

CHICAGO: 2007–2009



COMPREHENSIVE HIV PREVENTION PLAN



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June 2006

Dear Friends,

On behalf of the HIV Prevention Planning Group (HPPG) and the Chicago Department of Public Health (CDPH), we are pleased to release the 2007–2009 *Chicago Comprehensive HIV Prevention Plan*. This evolving and informative document was developed by the HPPG in partnership with CDPH. Guided by the Centers for Disease Control and Prevention (CDC), Chicago's prevention planning process began in early 1994. Since that time, community planning has become more effective and efficient in responding to the changing HIV/AIDS epidemic in Chicago. The HPPG and CDPH have successfully developed and maintained a strong working relationship and are recognized for their innovative and collaborative efforts.

Creating this plan is one of the primary milestones in the work of community planners in Chicago. It represents many months of research, analysis and prioritizing on the part of both HPPG members and CDPH staff. This plan represents continuous improvement in the quality of the community planning process. The gap analysis was more extensive with more data sources. For the first time, research was prioritized to explore co-factors to HIV infection. This plan also names more specific priority populations than previous plans. Furthermore, both HIV Counseling and Testing and Partner Counseling and Referral appear as prioritized interventions. We invite you to explore these differences in more depth by reading the plan.

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

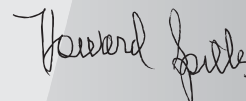
Sincerely,



Alicia Bunton
Community Co-Chair



Christopher Brown
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Howard Spiller
Community Co-Chair Elect

CHICAGO: 2007–2009



COMPREHENSIVE HIV PREVENTION PLAN

Developed by the
Chicago HIV Prevention Planning Group

In partnership with the
Chicago Department of Public Health,
Division of STD/HIV/AIDS Public Policy
and Programs

Prepared by the
CDPH HIV Prevention Team

In conjunction with the following CDPH offices:
Office of Substance Abuse Programs
Office of HIV/AIDS Surveillance and Research
Office of LGBT Health
Hepatitis Program Office

Acknowledgements

“The Plan” is the result of many hours of hard work and dedication on the part of many individuals. We would like to gratefully acknowledge all past and present HPPG members and CDPH staff that worked to create this plan and the plans that precede it. Their intense commitment, passion, expertise and participation in the HIV prevention community planning will be remembered for years to come. We would also like to specifically thank Hiari Imara, CDC Project Officer for Chicago; Tracey Hardy, former CDC Project Officer for Chicago; Terry Mason, M.D., F.A.C.S., CDPH Commissioner; and John Wilhelm, M.D., MPH, former CDPH Commissioner, for their support.

This plan is dedicated to the memory of the following members and friends:

Robert Ames

Charles Clifton

Thom Dombkowski

Grace Young Hynes

Jonathon McClure

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List of Commonly Used Acronyms In the Comprehensive Plan

ACRONYM	MEANING
AA	African-American
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community Based Organization
CBTTA	Capacity Building, Training and Technical Assistance
CDPH	Chicago Department of Public Health
CHIP	Context of HIV Infection Project
CPG	Community Planning Group
CPS	Chicago Public Schools
DEBI	Diffusion of Effective Behavioral Interventions
DFS	Dried Fluid Spots
GLI	Group Level Intervention
H	Hispanic
HAV, HBV, HCV	Hepatitis A/B/C Virus
HATU	HIV/AIDS Training Unit
HARS	HIV/AIDS Reporting System
HERR	Health Education/Risk Reduction
HIV	Human Immunodeficiency Virus
HIVCT	HIV Counseling and Testing
HPPG	HIV Prevention Planning Group
HRH	High-Risk Heterosexuals
HRSA	Health Resources Services Administration
IDU	Injection Drug Users
ILI	Individual Level Intervention
MMP	Medical Monitoring Project
MSM	Men who have Sex with Men
NHBS	National HIV Behavioral Surveillance
NIH	National Institutes for Health
NIR	Non-Identified Risk
N/SEP	Needle/Syringe Exchange Program
OHAS	Office of HIV/AIDS Surveillance
PCM	Prevention Case Management
PCRS	Partner Counseling and Referral Services
PEMS	Program Evaluation and Monitoring System
PLWH/A	People Living with HIV/AIDS
PN	Partner Notification
RFP	Request For Proposals
SAMHSA	Substance Abuse and Mental Health Services Administration
SETF	Syphilis Elimination Task Force
SPInS	Special Projects of Innovative Significance
STARHS	Serological Testing Algorithm for Recent HIV Seroconversion
STD	Sexually Transmitted Disease
VARHS	Variant, Atypical and Resistant HIV Surveillance
W	White

