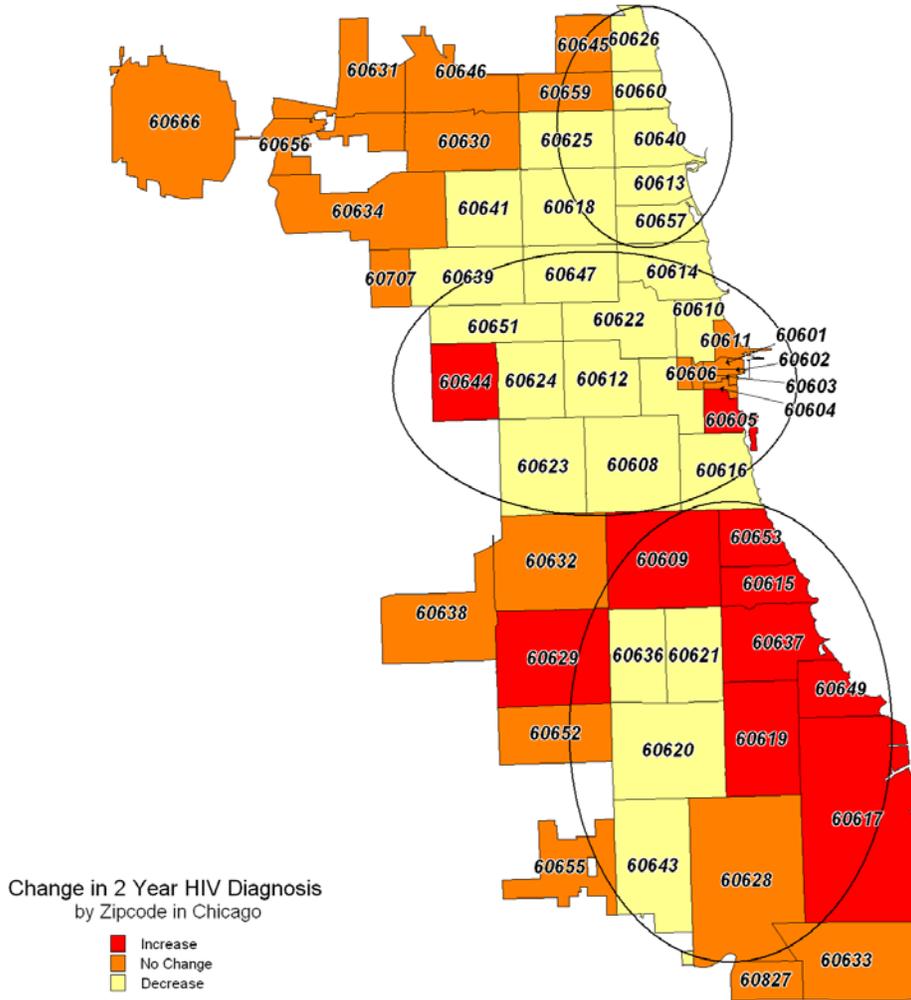
Section 5: Attachment 5 – HIV Diagnosis Rate 2006-2007

