

# Prevention with Positives: A Guide to Effective Programs



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# Prevention with Positives: A Guide to Effective Programs

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*Dedicated to:*

The Many  
HIV-Positive Individuals  
Throughout the AIDS Epidemic  
Who Have,  
Without Support  
or Recognition,  
Taken  
Extraordinary Steps  
to  
Protect  
Others

*and to:*

Donald P. Francis, M.D., D.Sc.  
an Early  
and  
Enduring  
Voice

## Table of Contents

I.	<b>Introduction</b> .....	5
	Background	
	New Factors in the AIDS Epidemic	
	The Logic of Prevention with Positives	
	Challenges for Prevention with Positives	
II.	<b>A Shift in Prevention's Focus</b> .....	10
	The HIV-Infected Community Begins the Dialogue	
	A Recommendation from California HIV Planning Group	
	The Centers for Disease Control and Prevention HIV Prevention Strategic Plan	
	Department of Health Services, Office of AIDS Responds	
III.	<b>HIV Prevention and Care Integration</b> .....	13
	A Cross-Cultural Journey	
	Integrated Statewide Planning	
	Local Planning – Prevention and Care Groups	
	Integrated Prevention with Positives Programs	
	An Additional Benefit	
	Traditional Public Health Approaches and Prevention with Positives	
IV.	<b>Formative Planning for Prevention with Positives</b> .....	21
	Formative Planning	
	Formative Research	
	Focus Groups	
	Epidemiological Profile	
V.	<b>Interventions for Prevention with Positives</b> .....	25
	General Factors to Consider	
	Formative Research Guides Program Development	
	Characteristics of Effective Programs	
	Levels of Interventions	
	Examples of Programs	
VI.	<b>Training and Technical Assistance</b> .....	36
VII.	<b>Evaluation</b> .....	40
VIII.	<b>Conclusion</b> .....	46

## Appendices

A.	Statement and Proposal from the 'Breakfast Club' on Prevention and HIV-Positive Persons to the California Prevention Working Group September 1998.....	47
B.	Prevention, Care, and Treatment Integration Recommendations, November 9, 2000.....	51
C.	"Every Person Infected with HIV-1 Should Be in a Lifelong Early Intervention Program" by Don P. Francis, M.D., D.Sc.....	58
D.	Biomedical Approaches - STD/HIV Interaction.....	60

## I. Introduction

*"Risky behavior by positive people is not the norm. Most of us take extraordinary steps to make sure that we are not infecting our partners, and we are doing so without a whole lot of support. There aren't big campaigns supporting us staying safe in our relationships. We're doing it of our own accord."*

- Terje Anderson, NAPWA

### **Background<sup>1</sup>**

As the HIV/AIDS pandemic enters its third decade, it continues to be one of California's most serious public health challenges. Recent treatment developments are encouraging – statewide, the number of deaths from AIDS and the rate of new AIDS diagnoses have declined each year since 1995. But the social and economic costs of the epidemic remain staggering.

Today, approximately one in seven Americans with AIDS resides in California, and at least 55,415 Californians are living with AIDS. The effectiveness of current treatments means people with AIDS are living longer and, consequently, the number of people living with AIDS in California has steadily risen. In 2003 alone, a total of 5,573 new cases of AIDS were reported in California. Researchers believe that over 130,000 Californians may now be living with HIV.

While prevention efforts have been successful in reducing seropositivity rates in some populations, HIV has gained new ground in vulnerable populations such as women of color, young men who have sex with men (MSM), and MSM of color.

The number of cases reported among African Americans and Latinos in California accounted for over 55 percent of new cases in 2003, including not only MSM, but also cases related to heterosexual transmission and transmission associated with injection drug use. The rate of HIV infection in Latino and African American communities has been so significant that states of health emergency have been declared in local health jurisdictions around the state.

The Department of Health Services, Office of AIDS (DHS/OA) has found that MSM still account for the majority of new and existing AIDS cases reported statewide, with an increase in reported cases among African American and Latinos. After years of low seroconversion rates, new infections of HIV among populations of gay men are increasing. Outreach workers report, and Centers for Disease Control and Prevention (CDC) research corroborates, that among many HIV-positive MSM, there has been a shift away from "safer sex" practices.

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<sup>1</sup> All data in the "Background" section are from DHS/OA HIV/AIDS Case Registry.

The development of effective HIV treatments has had a profound impact on every aspect of HIV services, and the advent of highly active antiretroviral therapy (HAART) provides a new context for prevention activities. HAART's life-extending benefits mean that the number of persons living with HIV disease will continue to spiral upward. Those who respond well to treatment are able to take part more regularly in activities that are important to them – and, for some, those activities are associated with increased risk of HIV transmission.

Treatment advances bring real hope to persons living with HIV. At the same time, they may contribute to a sense of complacency about transmission risk. There is a growing body of evidence that awareness of the success of HAART has contributed to increasing levels of high-risk behavior among sub-populations of both HIV-positive and HIV-negative persons.

### **New Factors in the AIDS Epidemic**

Throughout most of the epidemic, the emphasis has been on providing care and support services to those with HIV disease, and prevention efforts have been focused on persons who were HIV negative. There was justifiable concern that a strong focus on transmission prevention directed toward HIV-positive persons would be stigmatizing to a population that already faced discrimination and life-threatening illness. As the HIV/AIDS epidemic has progressed, legal and societal advances have resulted in more support for those living with HIV, and parallel advances in treatment and prevention require that we continually reassess the focus of our strategies to prevent new HIV infections.

Many factors – increasing numbers of persons living with HIV and AIDS, high rates of HIV infection in communities of color, a resurgence of HIV in some areas and populations, the impact of HAART, and the enhanced understanding of the challenges of maintaining low-risk behavior over time – point to the need for interventions specifically designed to meet the needs of HIV-positive persons.

The environment in which HIV transmission prevention takes place is increasingly complex. Many HIV-infected persons are living well, engaging in fulfilling personal, social, and work relationships, and coping with the challenges of HIV disease. At the same time, many studies indicate that while HIV-positive persons tend to report lower levels of HIV risk behavior than those who are HIV negative, many HIV-positive persons still take significant risks. Even though most HIV-positive persons are dedicated to taking responsibility for preventing HIV transmission to others, people living with HIV can occasionally lapse into unsafe behaviors. Even those who possess strong commitment and the best of intentions can suffer a lapse, reflecting the simple reality that it is very difficult to consistently maintain behavior change over time.

As the HIV epidemic moves into its third decade, neither providers nor consumers can ignore the issue of “prevention burnout,” a phenomenon found in some people with HIV who have been attempting to practice HIV risk reduction for many years. For some, a

fatalistic perspective can take hold based on the assumption that, because people continue to become infected, taking steps to prevent HIV transmission is futile. This may be the flip side (for HIV-positive people) of the “inevitability” argument heard from some HIV-negative people: “If I’m sexually active or engage in needle-sharing, it is inevitable that I will become HIV positive, so why alter the behaviors that may lead to it...it won’t make any difference.”

Many who have been HIV positive for a long time have also experienced multiple losses and may suffer from untreated grief and depression. In the case of severe depression, sex drive may be reduced or nonexistent. But for people who are HIV positive and suffer from chronic low-grade depressive symptoms, a correlation has been shown between depressive symptoms and increased rates of unprotected sexual encounters.

Additionally, HIV treatment “optimism” has been identified as a contributing factor in prevention burnout. There has been so much pressure over the years on sexually active individuals to change their behaviors, that the advent of hope that accompanied the introduction of effective HIV treatments has had the unintended consequence (among some people) of increasing unsafe behaviors. These trends, among others, have been identified with increased rates of sexually transmitted diseases (STDs) among sexually active gay male populations. The increases in STD rates in some locales (e.g., San Francisco, Los Angeles, Palm Springs) have been taken as indicators that the populations most affected (sexually active MSM) are not using effective risk-reduction strategies, possibly because “prevention burnout” has set in among individuals in these groups.

Finally, there is considerable confusion among HIV-positive people about two other subjects. First, is the subject of “reinfection” (or “superinfection”), i.e., the potential for being “reinfected” via unsafe behaviors with a different strain of HIV that may be drug resistant or more virulent. While cases of reinfection have been reported anecdotally, the legitimate questions surrounding it may contribute to a sense of denial among HIV-positive people that can compromise efforts to protect themselves and others from the possibility of reinfection.

The second subject about where there is confusion and conflicting information is whether or not infectivity is reduced (or eliminated) if an HIV-positive person has a low or undetectable viral load. There is evidence that HIV-infected individuals continue to shed (transmit) HIV after months of treatment, even with low or undetectable viral loads. However, there is no definitive information available about the relationship between viral load and the risk of transmitting HIV. Many HIV-positive persons find themselves uncertain about what viral load test results mean in terms of transmission risk, and some (understandably) believe that “no detectible viral load” means the same thing as “virus free.” Lack of information, uncertainty, and confusion can contribute to risky behavior even among those who are vigilant in their intent to eliminate transmission risk.

## The Logic of Prevention with Positives

*Successful HIV prevention for an HIV-negative person stops acquisition of the virus by that individual. But an HIV-infected person who avoids risk behavior, even temporarily, may avoid multiple transmissions of the virus.*

- California HIV Planning Group

While HIV prevention is important for everyone, every new HIV infection involves an HIV-infected individual transmitting the virus to an uninfected person. Many new HIV infections can be prevented by intensive efforts directed toward the much smaller population that is capable of transmitting the virus – those who are already HIV positive. This is a simple truth with complicated repercussions. Both providers and persons living with HIV want to be certain that any prevention efforts directed toward HIV-positive persons encourage a healthy sense of responsibility without assigning blame, and that they support a lifestyle that includes a fulfilling sex life and the enhancement of interpersonal and community relationships.

Sound public health policy has repeatedly demonstrated the wisdom of focusing prevention efforts toward the smaller group of those who are at risk of transmitting a disease rather than on the larger population that is at varying levels of risk for acquiring the disease. Such strategies have resulted in the eradication of smallpox and the control of tuberculosis (TB). A cure for HIV remains a distant dream, and in the absence of a vaccine to prevent HIV, behavioral interventions that help HIV-positive persons live well and live safely represent our best hope for stopping - or even slowing - the epidemic. Interventions developed for HIV-positive persons must support people with HIV even as they honor HIV prevention and the public health tradition.

## Challenges for Prevention with Positives

*"The goal of risk reduction with HIV-infected persons is to help individuals achieve behavior change that results in overall lower risk of HIV transmission. This includes assistance in creating a home, identity, and social environment that support lower risk behavior."*

- California HIV Planning Group

Many HIV-positive persons live with multiple diagnoses and therefore are not able to manage the demands, stresses, consequences, and responsibilities of being infected with HIV. DHS/OA care and treatment sites statewide report that up to half of their HIV-infected clients present with substance abuse problems and, that of those, 40 percent also suffer from some form of mental disorder. In addition, many clients are homeless or marginally housed, have a generalized lack of supportive family or social network, and have associated difficulties accessing basic living needs and achieving basic living skills. All of these factors contribute to increased risk of HIV transmission.

For some HIV-positive persons, the reality of struggling with poverty, caring for their families, living with the threat of violence, or contending with mental disorders, substance abuse, or other health problems are so compelling on a daily basis that health care adherence and HIV transmission prevention are not primary concerns. However, as planning for effective prevention with positives programs and interventions proceeds, it must not be forgotten that high-risk behaviors are not exclusive to those who struggle with poverty, stigma, mental illness, or substance use. Care must be taken to develop sensitive and respectful methods of assessing risk so that HIV-infected persons struggling to maintain safe behaviors receive support and needed interventions regardless of social, ethnic, racial or economic group, or other combination factors. Some risk behaviors transcend class, economic status, and demographic group. Individuals who, by all indications, lead stable lives, have good jobs, live in comfort, and whose basic needs are fully met may still be struggling with issues such as depression, sexual impulsivity, substance use, or other life challenges.

Finally, a significant challenge for prevention with positives programs is to identify HIV-infected persons who know their HIV status, but who are not engaged in care. A comprehensive approach to prevention with positives must include strategies that not only intervene with high-risk behaviors, but also include strategies for engaging out-of-care HIV-infected persons into HIV care.

## II. A Shift in Prevention's Focus

*A community-planned strategy of outreach and behavior change efforts directed at both HIV positives and high-risk negatives is more likely to be efficient and cost-effective than one targeting negatives only. In fact, some evidence indicates that interventions to achieve behavior change among HIV-positive persons may be by far the most cost-effective interventions available.*

- "Breakfast Club," California Prevention Working Group

Traditionally, HIV prevention programs have been primarily focused on high-risk HIV-negative individuals, and few have directed efforts toward HIV-infected persons to help them change the behaviors that place their sex and/or needle-sharing partners at risk for infection. In recent years, this complex and sometimes controversial area has begun to receive more attention.

### **The HIV-Infected Community Begins the Dialogue**

Much of the impetus - and many of the most eloquent voices - for the shift towards emphasizing prevention skills and risk reduction for people who are HIV positive has come from the directly-impacted community itself. As effective HIV drug therapies became more available, and people began to feel healthier, it became apparent to members of the HIV-infected community that one of the most effective ways to reduce transmission would be by having an impact on the thinking and behaviors of people who were already HIV positive.

For example, in September 1998, the "Breakfast Club," a group of HIV-infected persons who were part of the statewide California Prevention Working Group, formulated a set of strong recommendations for prevention with positives. The Breakfast Club members suggested that the statewide planning group adopt their "statement and proposal." Unfortunately, group process considerations and lack of time prevented the statewide group from discussing the recommendations. Nevertheless, in 2003, the Breakfast Club's 1998 proposal remains remarkably forward-thinking and insightful. [See Appendix A, "Statement and Proposal from the 'Breakfast Club' on Prevention and HIV-Positive Persons" to the California Prevention Working Group, September 1998.]

