

# Philadelphia Comprehensive HIV Prevention Plan 2009

## Executive Summary

Prepared for the Philadelphia HIV Prevention Community Planning Group (CPG)  
and the  
Centers for Disease Control (CDC) Atlanta, GA.

Authored by:

OFFICE OF **HIV** PLANNING  
PHILADELPHIA

[WWW.HIVPHILLY.ORG](http://WWW.HIVPHILLY.ORG)

---

## **Acknowledgements**

Thanks is given to the City of Philadelphia, Department of Public Health, AIDS Activities Coordinating Office; the City of Philadelphia, Department of Public Health, AIDS Activities Coordinating Office, Surveillance Unit; the Pennsylvania Department of Health, Bureau of Health Statistics and Research, Bureau of Epidemiology Data Support, HIV/AIDS Surveillance; and the New Jersey Department of Health and Senior Services, Division of AIDS Prevention and Control, HIV/AIDS Surveillance Unit.

### **Written by**

**Mari L. Ross-Russell**

**Aneeza Agha**

**Debbie Law**

**Monica Getahun**

### **Edited by**

**Nicole Johns**

# Philadelphia Comprehensive HIV Prevention Plan

---

## *Executive Summary*

The Philadelphia HIV prevention plan details the continuing progress towards the Community Planning Group (CPG) and the Centers for Disease Control (CDC) goals. The comprehensive decision making is documented through the work of the CPG's committees. The plan also reviews Philadelphia's epidemiologic profile and community services assessment to assist in identifying prioritized target populations and their respective science-based prevention interventions and activities. An annual membership survey supports in the monitoring and evaluation of the goals and objectives of the HIV prevention community planning body and documents ways to constantly improve the group's work.

The complete HIV prevention plan contains approximately 370 pages, with 73 tables and 60 figures with information related to the HIV prevention needs in Philadelphia. This Executive Summary provides a synopsis of the complete plan. Several data sources were evaluated, analyzed, and synthesized to create the document. The plan has four key sections, with each section addressing the various components of the community planning process. There are two additional pieces that are not included in this executive summary. These are the Appendix and Supplemental pieces to the plan. The Appendix includes key decision making information such as the CPG's ground rules and bylaws, worksheet examples that assisted the CPG in their decision making, a list of the recommended science-based interventions by their population demographics, the proposed activities to be conducted during the 5 Year Plan (2007-2011), and a prevention with positives counseling, testing and referral model. The Supplemental pieces to the plan include an integrated epidemiological profile that is approximately 350 pages, a review of literature on HIV prevention interventions and risk behaviors, and an integrated resource inventory for HIV care and prevention in the Philadelphia Eligible Metropolitan Area. All of this information adds comprehensive insight into the prevention needs of the community.

The information contained in the Philadelphia HIV prevention plan was made possible through the dedicated hard work of members of the Philadelphia CPG and with the assistance of the Philadelphia AIDS Activities Coordinating Office (AACO). Both parties have spent countless hours of commitment in planning for the well-being of their community. This executive

summary is a brief reflection of this work. For the full plan and corresponding information, please visit [www.hivphilly.org](http://www.hivphilly.org) or call the Office of HIV Planning at (215) 574-6760.

The following information provides an overview of each section and highlights key points to consider.

## Section I – Who We Are

---

### Overview

- ➔ Provides Membership Information
  - Demographic information on CPG members
  - Affiliation, expertise and at-risk community information
  
- ➔ Reviews CDC & CPG Goals and Objectives
  
- ➔ Reviews each CPG committee role & their respective decision-making
  
- ➔ Reviews CPG affiliated workgroups role & their respective decision-making
  
- ➔ Reviews other cross-collaboration work

## Key Points to Consider

---

- 21 active CPG members with expertise in HIV prevention, behavioral health, substance abuse treatment, social work, research, community advocacy and other disciplines.
  
- 4 active CPG committees:
  - Nominations/Membership Committee focuses on PIR (participation, inclusion, and representation) issues.
  - Literature/Education Committee ensures that members are provided with the information and resources needed to carry out membership responsibilities and duties.
  - Planning/Priorities Committee oversees the development of an epidemiologic profile, gap analysis, and strategies for prioritizing populations and interventions.
  - Monitoring Committee develops and evaluates the planning process and cycle.
  
- The CPG and its respective committees (mentioned above) have spent the last two planning cycles reviewing and updating their 5 year plan in order to ensure that it remains current in its efforts towards HIV prevention planning in Philadelphia.
  