We Have a Plan. Do You?

Preventing the spread of HIV is our goal. This document describes how Chicago plans to achieve this goal.

The following nine chapters describe the steps involved with any successful HIV prevention initiative. These steps are especially relevant for the community planning process. The HIV Prevention Planning Group (HPPG), which submits recommendations to the Chicago Department of Public Health (CDPH) on how to stem the spread of HIV in Chicago, uses these steps continuously. These nine components also represent steps that CDPH follows to successfully implement HIV prevention activities in Chicago. Most importantly, these are the steps any service provider should follow to ensure the most comprehensive HIV prevention programs in our communities.

THE STEPS ARE:

- **Discover**
- **Prioritize**
- **Assess**
- **Recommend**
- **Implement**
- **Evaluate**
- **Assist & Improve**
- **Link & Coordinate**
- **Monitor & Research**

Every project starts with knowing the community. Such knowledge can come from formal surveillance and evaluation, but it also can come from simply living life. “Discover” describes the sources of information that the HPPG used for its 2005 priority-setting process. These include information from surveillance data, a resource inventory and social barriers analysis, community presentations, relevant scientific papers, the expertise of CDPH staff and HPPG members’ personal experiences and professional expertise.

“Prioritize” describes how the HPPG used the information gathered in discovery to set the HIV prevention priorities. Setting priorities provides an answer to the question, “Which populations and geographic areas should Chicago focus on in order to have the most impact on the HIV epidemic?” The crucial need to answer this question guided the HPPG in 2005 and continues to shape conversations at HPPG meetings today.

We Have a Plan. Do You?

The next two chapters, “Assess” and “Recommend” include the Gap Analysis and Finishing Committee processes for 2005. The Gap Analysis Committee assessed the current state of HIV prevention in Chicago in order to determine whether gaps exist in various communities. The Finishing Committee recommendations complete the process of the 2005 priority-setting process, based on information from the previous three steps. There are sixteen final recommendations, which were approved by the HPPG in November 2005.

“Implement” briefly outlines how the recommendations become reality. There are four primary ways for this to happen. One way is for agencies to apply for and receive funding to implement programs that are based on the sixteen recommendations. When CDPH releases a Request for Proposals (RFP), agencies compete for funds dispersed by CDPH. The quality of those proposals determines which agencies receive funding and how much funding they receive. A second way to implement the recommendations involves working with the structural components of large-scale entities, such as governments or businesses, to alleviate barriers, simplify processes or improve quality. Third, CDPH incorporates these recommendations internally especially with regard to HIV Counseling and Testing (HIVCT), Partner Counseling and Referral Services (PCRS) and outreach activities. Fourth, non-funded CBOs will ideally tie their work to the recommendations in the comprehensive plan regardless of their funding sources.

The next three chapters, “Evaluate,” “Assist & Improve” and “Link & Coordinate” provide an overview of how projects led by CDPH either contribute to Community Planning or to HIV prevention efforts in Chicago, or both. These steps also describe why evaluation, capacity building, technical assistance and the ability to link and coordinate programs, are important to building effective HIV prevention programs.