### **A Recommendation from the California HIV Planning Group**

After significant inquiry, testimony, and discussion, in November 2000, the California HIV Planning Group passed a recommendation to dedicate a portion of HIV prevention funding for prevention with positives. The California HIV Planning Group, a statewide group comprised of prevention and care providers, consumers, public health administrators, and other advisors to DHS/OA, recommended that between 25 and 50 percent of local education and prevention (E&P) funds be allocated for HIV

prevention strategies and interventions with HIV-positive individuals<sup>2</sup>. In addition, the California HIV Planning Group passed a number of related recommendations, including a report by the Prevention, Care, and Treatment Integration Committee. (*For the complete text of these recommendations and the committee's report, see Appendix B, Prevention, Care, and Treatment Integration Recommendations, November 9, 2000.*)

### **CDC HIV Prevention Strategic Plan**

Simultaneously, CDC released its HIV Prevention Strategic Plan Through 2005. For the first time, the plan placed emphasis and priority on prevention with positives. Specifically, their primary goal was, "*By 2005, reduce by at least 50% the number of persons in the United States at high risk for transmitting or acquiring HIV by delivering targeted, sustained, and evidence-based HIV interventions.*" The objective assigned highest priority for attaining that goal was, "*Among people living with HIV, increase the proportion who consistently engage in behaviors that reduce risk for HIV transmission or acquisition.*"

### **DHS/OA Responds**

#### Positive Changes

DHS/OA first responded to the November 2000 California HIV Planning Group recommendations by sponsoring a statewide symposium on prevention with positives. In August 2001, DHS/OA sponsored *POSITIVE CHANGES: Focusing on Prevention for the HIV-Infected*, a statewide symposium for both prevention and care providers held in San Diego, California.

The overall purpose of the *POSITIVE CHANGES* symposium was to present current theory and practice in HIV prevention work with HIV-positive individuals, including the ways in which this work is different than prevention work with HIV-negative persons. Additionally, the conference provided a forum to share effective approaches in prevention with positives, introduce new programs, and exchange ideas between researchers, community members, and academic partners in prevention with positives. Three final goals of the symposium were to understand the interplay of individual, cultural, and community issues in prevention with positives, to create basic strategies for developing programs for prevention for HIV-positive persons, and to discuss the roles of both prevention and care in prevention with positives.

#### A New Prevention Policy

In January 2002, DHS/OA implemented a prevention policy based on the recommendation from the California HIV Planning Group that a portion of E&P funds be redirected to prevention with positives. DHS/OA required that, beginning with fiscal year (FY) 2002-03, all of California's local health jurisdictions redirect between 5 and

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<sup>2</sup> As discussed in "DHS/OA Responds," DHS/OA implemented a modified version of this recommendation, requiring that local health jurisdictions redirect up to 25 percent of E&P funds.

25 percent of their total E&P funds toward HIV prevention programs for the HIV-positive community. (Allowance was made for some jurisdictions with few or no HIV-infected persons in their communities to target between zero and five percent of E&P funds to prevention with positives.)

During FY 2002-03, all local health jurisdictions submitted plans that included specific focus on HIV-positive persons, and some local health jurisdictions made exceptional progress in designing and implementing prevention with positives programs. Most jurisdictions, however, engaged in local planning processes to assess need, define target groups, and to research the effectiveness of possible interventions.

### New Training and Special Initiatives

DHS/OA has made prevention with positives a high priority. An Inter-Branch Committee for Prevention with Positives was formed so that efforts would be coordinated between the HIV Education and Prevention Services Branch and the HIV Care Branch. The HIV/AIDS Epidemiology Branch also participates as needed.

In support of prevention with positives program development, several special trainings (and technical assistance) have been developed and made available statewide. Specifically, DHS/OA contracted with the DHS STD/HIV Training Center; the University of California, San Francisco, AIDS Health Project; and the Center for HIV Identification, Prevention, and Treatment for trainings and technical assistance on prevention with positives, or related subjects. (*See Section VI, Training and Technical Assistance for further details on these trainings and technical assistance.*)

In addition, DHS/OA applied for, and received, one of CDC's five national Prevention for HIV-Infected People Project (PHIPP) grants. This grant has allowed DHS/OA to develop pilot prevention with positives programs, the HIV Transmission Prevention Program (HTPP), and the Bridge Project. The HTPP is an intensive, individualized behavior change support program that is clinic-based. The Bridge Project is a program that brings out-of-care HIV-positive persons into care. (*For more information on these PHIPP programs, see Section V, Interventions for Prevention with Positives.*)

Finally, as part of their focus on prevention with positives, DHS/OA has continued to support two special programs. The first, Partner Counseling and Referral Services (PCRS) is based on a traditional public health approach which assists HIV-positive persons to inform their sex or needle-sharing partners that may have been placed at risk for HIV. (*For more information on PCRS, see Section III, HIV Prevention and Care Integration.*) The second, the Transitional Case Management Program is part of a larger CDC Corrections Initiative. The program focuses on transitional links for pre- and post-release HIV-infected inmates who will be making transitions back to their communities. One of the primary goals of the Initiative is to initiate and sustain positive behavior change for pre- and post-release HIV-positive inmates with high-risk behaviors related to substance abuse and/or the transmission of HIV, STDs, TB, and/or hepatitis.

### III. HIV Prevention and Care Integration

#### A Cross-Cultural Journey

*"Our agency tried to integrate our prevention and our client services departments, and it was very difficult. Prevention was telling people, 'This is horrible, you don't want to get it,' and the Client Services was going, 'Oh, it's OK. It's all right. You know, it's not so bad.' "*

- AIDS Research Institute, University of California, San Francisco

There can be many barriers to the successful integration of prevention and care: varying approaches, priorities that may differ, separate funding sources with implementation and reporting requirements that differ or conflict, distinct agencies and/or programs, separate administrative oversight, staff trained in disciplines with contrasting approaches, separate local planning bodies, and much more. However, the potential benefits of such integration for the HIV-infected client – and for achieving the public health goals of prevention with positives – are so compelling that HIV programs must now include an integrated approach.

The journey toward effective collaboration between, and integration of, care and prevention may be challenging, but there are few communities more appreciative of diversity, and more practiced in cultural competence, than the HIV service community. Bridging the gap between the “cultures” of care and prevention to achieve common goals may be a difficult journey, but it is a journey that must be taken.

#### Integrated Statewide Planning

*"The CHPG spoke clearly at the last two meetings about the need for 'integration' and the state OA has responded with a willingness to support our recommendations for change... This is an example of community involvement at its most effective."*

– 2002 California HIV Planning Group Steering Committee

For many years, DHS/OA's two statewide planning groups, the California Prevention Working Group and the HIV Comprehensive Care Working Group, worked independently. Recognizing the advantage of integration, DHS/OA merged the two groups in 2000, forming the California HIV Planning Group.

The combined California HIV Planning Group was very successful; however, new federal requirements, and the resulting budgetary constraints related to the new DHS/OA care planning process, created the need for separate planning processes. In 2002, the California HIV Planning Group represented only prevention. During the final meetings in 2002, the California HIV Planning Group recommended that the group again be integrated to include both prevention and care representation and focus on both prevention and care goals and issues. Since late 2002, DHS/OA care planning

process was nearing completion, thus clearing the way for the reintegration of the care and prevention groups, DHS/OA agreed with this recommendation and, beginning with the April 2003 meeting, the California HIV Planning Group again represented both prevention and care planning.

### **Local Planning – Prevention and Care Groups**

*"HIV-positive persons are a unique population in that they require both care and prevention, which requires better coordination between these two worlds."*

- University of California, San Francisco,  
Center for AIDS Prevention Studies Fact Sheet

Much of the federal prevention, care, and treatment funding administered and allocated to local communities/local health jurisdictions via DHS/OA requires a community planning process. In the past, most prevention community planning has been independent of care community planning. However, as resources become scarcer and especially with the emphasis on prevention with positives, new value has been placed on coordinated or combined community planning that links prevention and care. It is more important than ever that prevention planning groups and care and treatment planning groups work together: the HIV-infected community is the target group for prevention with positives services; prevention programs often have developed expertise in behavior change; care providers have developed trusting relationships with HIV-infected persons; and care and treatment sites may be one of the best venues for these activities.

As described below, each local planning area, whether prevention or care, has DHS/OA staff assigned to it. Your program contact in DHS/OA should be able to provide you with the contact information for DHS/OA staff or for your local planning partners. If your program contact does not have this information, please contact:

DHS/OA  
HIV Education and Prevention Services Branch  
HIV Community Prevention Section  
Gail Sanabria, Chief  
(916) 449-5790 or e-mail: [gsanabri@dhs.ca.gov](mailto:gsanabri@dhs.ca.gov)

DHS/OA  
HIV Care Branch  
CARE Section  
Peg Taylor, Chief  
(916) 449-5950 or e-mail: [ptaylor@dhs.ca.gov](mailto:ptaylor@dhs.ca.gov)

### Prevention Community Planning

HIV prevention community planning is an ongoing comprehensive planning process that is intended to improve the effectiveness of local HIV prevention programs by

strengthening the scientific basis, community relevance, and population focus of prevention interventions. According to CDC's *HIV Prevention Community Planning Guidance* document, community planning is:

1. Evidence-based, and
2. Incorporates the views and perspectives of groups at risk for HIV infection for whom the programs are intended, as well as providers of HIV prevention services.

The important overall goal of HIV prevention community planning is to have in place a comprehensive HIV prevention plan that is current, evidence-based, adaptable as new information becomes available, tailored to the specific needs and resources of the local health jurisdiction, and widely distributed in an effort to provide a roadmap for prevention that can be used by all prevention providers in the jurisdiction.

Local health jurisdictions should collaborate with their local implementation groups (LIGs) and local care planning groups in the development and implementation of their HIV prevention with positives programs or activities. This will ensure the fostering of strong logical linkages between the local health jurisdictions and its community partners.

#### Care Community Planning

DHS/OA's Care Services Program (CSP) provides Health Resources and Services Administration, Ryan White CARE Act Title II funding to local communities for the provision of medical and support services for persons living with HIV/AIDS. CSP provides funding for care and treatment services, and contains strong mandated community planning components. Contractors funded through CSP are required to develop comprehensive service delivery plans for their counties or regions that address approaches for care, treatment, and prevention integration. This coordination is focused primarily, but not exclusively, on:

1. Linking newly HIV-infected individuals immediately into care;
2. Identifying HIV-positive, out-of-care individuals/populations and providing access to care;
3. Prevention programs/strategies for HIV-infected persons; and
4. Integrated and/or complementary state and local planning for care, treatment, and prevention activities.

The local planning component of CSP requires that fiscal agents prepare local comprehensive service delivery plans. It also requires that they consult with a wide range of HIV and non-HIV service agencies, programs, service providers, and HIV-positive individuals in developing their plans. CSP strategy is to continue creating and strengthening these linkages, using technical assistance when needed, and creating opportunities to focus on issues in a collaborative manner.

CSP comprehensive service delivery plans must describe the steps they are implementing, or proposing to implement, to ensure that prevention for high-risk

HIV-infected persons is a part of a standard of care. They must also describe how they will initiate and/or support efforts to integrate the assessment for high-risk behaviors and the provision of risk reduction interventions into care settings. Service delivery plans will include goals and objectives that address the integration of HIV prevention services in care settings to help halt the spread of HIV.

Each CSP contractor is assigned a Care Services Advisor at DHS/OA. At the local level, fiscal agents manage CSP contracts and ensure appropriate planning and fiscal documentation. Care Services Advisors can provide a list of fiscal agents and contact information by county or by CSP region, can help introduce HIV E&P planning staff and their contractors to CSP staff, and can facilitate communication between CSPs and LIGs. DHS/OA HIV E&P Program Consultants can assist in making contact with CSP Care Services Advisors. Working together creates a more inclusive and comprehensive planning model that addresses the needs of persons with HIV and AIDS.

### **Integrated Prevention with Positives Programs**

*"...the lessons of tuberculosis control and smallpox eradication, together with those of chronic disease prevention, would suggest that targeting of available prevention modalities (behavior change programs) toward HIV infected persons...would be an important adjunct to current AIDS prevention programs. ...We propose a program that would...apply both medical and behavioral intervention tools to maximize the healthy and productive lives of the individuals and assist them to minimize the chance of infecting others. ...The program design is predicated on the assumption that both the medical follow-up and treatment and counseling and education would have personal as well as societal benefits."*

- Donald P. Francis, M.D., D.Sc., et al; JAMA, November 1989

The logic of integrating HIV prevention and care is as compelling in 2003 as it was in the mid-1980's when Don Francis first proposed it. In 2003, however, it seems more possible. Societal and political realities have changed and barriers to integration that existed early in the epidemic have diminished, although they may not have disappeared. (See Appendix C, "Every Person Infected With HIV-1 Should Be in a Lifelong Early Intervention Program" for a 1996 editorial about such barriers, reprinted from Sexually Transmitted Diseases.) The most profound change is the degree to which both care and prevention providers have come to share a common vision for prevention as well as the commitment required to create such integrated care and prevention programs.

CDC, in their work on the national PHIPP, has identified several reasons why programs based on prevention and care integration are critical:

- More people living with HIV and AIDS may be engaged (i.e., for prevention interventions) in care settings than anywhere else;
- For many, clinical care may be the only point of contact;

- HAART and other biomedical approaches are prevention interventions;
- Engagement in care and support services predict and facilitate transmission risk reduction; and
- The whole person must be the subject of successful prevention interventions.