- Work conducted by the CPG in the 2008-2009 planning cycle included:
  - Trainings and presentations on topics such as vaccine trials, ballroom communities, the current HIV prevention system, results from AACCO's population workgroups, epidemiological review of HIV data and unmet need, information from the new CDC Project Officer on her site visit, a data presentation on PEMS, and trainings on various sections of the prevention plan, conflict of interest, the prioritization process, the concurrence process and the CPG membership survey.
  - Elections for a new community co-chair elect.

- Group work to discuss the CPG's collective expertise.
  - Approval of a process change to restructure the work flow to allow Planning and Priorities to lead in prioritizing populations and Literature and Education to lead the work in prioritizing intervention.
  - Approval to include the option of restructuring future CPG meetings to allow for smaller breakout sessions where prioritizing work could be conducted by the entire group.
  - Some adjustments to the CPG's bylaws in the areas of passing a vote, resolving tie votes, conflict of interest, conflict management, and subcommittee responsibilities.
  - Approval of a new CPG application that was significantly shorter than the previous application and more user-friendly.
  - Supporting a prioritization timeline that ensured deadlines for prioritization were met.
  - Modifying the CPG agenda to allow for prioritization work to be included in meetings as needed.
  - Giving approval to the Planning and Priorities Committee to write a letter to Community Behavioral Health to request mental health data.
  - Filling out the annual CPG membership survey.
  - Annual review of work and concurrence approval.
- ➡ Work conducted by the Monitoring Committee in the 2008-2009 planning cycle included:
- Establishing how to best utilize CPG members and their expertise when revisiting priority setting.
  - Deciding to have both Planning and Priorities and Literature and Education oversee the bulk of the prioritization work. Planning and Priorities would focus on populations and Literature and Education on interventions. The committee also suggested that since Nominations would only be adding members twice a year, this would then free up some time for those individuals to participate in the prioritization process assigned to the other two committees.

- Reviewing the bylaws changes and also making suggestions for CPG voted approval.
  - Developing a calendar to plan out the work needed to be completed in the remaining three years before the plan is updated.
  - Suggesting relevant trainings to aid in making the prioritization process.
  - Discussion on who should be community representatives at the Urban Coalition on HIV AIDS Prevention Services (UCHAPS) meetings.
  - Discussion on content for a prevention summit around community planning.
  - Shared discussion with Nominations on hosting a community planning open house to attract new members to the CPG tentatively scheduled for the Fall.
  - Making some changes to the process to help reduce lost time. These included:
    - Renaming “What’s New in the Community” to “Research Update” on the agenda.
    - Putting time limits on every agenda item to ensure that all the topics at hand were discussed.
    - Providing written reports to the chairs of committees to replace the standard verbal committee reports.
    - Adding the option of breakout workgroups at the end of the monthly CPG meetings on topics relevant to prioritization.
    - Adding a “next steps” item to each of the sub-committee agendas to allow members to review the decisions made at the current meeting and what they hoped to accomplish at their next meeting.
- ➔ Work conducted by the Nominations Committee in the 2008-2009 planning cycle included:
- Starting a targeted recruitment campaign by reviewing CPG membership gaps and creating a grid that was shared with the CPG to support their efforts in recruitment and sending out sample letters and recruitment materials via email to CPG members to encourage ongoing targeted recruitment.
  - Discussions on holding an open house event in the Fall to attract new members.

- Redeveloping guidelines for scoring applications.
  - Some specific changes to the application such as adjusting it to be shorter, adding an additional line to allow applicants to select whether they wanted to become full or ex officio members, and changing some language to ensure those with low literacy were comfortable filling it out.
  - Developing a guest card for those individuals who were new, non-voting members of the CPG.
  - Removal of four individuals for excessive violations.
  - Review of 17 applications with 11 members being seated. The remaining applicants received a hold letter in lieu of a rejection letter for possible membership consideration in the future.
  - Some process changes such as limiting open seating for membership to the CPG to twice a year and adopting a 3-month meeting cycle. The change in meeting times was to allow members the flexibility to participate in meetings held by Planning and Priorities and Literature and Education as these committees were leading the process on prioritizing populations and interventions.
  - A vote to extend the membership terms of a few CPG members to coincide with the new seating schedule.
  - Providing a letter of recognition to a member for his commitment to the prevention planning process.
  - Receiving a presentation on the nomination process.
  - Electing a new co-chair.
- ➡ Work conducted by the Literature and Education Committee in the 2008-2009 planning cycle included:
- Electing a new co-chair for the committee.
  - Having a joint meeting with Planning and Priorities to discuss roles and responsibilities. It was determined that the Literature and Education Committee would focus on prioritizing HIV interventions. The group also discussed instruments they could use in the prioritization process and developed a schedule.

