

**Community Planning Group
Literature & Education Committee
Meeting Minutes**

Wednesday, April 28th, 2010

12:00 - 2:00 pm

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: Jennifer Chapman (Co-Chair), Terri Clark, Christopher Collins, Alison Lin

Staff: Joseph Ellis, Mari Ross-Russell

Excused: Dawn M. Acero, Wesley Anderson, Antonio Davis, Val Sowell, Roberta Waite

Absent: Arti Chhabria, Tyreef King, Dionna Samuel

Call to Order

J. Chapman called the meeting to order at 12:22 pm.

Approval of Agenda

The group took a moment to review the meeting agenda. A. Lin requested that a discussion on structural interventions be added to the agenda since D. Acosta had recently sent the group some information. The rest of the group agreed. **Motion:** With the noted addition, J. Chapman moved and A. Lin seconded to approve the agenda.

Motion Passed: All in favor.

Approval of Minutes (*March 24th, 2010*)

The group spent some time reviewing a draft of the minutes from their last meeting.

Motion: Afterwards, J. Chapman moved and A. Lin seconded to approve the draft of the minutes included in the handouts. **Motion Passed:** All in favor.

Report of Staff

None

Report of Co-Chairs

None

Discussion Items:

• **Finish Review of Interventions**

M. Ross-Russell directed the group's attention to the handout that summarized the interventions for review. She noted that the six programs that had not been reviewed were highlighted in yellow in the document. She informed the committee that, for reviewed programs that targeted more than one population, she had copied their decisions for all populations.

Teen Health Project - APPROVED (GLI) w/RESERVATIONS (CLI)

- Targets a specific population?
Adolescents of high risk for HIV who live in urban, low-income housing developments
- Targets a specific behavior?
Increasing abstinence and condom use
- Effectiveness?
Participants were more likely to remain abstinent and more likely to use condoms
- Sound theoretical basis?
Diffusion of Innovation and Social Cognitive Theory
- Norms, Values, Consumer Preferences?
No specific language
- Intervention Feasibility?
Cost – Two 3-hour workshops delivered by two trained facilitators and peer opinion leaders in low-income housing developments
Materials – package available
- Other considerations – only difference between CLI and GLI is the addition of community events
PCRS connection – no specific language

Condom Promotion - REJECTED

- Targets a specific population?
Young, unmarried college women
- Targets a specific behavior?
Increase intentions to use condoms and condom use
- Effectiveness?
Increased condom use
- Sound theoretical basis?
Psychosocial Model of Condom Use and Health Belief Model
- Norms, Values, Consumer Preferences?
No specific language
- Intervention Feasibility?
Cost – one 45-minute session delivered by a female graduate student on a college campus
Materials – package not available

- Other considerations – None
PCRS connection – no language

The group decided to reject Condom Promotion because there was no intervention package available, it had used only small analytical sample sizes, and it was originally published in 1996.

Salud, Educación, Prevención, y Autocuidado (SEPA) - APPROVED

- Targets a specific population?
Low-income, urban, Mexican and Puerto Rican women
- Targets a specific behavior?
Eliminate or reduce sex risk behaviors
- Effectiveness?
Increased Condom Use
- Sound theoretical basis?
Social Cognitive Theory
- Norms, Values, Consumer Preferences?
Delivered by bilingual and bicultural Latinas
- Intervention Feasibility?
Cost – six weekly sessions delivered by bilingual and bicultural Latinas who are trained as HIV counselors
Materials – package is being developed
- Other considerations – none
PCRS connection – no specific language

A. Lin felt that SEPA would be a good intervention for the city as long as a package was developed. J. Chapman agreed but noted that the program's low retention rates could have been caused by its location, which was not reported.

A. Lin asked whether any data were available for Protect and Respect. M. Ross-Russell replied that data for the program were available and that Michelle Teti had offered to attend a meeting to discuss Protect and Respect. As a result, the group decided to approve the program with reservations and delay their final decision until after their discussion with M. Teti.

In response to a question by A. Lin, the committee ascertained that AACO and Philadelphia FIGHT were jointly responsible for Prison Case Management. However, T. Clark said that Action AIDS might also be involved in the program and offered to investigate the matter further. M. Ross-Russell told the committee that she had not

included Prison Case Management in the list of programs for the panel discussions. She said that she would explain the matter during the next discussion item of the agenda. T. Clark suggested that the committee reject HIV Education and Testing because the program had been developed before the rapid test was in use. The rest of the committee supported her suggestion.

T. Clark felt that HRCs (Health Resource Centers) and Connect and Protect were more like structural interventions than those that attempted to alter individual behaviors. A. Lin agreed but said that some of the HRCs also offered ILIs and STI testing. She then asked whether organizations could apply for funding to open HRCs if the committee opted to approve them for the system. M. Ross-Russell responded positively and then reiterated that the committee's intervention review was to decide whether programs were appropriate for the entire system. She said that it was acceptable for the group to reject programs that did not have packages available because they were necessary for implementation. She also told the group that, during the development of the current 5-year plan, the CPG had approved an all-inclusive list of interventions because there was insufficient data available to properly review them. Additionally, she continued, because the CDC had pushed for the use of HRCs, the local prevention system had approved them despite insufficient data for reviewing them. However, she said that since some HRCs had been operating for a few years, some data should be available on them. She added that Judith Peters might also have some information on the centers.

A. Lin believed that PALMS (Preventing AIDS through Live Movement and Sound) had been expanded since the information included in the binders was written. She told the group that the program now separated males and females and, while it often operated in E3 centers, she was not sure whether there was any relation with juvenile detention centers. She then gave her approval to the program and the rest of the group agreed.

J. Chapman pointed out that the study for PALMS had been conducted in 2007, saying that data on the program could be available by now. T. Clark agreed and noted that, if the program was run through AACO, the grantee should have some data. However, M. Ross-Russell informed the group that, if PALMS was directly-funded by the CDC, it could be very difficult to obtain any data on it. However, she offered to send an email to find out whether any data were available.