Additional reasons to support an integrated prevention with positives model are:

- Interventions based on repeated contact with the client are more successful. Care settings provide the opportunity to develop trusting relationships based on frequent, repeated contact with individuals;
- When prevention is integrated as part of the standard of care for HIV-infected individuals, the client receives ongoing support for sustained behavior change;
- HIV-infected individuals are more likely to have their disclosure needs addressed – resulting in less isolation, more peer support (factors which have been shown to lower risk behaviors);
- Opportunities to support clients in informing their partner(s) of possible HIV exposure are more likely;
- Much of the behavioral work that supports reduced risk behaviors also supports increased adherence to HIV medications (See An Additional Benefit). Increased adherence improves effectiveness of HIV medications. This improves the individual's health status, decreases the possibility of the development of multi-drug resistant strains of HIV, and utilizes HIV medication resources more efficiently;
- Most care settings offer (or link with) case management and psychosocial support services, those types of services that mitigate some of the underlying causes of high-risk behaviors. Providing prevention and behavior change support complements and completes the standard of care; and
- When prevention interventions are offered in clinical settings where many HIV-infected persons receive services, the opportunity for clients to experience generalized peer support for safe behaviors is increased.

As described earlier, there are many challenges to developing integrated models of prevention and care for prevention with positives. But the experiences of CDC's PHIPP, California's Early Intervention Program (EIP), and other similar programs have shown that the ultimate benefits - for the individual and for society - are worth the effort. In addition, HIV service providers who have successfully bridged the "cultural" gap between HIV prevention and care report renewed purpose, increased efficiencies, and strengthened, more vigorous programs.

## **An Additional Benefit**

*"...while the ultimate goal is to prevent transmission of HIV, programs need to engage clients in risk-reduction work by focusing on enhancing the quality of their lives. Doing so will create greater opportunities for risk reduction than solely emphasizing the need to stop risky behaviors."*

*- California HIV Planning Group*

The same factors that contribute to increased risk of HIV transmission (substance abuse, mental disorders, lack of social support, and other social or economic challenges) also impact the ability to adhere successfully to complex treatment regimens. HIV/AIDS medication regimens are complicated and demanding. Most HIV-positive persons find strict adherence to these regimens difficult. Sporadic or partial adherence encourages the development of drug-resistant strains of HIV that may be transmitted to others. HIV-infected individuals who have responded well to treatment may subsequently fail treatment if they engage in high-risk behaviors and are reinfected with other strains, or drug-resistant strains, of HIV.

Federal treatment guidelines emphasize that all HIV-positive persons, including those with substance abuse or mental disorders, should be given access to HAART, and should be assisted in developing individualized treatment plans that lead to successful adherence. Successful prevention with positives interventions that address factors that contribute to high-risk behaviors may also result in increased adherence to HIV medications.

## **Traditional Public Health Approaches and Prevention with Positives**

### STD Screening

STDs play a critical part in the transmission as well as acquisition of HIV. An HIV-infected person who is infected with another STD is more likely to transmit HIV through sexual contact than other persons with HIV (Wasserheit, 1992). Therefore, recent increases seen in syphilis and other STDs in some areas of California elevates the importance of STD screening and treatment.

Activities that increase provider awareness of the importance of STD/HIV interaction issues and the role of biomedical approaches in HIV prevention play a critical role in reducing acquisition and transmission of HIV. Interventions implemented in clinic or community settings must be sensitive to program realities which may inhibit optimal delivery of some services. For example, medical providers in busy clinical settings may not be able to implement a 20-minute risk assessment/risk reduction counseling setting. They can, however, refer patients who would benefit from such services to other specially-trained staff or other programs. In addition, it may be very feasible for a

clinician to offer STD screening to patients with a past history of STDs, or those at increased risk, and inform them of the increased potential for HIV transmission if also diagnosed with an STD. Training and technical assistance needs and the realities of different program settings must be considered before decisions are made to implement these services. At a minimum, provider settings should have good referral sources for services that would be of benefit to their clients or patients.

Training and technical assistance should be provided for HIV prevention and care providers in STD/HIV interaction issues, as well as the role of biomedical approaches in HIV prevention. STD/HIV prevention and care providers could benefit from an understanding of behavioral interventions, including those implemented at the individual, group, and community level.

*(For a comprehensive explanation of STD/HIV interaction and recommended approaches to this issue, see Appendix D, Biomedical Approaches – STD/HIV Interaction.)*

## PCRS

It is important that HIV-infected persons be provided the opportunity to consider informing others of possible exposure to HIV – and it is imperative that they be supported in nonjudgmental ways as they consider if, when, and how to inform partners who may have been put at risk for HIV. PCRS are voluntary services that offer this support. PCRS-trained staff will be supportive of HIV-infected persons considering disclosure, whether or not the HIV-infected person chooses to inform partners of possible risk for HIV.

The goals of PCRS are to inform sex or needle-sharing partners of potential exposure, offer testing options, and provide referrals for clinical care for those testing positive. PCRS-trained staff can help the HIV-positive individual to explore the options and to weigh carefully the benefits and possible risks of disclosure. Staff can also help the individual to anticipate and address any consequences of disclosure and, when desired, staff can also help with referrals for the partner(s). There is also an opportunity to assess for threats of domestic violence and, as needed, to recommend against disclosure.

HIV-infected individuals wishing to inform a partner(s) of a possible exposure to HIV can receive assistance and support to disclose or to inform in three different ways:

- Self-referral: the HIV-infected person chooses to self-disclose, to inform the partner(s) him or herself. PCRS-trained staff can assist the client in deciding how and when to self-disclose;
- Dual referral: the HIV-infected person chooses to self-disclose with PCRS-trained staff present. PCRS-trained staff can facilitate the disclosure to the partner(s); and

- Provider referral: the HIV-infected person chooses to have his/her partners informed anonymously by specially-trained field staff. PCRS-trained staff can obtain partner(s) information from the client and anonymously transfer partner information to a Disease Intervention Specialist. The Specialist or similarly trained staff will make anonymous field notification to partner(s).

## IV. Formative Planning for Prevention with Positives

The shift that has taken place in the focus of HIV prevention is clearly a logical outgrowth of the changing realities of HIV disease. For some local health jurisdictions, this new focus will require a radical departure from business as usual, while for others it may be less challenging. However, no matter what the level of existing expertise may be, the question facing health policy planners, local health jurisdictions, and HIV providers trying to reduce HIV transmission rates is, "Where do we begin?" Many providers are looking for good, workable ideas and interventions that they can use as-is or modify in order to adapt them to local needs. The next few sections are designed to assist HIV planners in thinking about ideas and interventions that they might implement.

### Formative Planning

Formative planning is a valuable tool for understanding the behavioral, structural, or systemic factors that influence decisions and actions. Formative research methods help planners better understand the context of the issues an intervention is designed to address, and to design better tools and programs as a result.

Formative planning helps an agency take a close look at the community in which it is situated. It increases understanding of the interests, attributes, and needs of the various populations and individuals that make up the community. Formative planning and research informs the goals, parameters, activities, and settings of interventions and programs and, as such, it should occur as a first step - prior to program design and program implementation.

Many agencies have done formative planning while developing their existing HIV prevention and/or care programs, but because prevention with positives focuses on new populations and may require new approaches, formative planning is an integral part of developing prevention with positives programs. Formative planning that addresses the prevention needs of HIV-infected individuals in your community can:

- Ensure that prevention with positives programs are not stigmatizing or blaming;
- Help to develop assessment techniques for determining who is at greatest risk for transmitting HIV;
- Define the needs of those at greatest risk for transmitting HIV;
- More clearly define the elements of programs responsive to the needs of those at greatest risk for transmitting HIV;
- Increase the likelihood that programs will be located in suitable settings;
- Help to delineate the frequency and duration of interventions;
- Ensure programs are acceptable to, and feasible for, HIV-positive individuals;
- Define the potential for cooperation between agencies and existing service providers; and
- Anticipate problems that might arise.

## Formative Research

There has been some formative research already completed on prevention with positives in California communities. (*For some of the information gleaned from this research, see Section V, Interventions for Prevention with Positives, Formative Research Guides Program Development.*)

### Focus Groups

Formative planning can mean researching existing data and/or it can include the collection of new data via surveys, individual interviews, or needs assessments. Focus groups are a particularly effective, inexpensive way to do formative research in a community.

Focus groups are in-depth guided discussions among several individuals led by a trained moderator. Focus groups can be comprised of groups of HIV-positive individuals, partners or family members, high-risk individuals, service providers who work with the population, persons who do similar work (e.g., behavior change specialists who do work with substance users), or persons who influence your clients (i.e., opinion leaders). Focus groups are used to answer a specific question or to explore a particular issue. They can also be used as a beginning step, to gather information about a population with whom an agency may have little experience.

Focus groups are a good way to find out about the perceived norms of groups and subgroups. They can give detailed information about people's experiences and perceptions. Focus groups can also be useful when exploring difficult topics because participants get support from others in the group.

Focus groups often:

- Reimburse participants by offering incentives such as money, food, or vouchers;
- Are recorded in some fashion (by tape recorder or a note taker);
- Are facilitated by a moderator;
- Last one to two hours;
- Over-invite people (often times people do not show up); and
- Take place in a safe, private environment.

Any focus group convened to assist in the development of a prevention with positives program should carefully consider:

- Client recruitment, particularly how the participants selected will help inform specific questions;
- Developing a brief questionnaire to screen participants to increase the likelihood of recruiting the people you want into your groups;
- Developing a discussion guide;

- Selecting one topic and exploring it in-depth;
- Consent and confidentiality;
- Choosing an appropriate, experienced moderator or facilitator;
- Documenting either by videotape, audio, or taking notes; and
- Debriefing.

Planning and working with a focus group is an excellent way to learn from members of a particular group. At the same time, when asking individuals to disclose information about themselves, sponsors of focus groups must be careful to provide an environment that is safe, confidential, and respectful. In addition, the group facilitator must be skilled and experienced so that group discussion is productive, focus group members do not leave the group with regrets, and individuals' vulnerabilities are not exposed needlessly.

### **Epidemiological Profile**

The formation of an epidemiological profile is an important part of planning local HIV services. The epidemiological profile should provide a thorough understanding of the HIV epidemic among the various populations in a local health jurisdiction, as well as identify characteristics of HIV-infected individuals. There are many factors to consider when developing an epidemiological profile for a prevention with positives program. According to CDC, the following four key questions should be considered:

- What are the socio-demographic characteristics of the local health jurisdiction's HIV-positive population? (This should include a description of the racial and ethnic composition of the jurisdiction's population.)
- What is the percentage of HIV/AIDS cases for the jurisdiction?
- Who is at risk for transmitting HIV? (This can assist in setting priorities for HIV interventions among specific target populations.)
- What is the geographic distribution of HIV/AIDS infection in the jurisdiction?

For additional information on developing an epidemiological profile, please refer to CDC's *Suggested Guidelines for Developing an Epidemiologic Profile for HIV Prevention Community Planning*.

One important aspect of developing an epidemiological profile is the use of data. Data can assist in refining programs, highlighting problems that may be otherwise hidden, monitor programs over time, and make a strong case for the program's validity.

There are data available from DHS/OA that can be used to create epidemiological profiles and monitor current and future trends of both disease and related risk behaviors. DHS/OA data, including a data request form, can be accessed at DHS/OA web site:

- [www.dhs.ca.gov/AIDS](http://www.dhs.ca.gov/AIDS) or by calling DHS/OA at (916) 449-5900.

Other available data:

- Drug Treatment Clinic Reports: Department of Alcohol and Drug Programs, 1700 K Street, Sacramento, CA 95814, (916) 445-0834.
- DHS/Center for Health Statistics, MS 5103, P.O. Box 997413, Sacramento, CA 95899-7413, (916) 552-8095, [www.dhs.cahwnet.gov/org/hisp/chs/chsindex.htm](http://www.dhs.cahwnet.gov/org/hisp/chs/chsindex.htm).
- CDC/Divisions of HIV/AIDS Prevention, [www.cdc.gov/hiv](http://www.cdc.gov/hiv).
- U.S. Census Bureau, [www.census.gov](http://www.census.gov).
- National Center for Health Statistics, [www.cdc.gov/nchs](http://www.cdc.gov/nchs).
- FEDSTATS, [www.fedstats.gov](http://www.fedstats.gov).

The current and future prevalence and incidence of HIV, STDs, and their associated risk factors (including behaviors and beliefs) can be used in designing prevention efforts as well as in evaluating their effect. Merging data from existing surveillance systems can identify the frequency of co-morbidity. In the case of HIV and STDs, the prevalence of STDs may indicate where future HIV transmissions can occur.

## V. Interventions for Prevention with Positives

*"A change in the risky behavior of an HIV-positive person will, on average, and in nearly all affected populations, have a much bigger effect on the spread of the virus than an equivalent change in the behavior of a negative person."*

- King-Spooner, 1999

### General Factors to Consider

Because of the complexity of the factors influencing risk, there is no single "best approach" to addressing prevention with HIV-positive persons. Also, contending with the reality of limited resources means that many communities simply cannot provide the entire range of possible interventions. Instead, each jurisdiction will need to prioritize its own array of prevention needs, drawing from information provided through epidemiological data, formative research, and community assessments.