Finally, the *2007–2009 Comprehensive HIV Prevention Plan* comes full circle with “Monitor & Research.” Successful research increases the options for effective programming by determining what does and does not work. A successful surveillance program monitors the state of HIV and AIDS in Chicago and helps to determine whether prevention programming makes a difference. Information from both contributes to the discovery components of all future priority-setting processes.

To achieve the goal of preventing the spread of HIV, all steps must run simultaneously, and all must be strong in order to contribute to a successful community plan. The steps are also relevant to how CDPH and community agencies function in our city. Armed with a complete portfolio of successful programs, projects and activities, Chicago is prepared to prevent the spread of HIV.

Discover

[IN THIS SECTION]

- Surveillance Data
- Resource Inventory and Social Barriers Analysis
- Presentations and Literature Reviews
- Professional Expertise
- Personal Experience
- Important Models

[COMMUNITY PLANNING]

HIV prevention needs outweigh the resources available to address them. Because of this, community planning groups depend heavily on multiple data sources to better understand the current state of the HIV epidemic. Data sources range from highly quantitative sources like HIV surveillance data to qualitative sources like personal and professional experiences.

[CDPH]

CDPH relies on data to help guide the implementation of recommendations set by the HPPG. CDPH explores the most efficient and effective ways to make the HPPG's recommendations a reality.

[SERVICE PROVIDERS]

Service providers should always be on the lookout for additional sources of information that can help them better design, implement and evaluate their programming. In order to optimize the opportunities for HIV prevention in Chicago, we all must stay in this state of discovery.

Fundamental to any planning process is the accumulation and analysis of data. Data sources come in many different forms, but all are necessary and useful in the planning process. This chapter highlights the sources of data that HPPG used in the 2005 priority-setting process.

SURVEILLANCE DATA

The most fundamental source of information for HIV prevention planning is HIV and AIDS surveillance data. Surveillance is a core public health function. It is the ongoing, systematic collection, analysis and interpretation of data essential for the planning, implementation and

evaluation of public health practices. Analysis of surveillance data can reveal shifts in the epidemic, or it can point us toward optimum intervention strategies. Coupled with systematic scientific investigation, otherwise known as research, surveillance is an important tool for planning groups, health departments and service providers.

RESOURCE INVENTORY AND SOCIAL BARRIERS ANALYSIS

Within HPPG, one formal process for information discovery is a needs assessment—a process for identifying barriers to reaching high-risk populations. In order to complete their 2005 needs assessment, the HPPG used data from a resource inventory and social barriers analysis. Together these analyses form a key element of HIV prevention community planning. Not only are the needs assessment findings used to set priorities, but the information is also used to educate the community about the state of HIV prevention in Chicago.

Each priority-setting year, the Needs Assessment Committee sends out a resource inventory survey to all HIV prevention service providers in Chicago. The results of this survey provide information on the number and type of HIV services and interventions in Chicago.

The 2005 priority-setting year represented the first year that HPPG looked at social barriers in relation to HIV prevention needs. The Gap Analysis Committee collected many data sources on topics such as transportation access by zip code and drug arrests by community area [see Appendix A for a complete list of data sources].

PRESENTATIONS AND LITERATURE REVIEWS

In 2004 and 2005, the Communications, Membership and Technical Assistance Committee was responsible for inviting community presenters to HPPG meetings. The presentations educated members about various issues surrounding HIV, from how legislation affects the work we do to in-depth presentations on intravenous drug users (IDUs) in Chicago. These presentations allow for a wide forum to disseminate and discuss relevant issues surrounding HIV.

PROFESSIONAL EXPERTISE

Many professional experts assist the planning process. Whether this expertise comes from an epidemiologist at CDPH, or whether it comes from a sociology PhD student member of the HPPG, many members brought specific expertise to the discussions. Without these expert contributions, HIV prevention planning would not be as comprehensive as it is.