T. Clark reminded the group that, at the last CPG meeting, one member had voiced concern over whether Healthy Relationships would be approved or rejected. She said that she did not want individuals to worry that programs they were running would be rejected. M. Ross-Russell replied that the only local program that individuals could legitimately be concerned about was Community Promise, which had been rejected with reservations. However, she said that the decision to reject the program was sound because of questions about its effectiveness and ability to perform long-term follow ups. T. Clark noted that some current programs did not have strong tools for self-evaluation. A. Lin felt that researchers were responsible for any lack of proper evaluation methods.

- **Planning for Provider Panel Discussions**

M. Ross-Russell directed the group's attention to the draft outline of providers and dates for the panel discussions. She informed the group that, currently, she had not received confirmation from any local providers for the panel discussions. She said that she would send out the letters on a monthly basis because providers might not be willing to commit too far in advance. She clarified that she had already sent out letters for the May meeting and would send those for the June meeting next month. She pointed out that Protect & Respect, Teach, and TIP were the only local programs currently on the list. However, she said that she would add HRC and Prison case management to the list. Reading over the document, the group approved of planning on a half hour for each discussion.

T. Clark reported that she had received confirmation that a representative for Healthy Relationships would be at the May meeting with an interpreter. M. Ross-Russell noted that two interpreters might be necessary because interpreting back and forth between the representative and the CPG would be a lot of work.

T. Clark said that she had not received a response from T. Dressel concerning her attendance at the panel discussion. J. Chapman also reported that she had been unable to discuss the matter with Y. Alicia. M. Ross-Russell noted that, in order to follow the appropriate protocol, she had sent the letters to the executive directors of all the respective providers. However, she said that she had also sent letters to the likely representatives of the programs if she knew the individuals. She told the group that her letter included the discussion questions that the committee had developed but made no mention of who else would be on the panels. She also noted that she had not included Philadelphia FIGHT for any of the discussions in June because the organization would likely be busy with all of the activities related to AIDS Education Month. She said that she had tried to group the providers in such a way that would cut down on the numbers of meetings that individuals would have to attend. T. Clark gave her approval to the planning that had been done for the prevention provider panel discussions, saying that, after the first discussion, the committee could re-evaluate their plans and decide if any alterations were necessary. The rest of the group agreed.

- **Structural Interventions**

T. Clark started the discussion by saying that the debate on structural interventions was not focused on whether or not such programs were effective, but rather on how more of them could be implemented in Philadelphia. She said that implementation of some of the larger structural interventions would require cooperation between government entities and possibly even universities. She clarified that, in general, while she understood structural interventions and felt that their benefits were undeniable, she did not understand how the committee could help to instill more of them in Philadelphia.

M. Ross-Russell suggested that the committee simply include in the prevention plan a brief description of structural interventions that explained why they were effective and why they would be beneficial to Philadelphia. She added that the language could also include ideas for implementing and evaluating such programs in Philadelphia. A. Lin

agreed that some language on structural interventions should be included in the plan, just to show that the committee supported them. The rest of the group agreed.

T. Clark suggested coordinating meetings with individuals from universities, AACO, and the Health Department to discuss ways of implementing structural interventions in Philadelphia. M. Ross-Russell supported the idea but noted that discussions on possible sources of funding could dissuade some groups from participating. T. Clark felt that the most difficult part of the process would be determining how to evaluate structural interventions. M. Ross-Russell agreed, saying that some outcomes could take as much as ten years to measure.

M. Ross-Russell suggested that the committee start the process of including structural interventions in the prevention plan by defining the programs and developing a list of those that were already operating in Philadelphia. She said that the new website of the OHP and its connections with social media sites could possibly be used to get groups from outside of the CPG network to add programs to the list. T. Clark also suggested having David Acosta make an announcement at AACO about the list.

Old Business

None

New Business

After a few members of the Lit & Ed Committee noted that they might be unable to attend the June meeting, the group considered cancelling the meeting. However, they decided to make a decision on the matter after completing the first panel discussions so that the meeting could be used for further planning if necessary.

Announcements

None

Adjournment

The meeting was adjourned by general consensus at 1:50 pm.

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*March 24th, 2010*)
- Summary of Interventions for Review
- Interventions and Providers for Panels Spreadsheet
- Prevention Panel Discussion Points
- OHP Meeting Calendar

COMMUNITY PLANNING GROUP (CPG)

Literature & Education Committee

Wednesday, April 28th, 2010

12:00 - 2:00 pm

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

Call to Order/Introductions

Approval of Agenda

Approval of Minutes (*March 24th, 2010*)

Report of Staff

Report of Co-Chairs

Discussion Items:

- **Finish Review of Interventions**
- **Planning for Provider Panel Discussions**

Old Business

New Business

Review/Next Steps

Announcements

Adjournment

*The next meeting of the Lit & Ed Committee will be on **Wednesday, May 26th, 2010***

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

Please refer to the Office of HIV Planning's attached Calendar of Events or its website, www.hivphilly.org, for updated committee meeting information.

Please contact the office at least 5 days in advance if you require special assistance

**Community Planning Group
Literature & Education Committee
Meeting Minutes**

Wednesday, March 24th, 2010

12:00 - 2:00 pm

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: Wesley Anderson, Jennifer Chapman (Co-Chair), Terri Clark, Christopher Collins, Tyreef King, Alison Lin

Staff: Joseph Ellis, Mari Ross-Russell

Excused: Dawn M. Acero, Antonio Davis, Val Sowell

Absent: Arti Chhabria, Dionna Samuel, Roberta Waite

Call to Order

J. Chapman called the meeting to order at 12:19 pm.

Approval of Agenda

The group took a moment to review the meeting agenda. **Motion:** T. Clark moved and J. Chapman seconded to approve the document. **Motion Passed:** All in favor.