Developing effective prevention programs for HIV-positive persons may require changes in approach at all levels ranging from hiring and funding decisions, to case management practices, to shifts in the ways in which staff interact with clients and conceptualize risk behaviors. Change is never easy, and when implementing new interventions, it will be essential to remain sensitive to the fact that new approaches require time for adjustment by administrators, staff, and consumers.

The factors that place any HIV-positive person at risk for transmitting the virus are often highly individualized and encompass a wide array of social, environmental, psychological, and biological factors. Beyond simply identifying risk behaviors, it is even more important to gain an understanding of the place these behaviors hold within the context of each individual's life, and to begin to create a sense of the specific situations in which an HIV-positive person may be at risk for transmitting HIV.

The reality is that many people have no intention (at least initially) of giving up their substance use or sexual practices, even though they may be engaging in behavior that puts others at risk. Others are at least willing to consider change, but may be struggling with compelling reasons to continue behaving as they always have.

HIV transmission risk is a sensitive area of discussion for both clients and providers. One clinician working with high-risk persons reminds us "...how difficult it is to disclose information that is very private, very intimate, and potentially damaging if heard by the wrong person."

The ability to remain utterly nonjudgmental yet to gently confront when necessary, to elicit information that is often difficult to discuss, and to think in realistic terms about how providers and consumers can ally to reduce the risk of HIV transmission – these are daunting tasks in any circumstances. When working with persons at high risk, and who may make only minimal progress in reducing that risk, staff may feel frustration,

sadness, and even anger. Resources need to be in place to ensure that staff doing this important work are given opportunities to consult regularly with colleagues doing similar work, and that they are provided with timely, accurate information allowing them to function comfortably within the legal and ethical bounds of their professions.

There are institutional responses to be considered, as well. Programs and agencies may press for results that fit definitions of success more appropriately applied to interventions with HIV-negative populations. Other common pitfalls include setting initial goals too high (e.g., “I will use a condom every time I have sex”) and categorizing clients that are not immediately committed to abstinence from drugs, or totally risk-free sex, as being “resistant” or “in denial.” These approaches put both staff and clients in an impossible situation that may become more of a struggle for control than risk reduction work. As a result, high-risk, high-need clients may drift away from services altogether, joining the ranks of those who are “lost between the cracks.” Others may participate only marginally in important services, thus compromising treatment adherence, continuing to put others at risk, and reducing their chances to achieve better health and quality of life.

### **Formative Research Guides Program Development**

Those involved with interventions focused on prevention with positives are always concerned with designing programs that are responsive to the real needs of their communities. Decisions about programs are also informed by the need to create culturally competent interventions. But given shrinking resources, the task of assessing community needs is daunting. California is fortunate in that many communities have already engaged in formative research activities that solicited direct input from diverse populations of HIV-positive persons. The results of this research provide valuable information that can be used as a basis for creating new programs or enhancing existing ones. The results of formative research involving many communities and populations indicate that those living with HIV and AIDS believe prevention efforts, tailored specifically to their needs, are needed in the following areas:

- HIV treatment education workshops;
- Community-building activities for specific groups (e.g., HIV-infected Latino MSM, HIV-infected African American MSM, or HIV-infected youth);
- General health and wellness support delivered in individual or small-group settings (e.g., nutrition information, buddy systems to encourage exercise, information on alternative therapies, stress reduction strategies);
- Substance abuse services that are sensitive to the needs of HIV-infected persons;
- Information and support for sero-discordant couples;
- Greater availability of mental health services;
- Peer-led support and information groups;
- Skills-building workshops for positives on:
  - How to date;
  - How to disclose HIV status;
  - How to communicate with partners; and

- How to negotiate safer sex;
- Individual and/or group counseling focused on contextual factors that can influence risk such as:
  - Poverty, racism, internalized and externalized homophobia;
  - Impact of HIV-positive status on sexual and cultural identity;
  - Family stresses;
  - Financial pressures (including money management); and
  - Work-related stressors (e.g., managing medications and/or side effects of medications at work, disclosure issues, and back-to-work issues);
- Domestic violence;
- Incarceration issues;
- Interventions that focus on relationship dynamics such as controlling sexual situations and communicating effectively with sexual partners;
- Telephone and/or web-based support for HIV-positive persons in rural areas or for those who are not comfortable in face-to-face settings; and
- Both peer and professional support in dealing with sexual compulsivity/sex addiction.

### **Characteristics of Effective Programs**

*"Thus far, efforts to reduce HIV transmission risk behavior have concentrated on strategies adapted from interventions for uninfected populations with disappointing results, and HIV antibody testing and counseling results in only modest behavior change in HIV-positive people."*

- Kalichman, 2001

Given the grave consequences of high-risk behavior on the part of HIV-positive persons, there is a compelling need for interventions that will effectively result in lowering risk of HIV transmission. Interventions focused on HIV-positive persons are a relatively new presence on the prevention scene, and it is not yet possible to determine which approaches are most successful. However, comprehensive literature searches have highlighted some general characteristics that increase effectiveness in risk reduction programs for HIV-positive persons. Such characteristics include:

- Structuring programs around the specific culture, behaviors, and circumstances of the persons being served;
- Designing programs for people living with HIV rather than adapting programs developed for HIV-negative populations;
- Emphasizing incremental, achievable steps toward behavior change;
- Providing multiple contacts with clients, and/or providing long-term contact with clients. (Sustained interventions lead to sustained behavior change);
- Structuring interventions to provide both individual and small-group work;
- Using harm reduction based approaches;
- Using motivational interviewing as a baseline to determine readiness for change;
- Maintaining a dynamic balance between peer support and use of professional staff (both are needed);

- Moving interventions to the next step based on client readiness to change;
- Focusing on client-defined motivators (i.e., better relationships, managing recreational drug use) as a basis for creating change;
- Using behavioral objectives that are specific and achievable from the perspective of the client;
- Explicitly factoring in the effects of multiple diagnoses (substance abuse, mental disorders, other illnesses) on motivation and behavior change;
- Including “relapse prevention” and/or acknowledging that lapses into old behavior are not unusual and can provide valuable lessons;
- Grounding programs in current behavioral research and clear theoretical frameworks; and
- Explicitly defining follow-up methods such as phone calls, street outreach, or home visits for those who are difficult to engage or who face barriers to participation (transportation, language, child care, etc.).

### Levels of Interventions

Different levels of interventions – individual, group, and community – provide different opportunities for working with HIV-infected persons and their communities regarding high-risk behaviors. Some programs incorporate multi-level interventions – for example, a program based on intensive, individual-level interventions that also incorporates occasional small group work.

The level of intervention that is best for a program or activity will vary based on the characteristics of the population being served, the type and extent of high-risk behaviors, the goals of the program, staff training and expertise, and program resources.

For HIV-positive individuals being served, the different levels of interventions allow various types of support and growth. A brief description of the benefits of each follows:

**Individual interventions** allow the development of a deeply collaborative relationship between client and provider. This enables interventions to be specifically structured to the client’s particular circumstances and needs, as well as providing a safe place to explore topics that clients may not be willing or able to address in group settings.

**Group-level interventions** allow for the exchange of ideas and sharing of experiences, and may serve as an invaluable source of support and education. Groups tend to function as a microcosm of the participants’ wider community, and thus offer the opportunity to enhance communication skills and to receive feedback about thoughts and behaviors as perceived by others.

**Community-level interventions** typically combine the use of mass media, community-wide events, peer opinion leaders, and social marketing. They can serve as an effective complement to individual counseling and small group interventions because they seek to change the attitude and behavior of entire communities. To the extent that

community-level interventions can change community norms, they provide an opportunity for the diffusion and support of lower risk behavior.

### **Examples of Programs**

While most current prevention for positives interventions are undergoing evaluation, many have not yet completed the evaluation process. As a result, there are minimal reference examples of fully documented interventions for communities that may wish to implement similar programs. Several existing programs do seem promising based on preliminary evaluation results, and examples of some of these are provided in this document. Please note that this is not meant as a comprehensive list or to represent recommendations for “best practices” for prevention with positives, but rather to provide illustrations of possible approaches.

#### **Prevention for HIV-Infected Persons Project (PHIPP) *Multi-site, National Demonstration Project***

PHIPP is a five-year, CDC-funded demonstration project focused on prevention needs for people who are HIV positive. Project goals include increasing the number of high-risk individuals who know their status, providing prevention services for those who are HIV infected, linking HIV-positive persons with care, and developing models for technology transfer from PHIPP to health departments, community planning groups, and community-based organizations. Five health departments were selected to implement PHIPP, as summarized below.

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(404) 639-1913  
[kpt0@cdc.gov](mailto:kpt0@cdc.gov)

- **PHIPP: California**

DHS/OA developed two programs funded by PHIPP: One focused on achieving behavior change for HIV-positive individuals at high risk for HIV transmission (HIV Transmission Prevention Project, or HTPP), and another focused on bringing HIV-positive persons of color into prevention and care services (the Bridge Project).

Contact: Carol Crump, M.F.T.  
(916) 449-5965  
[ccrump@dhs.ca.gov](mailto:ccrump@dhs.ca.gov)

#### ***HTPP***

HTPP consists of intensive risk reduction counseling offered to HIV-positive individuals enrolled in EIP sites who are identified as being at high risk for HIV transmission and who require more than EIP’s standard risk reduction interventions (see earlier EIP program description) to achieve behavior change.

### ***The Bridge Project***

Located in EIP sites in communities of color, the Bridge Project links HIV-positive persons of color to prevention and care services via peer counselors trained as treatment educators. Bridge workers assist clients in identifying and overcoming barriers to entering and remaining in care, and also reach and re-engage individuals who have been previously lost to care.

- **PHIPP: Los Angeles**

The Los Angeles PHIPP offers a multi-site approach to prevention with positives, combining outreach, testing and counseling, linkage to prevention and care services, and community-based interventions.

Contact: Mario Perez  
(213) 351-8136  
[mjperez@dhs.co.la.ca.us](mailto:mjperez@dhs.co.la.ca.us)

***AIDS Project Los Angeles*** conducts the POWER (Positive Wellness and Renewal) Program. POWER provides individual and group-level education and support to people living with HIV and their partners. Wellness Case Managers and Health Promotion Specialists help clients address relationship issues, disclosure concerns, substance use, individual sexual expression, adherence to HIV medications, and other health and wellness matters. Program manuals and modules available by request from Greg Cardona at (213) 201-1539 or [gcardona@apla.org](mailto:gcardona@apla.org)

***Los Angeles Gay and Lesbian Community Center*** is working on the Positive Images Program, including linkage to prevention and care services, telephone chat line, web site, individual counseling, support group, and workshops.

***AIDS Healthcare Foundation*** offers prevention services for partners of HIV-positive persons.

***Tarzana Treatment Center*** provides *prevention services to individuals who have been HIV-positive for less than two years and who are in substance abuse treatment.*

- **PHIPP: Maryland**

Maryland has worked closely with the city of Baltimore to develop PHIPP programs in order to target high-risk communities, particularly those with high HIV incidence based on injection drug use.

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[christmyerc@dhmh.state.md.us](mailto:christmyerc@dhmh.state.md.us)

Through the **UJIMA Project**, a van offering HIV/STD counseling and testing visits high-risk neighborhoods. Outreach workers establish a connection with potential clients and over time, attempt to link them to prevention case management and other appropriate services.

Maryland has also developed PHIPP-based programs that work within correctional facilities in suburban Washington, D.C., in order to provide inmates with HIV counseling and testing and link them with post-release services such as prevention case management.

- **PHIPP: San Francisco**

San Francisco's PHIPP programs include the social marketing campaign described earlier and aimed at changing attitudes HIV-positive persons have about their role in the epidemic (see below for information on **HIV Stops with Me**).

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In addition to the social marketing campaign, San Francisco's PHIPP includes the University of California, San Francisco's **AIDS Health Project**, which has developed a provider training designed to increase the prevention skills of individuals that provide services to HIV-positive people.

Other San Francisco PHIPP programs include a *series of group interventions* run through the **Stop AIDS Project** that seeks to reduce risky behaviors among gay and bisexual men through workshops, social events, community forums, and weekend seminars.

- **PHIPP: Wisconsin**

Wisconsin's PHIPP has focused their prevention with positives efforts within three initiatives:

**Prevention Case Management** assists those living with HIV infection as well as those at high risk of contracting HIV to make behavior changes to reduce likelihood of further transmission.

**Outreach Counseling, Testing, and Referral** targeted to African Americans and Latinos in southeastern Wisconsin, enables people to know their serostatus and helps those living with HIV access treatment and services.

**Circle of Friends: Gay Men of Color Social Networks Initiative**, provides a social-network approach to testing in the Milwaukee area, geared to increase the number of African American MSM who are aware of their HIV serostatus and linked to appropriate prevention and care services.

Contact: Miche Llanas  
(608) 261-6731  
[llanamr@dhfs.state.wi.us](mailto:llanamr@dhfs.state.wi.us)

### **Prevention Integrated with HIV Care and Treatment**

#### ***DHS/OA, EIP***

EIP is located in 35 California counties and was established in 1987 as the only HIV care and treatment program providing prevention as part of its standard of care. EIP clients receive transmission risk reduction counseling, medical treatment, case management, psychosocial services, and health education delivered in a team-based setting. Prevention interventions include prevention case management, individual or group work, HIV status disclosure support, and interventions with HIV-negative partners.

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### **Linking HIV-Positive Teens to Care**

#### ***University of California, Los Angeles, Center for HIV Identification, Prevention, and Treatment Services***

Choosing Life: Empowerment, Action, Results (CLEAR) is a National Institute on Drug Abuse (NIDA) funded project that continues from a previous project (Teens Linked to Care, or TLC). TLC provided a group-based intervention designed to reduce HIV transmission, increase adherence to medical treatment, and improve quality of life. CLEAR has modified the intervention to better address the needs of HIV-positive youth and now focuses on one-on-one in-person sessions. Manuals and workbooks from both CLEAR and TLC are available at <http://chipts.ucla.edu>.