- Discussions around the presentations on vaccine trials and the ballroom community including their impact on HIV prevention and possible intervention strategies.
  - Receiving a short presentation on the decision making process used for the last prevention plan along with a list of the interventions currently being funded in Philadelphia.
  - Reviewing other jurisdictions work and the CDC's compendium of interventions to help further identify a prioritizing approach.
  - Looking at factors associated with interventions and data review.
  - Deciding to begin reviewing interventions in the compendium by populations.
  - Continuing to review research articles and the results from an online prevention provider survey as they relate to the populations and interventions being examined.
  - Reviewing the worksheets provided by the AED in their guidance.
  - Choosing factors for the review of science based interventions. These factors included who the intervention targeted; the behavior that it aimed to change; information on the interventions effectiveness and feasibility; whether the intervention was based on theory; the norms and values considered for the intervention and other considerations based on local needs.
  - Beginning their process of reviewing their current interventions and identifying and defining new interventions.
  - Establishing some next steps such as weighting, rating, scoring and ranking interventions.
- ➔ Work conducted by the Planning and Priorities Committee in the 2008-2009 planning cycle included:
- Reviewing the CDC's Priority Setting Guidelines and the process used to develop the previous prevention plan.
  - Contributing to the review and adjustment of the bylaws and conflict of interest information to ensure they were up to date.

- Having a joint meeting with Literature and Education to determine roles and responsibilities during the prioritization process. The Planning and Priorities Committee was assigned the task of identifying priority populations. Members then began identifying instruments they could use to aid their work and loosely developed their planning schedule for the year.
- Clarifying the current list of priorities.
- Receiving a presentation on epidemiology data including national and local HIV incidence estimates and an analysis of unmet need.
- Reviewing data and other statistics as they relate to potential HIV risk taking behaviors.
- Selecting co-factors such as homelessness, poverty, incarceration, mental health issues, drug addictions, STDs, limited English proficiencies, etc. and noting their potential impact on HIV prevention.
- Requesting additional data on mental health and HIV.
- Beginning a draft listing of prioritized populations.

### *Prevention with Positives*

- ➡ The CPG has collaborated with the Ryan White Part A Planning Council (RWPC) since 2003 to ensure that there is cross-communication and system-wide integration efforts between HIV prevention and HIV care wherever possible. A work group known as Points of Integration is responsible for this task and is made up of members of both planning bodies. This work group meets routinely and continually flushes out recommendations for the Grantee to consider. The work conducted by the Points of Integration Committee in the 2008-2009 planning cycle included:
  - Requesting updates from the Grantee on the Counseling, Testing and Referral Model that was forwarded to the health department for consideration and on some pilot projects that used community agencies for partner notifications. Members took note that system wide changes to the intake process had already been implemented and that these changes were addressing the need for a uniform assessment tool via an indicator in CAREware.

- Receiving an update on the health department integration meetings:
    - An overlap grid that was being implemented was shared. This overlap grid was the culmination of the previous years of dedicated work initiated by the Points of Integration Workgroup. The health department was able to use the suggestions, along with the CDC white paper on program collaboration and service integration (PCSY) to begin their integration efforts. Some key advances include having routine HIV testing available through TB, Hepatitis and STD systems, and conducting rapid testing in a local TB center.
    - Some next steps for the group include reviewing various datasets for better service planning; looking at San Francisco’s consumer driven website; and meeting with the Office of Addiction Services to address hepatitis integration into substance abuse. Ongoing dialogue between the health department’s integration workgroup and the points of integration workgroup is anticipated for the next planning cycle.
  - Reviewing San Francisco’s Prevention with Positives: Best Practice Guide document and using it as a model for local standard procedures for prevention with positives.
  - Anticipated next steps are to revise some of the language in the prevention with positives best practices guide to better reflect local needs and to determine feasibility for implementation in Philadelphia.
- ➔ The Positive Committee of the Ryan White Planning Council’s mission is to support and enhance the participation of PLWHA in community planning, in both the CPG as well as the Philadelphia EMA Part A Ryan White Planning Council.
- The committee meets monthly and discusses topics related to community planning, including training on epidemiological data, service provision, and how to best participate in community meetings.
  - The Positive Committee Co-Chair reports on the group’s activities at all CPG meetings and also brings CPG activities and discussions to the committee when appropriate.

- The Positive Committee will offer input on Prevention with Positives, as well as other prevention-related topics, whenever the general CPG body requires their expertise during the prioritization process.