Approval of Minutes (*February 24th, 2010*)

The group spent some time reviewing a draft of the minutes from their December meeting. **Motion:** Afterwards, T. Clark moved and J. Chapman seconded to approve the draft of the minutes included in the handouts. **Motion Passed:** All in favor.

Report of Staff

• **Structural Interventions**

M. Ross-Russell told the group that they needed to decide what their next steps would be as they were about to complete the first pass of their interventions review. She felt that the next logical step in the committee's process would be to investigate structural interventions and any other programs that were not classified as DEBIs or EBIs. She said that, as a result, she had sent D. Acosta an email the day before in order to get a list and information on any such programs that were available. However, she said that she had not yet received a response. She also noted that, before the committee started reviewing structural interventions, they would need to devise a method for evaluating such programs since they were completely different from the behavioral interventions currently in review.

M. Ross-Russell also informed the committee that N. Johns had developed a presentation to explain the different types of interventions and their bases. She then asked the group whether or not they wanted to preview the presentation in their own committee meeting before it was shown to the full CPG. T. Clark felt that it would be unnecessary for the committee to preview the presentation before it was shown to the full CPG and the rest of

the group agreed. However, A. Lin pointed out that, if the committee was going to review structural interventions, the presentation should include any theories that supported such programs.

A. Lin pointed out that the responsibility for instituting structural interventions was largely on the Health Department and not CBOs, with the exception of a few programs such as Prevention Point. M. Ross-Russell replied that, while the Health Department would have to work out the details, the committee and the CPG would have to discuss and support structural interventions for them to be included in the prevention plan and the next prevention system. T. Clark recalled that a recently enacted program used text messages to disperse information on HIV prevention programs. She noted that the program could be considered a structural intervention and asked whether anyone knew how it was funded. A. Lin believed that a drug company had funded the program. M. Ross-Russell noted that Prevention Point was funded by the city and that AACO had oversight; however, she was unsure who had funded the texting program. T. Clark said that she would ask D. Acosta about the matter.

A. Lin noted that some structural interventions were so large that they had to be induced and supported by the government, using the addition of fluoride to drinking water as an example. M. Ross-Russell agreed but pointed out that the recent ubiquitous appearance of anti-bacterial hand cream in response to the H1N1 outbreak was also a structural intervention. The rest of the group agreed, noting that the hand cream could be found at all types of public locations.

A. Lin felt that the committee should approach structural interventions differently than the other programs they had already reviewed. She said that it would be difficult for the committee to develop a list of all structural interventions and so she proposed asking CBOs whether they were planning any such programs. The rest of the group agreed and decide to add the question to the panel discussions.

Report of Co-Chairs

None

Discussion Items:

• Finish Review of Interventions

3MV – APPROVED

- Targets a specific population?
HIV-negative or HIV-unknown serostatus black MSM.
- Targets a specific behavior?
Reduce unprotected insertive and receptive anal intercourse, reduce the number of sex partners, increase consistent condom use during anal intercourse, and increase testing for HIV and other STIs.
- Effectiveness?

Reduced unprotected anal intercourse with casual sex partners and reduced number of male sex partners

- Sound theoretical basis?
Social Cognitive Theory, Behavioral Skills Acquisition Model, Transtheoretical Model of Behavior Change, and Decisional Balance Model
- Norms, Values, Consumer Preferences?
Facilitated by African American MSM
- Intervention Feasibility?
Cost – 6, 2-3 hour sessions at a retreat.
Materials – minimal materials required, package is available
- Other considerations – T. Clark informed the group that 3MV was not always performed as a retreat, despite what was written in the summary. T. King stated that the program’s retreat design sometimes posed a challenge because participants could not always fully commit.
PCRS connection – “participants ... are encouraged to select and implement a relationship-focused risk-reduction behavior change option with their partner(s).”

T. King informed the group that he knew an individual who worked on 3MV and was willing to participate in the panel discussions.

Healthy Relationships – APPROVED

- Targets a specific population?
PLWH/A (men and women)
- Targets a specific behavior?
Reduce HIV-transmission risk behaviors
- Effectiveness?
Reduced unprotected anal or vaginal intercourse, fewer non-HIV+ sex partners, increased condom use, and increased refusal of unsafe sex
- Sound theoretical basis?
Social Cognitive Theory
- Norms, Values, Consumer Preferences?
Utilizes positive facilitators
- Intervention Feasibility?
Cost – Five 2-hour sessions, with 2 sessions delivered weekly for 2.5 weeks, delivered in a community AIDS service organization, One male and one female group facilitator (one being an HIV-positive peer counselor), gift card incentives
Materials – package available

- Other considerations – W. Anderson, whose organization runs Healthy Relationships, said that the program was successful. However, he noted that the part of the intervention that focused on teaching men to deal with disclosing their status was only effective for men who were newly infected, versus those who had lived with the disease for a while and had already learned about disclosure. Additionally, he said that Healthy Relationships helped women in dealing with domestic abuse issues.
PCRS connection – enhances decision-making skills for self-disclosing HIV-serostatus to sex partners, and develops strategies to maintain satisfying relationships while protecting both themselves and their partners.