Contact: Mary Jane Rotheram-Borus  
(310) 794-8278 Fax  
[rotheram@ucla.edu](mailto:rotheram@ucla.edu)

## **Short-term Group Intervention**

### ***Center for AIDS Intervention Research, Medical College of Wisconsin***

A five-session group is offered to multiple HIV-positive target populations at two community-based organizations. The groups are grounded in Social Cognitive Theory and framed as managing stress related to HIV disclosure and practicing safer sexual behavior. They are delivered by community-based paraprofessionals and mental health counselors. Sessions emphasize building behavioral skills, enhancing self-efficacy for practicing risk reduction behaviors, promoting intentions to change risk behaviors, and developing strategies for behavior change. Note: Intervention manuals from this project are available upon request.

Contact: Dr. Seth C. Kalichman  
Department of Psychology  
University of Connecticut  
(860) 486-4042  
[sethk@mcw.edu](mailto:sethk@mcw.edu)

## **Supporting Client Disclosure of HIV Status**

### ***DHS, STD/HIV Prevention Training Center***

A skills-based training is offered that explores the many issues surrounding client HIV status disclosure and discusses strategies for supporting disclosure in a number of different settings. Participants learn a five-step process that supports HIV-positive clients in disclosing their HIV status to others in a variety of relationships. The course also promotes safer sex strategies for clients, regardless of disclosure.

Contact: Geraldine Rodriguez  
DHS, STD/HIV Prevention Training Center  
(510) 883-6600  
[captc@dhs.ca.gov](mailto:captc@dhs.ca.gov)  
[www.stdhivtraining.org](http://www.stdhivtraining.org)

## **Integration of Psychotherapy, Social Events, and Community Building**

### ***Asian and Pacific Islander Wellness Center, San Francisco, California***

This multi-faceted intervention includes social support and community building (monthly theme-based events, annual events), a general health and wellness program (nutrition and exercise information and support), treatment education workshops (Basic,

Intermediate, and Advanced), group psychotherapy (a series of three six-to-eight week sessions offering support and problem-solving skills), and individual psychotherapy.

Contact: Anthony Huynh  
(415) 292-3420 ext. 358  
[ahuynh@apiwellness.org](mailto:ahuynh@apiwellness.org)

### **Three-Part Intervention for HIV-Positive African American MSM**

#### ***AIDS Project of the East Bay, Alameda, California***

This intervention includes an early focus on identifying and recruiting HIV-positive African American MSM through outreach at popular target population venues, establishing linkages with HIV testing programs, and developing peer-to-peer recruitment protocols. Later activities offered include group level interventions via weekly drop-in education and social support (peer-led) groups as well as community social events and a weekend retreat. The project manual is still in development, but the most current version is available upon request.

Contact: Bongane Nyathi  
(510) 663-7978  
[bnathia@apeb.org](mailto:bnathia@apeb.org)

### **Skills-Building Workshops for HIV-Positive Monolingual Latino MSM**

#### ***Bienestar Human Services, Los Angeles, California***

This is a five-session workshop series (two series for couples and three for singles) facilitated by a peer counselor and a prevention case manager. Topics include ethnic, sexual orientation, and sexual roles; disclosure and coming out issues; the interplay of desire, passion, and guilt; relationships and communication; and community action steps and leadership development. Workshop participants are invited to a “graduation” weekend retreat.

Contact: Victor Martinez  
(323) 264-5900  
[vmartinez@bienestar.org](mailto:vmartinez@bienestar.org)

### **Social Marketing**

#### ***HIV Stops with Me: Los Angeles, California; San Francisco, California; and Boston, Massachusetts***

This campaign uses HIV-positive spokesmodels, a web site, newspaper and magazine ads, postcards, billboards and transit media, and (in one site) a television commercial aired during primetime and available online. All are centered around seven HIV-positive

people talking about their commitment to, and strategies for, ending the epidemic. The overall goal of the campaign is to support HIV-positive men, women, and transgenders in their efforts to be leaders in HIV transmission prevention.

Web site: [www.hivstopswithme.com](http://www.hivstopswithme.com)

### **HIV-Positive Injection Drug Users**

#### ***Center for AIDS Prevention Studies, San Francisco, California***

INSPIRE (Interventions for SeroPositive IDUs: Research and Evaluation) is a behavioral intervention for injection drug users to lower sexual and drug use risk, increase access to care, and increase adherence to HAART regimens.

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(415) 597-9267  
[cgomez@psg.ucsf.edu](mailto:cgomez@psg.ucsf.edu)

### **HIV-Positive Jail Inmates: Pre- and Post-Release**

#### ***The Homebase Project, San Francisco, California***

As part of a CDC-funded initiative administered by DHS/OA, this jail-based project focuses on HIV-positive inmates, with goals of increasing post-release use of medical and social services, increasing post-release HIV medication adherence, decreasing post-release HIV risk behaviors, and reducing recidivism. A combination of medical and psychiatric services as well as substance abuse counseling, money management counseling, transitional housing referrals, and other adjunctive services are provided.

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(415) 701-0396 ext. 1003  
[guy@continuumhiv.org](mailto:guy@continuumhiv.org)

## VI. Training and Technical Assistance

To assist all local health jurisdictions in planning, development, implementation, evaluation, and ongoing staff education, DHS/OA offers the following Prevention with Positive trainings:

- **The Center for HIV Identification, Prevention, and Treatment Services** provides five regional trainings throughout California. The training includes a review of behavioral theories that can be used in the development, implementation, and evaluation of prevention's efforts targeting HIV-positive populations. Interventions that have been proven effective with HIV-positive populations are highlighted as well as different approaches each local health jurisdictions can utilize based on the nature of their epidemic.

Contact: Ky Coussey  
(310) 794-0448  
[kcoussey@mednet.ucla.edu](mailto:kcoussey@mednet.ucla.edu)

- **DHS, STD/HIV Training Center** provides two trainings:

***Bridging Theory and Practice: Applying Behavioral Theory to HIV/STD Prevention.*** This one-day training describes complex, contextual client issues surrounding disclosure of HIV status; identifies client benefits of, and concerns about disclosing HIV status to others; and assists providers to become familiar with a four-step process to support client disclosure of HIV status and develop skills to counsel and coach clients through the steps of HIV status disclosure, including safer sex strategies, regardless of decision.

***Supporting Client Disclosure of HIV Status: A Skills-Based Training for Providers.*** This two-day course assists participants in demonstrating an understanding of behavioral science and behavior change theories, learning intuitive ways of understanding behavior science theory through use of theoretical domains, identifying complex factors that influence risk-taking behaviors, developing effective prevention interventions with people living with HIV, and applying behavior science theory to program design and implementation.

These training are provided free and on-site. Please call (510) 883-6614 for more information and to schedule a training.

- **The University of California, San Francisco, AIDS Health Project** provides training, ***Enhancing Prevention Skills for People Living with HIV***, which is designed to enhance the ability of providers to work with HIV-infected clients. Specifically, the focus of this training is on increasing the ability of providers to be conscious of the issues their HIV-positive clients face.

To register for this training, please contact (415) 502-4586 or [www.ucsf-ahp.org](http://www.ucsf-ahp.org).

Additional training opportunities valuable for prevention with positives are:

- **The University of Southern California, Keck School of Medicine** offers the ***Partnership for Health Program***, which is funded by the Health Resources and Services Administration. This is a program designed to train health care providers in outpatient HIV clinics how to talk more effectively with patients about protecting themselves and their partners, and disclosing their status to sex partners. Through a two-day “train the trainer” program, clinic representatives learn about Partnership for Health and how they can train providers at their clinic using this prevention with positives model. They, in turn, train providers at their individual sites in skills for talking with clients about prevention and disclosure. It includes extensive training on behavioral change theories and models, communication skill building, conducting brief interventions, and integration of these interventions into on-going client contacts.

Contact: Maggie Hawkins, M.P.H.  
University of Southern California  
Keck School of Medicine  
(323) 865-0343  
[margareh@usc.edu](mailto:margareh@usc.edu)

- **The Mental Research Institute**, or MRI, is a research and training institute whose founders established the "brief therapy project" and introduced the brief, interactional approach to psychotherapy that eventually led to brief, solution-focused counseling techniques. MRI continues as a center for the study of human interaction and the Brief Therapy Project continues. Training is available to licensed and pre-licensed mental health professionals only. MRI also offers training in brief therapy techniques focused on the needs of Spanish-speaking individuals and families through the Latino Brief Therapy and Training Center.

Contact Information:  
Web site: [www.mri.org](http://www.mri.org)

MRI  
555 Middlefield Road  
Palo Alto, CA 94301  
(650) 321-3055  
fax (650) 321-3785  
[mri@mri.org](mailto:mri@mri.org)

Latino Brief Therapy and Training Center  
Centro Latino de Terapia Breve y de Entrenamiento  
(650) 323-5457  
[kschlanger@igc.org](mailto:kschlanger@igc.org)

- **The Harm Reduction Coalition’s Harm Reduction Training Institute (HRTI)** is the first national training institute focused exclusively on harm reduction. The purpose of HRTI is to increase understanding of the harm reduction philosophy; build the skills necessary to implement harm reduction strategies; strengthen harm reduction leadership across a diversity of disciplines and communities; and develop an awareness of the attitudes that contribute to discrimination against drug users and other marginalized groups. HRTI will collaborate with any organizations or groups committed to these aims. HRTI offers regular training in the San Francisco Bay Area, and trainers may also be engaged for conferences and workshops in other locations.

The training calendar changes quarterly, and may be accessed through their web site at [www.harmreduction.org/](http://www.harmreduction.org/). Examples of recent training include, “Harm Reduction Counseling,” “Youth, Sexual Health, and Harm Reduction,” “Harm Reduction and HIV,” “Harm Reduction in Latino Communities,” and “Reinventing HIV/STD Prevention: Understanding Unprotected Sex and Accomplishing Behavior Change.”

Contact Information: Harm Reduction Coalition West Coast Office  
 1440 Broadway, Suite 510  
 Oakland, CA 94612  
 Telephone: (510) 444-6969  
 Fax: (510) 444-6977  
[hrcwest@harmreduction.org](mailto:hrcwest@harmreduction.org)

In addition to the above trainings, technical assistance is available from the following resources:

- **The Center for HIV Identification, Prevention, and Treatment Services (CHIPTS)** also provides technical assistance to local health jurisdictions (and/or local agencies identified by the local health jurisdictions) that need assistance in developing their prevention with positives programs. CHIPTS will work with designated individuals to develop appropriate prevention strategies to target HIV-positive populations in their respective jurisdiction. Please contact a DHS/OA program advisor/contact person for more information.
- CompassPoint Nonprofit Services has contracted with **Northern California Grantmakers AIDS Partnership California** to provide technical assistance to organizations that are currently providing or considering providing prevention programs with HIV-positive people of color. The goal of this two-year project is to improve the strength of HIV prevention with positives services throughout California.

Both consulting and training technical assistance opportunities are available. Typically a consultant provides help in designing a new program or strengthening a current program. The focus of technical assistance is flexible and may vary from help with budgeting, to methods of client recruitment to program evaluation. To be

eligible for this technical assistance, an organization must have a 501 c (3) status, be based in California, and either be currently offering, or considering, a prevention with positives program.

For further information or an application, please contact:

Kara Vassily  
Project Manager  
(800) 886-2242  
[karav@compasspoint.org](mailto:karav@compasspoint.org)

## VII. Evaluation

*"Given the somewhat unpredictable (and, at the same time, somewhat predictable) elements of sexual encounters, all-or-nothing measures of the effectiveness of prevention programs, including measures like consistent and inconsistent use of condoms, set these programs, their participants, and educators up for failure. In short, binary categories do not and cannot tell us how well education and prevention are doing."*

- Dwayne C. Turner

Consumers, providers, and evaluators can all attest to the fact that describing the process of behavior change is not as simple as, for example, counting units of service delivered. Documenting whether or not an HIV-positive individual ultimately uses a condom or a clean needle may certainly represent the endpoint of an intervention. But, while essential, such documentation does not fully represent an intervention's effectiveness; nor does it provide the information needed to duplicate a successful program. The path to behavior change is complex and often elusive; no single evaluation strategy can hope to capture the elements involved. Perhaps more than any other area of HIV services, programs focused on producing behavior change require a wide range of evaluation strategies, embracing both quantitative and qualitative methods of evaluation.

As prevention with positives programs and activities are designed and implemented, it is important to have an evaluation plan in place. Effectively evaluating prevention with positives programs will be very challenging. However, carefully evaluating a program or activity affords opportunities to improve, redesign, or even eliminate, aspects of the program in order to better serve clients. The ultimate success of a program can be determined by an effective, objective evaluation combined with a willingness to modify and improve based on community need, participant feedback, and scientific merit.

The basic evaluation information in this section is excerpted from:

Developing and Implementing an Evaluation  
of HIV Risk Prevention Programs:  
Training Materials

Compiled by:

Ronald Brooks, Ph.D.  
Associate Director of the Evaluation Core  
University of California, Los Angeles  
Center for HIV Identification, Prevention,  
and Treatment Services  
December 1999

The sections included below are brief, sample excerpts from the training material shown on the web site. The complete document contains many examples and specific forms and tools, in addition to more detailed information about evaluation in general. The materials can be accessed in their entirety at: [www.chipts.ucla.edu/index.html](http://www.chipts.ucla.edu/index.html).