### *Outreach and Cross Collaborations*

- ➡ Community representation at the CPG has remained a priority for this group and outreach to members of other service areas, such as hepatitis, STD, and corrections continue on an ongoing basis.
- ➡ A general recruitment letter was sent out to HIV prevention providers highlighting any membership gaps, which included membership applications and general information about the CPG and its activities.
- ➡ OHP staff also participated in several community events during Philadelphia AIDS Education month (June 2009), including a workshop on community planning at the 8<sup>th</sup> Annual HIV Prevention and Outreach Summit.
- ➡ Despite funding cuts that led to the disbanding of the Young Adult Roundtable, the CPG continually considers the special HIV prevention needs of youth in the community through outreach, communication and feedback efforts. Additionally, the CPG continues to include representatives whose primary area of expertise is youth.
- ➡ The CPG receives ongoing updates for planning and partnership purposes from national meetings such as the Urban Coalition of HIV/AIDS Prevention Services (UCHAPS), Communities Advocating for Emergency AIDS Relief (CAEAR), Suburban HIV/AIDS Coalition (SHAC) in the Pennsylvania suburbs, AIDS Coalition of Delaware County (ACDC) and the State CPG.



## Section II – Community Services Assessment

---

### Overview

- ➔ Provides needs assessment data
  - General population online survey on knowledge, attitudes, and behaviors around HIV
  - Transgender one-on-one surveys and interviews
  - HIV prevention youth roundtables
  - Prison panel discussion on accessing HIV services
  - Prevention Provider Survey
  - Prevention Provider Focus Groups
  - Philadelphia EMA Town Hall meetings
  - HIV case management interviews and surveys
  
- ➔ Provides a geographic gap analysis
  - Ethnic population distribution
  - AIDS and STD epidemic
  - Geographic risk and service gap analysis
  - Race, segregation, and AIDS
  - Study of Philadelphia neighborhoods
  - Study of geographic risk in Philadelphia
  - Overview of geographic risk and unmet need for the planning of prevention services
  - Hepatitis C prevalence rates In Philadelphia

- ➡ Summary of the integrated resource inventory for the Philadelphia EMA
- ➡ Summary of the integrated epidemiological profile for the Philadelphia EMA
- ➡ Current Philadelphia HIV prevention system grid

## Key Points to Consider

---

### Needs Assessment Results

#### ➔ *HIV Knowledge, Attitude and Behavior Online Survey (n=403):*

- Most respondents had a good working knowledge on how HIV was transmitted, however some areas that could use improvement were responses to whether sharing a razor or a toothbrush were possible risk factors; whether a pregnant woman could get treatment to help to lessen the chances that she will pass the virus on to her baby; and whether there was a cure for AIDS.
- The majority of individuals in this survey had relatively positive attitudes towards persons with HIV/AIDS.
- A key point in attitudes was that respondents felt their friends were at a higher risk for HIV than themselves.
- When comparing respondent's perception of friends' risk behaviors to the respondents actual risk behavior, there was a disconnect as some respondents were engaging in risky behavior themselves but did not perceive themselves as 'at-risk'.

#### ➔ *Transgender Interviews and Survey on HIV Knowledge, Attitude and Behavior (n=31):*

- 90% identified as HIV Positive, 73% were Non-White.
- Many individuals in this group had risk factors regardless of HIV status:
  - 13% were actively using a substance.
  - 40% did not use a new needle the last time they injected hormones.
  - 47% ever had an STD.
  - 58% had been paid drugs or money by someone for sex.
  - 32% had 11 or more partners in the past 12 months of being surveyed.
  - 42% had ever been incarcerated.
  - 34% had ever been homeless.

- 36% were under the influence of alcohol or drugs the last time they had sex.
- Some reasons mentioned for not using a condom included, “Don’t like the way it feels”, “Our sexual activity does not require a condom”, “It was with my husband whom I trust” and “We both are HIV positive and comfortable with our decision”.
- Some HIV prevention program suggestions for transgender people included creating education programs and job opportunities that are trans-friendly, sensitivity training for staff in a medical care environment, promoting culturally competent advertising and safe-sex education, night outreach, support groups, more comprehensive and holistic models of care, and providing interventions that have community involvement, peer education and affirmation of transgender identity.
- A harm reduction, non-judgmental, stages of change approach to both prevention and care can help trans clients to address their competing factors for basic survival while allowing the client to make active decisions in their healthcare and risk behavior choices.

➡ *HIV Prevention Youth Roundtables* (n=48 – focus groups, n=137 - surveys):

- Both survey respondents and focus group participants have a basic, correct understanding of HIV transmission. They are also able to correctly identify HIV risks.
- Three areas indicate any uncertainty about correct answers: 1) whether or not sharing razors and toothbrushes can transmit the HIV virus, 2) whether unprotected oral sex is safe if the partners do not swallow, and 3) whether or not there is a cure for AIDS.
- In the survey, 8.8% report being unsure as to whether or not they were at high risk for HIV, 12% reported being at high risk and 2% reported they were HIV positive.
- Much of the talk about sex (typically by the male participants) could be seen to exemplify sexual bravado and may be reflective of larger social values with respect to discussions about sexuality. If prevention messaging is going to work, it is important to understand that teens view sex this way.