Partnership for Health – APPROVED

- Targets a specific population?
HIV-positive patients in an HIV outpatient clinic
- Targets a specific behavior?
Improve patient/provider communication about prevention and eliminate or reduce unprotected anal or vaginal sex
- Effectiveness?
Those with more than 1 partner were significantly less likely to engage in sex, reduced unprotected sex
- Sound theoretical basis?
Message Framing Theory, Mutual Participation, and Stages of Changes
- Norms, Values, Consumer Preferences?
No specific language
- Intervention Feasibility?
Cost – uses existing clinical staff, 3- to 5-minute session at every clinic visit over 10 to 11 months
Materials – package is available
- Other considerations –could be considered a structural-level intervention as the entire clinic procedures were altered and all clinic patients received the intervention while only a sample of patients were included in the evaluation. low retention rates (see below)
PCRS connection – no specific language

M. Ross-Russell felt it was strange that a program had difficulty retaining clients when it was located in the offices where PLWHA received their primary care. W. Anderson reported that, when he had reviewed Partnership for Health in Atlanta, he had learned that the outreach had worked in a real-world setting but not in the test. J. Chapman agreed and added that, as an individual who regularly worked with clinical patients, she knew that it was difficult to retain them in care. She said that the lack of retention was usually

due to the chaotic lives of patients and not necessarily to whether or not they liked the staff. Furthermore, she said that many patients would simply not go to their doctors unless they were sick. W. Anderson agreed and noted that the locations and hours of operations of doctors' offices could also be inhibitive. J. Chapman suggested approving Partnership for Health and investigating the claim on the CDC website that the program would be updated in the "structural-level intervention section" of the website. The rest of the group agreed.

Nia: A Program of Purpose - REJECTED

- Targets a specific population?
Inner-city heterosexually active, African American men
- Targets a specific behavior?
Improve behavioral and communication skills, and eliminate or reduce sex risk behaviors
- Effectiveness?
Reduced unprotected vaginal sex and increased condom usage
- Sound theoretical basis?
Information-Motivation-Behavioral (IMB) Skills Model
- Norms, Values, Consumer Preferences?
No specific language
- Intervention Feasibility?
Cost – Two 3-hour sessions delivered over a week in community-based center that house multiple social services by two community-based prevention service providers (1 man and 1 woman)
Materials – package is being developed (as of 1994)
- Other considerations – failed to meet best-evidence because of small sample size
PCRS connection – No specific language

The group opted to reject Nia because it was similar to other programs but lacked an intervention package.

Brief Group Counseling – APPROVED

- Targets a specific population?
Asian and Pacific Islander MSM (only program specific to this population)
- Targets a specific behavior?
Increase positive ethnic and sexual identity, increase acknowledgement of HIV risk behaviors, enhance AIDS knowledge, attitudes towards safer sex, safe-sex negotiation skills, and eliminate or reduce sex risk behaviors

- Effectiveness?
Reduced number of sex partners and occasions of unprotected sex
- Sound theoretical basis?
Health Belief Model, Theory of Reasoned Action, and Social Cognitive Theory
- Norms, Values, Consumer Preferences?
Culturally specific
- Intervention Feasibility?
Cost – One 3-hour session in a community-based agency delivered by a highly trained, paid intervention coordinator and one community volunteer with 6 hours of training
Materials – package is available
- Other considerations – None
PCRS connection – No specific language

Responsible, Empowered, Aware, Living (REAL) Men – APPROVED w/ RES

- Targets a specific population?
African-American adolescent boys ages 11 to 14 and their fathers
- Targets a specific behavior?
Increase communication about sexuality between fathers and sons, promote delay of intercourse, and increase condom use among sexually-active adolescents
- Effectiveness?
Increased abstinence
- Sound theoretical basis?
Social Cognitive Theory
- Norms, Values, Consumer Preferences?
No specific language
- Intervention Feasibility?
Cost – Seven 2-hour sessions delivered over 7 consecutive weeks in Boys and Girls Clubs by facilitators (first 6 sessions are for fathers only to teach them how to communicate with their kids)
Materials – no package available
- Other considerations – This intervention did not meet best evidence criteria due to use of a one-tailed statistical test.
PCRS connection – No specific language

A. Lin pointed out that the article was published in 2007, noting that the intervention package might now be available. J. Chapman said that she had worked with Collen DiIorio in graduate school and offered to follow up with her on the matter.

As the committee was running out of meeting time, they opted to assign the last three programs as homework assignments. T. King offered to review Condom Promotion while A. Lin and T. Clark offered to review Teen Health and HIV Education and Testing respectively.

- **Planning for Provider Panel Discussions**

M. Ross-Russell directed the group's attention to the handout which grouped all of the city's funded organizations for the purpose of planning the provider panel discussions. She said that she was debating whether to plan for two discussions per CPG meeting with the hope that some providers would overlap on different types of interventions. She clarified that the length of each discussion would depend largely on how many questions the committee developed for the participants. She also noted that the list was only a draft and, as a result, many of the providers included might not be able or willing to participate in the process. In response to a question by W. Anderson, she said that the questions should inquire about whether the interventions worked.

A. Lin noted that there were only nineteen different interventions represented on the handout. She asked whether any other programs should be included in the discussions. M. Ross-Russell replied that the point of the panels was not to focus on individual programs but rather on types of programs and the populations they targeted.

J. Chapman suggested that the committee structure the panels by introducing the interventions, giving a general overview of the types of programs, and then letting the participants talk about their experiences. W. Anderson noted that, following the suggestion, the conversations would have the potential to be very long. He also said that the committee should try to keep the conversations neutral as some programs might have difficulties with recruitment or retention. T. King suggested placing a time limit on the discussions to keep them succinct. M. Ross-Russell agreed and added that, by developing the questions and sending them to participants ahead of time, they could keep discussions on track.

A. Lin suggested that the group focus on front-line staff workers and ask questions about challenges, adaptations, successes, and the uniqueness of programs. The rest of the group agreed and added implementation concerns, evaluations, targeted populations, and training as other topics for questions. A. Lin requested that providers complete their questions before the panel discussions so that the members of the Lit & Ed Committee could have hard copies of their answers. The group closed the discussion by deciding to hold the first panel in May so that they would have more time for planning.

Action Item:

- **Lit & Ed Co-Chair Election**

W. Anderson nominated T. Clark as the new Co-Chair for the Lit & Ed Committee. She accepted the nomination and the rest of the committee unanimously approved her for the position.