### **What is Program Evaluation?**

- A thorough investigation of a program's characteristics and merits.
- Its purpose is to provide information on the effectiveness of programs to allow an agency to optimize the outcomes, efficiency, and quality of their programs.
- Evaluations can analyze a program's structure, activities, and organization and examine its political and social environment.
- Evaluations can also appraise the achievement of a program's goals and objectives and the extent of its impact and costs.

### **Purposes of Program Evaluation**

Most program evaluations are concerned with five broad questions:

1. Is the project/program/intervention reaching the appropriate target population?
2. Is it being implemented in the ways specified?
3. Is it effective?
4. How much does it cost?
5. What are its costs relative to its effectiveness?

### **Types of Evaluation**

The two types of evaluation that are most often used on program evaluation are:

**Process evaluation:** An evaluation that provides documentation on what is going on in a program. This evaluation primarily looks at the program's objectives and activities (a program's objectives are its planned purposes).

- A primary function of process evaluation is to provide data on the extent to which a program's objectives are achieved.
- Process evaluations can also answer questions about a program's activities and offer insight into a program's implementation and management.

**Outcome monitoring/outcome evaluation:** An evaluation that assesses the overall effectiveness of a program in producing favorable behavioral effects in the target population.

- This type of evaluation measures the program's impact; that is, the scope of its effects, the duration of its outcomes.

- Its principal purpose is to determine whether changes have occurred over time in the areas defined in the intervention plan and if the changes can be attributed to the program.

### **Steps in Developing an Evaluation Plan**

Developing a program evaluation requires systematic steps. These steps include formulating evaluation questions; setting standards of effectiveness (i.e., establishing a program's merits); designing the evaluation; collecting data; and analyzing, interpreting and reporting evaluation results, as follows:

#### **1. Formulating evaluation questions.**

The questions that an evaluation will answer will vary from one program to another and are based on the program's goals and objectives, agency resources, and extent or time frame of the evaluation.

Typical evaluation questions include:

- To what extent did the program achieve its goals and objectives?
- What are the characteristics of the individuals and groups who participated in the program?
- To what extent were the activities implemented as planned?
- What are the key activities that were implemented?
- Were there any changes in the programs that were implemented?
- How well was the program administered?
- For which individuals or groups was the program most effective?
- For which individuals or groups was the program the least effective?
- How enduring were the effects (effects over time)?
- Which features of the program were most effective?
- Which features of the program were the least effective?

#### **2. Setting standards of effectiveness.**

Setting standards means deciding on the information needed to provide convincing evidence of a program's effectiveness. The challenge to any evaluator is to identify standards that are appropriate for the program, possible to measure and credible. In selecting standards, the following items should be considered:

- Standards must be purposeful;
- Standards should be realistic and measurable; and
- Standards for interventions can come from several sources (e.g., use of expert panels, past performance of a group(s), comparisons with other groups and comparisons over time, use of norms, or previously reported data).

### 3. Designing the evaluation.

General questions that are asked when designing the plan for evaluation will include:

- How many measurements should I make?
- When should the measurements be made?
- How many groups or persons should be included in the evaluation?

### 4. Collecting data.

The collection of evaluation information (i.e., data) is really a set of tasks that includes the following:

- Identifying the items to measure;
- Selecting, adapting, or creating measures;
- Demonstrating the validity (accuracy) of the measures;
- Administering the measure; and
- Scoring and interpreting the results.

### 5. Analyzing data.

A simple data analysis generally involves the following steps:

- Select clients who receive the intervention and complete the measurement before and after the intervention;
- Report the frequency distribution (i.e., counts) of key variables (e.g., number of men, women, ages, education, risk groups, risk behaviors, etc.);
- Calculate the mean scores for pre-intervention and for post-intervention; and
- Compare the pre- and post-intervention mean scores to determine amount of change and if the change is significantly different.

### 6. Reporting the results.

An evaluation report consists of descriptions of a program's characteristics and explanations as well as judgments of its merits. The report generally includes:

- Description of the purposes of the evaluation (process and outcome);
- Description of the methods used (e.g., type of measurement used, when data was collected, and types of analysis);
- Results of process and outcome data analysis; and
- Discussion of the program's strengths and weaknesses and the implications of the results.

## **Monitoring and Evaluating the Implementation of an HIV Prevention Program**

Because HIV prevention programs can be complex, there are many reasons why they may not be implemented as they were designed. The purpose of implementation evaluation (also referred to as process evaluation) is to objectively examine the implementation of the intervention and to improve it, if necessary.

### Process evaluation

Process evaluation is defined as an assessment of a program's conformity to its design, implementation, and the extent to which it reaches its intended audience.

An evaluation of the implementation of a program can be done by comparing it with the intervention plan, which describes the intended objectives and steps of the intervention.

Process evaluation does not address the extent to which an intervention has achieved its desired outcomes (e.g., less risky behavior or changes in attitudes and beliefs that support those behaviors).

### Reasons for conducting process evaluation

The real test of the intervention plan – Will the intervention achieve its objectives? - is in the “nuts and bolts” of intervention implementation.

This issue can be framed simply by the question: “Did we really do what we said we were going to do?”

Process evaluation is the way to assess the mediating role of intervention implementation in the final outcome of the prevention program. This is crucial because focusing only on the intervention plan and outcomes can result in misleading interpretations of how certain outcomes were achieved.

### Benefits of process evaluation

In general, process evaluation provides information such as:

- Whether the intended audience has been reached;
- The level or extent of services provided; and
- The resources required to support the prevention effort made.

HIV prevention interventions must be accountable to their stakeholders in terms of two aspects: (1) the quality of implementation – measured through process evaluation, and (2) the effectiveness of the intervention – measured through outcome monitoring and outcome evaluation.

## What is the Difference Between Outcome Monitoring and Outcome Evaluation?

Both outcome monitoring and outcome evaluation can be used to assess whether an intervention achieved its specified objectives (i.e., measurable outcomes). The primary difference between the two is that a rigorous evaluation design is essential to outcome evaluation.

*Outcome Evaluation:* Outcome evaluation involves use of rigorous research methods to assess whether the prevention program has an effect on the predetermined set of goals. Using rigorous methods allows one to rule out factors that might otherwise appear responsible for the changes seen. Rigorous methods usually refer to experimental and quasi-experimental designs.

An example of a rigorous method is a randomized experiment in which some clients are randomly assigned to a treatment group receiving an intervention and others are assigned to a control group receiving no intervention (or delayed intervention). The use of a rigorous design is the only way to make the claim that any changes in outcomes in the treatment group were due to the intervention.

*Outcome Monitoring:* Outcome monitoring refers to efforts to track the progress of clients based upon the outcome measures set forth in the program goals and objectives. These measurements assess the effects of interventions on client knowledge, attitudes, beliefs, and behaviors.

The purposes of outcome monitoring are to understand:

- Clients' progress toward behavioral goals and objectives;
- Differential progress within subgroups of clients (e.g., Do young clients make more progress than older ones?); and
- If particular aspects of implementation contribute to or hinder clients' progress.

Outcome monitoring requires the collection of outcome data at least once before and once after the intervention. In the evaluation literature, this is commonly called the one-group pre- and post-test design (Cook and Campbell, 1979).

## VIII. Conclusion

*"...in one last plea, let me drive home the point that reducing - not eliminating transmission - is truly our only hope at this stage of the epidemic. To realize this feat is no small endeavor and would be the noblest of accomplishments. But it requires the pragmatic and steadfast efforts of individuals, communities, professionals, and governmental agencies..."*

- Dwayne C. Turner

HIV is arguably the most dangerous infectious disease known in the history of humans on this planet. Like Aesop's tortoise, whose ability to patiently and persistently plod along enabled it to beat the swift and confident hare, HIV continues to slowly, but inexorably, invade - and sometimes decimate - populations in virtually every corner of the globe.

In California, the availability of effective medications has significantly reduced the "visibility" of AIDS. Even though living with HIV may be difficult, and side effects from medications can be severe, the fact remains that AIDS deaths have plummeted in California. It is sometimes easy to forget that AIDS has a mortality rate of 59 percent in California and is higher in HIV-positive persons who are not in care.

However, as decades pass and HIV infections continue to increase, we are reminded that the virus is chameleon-like, able to change shape and structure to ultimately resist even the cleverest of therapies and vaccine methodologies. The virus can remain hidden for years before announcing itself in symptoms. Through stealth and subterfuge, the virus infects many others without even its host's knowledge. Some diseases may be more violent in their assault, swifter in their race, but perhaps, in the end, none will be as victorious as the cunning, unrelenting, tortoise-like HIV.

In our society, that greatly values instant results, fast cures, and immediate gratification, prevention is a hard sell. But against HIV, prevention – specifically *transmission* prevention – is our best, long-term hope. We may not see a dramatic, immediate change as a result of prevention with positives programs, but, with time, change will occur. Small changes that magnify and multiply over time can change the outcome of the epidemic.

## Appendix A

NOTE: This statement is from September 1998.

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### **“Statement and Proposal from the ‘Breakfast Club’ on Prevention and HIV-Positive Persons” to the California Prevention Working Group (CPWG) September 1998**

#### Background Facts and Assumptions

1. Every new HIV infection involves at least one HIV-positive person. Primary prevention, in public health theory and practice, refers to the prevention of new infections by any available and acceptable means.<sup>1</sup> “Primary” refers to the **aim** of the intervention, not to its form or target. Logically, therefore, primary prevention interventions should be directed at infected as well as uninfected individuals, since sufficient behavior change by either the seropositive or the seronegative partner in a potentially risky encounter can prevent a new infection. **A community-planned strategy of outreach and behavior change efforts directed at both HIV positives and high-risk negatives is more likely to be efficient and cost-effective than one targeting negatives only.** In fact, some evidence indicates that interventions to achieve behavior change among HIV-positive persons may be by far the most cost-effective interventions available.<sup>2</sup>

2. Researchers have documented the possibility of transmitting drug-resistant strains of HIV, even multi-drug-resistant strains. While the epidemiologic extent of such transmission is still being investigated, preliminary studies in several areas (including San Francisco and South Central Los Angeles) have shown that as many as 20 percent of new infections are with drug resistant virus. This new threat is clearly best met by enhancing both primary and secondary prevention efforts for HIV infected individuals: primary prevention to change and maintain change in risk behaviors, and secondary prevention to support positive people in self-care and adherence to medication regimens.

3. The CDC has for several years made clear that funds provided through its prevention cooperative agreements can be used for primary as well as secondary prevention activities targeting HIV positive individuals<sup>3</sup>. It is a matter for community planning to decide.

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<sup>1</sup>‘Secondary prevention,’ on the other hand, refers to the prevention of illnesses, symptoms and disease progression after the primary infection. The CDC Guidance for 1998 Community Prevention Planning clearly states this understanding and definition of these terms.

<sup>2</sup>Pinkerton, S.D., Holtgrave, D.R., Valdiserri, R. O. Cost-effectiveness of HIV prevention skills training for men who have sex with men. *AIDS*, 1997, 11:347-357.

<sup>3</sup>Presentations by Ronald Valdiserri, Gary West and David Holtgrave at 1996, 1997 and 1998 CDC Prevention Summits (aka “Co-Chairs meetings”); speeches by Dr. Helene Gayle at National Conference on HIV in Women, Washington, DC, March 1995 and U.S. Conference on AIDS, Miami, September, 1997; personal communications with project officers Tim Quinn and Tomas Rodriguez; instructions to External Reviewers of CDC prevention cooperative agreement applications, 1996 and 1997.

4. HRSA has similarly made clear that support for risk reduction interventions is permitted and encouraged with CARE Act funds.

5. The policy of the California Office of AIDS has been to restrict use of CDC prevention funds from use in efforts explicitly directed at HIV positive individuals, except for the small portion dedicated to EIP of which prevention is one part, and with perhaps very recent case-by-case exceptions upon petition of LIGs.

6. CARE Act planning bodies and providers have seldom if ever prioritized providing prevention services, including case management. State EIPs are mandated to include prevention services and some other care providers do integrate risk reduction into their services, but the extent and effectiveness of such efforts are unknown. Anecdotal and very limited survey data suggest that overall throughout the state, such programs are minimal.<sup>4</sup>

7. The HIV positive advocacy community itself has in the past opposed prevention efforts targeted at HIV positives, for fear of increasing stigma and in order to focus resources on treatment and support. The social stigma and resulting discrimination associated with being known as HIV positive have been and continue to be very real. Fear-based proposals to quarantine or criminalize the behavior of HIV-positive persons are worst-case scenarios of so-called "prevention strategies" that target HIV-positives and have tended to make infected communities leery of anything that could be so distorted.

Changes in the treatment and care environment since 1996 have created a new perspective in the positive communities, which can develop into extensive support for new prevention initiatives if they are developed with vision, sensitivity and continuous community interaction. Treatments now clearly do more good than harm in the lives of nearly all positives, and they work best and harm least when started at least relatively early in the history of infection. This creates strong incentive for us positives to help find as many as possible other positives and hook them into a network of information, support and access to treatment and prevention services. We also need to create new ways of providing each other support for medication adherence, for dealing with work and other life issues, and generally for sustaining a longer life than we had earlier anticipated.

Longer life also means a prolonged period of sexual activity. This adds incentive to develop lasting strategies of finding love and sex which is both safe and satisfying. While ultimately each of us is the one most responsible for our own health and safety (and thus each uninfected person is the one most responsible for his or her remaining uninfected), we also each have the choice to protect our partners, families and communities as well as ourselves. By anchoring our own fulfillment in this larger context, most of us find our "highest or best selves" thus empowered, and live richer lives as a consequence.