- Preventing pregnancy was mentioned more frequently than STD's as a reason for safe sex.
- Some reasons for not using condoms included not having a condom, wanting to have sex and forgetting the condom, embarrassed, afraid it might not fit, allergic to latex, having oral sex, loss of feeling, not wanting to stop, no one telling them about using one, they don't care about themselves, don't think, and the individual might already have HIV.
- Combination programs such as multiple foci, "edutainment" programs, behavioral-change programs with goals that include risk reduction, peer education, self-efficacy and sexual negotiation, and social marketing programs all appear successful for youth.
- Some key elements to success for the youth included having culturally appropriate leaders, instilling both ethnic pride (for African American girls) and self esteem, being able to relate to a personal experience with HIV, knowing someone who is positive (makes the threat of HIV become "real") and addressing fear surrounding first HIV tests.
- Suggestions for prevention approaches for youth include concert venues and celebrities; better advertisements" that are "realistic"; and topics appropriate to today's youths that make HIV relevant in their lives "Think on a teenager's level".

➡ *Prison Panel on Access to Care (n=6):*

- Four of the 6 participants tested positive while incarcerated.
- Concerns around medications included delays in receiving medications when first being processed, receiving medications in an untimely or inconsistent fashion, lack of confidentiality while receiving medications (in the pill line), and not receiving food with medications.
- Stigma and lack of confidentiality around HIV status in general was a concern.
- Linkages to HIV services upon release appeared inconsistent among the participants.

- Continuing importance for community based organizations to work with the correctional institution in providing HIV care and prevention service linkages for those recently released prisoners is critical.

➡ *Prevention Provider Survey (n=56):*

- Twenty-four respondents estimated serving between 500 to over 1,000 prevention clients.
- Thirteen respondents estimated serving more than 200 HIV positive or AIDS diagnosed clients.
- Top prevention services provided by the respondents were basic HIV/AIDS education, safer sex information, client assessment and skills building.
- Top care services provided by the respondents were case management, support group, advocacy/peer counseling and mental health treatment.
- Older adults, teenagers, minorities, heterosexuals and homeless were listed as underserved populations by the respondents.
- Heterosexuals, youth, older individuals, MSM and minorities were observed as emerging populations at a high risk for HIV.
- When asked to report what risk behaviors were seen in these emerging populations, unsafe sex was by far the most common answer followed by IDU.
- Stigma, lack of understanding about HIV risk, Fear, and not thinking a service was needed were barriers listed as affecting a client's ability to access services.
- Poverty, mental health issues, having STD's, homelessness, being unemployed, stigma, violence, and addictions were among the list for common factors contributing to a clients risk for acquiring HIV.
- Some services noted as difficult to obtain included housing, C&T results, education, and funding.
- More cultural sensitivity, more opportunities to network, more effective outreach and more trainings were listed as things that would help a provider serve their clients better.

- Some internet based prevention strategies used by some agencies included: web based outreach, use of social networking sites, text messaging programs, online informational videos on safe sex, and web based social marketing initiatives.
- Approximately 19 different HIV intervention strategies were selected by the respondents and reviewed. The majority of these interventions were deemed effective in changing a client's risk behaviors.
- Fifty-seven percent of the respondents directly reported their PEMS data to the CDC.

➔ *Prevention Provider Focus Groups (n=29):*

- Three focus groups held. Two were with front line staff that had experience working with clients at risk for HIV in the community (10 participants in these two groups). The remaining focus group was with supervisors at local agencies (9 participants).
- There was a strong emphasis in the groups on engagement in order for any intervention to be effective.
- Assessments and referrals were more common in larger agencies that often have more services in-house.
- Persons with disabilities were often not offered referrals due to the lack of appropriate referral options for them.
- Incentives and use of community resources were identified as helpful with the IDU population.
- Education and linkage with services was emphasized for persons newly diagnosed with HIV.
- High impact techniques such as skits and use of peer educators, and use of several different counselors (to better find a "fit") were emphasized for youth.
- The Internet as a form of outreach for non-gay identified MSM was deemed helpful, but the level of secrecy in the population was a major barrier.
- For both heterosexual men and women, it was emphasized that making safe sex fun was important to reducing risk.
- GLI's were indicated to be helpful for MSM.