Old Business

None

New Business

None

Review/Next Steps

- The committee continued with their review of interventions, making decisions on the following programs: 3MV, Brief Group Counseling, Healthy Relationships, Partnerships for Health, Nia, Real Men.
- The group also started planning for the upcoming prevention provider panel discussions and developed some preliminary questions.
- Additionally, the group elected T. Clark as their new Co-Chair.

Announcements

None

Adjournment

The meeting was adjourned by general consensus at 2:06 pm.

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*February 24th, 2010*)
- Interventions and Providers for Panels Spreadsheet
- OHP Meeting Calendar

Intervention Name	Approval Status	CDC Designation	Intervention Type	Target Population (Risk)	Target Population (Gender, Race & Age)	Target Behavior	Efficacy	Theoretical Basis	Norms/Values	Feasibility	Greatest Impact for less \$	Local Relevance	Partner Linkage	Others	Literature Resources
CLEAR	Rejected	Best Evidence	ILI	IDU	HIV+, Male, Female, AA, Hisp, W	Yes	Yes	Cog. Beh, Social Action	Nothing specific listed	Expensive, Lic. Therapist, Clinical SW					
Female & Culturally-Specific Negotiation	Accepted	Best Evidence	ILI	IDU/DU	Female, AA	Yes Risk reduction	Yes	planned beh., reasoned actions, soc. Cog., trans-theoretical change	Gender-specific behaviors	20 to 40 min sessions	Inexpensive				
Modelo de Intervención Psicomédica MIP	Accepted with reservations	Best Evidence	ILI	IDU	Male, Female, Hisp	Yes Risk reduction		Motivational interviewing, stages of change	Yes Spanish speaking IDU	Questionable	Questionable				
Motivational Interviewing HIV & Partner Violence Risk Reduction (new 2009)	Accepted with reservations	Best Evidence	ILI	IDU	Female, AA, W, Hisp, AI	Risk Reduction	Yes less likely to have risky sexual contact 3 & 6 months	Motivational interviewing, stages of change	Gender-specific behaviors	12 sessions over 3 months (no packet)			none		
SHIELD	Accepted	Best Evidence	GLI	IDU	Male, Female, AA, Otr	Yes Risk reduction	Yes	Act. Learning, Cog. Consistency, Soc. Idt, Soc, Cog.,	Yes Peer networks, program buy in	Questionable	Questionable				
STRIVE (new 2008)	Accepted	Best Evidence	GLI	IDU /HCV	Male, Female, AA, Hisp, W,Otr	Yes	Yes	Cog. Beh, Social Learning	Yes	Yes, adaptation may be required	Greatest impact for dec. new infections				
Women's Co-Op	Accepted	Best Evidence	GLI	DU/Crack	Female, AA	Yes Risk reduction	Yes 77% retention rate	AA feminism, empowerment	Yes gender & culture specific	Yes, cost effective, training avail.	high retention rate over time				

Intervention Name	Approval Status	CDC Designation	Intervention Type	Target Population (Risk)	Target Population (Gender, Race & Age)	Target Behavior	Efficacy	Theoretical Basis	Norms/Values	Feasibility	Greatest Impact for less \$	Local Relevance	Partner Linkage	Others	Literature Resources
BRAINE	Accepted	Promising	ILI	IDU/ Heavy alcohol users	Male, Female, W, Otr	Reduce alcohol and injection	Unknown	Motivational interviewing		Yes, adaptable, cost effective, some training	2 ILI 97% retention	original population sample different than local pops			
Community Promise	Rejected w/ reservations	Promising	CLI	IDU/ CDC identified all pops	Male, Female, AA, Hisp, W, Otr	sexual risk reduction	Unknown	None provided	peer driven	Cost effective, materials available		program in use. Similar to "get real"			
DUIT	Rejected	Promising	GLI	IDU/ Hep c neg	HIV+, Male, Female, Trans, AA, Hisp, W, Otr	Risk Reduction	results reported questioned	soc. Learning, peer ed, mot & beh skills							
Intensive AIDS Education	Accepted	Promising	GLI	IDU/ incarcerated	Male, AA, Hisp, W	Yes, Risk reduction	Increased condom use	problem solving therapy	none provided	Adaptable, cost effective, training		suggested for youth			