8. The risky behaviors of positives that can transmit HIV exist in a complex web of often conflicting needs values. The barriers to behavior change are both similar to and different from

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<sup>4</sup> A recent survey of CARE Act-funded case managers in Los Angeles County found that **not one** reported prevention or risk-reduction interventions as a significant priority of their work or that of the medical care providers they are associated with. [Programs and Services Section, Office of AIDS Programs and Policy, report, June, 1998.]

those affecting high-risk negatives. Positive persons, like high-risk negatives, may have other survival issues more pressing to them than reducing transmission-risk behaviors, may have complicating co-morbidities like mental illness or substance abuse disorders, and may find sexual and other risk behaviors so close to their core being that they are not amenable to the same theories and strategies as may guide other health promotion interventions. In addition to these issues in common, however, positives also face social stigma from many quarters, persisting even with the existence of special services and anti-discrimination laws. They (we) must cope with the demands of the infection's symptoms, treatment side effects, and extremely demanding medication regimens. They (we) may feel that their ability to meet legitimate intimacy needs are threatened by such recommended behavior changes as consistent disclosure of serostatus and universal advance negotiation of safer sex.

Furthermore, the essential prevention message to negatives is "protect yourself." While self-protection from STDs and hypothetical "re-infection" with HIV is a legitimate goal to promote, it is certainly partial and insufficient to motivate the behavior changes positives need to make. Modifying risk behaviors in positives requires a variety of **different** interventions and support, and different **kinds** of interventions and support than those now provided as part of HIV health care. [And by the way, prevention case management is only one of many kinds of interventions needed, and furthermore is a particularly expensive one appropriate only to a fraction of positives.] We need to describe and disseminate existing interventions that work, and need to devise new ones; we need to develop appropriate materials, training, and technical assistance to help these ideas work in general practice.

9. There are many concerns of various prevention and care stakeholders which need to be addressed and reconciled, including: What is the optimum balance between primary prevention for positives and primary prevention for negatives? How can we target primary prevention at positives without depriving high-risk negatives of already scarce resources? What resources should come from the "care side" vs. the "prevention side?" What interventions are best delivered to one or the other serostatus group and which to both? Where is the best venue to deliver prevention interventions to HIV positives, e.g., medical care providers, care case management, prevention CBOs, PWA/HIV self-help programs? How best to integrate primary and secondary prevention?

10. The consequence of all these factors is that a key opportunity to efficiently prevent HIV transmission is being missed. Furthermore, the prevention needs of a key target population, HIV-positive persons, has tended to slip through the crack. Recent improvements in HIV treatment, as well as testing methodology, have created the incentives and opportunity to change these facts.

### **Recommended Action by the CPWG and OA**

**1. The California HIV Prevention Plan Update of September 1998 should include HIV positive individuals as a priority target population. The plan should furthermore state that the planning and implementation of interventions specifically aimed at positive individuals are encouraged, if LIGs so decide, supported by OA and its statewide or set aside grantees and contractors. That the plan update further state that it is part of the 1999 planning agenda to amplify this section of prevention needs and address issues such as those posed in No. 8 above and in the coordination and linkages section of the plan update.**

- 2. The CPWG and OA should immediately state in writing to LIGs and other relevant groups that, in conformity with CDC guidelines, CDC and state prevention funds can be used for primary prevention activities directed at HIV positive individuals, if such use is decided by LIGs.**
- 3. The CPWG inform Ryan White CARE Act state and local planning and administrative bodies that it regards prevention interventions for positives as a priority for consideration of CARE Act funding and integration into care services.**
- 4. That the CPWG Steering Committee and other continuing committees plan for substantive presentations on primary prevention for positives as part of overall meeting agendas in the new merged planning body.**
- 5. That the OA and the CPWG, inviting co-sponsorship by the Title II Working Group and assisted by the two HIV-positive caucuses (“Breakfast Club” and “Jiminy Cricket Coalition”), sponsor and plan a statewide conference on “What is the Role of HIV-Positive Persons in HIV Prevention?” This conference, inviting both the prevention and care communities, would address issues such as those listed in No. 8 above, as well as best practices, and the elaboration of a prevention research agenda in this area. Planning for this conference should begin immediately, even if the actual event cannot practically occur until well into 1999.**

## Appendix B

NOTE: These recommendations and report are from November 2000.

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### **Prevention, Care, Treatment Integration Recommendations November 9, 2000**

#### **Vote:**

- **Recommendations 1 and 3-6 by consensus. Moved: Marc Hauptert Second: Felipe Garcia.**
- **Recommendation #2: 23 -- Yes; 11 -- No; 8 -- Abstain. Moved: Jules Mastro Second: Jessica Roemer.**
- **By consensus, the Committee Report was adopted**

#### Recommendations:

1. Adopt Committee Report
2. Resource Development
  - In each local health jurisdiction, from 25% to 50% of education and prevention allocations will be devoted to Primary Prevention with Positives (P3).
  - The State Office of AIDS may consider requests to set aside less than 25% or more than 50%, based upon documented justification, such as the number of AIDS cases, level of funding, availability of local expertise, or other factors identified in the local planning process.
  - If P3 is not already in place, the local health jurisdiction may utilize part, or up to the all of the first year to develop P3 and the necessary infrastructure.
3. The Local Support and Development Committee and the Prevention, Care, Treatment Integration Committee, or representatives thereof, shall work with the State Office of AIDS to develop the Spring 2001 P3 conference.
4. The PRE will explore the possibility of developing a strategic statewide evaluation of selected P3 programs.
5. Technical Assistance, Training, and Evaluation
  - The PCTI Committee will continue to identify TA, training, and evaluation needs regarding P3.
  - The State Office of AIDS will copy and make available materials provided to the PCTI regarding P3 effectiveness.
6. Representation
  - Individuals with P3 expertise will be appointed the CHPG and Care planning bodies.
  - Care providers will be represented on the CHPG.

## **Committee Report:**

# PREVENTION, CARE, AND TREATMENT INTEGRATION

## **COMMITTEE REPORT**

### MISSION

To prevent the transmission of HIV by providing primary HIV prevention services for people living with HIV in California.

### OVERVIEW

The committee has been charged with addressing prevention planning and services for HIV-infected persons. Traditional prevention programs have been primarily focused upon HIV-negative individuals, and very few have directed efforts toward HIV-infected persons to help them change the behaviors that place others at risk for infection. In recent years, this complex and sometimes controversial area has begun to receive more attention in the HIV prevention and care and treatment communities. The committee is mindful of the need to root its discussions and recommendations in an understanding of the depth and sensitivity of the issues encompassed by the topic of HIV prevention for positives. The committee stresses the importance of clearly and directly confronting the questions that may be raised during the initiation of these new programs.

The committee finds that the need for prevention services for those living with HIV is paramount at this time. Prevention services should be a core element of comprehensive health promotion for those living with HIV, particularly given the reality that for many individuals, HIV has become a chronic illness requiring long-term interventions. A diagnosis of HIV infection has a wide-ranging impact on risk behaviors. It appears that many HIV-infected persons reduce their risk behavior soon after learning of their diagnosis. Others are more resistant to change, and prevention for HIV-positive persons must address varying levels of motivation and reluctance to change. Programs need to provide ongoing support for those who have successfully reduced their risk behaviors and encouragement and guidance for those who have been unable or unwilling to do so.

### FRAMEWORK

Due to the committee's belief that any intervention must be rooted in the specificity of individuals, communities, and cultures, it has chosen to present a general framework and context rather than recommend specific service models. It is essential to provide strong guidance that is fluid, flexible, and easily tailored to the individual client as well as to community context and local needs and concerns. Ideas and concepts that are critical to the development and implementation of successful prevention programs for

positives have been identified by the committee as falling within the following general categories: Background, Guiding Principles and Considerations, Characteristics for Increasing Program Effectiveness, and Technical Assistance.

## BACKGROUND

Primary prevention for those living with HIV must be placed within the context of the history of the epidemic and the cumulative experience of ongoing programs. With this as the foundation, we can reflect on what has been learned, engage in new thinking, and propose a new prevention framework that includes:

- The need for a dual emphasis in prevention – to services crafted not only for the prevention needs of HIV-negative persons, but specifically directed to HIV-positive persons. This dual focus must include the understanding that prevention strategies with demonstrated effectiveness in HIV-negative populations will not necessarily be effective for those living with HIV.
- The need to create a climate that is non-stigmatizing and non-blaming, and which recognizes the difficult choices faced by those living with HIV.
- Accepting and understanding the value that each individual may place on specific risk behaviors, and assessing the factors that motivate maintenance of these high-risk behaviors within the framework of harm reduction theory.
- Recognition that while the ultimate goal is to prevent transmission of HIV, programs will need to engage clients in risk-reduction work by focusing on enhancing the quality of their lives. Doing so will create greater opportunities for risk reduction than solely emphasizing the need to stop risky behaviors.
- The willingness to rethink traditional prevention strategies from the ground up. This includes a focus on reinvigorating basic concepts and strategies, as well as providing more specifically directed resources. Also necessary are richer sources of practical and emotional support for providers who are initiating new ways of working that are often more demanding than traditional prevention interventions.
- The commitment to build programs that embrace the willingness to persevere, to rethink existing program structures, and to try other approaches, strategies, and interventions when desired results are not being achieved.

## GUIDING PRINCIPLES AND CONSIDERATIONS

The following principles must guide the development of any successful program of primary prevention for HIV-positive persons:

- The goal of risk reduction is to help individuals achieve behavior change that results in overall lower risk of HIV transmission. This includes assistance in creating a

home, identity, and social environment that support lower risk behavior, and altering the interaction patterns that sustain high-risk behavior.

- Thoughts, feelings, the influence of set and setting, belief systems – each of these will differ from individual to individual, and each must be taken into account in developing transmission reduction interventions.
- Interventions must be specific, context-sensitive, and rooted in the real circumstances of the individuals and communities we serve. An intervention structured on the foundation of a client's own life and priorities is an intervention that has a higher likelihood of success.
- Interventions must be grounded in an explicitly collaborative relationship between client and provider, creating an alliance that will support enhanced self-determination and well being.
- Clients must agree that any given intervention goal makes sense and is something they wish to achieve. Interventions can only begin at the level of change the individual client is prepared to accept – not necessarily the level of change the provider believes would be “best” for clients.
- Interventions must take into account the fact that risk behaviors may act to maintain important emotional, social, or family systems. What is it that the client is really being asked to give up? What can be offered to replace the benefits of the old behavior?
- It is the individual client who will ultimately determine the time frame for achieving change, not the provider or the program.
- Intervention goals should reflect incremental, realistic, stepwise change that is achievable from the perspective of the client rather than broad, overarching goals. For example, using “I will list the things that make it difficult for me to decide to use a condom” as a first-step goal rather than immediately declaring the idealized goal of “I will always wear a condom.”
- Risk reduction plans, once developed between client and provider, should be frequently revisited and accelerated or decelerated – backtracking to earlier or less ambitious goals – as needed.
- Interventions should be structured to support stepwise planning for not only short-term but also long-term maintenance of behavior change. Long-term planning should include acknowledging the probability of lapses back into high-risk behaviors. Lapses need to be framed as part of the natural process of change and of learning new behaviors rather than framed as “failures.”

- It is critical that programs not restrict their activities only to those who are ready to change their behavior. Programs should include services and strategies to keep HIV-positive persons engaged even if they are not yet ready to change, and interventions designed to help them move towards a decision to reduce their risk behaviors.
- Interventions must be structured in a fashion that recognizes and takes into account the inherent strengths of each client or community of clients, even if those strengths may not be immediately apparent either to the client or to the provider.

The following considerations should be included in the development of primary prevention programs for positives:

- Does the institutional environment in which the new prevention project will take place support implementing new models and practices such as harm reduction, or do barriers exist? An example would be to ask whether a program is willing to support working with active drug users who have no interest in entering abstinence-based programs.
- Does the program structure ensure that interventions can be individually tailored?
- Does the program utilize advocacy and service provision led by well-trained and supported peers?
- Does the program determine how and to what extent clients' sexual or needle-sharing partners, significant others, or social support systems will be integrated within risk reduction strategies? Does the program include work with at-risk, HIV-negative partners or family members?
- Do the proposed programs and interventions take into account the web of linked factors that include psychological, spiritual, community, racial, cultural, gender-based, and other influences such as illness or impairments?
- Are the programs structured in a way that ultimately supports evaluation and replicability – whether the emphasis is upon qualitative, process-based objectives or on evidence-based parameters? It may be important to consider that qualitative and process-based evaluation is just as important, if not more important, in programs representing innovative practices.
- Do the programs have clearly-described goals, e.g., have their proposed outcomes in mind, what they will do to achieve those outcomes, and why they think the program's components or activities will achieve this?
- Are primary prevention programs for positives available both within and outside of care and treatment sites (for those who may choose not to access care)? When a prevention program for positives is to be linked with care and treatment services,

then the prevention services must be fully integrated with HIV services, not regarded as supplemental.

- Is the structure of the intervention (small group, peer-focused, individual, etc.) based on the expressed needs of the target population? Interventions must emerge from the cooperative interaction of community providers and targeted communities, cultures, and individuals.
- Have real working relationships been forged with drug and alcohol prevention and treatment programs and providers of mental health services? The committee believes that these alignments are essential to success.
- Has the program considered using formative evaluation and pilot programs before launching the full intervention?
- Ongoing process evaluation is important to determine if the program is achieving expected results. If not, is it due to program design or is the program not being delivered as planned? Innovative programs need to have the flexibility to change their approach when expected results are not being achieved, and to do so without being labeled failed programs.