HIV Diagnosis Rate: 2006-2007
by Zipcode in Chicago



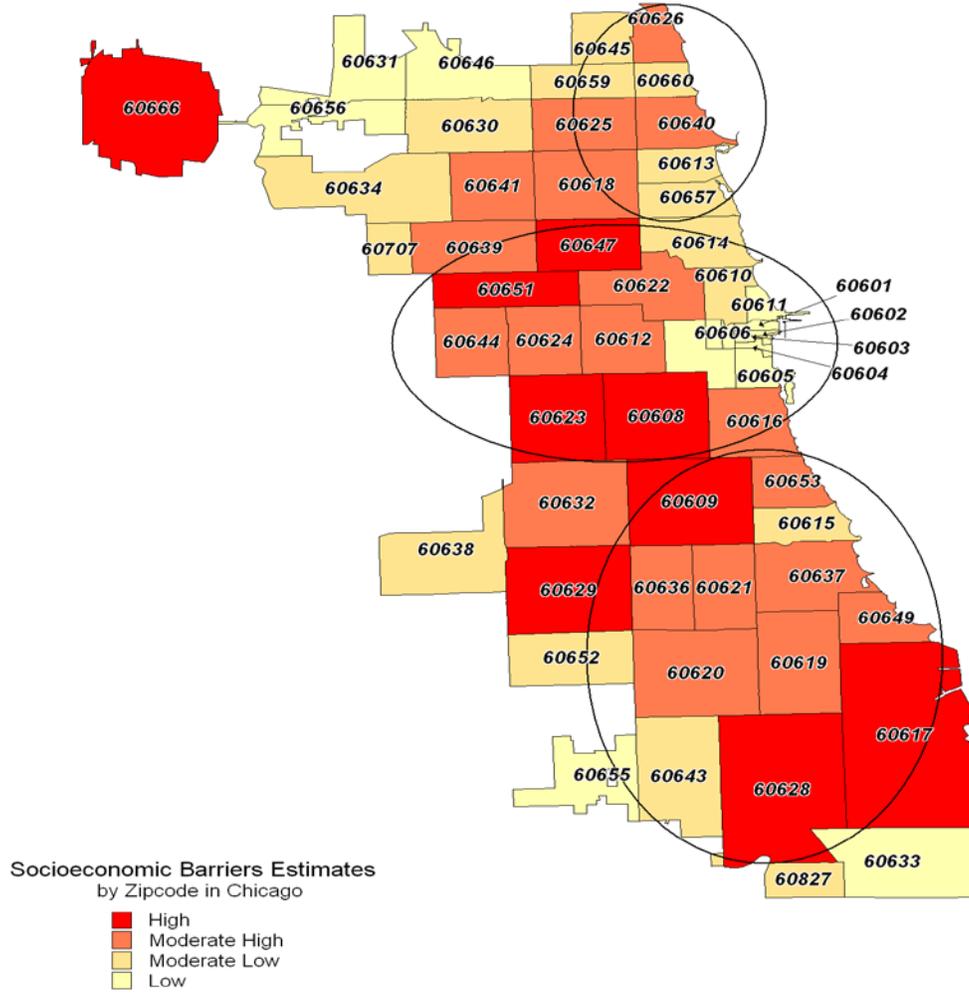
Section 5: Attachment 6 – Change in HIV Diagnosis Rate between 2002-2003 & 2006-2007

**Change in HIV Diagnosis Rate
Between 2002-2003 & 2006-2007
by Zipcode in Chicago**



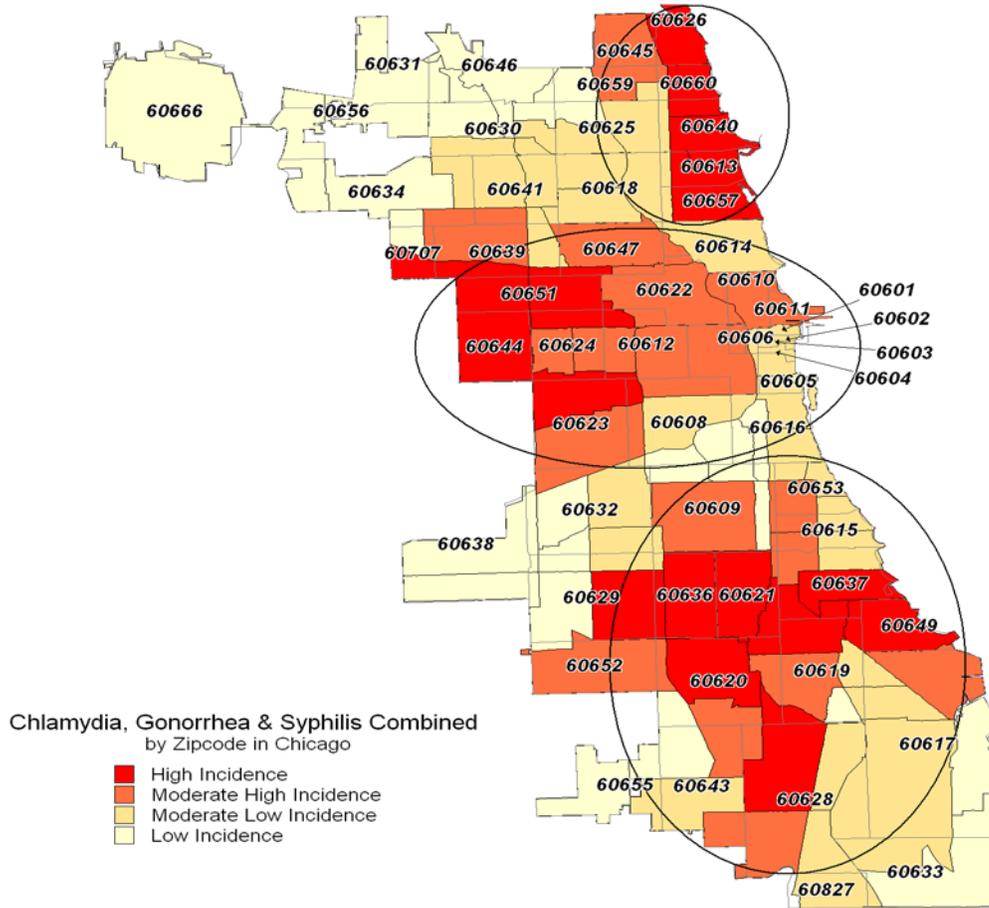
Section 5: Attachment 7 – Social Determinants of Health /Social Barriers Map