- Populations who were questioning their sexual identity or gender were at high risk.
- Muslim girls were identified as an emerging population as were bisexual women who may not disclose their orientation due to stigma.
- Interventions offered varied in the ways sites carried them out.
- Most individual interventions ILI and PCM had an assessment followed by risk reduction and counseling.
- Supervisors did not seem to be clear about the goals of GLIs, but were familiar with their content. Most supervisors indicated a willingness to refer out when needed.
- There seemed to be a high level of oversight of staff, with reports of direct observation, weekly supervision and chart reviews.
- Low response in work experience with the transgender population for all groups. Important to increase the cultural competency of staff in working with this population.
- Need for the development of community partners to allow for the expansion of prevention services and to help remove stigma around HIV.

➔ *Case Management Key Informant Interviews and Surveys (n=27 – interviews, n=31 - surveys):*

- A total of 16 agencies from the EMA resulted in 27 case manager interviews and 31 surveys.
- Of the 30 HIV case managers interviewed, 7 case managers mentioned that all of their clients were using drugs and/or alcohol, 5 respondents mentioned their clients had mental health problems and, 4 mentioned homelessness as a special need for their clients.
- 37% of the case managers estimated that between 20-35% of their client base had substance abuse problems, while 33% estimated between 75-95% and 30% estimated between 40-70% of their clients had substance abuse problems.
- 40% of the case managers estimated that between 80-99% of their clients had mental health problems, while 33% estimated that between 55-75% of their clients had mental health issues. Additionally, 27% of the case managers estimated that between 25-50% of their client base had mental health problems.

- 93% of case managers noted that most of their clients had ‘medium to high needs’.
- 85% of the case managers articulated that they provided some sort of HIV prevention to their clients.
- For the services that many clients needed but did not get, housing was mentioned 19 times, while mental health and drug and alcohol services were mentioned 6 times respectively.

➡ *Town Hall Meetings (n=120):*

- There were a total of 101 individuals who filled out a survey that asked about the use of HIV prevention services during the past year. Of the HIV positive participants in the survey, the top prevention services used were condoms or safe sex kits (73), receiving safe sex information (57), information on disclosure (46), Information on substance abuse programs (24), street outreach (21), needle exchange program information (15), information on HIV counseling for pregnant women (14), and safer injection/bleach kits (11).

➡ *AACO’s Population Workgroup Results (n=unavailable):*

The top 3 areas identified by the *Heterosexual* work group were:

- More funding for mobile testing.
- Better collaboration to target hot spots with other providers and make use of census track data to inform the work.
- Develop innovative and collaborative efforts with other providers.

The top 3 areas identified by the *MSM* work group were:

- Develop new creative strategies outside of current list of DEBIs.
- Research best practices in different areas and adapt to Philadelphia.
- Develop strategies to collaborate with other systems including mental health and substance abuse.

The top 3 areas identified by the *Youth* work group were:

- Make use of non-traditional access points to provide testing and prevention services to youth.
- Work with and establish coordinated conversations with other stake holders i.e., SDP, JJC, B&G Clubs, etc.
- Improve collaboration and communication among youth HIV prevention providers including better ways to promote agencies and their services.

The *IDU & Transgender* work group meetings are either still pending or to be determined.

- The Transgender workgroup meeting is scheduled for September 2009.

### *Geographic Gap Analysis*

- The Geographic Risk and Service Gap Analysis shows:
  - Philadelphia remains highly segregated by both income and race.
  - Neighborhood economics, as they intersect with race, severely affect PLWA.
  - Language barriers, cultural barriers, gender barriers, and residential segregation may keep members of specific minority groups from seeking HIV/AIDS services beyond their communities.
  - Active addiction, a lack of support and/or a lack of accessible services, and a lack of education were often cited as reasons consumers were not in care or entered care late.
  - Racially segregated portions of the city experience social pathologies – higher levels of crime, more problems with housing, more complaints to city departments, more births to teenagers and/or to women with late/no prenatal care, etc.
  - Psychological stress and economic stress related to life in these neighborhoods can serve as barriers to care.
  - The areas most at risk using a statistical and geographic analysis are:
    - Overwhelmingly and disproportionately affected by crime

- Overwhelmingly and disproportionately poor
- Overwhelmingly disadvantaged and/or disenfranchised
- Overwhelmingly suffering from poor living conditions, and
- Overwhelmingly experience higher rates of teen births and AIDS.
- Prevention providers need to adapt to these unique situations when providing services.

### ***Integrated Resource Inventory***

- ➡ The resource inventory has been prepared as a tool for consumers, providers and other interested parties to learn about the HIV/AIDS resources available in the Philadelphia eligible metropolitan area.
  - The full inventory is 270 pages with over 370 entries listing HIV care and prevention service providers throughout the region.