#### CHARACTERISTICS THAT INCREASE PROGRAM EFFECTIVENESS

Following are some of the characteristics that have been demonstrated to increase program effectiveness in risk reduction interventions for HIV-infected persons.

- Multiple client contacts with the intervention – these allow for greater sensitivity to clients' readiness to change, and for shaping behavior more effectively than single or infrequent contacts.
- Programs which are structured to support both individual and small-group interventions, since each intervention type has been demonstrated to be effective for specific sets of clients or circumstances.
- Interventions that are structured to regularly monitor, promote, and take advantage of the person's readiness to change, while recognizing that each individual's readiness to change has its own timetable.
- Interventions that address and strengthen client-defined motivators (e.g., healthy relationships or improved self-esteem), and which factor in the effects of multiple diagnoses (substance abuse, mental disorder, other illnesses) and/or co-infection on individual behavior change.
- Programs and specific interventions informed by behavioral research – particularly in emerging areas demonstrating known impact on high-risk behaviors such as client

histories of childhood sexual abuse, violent or coercive adult relationships, or Post-Traumatic Stress Disorder (PTSD).

## TECHNICAL ASSISTANCE

Primary prevention for positives must be rooted in flexible guidance that allows for specialization and individualization at the local level. There is an established body of knowledge in behavior change that can inform general decisions about interventions. However, there is not yet a well developed, specific body of knowledge, about prevention programs for positives upon which to rely.

Therefore, statewide, there is a serious need for technical assistance for local jurisdictions as they develop and implement prevention programs for HIV-positive persons. Besides needing basic information about implementation and evaluation, local jurisdictions need support and encouragement in structuring programs in innovative ways that go beyond the parameters of traditional prevention approaches.

Technical assistance targeting “primary prevention for positives” will also further the prevention/care integration process, build local capacity, and reinvigorate local efforts and individuals providing services.

The following have been identified as tentative training and technical assistance needs:

- Training of local prevention and care and treatment staff in the principles of behavior change, harm reduction, and related topics. This includes staff of county health departments, CBOs, client constituency groups, and peer advocacy organizations.
- Training and capacity building, focused on primary prevention for positives, provided to existing and new peer advocacy programs within local jurisdictions and communities.
- Technical assistance to build cultural and linguistic competency with regard to primary prevention to positives. Subcultures such as the disabled community, transgendered community, injection drug users, and others should be included.
- Technical assistance in changing approaches to measuring program success. This should include information on qualitative and phenomenological evaluation techniques. It is essential to value incremental change as representing progression towards reduced risk, and to understand the reality of lapsing back into risky behavior as part of the natural process of behavior change rather than as a failure on the part of clients or programs.
- Training for administrators and managers to ensure that those writing grant proposals and managing future programs for primary prevention for positives will have proper staff in place, budgets appropriately developed (these new programs may cost more than what is traditionally budgeted for prevention, education, or

outreach activities), and the framework proposed by this committee realized in the field.

- Training for those providing other services to HIV-positive persons in methods of supporting prevention interventions in their communities and among their clients.

## Appendix C

Note: This article is from September-October 1996.

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**Editorial**

### ***Every Person Infected With HIV-1 Should Be in a Lifelong Early Intervention Program***

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PREVENTIVE MEDICINE LOGIC dictates that when a dangerous infectious agent enters this country, all infected and exposed persons should be identified and proper preventive measures should be instituted to prevent the infection of others. Part of this preventive effort involves any therapeutic intervention that could either decrease transmission or alleviate suffering. The more virulent and invasive the imported agent, the more urgent is the need to field such a program.

Because of its extreme virulence and its remarkable ability to spread, human immunodeficiency virus (HIV)-1 is perhaps the most dangerous infectious agent known. No other human virus kills essentially everyone it infects, and few viruses have equaled HIV-1 in its ability to spread around the world. Moreover, with HIV's decade-long incubation period and chronic viremia, infected persons are capable of exposing many persons before they themselves die. With improved anti-viral agents, high-level viremia can be blunted at least until resistance develops. Decreasing viremia presumably will decrease transmission to others and improve the longevity and the quality of life of the infected person.

Given the dangers of HIV-1, have we established widespread HIV testing programs and, for those who test positive, lifelong prevention and care programs? The answer is no. Why not? Several answers come to mind. First, testing became a polarized political issue before public health officials acted. Extremists on one side called for testing and ill-founded repressive actions for those who tested positive. On the other side, some influential AIDS activists resisted testing from the outset for fear of added marginalization of already marginalized groups. Caught in the middle, the government, which holds responsibility for preventive medicine, never had the political will, the funds, or the staff necessary for widespread testing, not to mention lifelong medical and preventive care for all those infected. In the absence of government leadership to establish an integrated prevention and care program, isolated funding streams for testing (originally to protect the blood system), medications, home care, medical coverage, and so on were added to the AIDS budget in a piecemeal fashion. The integration of long-term preventive measures was never given prominence.

Where preventive services for persons infected with HIV-1 were integrated into what has been called early intervention, the results generally have been positive. In the longest running government-sponsored pilot program in California, prevention has been integrated successfully into the continuum of medical care. As persons infected with HIV-1 enter such programs, many of the most politically sensitive issues concerning HIV become mute. For example, the issue of HIV reporting, which has become a political lightning rod in many areas, is silenced. Not only is the name of the person known to the public health officials who run the program, that person is a patient in the clinic. In such a system, preventive and

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social services can be provided as part of the medical follow-up of the patient. Partner notification becomes routine as the patient and clinic staff develop a trusting relationship. Behavior changes among infected persons and their contacts become more likely because long-term counseling is provided as they all come in for medical appointments. Ongoing counseling can be effective at preventing further transmission, as documented from studying discordant couples<sup>1,2</sup> and antiviral agents, by decreasing viral load, will likely add to the counseling effect.<sup>3,4</sup> In addition, planning for future health care needs and establishing seamless transitions to more medically intensive services become automatic.

With such a logical concept, why would anyone resist establishing early interventions programs? Simple. When the political winds call for less government, they are considered too expensive. In the short term, the care of each infected person—especially when the increasing costs of therapeutic drugs are added—is expensive, totaling several thousand dollars per year. Considering, however, that each new HIV-1 infection eventually will cost society more than \$100,000, the savings garnered if each person infected with HIV-1 and his or her contacts were taught to prevent further transmission would be vast. In today's short-sighted political worlds, though, few in government are able to look ahead toward long-term savings. If the government is not going to be responsible for public health, who will? The answer: nobody. Certainly not the existing AIDS political forces.

The AIDS activist community is the major political force to stimulate AIDS-related funding. But they have not accorded prevention a major priority for action. With most AIDS activists representing the HIV infected portion of the community, there has been less interest in prevention than in a cure. Indeed, fears of civil rights violations in prevention programs often have overshadowed the need to save lives. There continues to be distrust of widespread testing, and priority for prevention through early intervention programs has never been high.

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<sup>1</sup>Padian N, Francis DP, Preventing heterosexual spread of AIDS. JAMA 1988; 260:1869. Letter

<sup>2</sup>Allen S, Serufulira A, Bogaerts J, et al. Confidential HIV testing and condom promotion in Africa: Impact on HIV and gonorrhea rates. JAMA 1992; 258:3338-3343.

<sup>3</sup>Connor EM, Sperling RS, Gelber R, et al. Reduction of maternal-infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. N Engl J Med 1994; 331:1173-1180

<sup>4</sup>Ho DD, Nuemann AU, Perelson AS, Chen W, Leonard JM, Markowitz M. rapid turnover of plasma virions and CD4 lymphocytes in HIV-infection. Nature 1995; 373:1236

## Appendix D

### BIOMEDICAL APPROACHES -- STD/HIV INTERACTION

#### STD Screening in HIV Prevention and Care Settings

Biomedical approaches are not typically viewed as prevention with positives activities, chiefly because they are not primary prevention strategies. However, STD screening and treatment programs can have a considerable impact on HIV prevention. There is substantial biological evidence demonstrating that presence of some STDs increases the likelihood of both transmitting and acquiring HIV (Fleming, Wasserheit, 1999). In fact, individuals who are infected with some STDs are at least two to five times more likely than uninfected persons to acquire HIV if they are exposed to the virus through sexual contact. Furthermore, if a person with HIV is infected with another STD, that person is more likely to transmit HIV through sexual contact than other persons with HIV (Wasserheit, 1992). Increased chances for acquisition and transmission can be attributed to two factors:

**Increased susceptibility** – Genital ulcers (i.e., syphilis, herpes, chancroid) cause breaks in the genital tract lining or skin, creating a portal of entry for HIV. Non-ulcerative STDs (e.g., chlamydia, gonorrhea, and trichomoniasis) increase the concentration of cells in genital secretions that can serve as targets for HIV (e.g., CD4+ cells).

**Increased infectiousness** - Persons with HIV who are also infected with an STD have more HIV in their genital secretions. For example, men with both gonorrhea and HIV are more than twice as likely to shed HIV in their genital secretions than those who are infected only with HIV. Furthermore, the median concentration of HIV in semen is as much as ten times higher in men who are infected with both gonorrhea and HIV than in men with HIV only.

Intervention studies have demonstrated that detecting and treating STDs can substantially reduce HIV transmission at the individual and community levels. Treating STDs in persons with HIV decreases both the amount of, as well as the frequency of, viral shedding. In addition, studies found that ongoing, continued access to effective STD treatment services can be successful in reducing HIV infection, especially in areas where STD rates are high. Early detection and treatment of STDs are an important component of a comprehensive HIV prevention program.

From the CDC's *The Role of STD Detection and Treatment in HIV Prevention* (May 2001)

#### Current Epidemiology

HIV-positive persons who also have STDs can benefit greatly from early STD diagnosis and treatment. In fact, detection and treatment of both symptomatic and asymptomatic

STDs may reduce new infections by as much as 23 percent (see CDC reference, above). Persons with both HIV and gonorrhea (GC) may be eight times more likely to transmit HIV, as studies have found HIV viral levels to be elevated up to eight-fold, compared with those who are not co-infected. Because most people with GC typically experience symptoms, they are more likely to be treated. Syphilis, on the other hand, can be asymptomatic during the early infectious stages. Viral loads have been found to be elevated two- to five-fold in persons with both HIV and syphilis. While lower than viral loads found in those co-infected with HIV and gonorrhea, persons may not know they are infected during these stages, and therefore unknowingly transmit syphilis or HIV during unprotected sex.

LIGs should be aware of STD rates in their jurisdictions, including those in outlying geographic regions. For example, in 2000, 279 cases of primary and secondary syphilis cases were reported in men, of which 59 percent were in MSM and gay communities. In 2001, that number increased to 506, of which 75 percent were MSM/gay; in 2002 the numbers continued to increase to 971, with over 81 percent in MSM/gay men. The number of persons also infected with HIV during this time period were 46, 56, and 57 percent respectively, reflecting a continued rise in unprotected sex.

### Recommendations and Guidelines

In 1998, the CDC published recommendations in the Morbidity and Mortality Weekly Report (MMWR) for STD diagnosis and treatment as an HIV prevention strategy. Nearly five years later, these recommendations have not been widely implemented, primarily due to lack of new or available funds, as well as infrastructure or programmatic barriers. For instance, many STD and HIV programs are not integrated, with staff having little opportunity to network and coordinate related activities. This is also true of some HIV programs for which prevention and care/treatment responsibilities are separated. This lack of coordination is further compounded by separate funding streams. Efforts should be taken to address the above issues and increase awareness regarding the increased biological risk of acquisition and transmission of HIV in the presence of other STDs.

### Integration of STD screening in traditional and non-traditional settings

STD screening in public and private clinical care, as well as community settings, could provide increased opportunities to identify persons with new infections and promptly treat them. Both bacterial (GC, syphilis, CT) as well as viral STDs (HBV, HCV, HSV, HPV) should be diagnosed and treated, if possible.

HIV counseling and testing in STD clinics could also help reduce HIV acquisition and transmission of disease. Persons who have a history of repeat STDs, do not know their HIV serostatus, and/or have multiple and/or anonymous partners could greatly benefit from the above services. In addition, integrated STD/HIV counseling, testing, and other prevention interventions could be of benefit in drug treatment programs, mobile testing sites, bath houses, sex clubs, and bars, as persons frequenting these venues may not

otherwise have access to such services. The following guidelines further outline the STD/HIV counseling and screening activities that can be integrated into traditional and nontraditional clinic settings:

1. Increase STD screening in public and private HIV clinical care settings:
  - Bacterial STDs, especially rectal and pharyngeal GC, syphilis, and CT.
  - Viral STDs, (e.g., hepatitis B and C, etc).
  - Alert patient of STD/HIV interaction issues (i.e., increased risk for HIV acquisition and/or transmission with co-infection).
  - Alert patients about STD symptoms (including asymptomatic nature of some STDs) and need for prompt treatment if infected.
  
2. Increase HIV counseling and testing in STD clinical venues:
  - Conduct enhanced counseling and testing for patients with history of repeat STDs.
  - Alert patient of STD/HIV interaction issues (i.e., increased risk for HIV acquisition and/or transmission with co-infection).
  
3. Offer STD counseling and/or screening for syphilis, GC, and CT in traditional and nontraditional HIV testing venues.
  - Anonymous testing sites (ATS).
  - Confidential testing sites (CTS).
  - Drug treatment programs.
  - Mobile testing sites (e.g., mobile vans).
  - Bath houses.
  - Bars.
  - Other relevant venues.