Female Condom Skills Training (new 2009)	Accepted w/reservations	Best Evidence	GLI	Heterosexual	Female, AA, Hisp, API, W	increased condom use	increased condom use including female condoms	social learning theory		4, 2-2.5 hr sessions delivered over 6 weeks w/ 30 min follow-up telephone session					no materials package
Focus on the Future (new 2008)	Accepted	Best Evidence	ILI	Heterosexual/w/std	Male, AA	Risk reduction	less re-infections	IMB skills, lay health advisor	culture and gender specific	Adaptable, cost effective, training	large target pop	yes			
Health Improvement Project (HIP)	Accepted w/reservations	Best Evidence	GLI	Heterosexual	Male, Female, AA, W, Otr	increase knowledge reduce sexual risk	the number of partners, unsafe sex, improved	IMB	none noted	PhD level facilitators, clinical setting assoc w/ hospitals					Packet available through researcher
"Light"	Accepted	Best Evidence	GLI	Heterosexual	Male, Female, AA, H, Otr	skills building	less re-infections, risk reduction	Soc. Cog.	small gender specific groups	Cost effective		yes			
Motivational Interviewing HIV & Partner Violence Risk Reduction (new 2009)	Accepted W/reservations (see above)	Best Evidence	ILI	Heterosexual	Female, AA, Hisp, W, AI, Otr										
Project Connect	Accepted	Best Evidence	ILI/Couple	Heterosexual	Male, Female, AA, Hisp	Increase condom use-									
Project FIO	Accepted	Best Evidence	GLI	Heterosexual	Female, AA, Hisp, W, API	skills building, safer sex negotiation	sex risk reduction 79%	soc. Learning, risk reduction	culture and gender specific	Cost effective 6-2 hr sessions		yes, condom neg skills		PCRS - partners included in program	
Project S.A.F.E	Accepted w/reservations	Best Evidence	ILI	Heterosexual/w/std	Female, AA, Hisp	sexual risk / infection reduction	unknown	risk reduction	culture and gender specific	std clinician, 3 1hr sessions, small group		yes, condom neg skills			
Intervention Name	Approval Status	CDC Designation	Intervention Type	Target Population (Risk)	Target Population (Gender, Race & Age)	Target Behavior	Efficacy	Theoretical Basis	Norms/Values	Feasibility	Greatest Impact for less \$	Local Relevance	Partner Linkage	Others	Literature Resources
RESPECT : Brief Counseling	Accepted	Best Evidence	ILI	Heterosexual/w/std	Male, Female, AA, Hisp, W, Otr	sexual risk / infection reduction	less re-infections, risk reduction	Soc. Cog., Reasoned action	unknown	2-20 minute sessions					
RESPECT: Brief Counseling + Booster	Rejected	Best Evidence	ILI	Heterosexual/w/std	Male, Female, AA, Hisp, W, Otr	sexual risk / infection reduction	no change w/ booster			4-20 minute sessions plus extra at 6 mth.					
Safe in the City (new 2008)	Accepted	Best Evidence	ILI	Heterosexual	Male, Female, AA, W, Hisp, Otr	prevent new STDs	fewer STD re-infections	IMB, Soc. Cog. , Planned behavior		1 session video based	inexpensive conducted in STD clinic waiting room				
Sister- to -Sister : One-on-one or Group Skills-building	Accepted w/reservations	Best Evidence	ILI	Heterosexual	Female, AA	prevent new STDs, risk reduction	no significant effect at 6 months.	Soc. Cog.		nurses w/ 10yrs exp conducted intervention	1-200 minute session for group, 1-20 min session ind.				

Safer Sex Skills Building - SSSB (New 2009)	Accepted	Promising	GLI	Heterosexual	Female, AA, W, Hisp, Otr	increased condom use, safer sex behaviors	reduced unprotected vaginal & anal sex		female counselors	5, 90-min sessions over a 3 week period delivered in meth maintenance CBO		materials available			
Salud, Educacion, Prevencion y Autocuidado (SEPA)		Promising	GLI	Heterosexual	Female, Hisp	Risk reduction	After 2 follow-ups, participants were significantly more likely to report consistent condom use	social cog. theory	Bilingual and bicultural Latinas	Six weekly sessions	negotiating safer sex with partners, and problem solving	package is currently being developed			
CRCS	Accepted (see above)	Local	ILI	Heterosexual	All pops										
Prison Case Management		Local		Heterosexual HIV+											
Protect & Respect		Local	GLI	Heterosexual	Women										
TEACH	Accepted (see above)	Local	GLI	Heterosexual	All HIV+ populations										
TEACH Outside	Accepted (see above)	Local	GLI	Heterosexual	All HIV+ populations										
TEACH Spanish	Accepted (see above)	Local	GLI	Heterosexual	All HIV+ Hisp populations										
Intervention Name	Approval Status	CDC Designation	Intervention Type	Target Population (Risk)	Target Population (Gender, Race & Age)	Target Behavior	Efficacy	Theoretical Basis	Norms/Values	Feasibility	Greatest Impact for less \$	Local Relevance	Partner Linkage	Others	Literature Resources
Brief Group Counseling	Approved	Best Evidence	GLI	MSM	Male, API	Increase positive ethnic and sexual identity, safer sex practices	reduced number of partners & unprotected sex	Health belief model, theory of reasoned action, and social cog. theory	culturally specific	1, 3-hr session in CBO				Materials available	
CLEAR	Rejected (see above)	Best Evidence	ILI	MSM	HIV+, Male, AA, Hisp, W										
EXPLORE	Accepted w/ reservations	Best Evidence	ILI	MSM	Male, AA, Hisp, W, Otr	prevent acquisition of HIV	85% retention, hive reduction not statistically significant	IMB, motivational enhancement, soc. Learning		not recommended to be used in present form by researchers			PCRS-connection but excluded people in monogamous relationships		
Healthy Living Project	Accepted	Best Evidence	ILI	MSM	HIV+, Male, AA, Hisp, W, Otr	Improve health and mental wellness	Sex risk reduction	Social Action	peer lead	Adaptable, 15-90 min. sessions, materials			yes, sexual risk reduction		