### ***Integrated Epidemiological Profile***

- ➡ *Section I: Demographics.*
  - Between the 2000 and 2008 census counts, the general population of the EMA increased by 107,973 individuals. It is estimated the population increased from 5,100,931 in 2000 to a total of 5,208,904 persons by the year 2008. The city of Philadelphia represented the only percentage drop in total population with an estimated -4.62% or 70,155 individuals.
  - Based on the census 2007 estimates, 67.54% of the population of the EMA was White, 19.94% was Black, 6.40% Hispanic, 4.40% Asian, .15% American Indian and Alaskan Native, and .01% Native Hawaiian and Pacific Islander.
  - White females made up the largest percentage of the total EMA population with 36.01% or 1,872,718, and the largest single age category for this group was those 55 and over with 10.71%. White males represented 34.21% or 1,779,024 individuals. The greatest single age group for males was the 19 and under category at 8.8%, followed closely by the 55 and over group at 8.51%.
  - Approximately 3.98% of the estimated 3,441,723 persons 25 and older for whom educational attainment was determined had completed less than nine years of

education. An estimated 17.62% of females and 14.79% of males had either a high school or equivalency diploma.

- According to the 2007 American Community Survey conducted by the Census Bureau, there are 1,930,804 households within the nine counties of the Philadelphia EMA for which linguistic isolation was determined. Of that number, 15.45% speak a language other than English at home and 3.65% are defined as having linguistic isolation.
- Philadelphia had the highest percentage of individuals living below the poverty level at 23.79%.
- The majority of supplemental security and public assistance recipient households were in Philadelphia.
- Philadelphia had the lowest median income of all nine counties with \$26,358.
- In 2007, 15.6% of persons in New Jersey were uninsured, as were 9.8% in Pennsylvania, as compared to the United States, which had 15.3%.
- Live births generally increased across all age brackets in the nine EMA counties during the period 2002 through 2006.
- Philadelphia had the highest TB case rate at 8.6% and the Philadelphia MSA was 4.0%.

➔ *Section II: Indicators of Risk.*

- According to BRFSS, of the 2,880 respondents, 46% of adult white males and 56% of adult black females had been tested for HIV disease in 2007.
- The NHSDA estimated that 30,000 12 to 17 years old New Jersey residents were drug dependent during 2005 and 2006. The Pennsylvania estimate totaled for the same age group 41,000.
- The Philadelphia ADAM showed that 67% of adult male arrestees tested positive for any drug was present.
- The UCR in 2008 showed that a total of 1,437 persons were arrested for prostitution and commercialized vice in the Philadelphia metropolitan area. The largest racial/ethnic group was Black.

➔ *Section III: Scope of the HIV/AIDS Epidemic.*

- During the period of 2003 through 2008, Philadelphia went from having 78.15% of the new AIDS cases in the EMA in 2003 to 73.21% of the EMA totals in 2007

and 78.14% of the EMA totals in 2008 (please keep in mind that 2008 data is only through June 31, 2008.)

- In 2007, Philadelphia accounted for 73.80% of the cumulative AIDS cases and 76.52% of the living AIDS cases in the EMA.

➔ *Section IV: Service Utilization Patterns.*

- In Philadelphia, a total of 719 HIV positive test results during 2007, 527 were male. The largest race to test positive was Black with 483 people. By age, the largest group to test positive in Philadelphia during 2007 was between 25 to 44 years old. Heterosexual (228) was the risk category most likely to test positive while MSM (198) was the second most likely.
- In 2007, AACO reviewed HIV-reporting data to determine how many people had developed AIDS over a 12-month period. Based on the analysis, concurrent HIV/AIDS is positively associated with age at HIV diagnosis. That is, the older a person is when they are diagnosed with HIV, the more likely it is that they will be classified as concurrent HIV/AIDS. Cases with concurrent infection are also more likely to be Black males and heterosexuals.
- From the AACO implementation plan in 2002-2008, the most used services were case management and primary medical.
- Most clients in both the Pennsylvania and New Jersey counties were between 40 and 49 years old, male and black.
- According to the National ADAP Monitoring Project, in 2006 and 2007 neither New Jersey nor Pennsylvania reported having a waiting list for clients to access ADAP.

➔ *Section V: Measuring Unmet Need.*

- Unmet need was estimated for the city of Philadelphia by AACO. Unmet need was defined by HRSA as people who know their status but are not in primary medical care. The estimated number of individuals with HIV/AIDS not receiving primary medical in Philadelphia EMA is 5,317 (22%).
- The Commonwealth of Pennsylvania, Department of Health, HIV/AIDS Epidemiology Section, Bureau of Epidemiology, Division of Infectious Diseases

estimated unmet need for the southeastern region which includes the four Pennsylvania EMA counties. The total estimated number of HIV positive individual who know their status and are not in primary medical care was 3,945.