Socioeconomic Barriers Estimates in Chicago



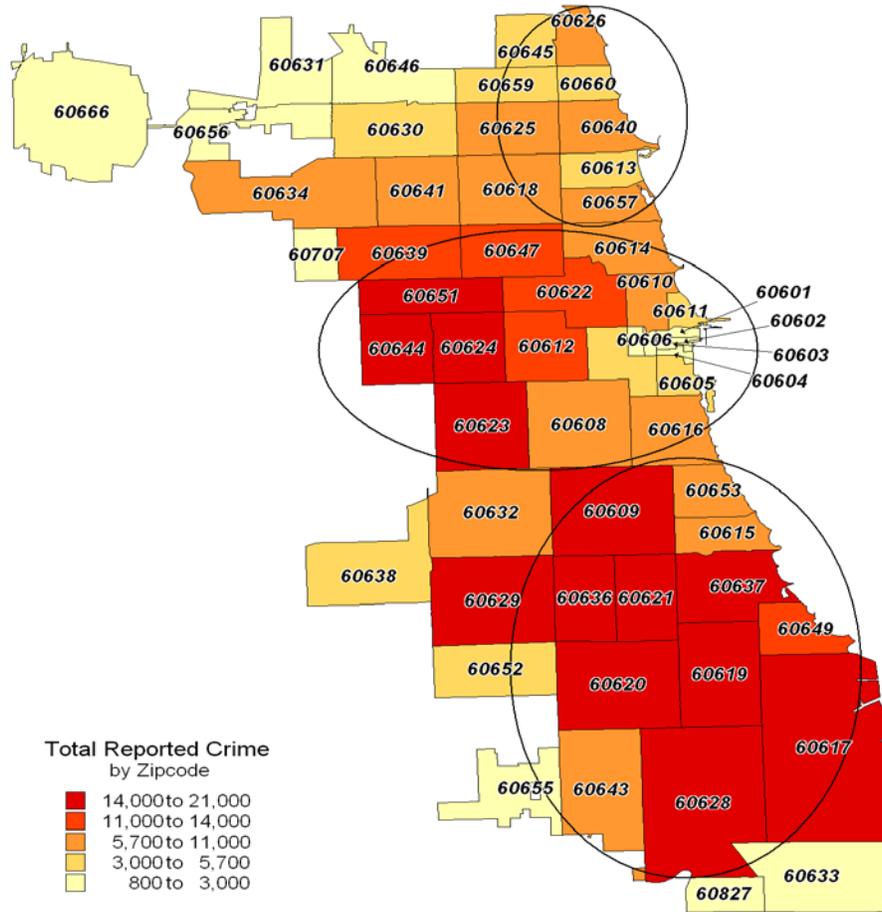
Section 5: Attachment 8 – Areas of Concentrated STDs in 2007 Map

Areas of Concentrated Chlamydia, Gonorrhea & Syphilis in Chicago in 2007



Section 5: Attachment 9– Areas of Reported Crime 2007 -2008 Map

Total of Reported in Chicago:
7/1/07 to 6/30/08



Section 8: Glossary of Terms

To assist the reader with the numerous acronyms referenced in this document, this glossary of frequently used acronyms has been provided for reference.

ACT	Assertive Community Treatment
ADAP	AIDS Drug Assistance Program
AED	Academy for Educational Development
AETC	AIDS Education and Training Centers
AFC	AIDS Foundation of Chicago
AIDS	Acquired Immune Deficiency Syndrome
ASC	Agency Support Center
ASO	AIDS Service Organization
CAEAR	Cities Advocating Emergency AIDS Relief
CAPS	Chicago Alternative Policing Strategy
CARE Act	Comprehensive AIDS Resources Emergency Act
CARR	Coalition for Adolescent Risk Reduction
CBC	Congressional Black Caucus
CBO	Community-Based Organization
CCDOC	Cook County Department of Corrections
CCJ	Cook County Jail
CCJTDC	Cook County Juvenile Temporary Detention Center
CCP	Community Coalition Project
CCR	Communications/Community Relations
CDBG	Community Development Block Grant
CDC	Centers for Disease Control and Prevention
CDCI	Communicable Disease Control Investigator
CDPH	Chicago Department of Public Health
CDRP	Communicable Disease Research Program
CF	Correctional Facility
CHS	Cermak Health Services (at Cook County Jail)
CJ PAC	Criminal Justice Population Advisory Committee
CL/SM	Community Level / Social Marketing
CMT	Communication, Membership and Technical Assistance Committee
COIP	Community Outreach Intervention Project
CPG	Community Planning Group
CPS	Chicago Public Schools
CT	HIV Counseling and Testing
CTRPN	HIV Counseling, Testing, Referral and Partner Notification
CY	Calendar Year
DASH	Division of Adolescent and School Health
DCFS	Department of Children and Family Services
DHAP	Division of HIV/AIDS Prevention
DHHS	Department of Health and Human Services
DIS	Disease Intervention Specialist
DOT	Directly Observed Therapy