PERSONAL EXPERIENCE

Each priority-setting year the HPPG gets stronger at basing decisions on data sources and research. This planning process was no exception. However, HPPG

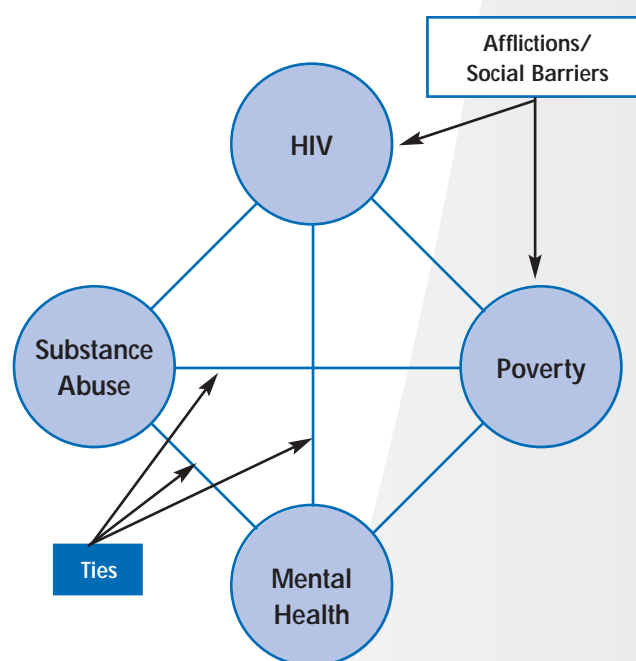
members are also selected based on the personal experiences and expertise they can bring to the planning process. This is particularly true in areas where there is a lack of data, for example in high-risk populations that are not captured through surveillance data.