### *Philadelphia HIV Prevention System Overview*

- The currently funded Philadelphia HIV Prevention System distributes resources among the prioritized target populations and science-based interventions in the following manner:
  - AACO allocated approximately 50% of the HIV prevention funding to programs targeting heterosexuals, about a third to MSM and 19% to IDU. Most recipients were HIV negative (80%) and 67% were adults.
  - AACO allocated 50% of the HIV prevention funding to CTR programs, about 34% went to HE/RR, 15% to CRCS and 1% went to HC/PI. Approximately, 20% of the funding went to home grown GLI's.
  - There were 144 new positives that received their results indicating a 71% return rate.
  - Most tests were performed on males (33,977) with 286 positive results and a sero-positivity rate of .84. There were 40,728 tests given to Black/African American clients, with 277 positive results and a sero-positivity rate of 0.68. By age, most clients were between 25-34 years old (16,179) with 100 positives and a .62 sero-positivity rate.
  - Most tests were taken by heterosexuals (37,185) followed by MSM (9,273). There were 125 positive results for the Heterosexual group with a sero-positivity rate of .34 and 139 positive results for the MSM group with a sero-positivity rate of 1.50.
  - There were 889 newly reported HIV positive individuals. Of that total, 359 were offered PCRS, and 237 agreed to it. From that effort, 317 partners were elicited, with 177 partners being notified of their possible exposure risk. This resulted in 83 partners receiving an HIV test, 18 of whom received a newly identified, confirmed HIV positive test. There were 59 partners with a previously confirmed HIV positive test.
  - The top three HIV testing sites were in zip codes 19146 (10,515 tests), 19136 (9,367 tests), and 19107 (7,361 tests). The top three zip codes of the client's residence were in 19132 (3,380 clients), 19134 (3,009 clients) and 19140 (2,959 clients).

- There were 31,831 clients who identified as heterosexual, most resided in 19132, 19134, and 19140. There were 6,898 clients who identified as MSM, most resided in 19146, 19143, and 19107. For those clients who identified as IDU (2,116), most resided in zip codes 19134, 19133 and 19140.



## Section III – Priorities and Recommendations

---

### Overview

- Provides information on the priorities selected by the CPG
  - Description of the prioritization process used to select priority target populations
  - Description of the ranking model for target population
  - Detailed description of populations most at risk for HIV
  - Overview of process used to determine effective interventions
  - Table of recommended interventions shown by target populations
  
- Additional resources for selecting effective interventions
  - Tiers of evidence framework
  
- Additional recommendations for addressing priority populations
  - Notes on how to address special populations at risk for HIV
  - Notes on requiring the use of optional PEMS variables
  - Overview of a special set aside fund of 8% for innovative programs

## Key Points to Consider

---

- ➔ The AED guidance was used as a tool with adjustments as needed.
- ➔ PLWHA were ranked as a top priority for the CPG, followed by IDU, Heterosexuals, MSM, and Perinatal.
  - There was a concern that HIV data were not available and using AIDS numbers would not be reflective of the current epidemic.
- ➔ Partners of PLWHA and IDUs are being considered as a priority population going forward.
- ➔ Populations were organized by adults and youth and also by subpopulations with special concerns such as mental health, homeless, limited English proficiencies, etc.
- ➔ Interventions were chosen based on factors that asked about need, effectiveness, feasibility, norms and evaluation.
- ➔ A menu list of interventions with the potential to be adapted were selected to allow the Philadelphia prevention system more flexibility in addressing its needs
  - Emphasis was placed on working with the Grantee on any adaptability requests to ensure the interventions core criteria were not compromised.
- ➔ Decision tree guides were also provided to guide providers in their selections.
- ➔ The CPG changed optional PEMS variables to be required. This would ensure adequate data on special populations would be available for the future. These variables included but were not limited to: the number of Internet Sex Partners, Language of Service

Delivery, Incarcerated, Sex Worker, Housing Status, Injection Drugs/Substances, Number of Unprotected Sex Events, and Number of Needle Sharing Events.

- The CPG sets aside 8% of the funds in the community pool for an “innovative program” focusing on populations that are disproportionately affected by HIV/AIDS, regardless of HIV status.



## Section IV – Monitoring and Evaluation

---

### Overview

- Monitoring the community planning process
  - CPG membership survey results

### *Key Points to Consider*

---

- There were 9 respondents to the CPG membership survey with an average attendance of 8.3 meetings and an average length of membership of 2.3 years.
- The majority of respondents indicated that community planning supports broad based community participation.
- The majority of respondents indicated that community planning identifies priority HIV prevention needs in each jurisdiction.
- The majority of respondents indicated that community planning ensures that HIV prevention resources target priority populations and prevention activities that are set forth in the plan.