DRC	Day Reporting Center
EIS	Early Intervention Services
ELISA	Enzyme-linked Immunosorbent Assay
EMA	Eligible Metropolitan Area
ESL	English as a Second Language
FSW	Female sex workers
G/C	Gonorrhea/Chlamydia
GLI	Group Level Intervention
HAART	Highly Active Anti-retroviral Therapy
HARS	HIV/AIDS Reporting System
HATU	HIV/AIDS Training Unit
HBHC	Howard Brown Health Center
HBV	Hepatitis B Virus
HC/PI	Health Communication/Public Information
HE/RR	Health Education and Risk Reduction
HITS	HIV Testing Survey
HIV	Human Immunodeficiency Virus
HPPG	(Chicago) HIV Prevention Planning Group
HRH	High Risk Heterosexual
HRSA	Health Resources and Services Administration
HOPWA	Housing Opportunities for People with AIDS
HUD	Housing and Urban Development
IDPH	Illinois Department of Public Health
IDU	Injection Drug User
IDU/AOD	Injection Drug Use/Alcohol and Other Drugs
ILI	Individual Level Intervention
LCR	Ligase Chain Reaction
LGBT	Lesbian, Gay, Bisexual and Transgender
MATEC	Midwest AIDS Training and Education Center
MCTC	Metropolitan Chicago Tuberculosis Coalition
MHC	Mental Health Clinic
MISA	Mental Illness/Substance Abuse
MOA	Memorandum of Agreements
MOCHA	Men of Color HIV/AIDS Coalition
MSM	Men who have Sex with Men
MSM/W	Men who have sex with men and women
MSW	Male sex workers
NAPWA	National Association of People With AIDS
NCHSTP	National Center for HIV, STD, and TB Prevention
NIH	National Institutes of Health
NIR	Non-Identified Risk
NMAC	National Minority AIDS Council
NEP	Needle Exchange Programs
OASA	Office of Alcohol and Substance Abuse
OD	Organizational Development

OHAS	Office of HIV/AIDS Surveillance
OMH	Office of Minority Health
PAC	Population Advisory Committee
PACPI	Pediatric AIDS Chicago Prevention Initiative
PCM	Prevention Case Management
PHA	Public Health Administrator
PIR	Parity, Inclusion and Representation
PPPC	Public Policy and Procedures Committee
PSR	Psychosocial Rehabilitation
PWA	Person with AIDS or People Living with AIDS
PLWH	Person Living with HIV/AIDS
PN	Partner Notification
PSP	Priority Setting Process
QA	Quality Assurance
RARE	Raid Assessment, Response and Evaluation
RFP	Request for Proposal
RPR	Rapid Plasma Reagin
SAM	Sexually Active Men
SAMHSA	Substance Abuse and Mental Health Services Administration
SAP	Substance Abuse Programs
SCBW	Survey of Child Bearing Women
SHAPPPD	STI/HIV/AIDS Public Policy & Programs Division
SHARP	Southside HIV/AIDS Resource Providers
SPInS	Special Project of Innovative Significance
SPNS	Special Project of National Significance
STARHS	Serological Testing Algorithm for Recent HIV Seroconversion
STD	Sexually Transmitted Disease
TA	Technical Assistance
TAP	Technical Assistance Project
TB	Tuberculosis
TBCO	TB Central Office
UAI	Unprotected Anal Intercourse
URAI	Unprotected Receptive Anal Intercourse
UCHAPS	Urban Coalition of HIV/AIDS Prevention Services
UIC	University of Illinois at Chicago
WB	Western Blot
WHARP	Westside HIV/AIDS Service Providers
WHAPA	Westside/Humboldt Park HIV/AIDS Service Providers
WSW	Women who have Sex with Women
YRBS	Youth Risk Behavior Survey

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