Healthy Relationships	Accepted	Best Evidence	GLI	MSM	HIV+, Male, Trans, AA, W, Otr	Reduced unprotected anal (and or vaginal) casual sex partners	Sex risk reduction	Social cognitive theory	Positive facilitators	Cost- 5,2 hour sessions delivered weekly, gift cards	Delivered at CBO or ASO	PCRS connection	Materials available
Many Men Many Voices	Accepted	Best Evidence	GLI	MSM	AA, Male	Reduced unprotected anal intercourse with casual sex partners	73% retained at 3 months, 77% at 6 months	Social cognitive theory, Behavioral skills acquisition model, Transtheoretical model of behavior change	Two trained black MSM peer co-facilitators	Cost 6, 2 to 3 hour session retreat. (not always provided as retreat)		PCRS connection	Materials available
Personalized Cognitive Risk-reduction Counseling	Accepted	Best Evidence	ILI	MSM	Male, AA, Hisp, W, Api, Otr	reduction in unprotected sex	reduction in unprotected anal sex	Gold's model of on-line vs. off-line self appraisal of risk behavior and relapse prevention		counselor was lice. Mental health professional, no materials, 1-1 hour session		sex diary optional-no great significance	
Positive Choice: Video Doctor	Accepted w/ reservations (see below)	Best Evidence	ILI	MSM	HIV+, Male, AA, Hisp, W, Otr								
SUMIT enhanced peer-led	Rejected	Best Evidence	GLI	MSM	HIV+, Male, AA, Hisp, W, API, Otr		Lead researcher recommends using other proven int.						
Community Promise (new 2008)	Rejected w/ reservations (see above)	Promising	CLI	MSM	Male, AA, W, Hisp, Otr								
Mpowerment (new 2008)	Accepted	Promising	CLI	MSM 18 to 29	Male, AA, W, Hisp, API, Otr	sexual risk reduction		Diffusion of innovation	peer lead cultural and gender specific	fairly inexpensive		condom skills building	Could be considered a structural intervention-entire clinic procedure altered
Partnership for Health (loss-frame)	Accepted	Promising	ILI	MSM	HIV+, Male, AA, W, Hisp, Otr	reduction in unprotected sex	those with < 1 partner were less likely to engage in unprotected sex	Message framing, Stages of Change, Mutual Participation		Uses clinical staff, 3-5 minute session every clinic visit over 10-11 months			
Popular Opinion Leader (new 2008)	Accepted w/ reservations	Promising	CLI	MSM	Male, AA, W, Hisp,	sexual risk reduction	reduced unprotected anal intercourse, increased condom use, decreased number of partners	Diffusion of innovation	peer education model, social networking	fairly inexpensive		provided locally	materials package available-implementation concerns noted

Intervention Name	Approval Status	CDC Designation	Intervention Type	Target Population (Risk)	Target Population (Gender, Race & Age)	Target Behavior	Efficacy	Theoretical Basis	Norms/Values	Feasibility	Greatest Impact for less \$	Local Relevance	Partner Linkage	Others	Literature Resources
TLC	See youth section	Promising	GLI	MSM	HIV+, Male, AA, W, Hisp, Otr										
CRCS	Accepted (see above)	Local		MSM	All populations										
Prison Case Management		Local		MSM											
TEACH	Accepted (see above)	Local	GLI	MSM	All HIV+ populations										
TEACH Outside	Accepted (see above)	Local	GLI	MSM	All HIV+ populations										
TEACH Spanish	Accepted (see above)	Local	GLI	MSM	All HIV+ populations										
BART	Accepted	Best Evidence	GLI	High Risk Youth	Male, Female, AA	Risk reduction	Good outcomes sexual risk reduction	Information Motivation Behavior		materials available		currently used in Phila with young msm & heterosexual	pcrs connection-program encourages info sharing	Conducted nationally well reviewed	
Be Proud! Be Responsible		Best Evidence	GLI	High Risk Youth	Male, AA	Risk reduction	sexual risk reduction	Soc. Cog. Reasoned action	tailored to be cultural and gender specific	Adaptable, cost effective		already in use	yes condom negotiation		
CLEAR	Rejected (see above)	Best Evidence	ILI	High Risk Youth	Female, AA, Hisp, W										
¡CUÍDATE! (Take Care of Yourself)	Accepted	Best Evidence	GLI	High Risk Youth	Male, Female, Hisp	sexual risk reduction	Good outcomes sexual risk reduction	Soc. Cog. Reasoned action, planned behavior	tailored to be culturally and linguistically specific	6-60 min. session on weekends, materials available		adaptation of be proud be responsible conducted in Phila	yes condom negotiation		
Focus on Youth FOY +ImPact	Accepted	Best Evidence	GLI	High Risk Youth	Male, Female, AA	reduction-sub. Abuse, sexual risk		protection motivation	parents and guardians are involved	9-1 1/2 hour sessions, materials		worked in Baltimore			
HORIZONS (new 2009)	Accepted w/ reservations	Best Evidence	GLI	High Risk Youth	Female, AA	sexual risk reduction	reduced STDs, increased condom use	Soc. Cog., Gender Power	Delivered by AA female health educator	2, 4-hr. group sessions, followed by 4 (15 min) telephone contacts every 2.5 months for 9 mon.		showed increased communication between male & female sex partners	materials package available		

SiHLE	Accepted	Best Evidence	GLI	High Risk Youth	Female, AA	reduction- sexual risk, STDs, pregnancy	reduced partners, STDs	Soc. Cog., Gender Power	tailored to be cultural and gender specific	4-4 hr sessions materials in development		PCRS connection	pregnancy reduction not sustained at 12 months
Sisters Saving Sisters	Accepted w/ reservations	Best Evidence	GLI	High Risk Youth	Female, AA, Hisp	sexual risk reduction	high retention rates	Soc. Cog. Reasoned action	tailored to be cultural and gender specific	1-250 min session, no training packet avail.		developed in Phila, not funded here	yes condom negotiation
STD/AIDS Risk Reduction Trial (START)	Accepted	Best Evidence	ILI	Heterosexual/ incarcerated soon to be released	Male, AA, Hisp, W, Otr	HIV, STD, HEP risk reduction	Sexual risk reduction post release no idu comparison conducted			2 session before and 4 session after release		at risk partner counseling	Package being developed

Intervention Name	Approval Status	CDC Designation	Intervention Type	Target Population (Risk)	Target Population (Gender, Race & Age)	Target Behavior	Efficacy	Theoretical Basis	Norms/Values	Feasibility	Greatest Impact for less \$	Local Relevance	Partner Linkage	Others	Literature Resources
ARK	Accepted w/ reservations	Promising	GLI	High Risk Youth	Male, Female, AA, Hisp, AI, W	increase abstinence and safer sex behaviors	reduced unprotected sex	Information Motivation Behavior	designed for drug facility inpatient use	12, 90 min sessions delivered over 28 days, co- facilitated by male and female psychologists				no materials package available	
Community Promise (new 2008)	Rejected w/ reservations (see above)	Promising	CLI	High Risk Youth	Male, Female, AA, Hisp, W, Otr										
Intensive AIDS Education	Accepted	Promising	GLI	High Risk Youth	Male, AA, Hisp, W		3 mon., participants were less likely to report unprotected vaginal or anal sex			4-7 hours of sessions before and after release from prison over a period of 14 weeks				Package being developed	
REAL Men (new 2008)	Accepted w/ reservations	Promising	GLI	High Risk Youth	Male, AA	promote delay of intercourse, increase condom use among sexually active teens	increased abstinence	social cognitive theory	Increased father & son communication around sexuality	7, 2 hr sessions over 7 weeks delivered at boys & girls clubs. 1st 6 sessions are w/ fathers only.				no materials package available	
Safer Sex	Rejected	Promising	ILI	High Risk Youth	Female, AA, Hisp, W, Otr										
Street Smart	Accepted	Promising	GLI	High Risk Youth, run always	Male, Female, AA, Hisp, Otr	sexual and drug use risk reduction	risk reduction	soc. Learning		10 small group sessions over 3 week period				large homeless youth population	

TEACH Outside	Accepted (see above)	Local	GLI	HIV+	All HIV+ populations
TEACH Spanish	Accepted (see above)	Local	GLI	HIV+	All HIV+ populations

CPG Meeting	Intervention	Agency	
05/26/10 3:00	3MV	GALAEI (Elicia Gonzales)	Panel by Population: Men who have Sex with Men
	3MV	MAZZONI (Trishia Dressel)	
	MPOWERMENT	THE ATTIC (Jay Grant)	
	HEALTHY RELATIONSHIPS	MAZZONI	
	HEALTHY RELATIONSHIPS	PA School for the Deaf (Gail Bober)	
5/26/2010 3:30	CRCS	THE ATTIC	Panel by Intervention type: CRCS
	CRCS	GALAEI	
	CRCS	MAZZONI	
6/23/2010 3:00	CRCS	ACTIONAIDS (Theresa Clarck)	Panel by Intervention Type: CRCS
	CRCS	CHOP R (James Vagnoni)	
	CRCS	CHOP V (James Vagnoni)	
	CRCS	CONGRESO (Lorett Matus)	
	CRCS	DREXEL ST. CHRIS (Theresa Parrino)	
6/23/2010 3:30	BE PROUD	ACTIONAIDS	Panel by Population: Youth
	Protocol Based Counseling	CHOP Adolescent (Chris Ambrose)	
	Teens Linked to Care	DREXEL ST. CHRIS	
7/28/2010 3:00	SAFETY COUNTS	BEBASHI (Najia Luqman)	Panel by Population: Drug User
	SAFETY COUNTS	FIGHT (
	SAFETY COUNTS	ODAAT	
	SAFETY COUNTS	PREVENTION PT (Silvana Mazzela)	
	SAFETY COUNTS TIP	PREVENTION PT	
7/28/2010 3:30	CRCS	BEBASHI	Panel by Intervention Type: CRCS
	CRCS	PREVENTION PT	
7/28/2010 3:30	TEACH	FIGHT (Juliet Fink)	Local Intervention
	TEACH OUTSIDE	FIGHT	
8/25/2010 3:00	BART	URBAN SOLUTIONS (Yvone Jones)	Panel/s by Population Type: Youth
	BART	YOACAP (Duerward Beale)	
	BE PROUD	PA School for the Deaf	
	BE PROUD	VISION for Equality (Emilio Pacheco)	
	PALMS	PHMC (Akil Pierre)	
	SUPPORT GROUP	YOACAP	
	VOICES	CONGRESO	
	VOICES	FIGHT YHEP (Katie Dumphy)	
9/22/2010 3:00	COMMUNITY PROMISE	COLOURS (Michael Hinson)	Panel by Intervention Type: Community Level Intervention -
	COMMUNITY PROMISE	FPC SAFEGUARDS (Brian Green)	
	COMMUNITY PROMISE	GALAEI	
	RAPP	Family Planning Council Circle of Care (Alicia Beatty)	
9/22/2010 3:30	PROJECT RESPECT	Family Planning Council Health Resource Centers (Tristan Ruby)	Panel by Intervention Type: Heterosexual
	PROJECT RESPECT	PA School for the Deaf	
	SISTA	Family Planning Council Circle of Care	
9/22/2010 3:30	PROTECT AND RESPECT	DREXEL Partnership Practice (Angela Yap)	Local Intervention

Prevention Panel Discussion Points*

Population

What is the population that this intervention serves?

- Is this intervention population specific?

Adaptability

In your opinion is this an intervention that is easy/difficult to adapt for other populations?

- Would the core elements work with other populations?
- Would the cultural components work with other populations?

Successes

What in your opinion makes this a successful intervention?

- Why is this intervention successful with the target population?
- Is this intervention successful from an implementation perspective?
- Is it sustainable over time (e.g. funding to provide the service, staffing, is it a cost effective intervention)?
- Are the goals and objectives achievable?

Challenges

What in your opinion are some of the challenges you encountered with this intervention?

- Did the intervention pose a problem for the target population (e.g. too many sessions, not enough sessions, behavior was not sustainable over time, etc.)?
- Did you encounter difficulty during implementation of the intervention?
- Did you have challenges with achieving the intervention goals and objectives?

Technical

Were there any technical issues that arose with respect to this intervention?

- Training
- Technical Assistance
- Did this intervention have an evaluation process?
 - If yes, please provide a description of the process
 - If no, did your organization develop a mechanism to evaluate the service/s provided?
- Is there an intervention materials packet available?

What would you share with another organization contemplating implementing this intervention?

***Please answer the questions and send or bring your responses to the Office of HIV Planning, 340 North 12th Street, Suite 203, Philadelphia, Pa 19107 Attn: Lit & Education**