IMPORTANT MODELS

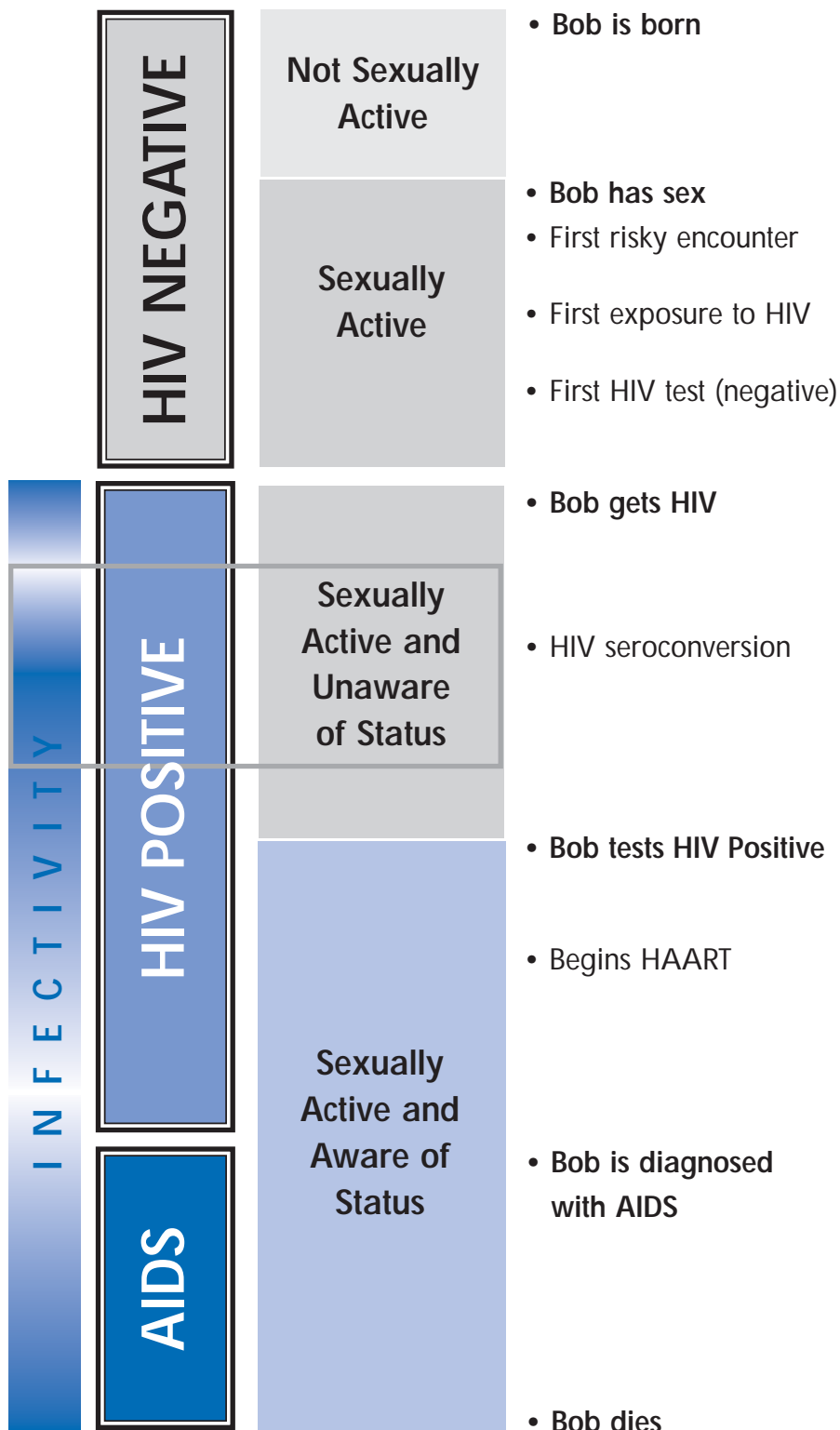
Syndemics

According to CDC, a syndemic is a heightened form of an epidemic. A syndemic describes a situation in which two or more afflictions, like HIV risk and substance use, interact to produce a burden on a population that is greater than the sum of those afflictions. In order to address any one individually, one must understand how they are bound together.

The idea of syndemics is significant because it expands the boundaries of public health activity. Organizing resources to address a syndemic must involve the science of epidemiology with the action and agenda of community leaders. Together this yields a framework that can guide initiatives of greater size and complexity than ever before. For more information on syndemics visit www.cdc.gov/syndemics/overview-definition.htm.



[BOB'S LIFE] HIV INFECTIVITY



This model, called "Bob's Life," displays the key milestones and disease stages in the life of a fictional character named Bob. The key milestones include birth, first sexual experience, getting HIV, testing positive for HIV, progressing to AIDS and eventually dying. The top bar indicates Bob's infectivity. Bob has a greater chance of passing on the disease when his viral load is at its highest levels. Bob's infectivity is higher as the bar gets darker.

This model reveals that the most infectious period in Bob's life is also the period before he knew of his positive status. Bob may be engaging in high levels of risky sexual activity during the time after his point of infection but before his positive test result. This model was used to form recommendation #3 in "Recommend" on pg 27.

Prioritize

[IN THIS SECTION]

- Overview of the Process
- Populations
- Interventions
- Special Projects

[COMMUNITY PLANNING]

CPGs understand that there are limited resources available to fund HIV prevention services. CPGs therefore face the difficult challenge of prioritizing populations and communities in need of HIV prevention services. This step is essential to determine where limited resources should go in a community to make the strongest impact on the spread of HIV in Chicago.

[CDPH]

CDPH uses the information from this step to make improvements to its internal units, including the Capacity Building, Training and Technical Assistance Unit; the Evaluation Unit; and other units that provide direct services to the community like HIV Primary Care, HIVCT and PCRS.

[SERVICE PROVIDERS]

While the populations prioritized by HPPG do not represent an exhaustive list of all communities affected by HIV in Chicago, service providers can use these priorities to guide their work toward answering the question, "Where is my effort best spent to produce the largest affect on the spread of HIV in Chicago?"

As the HIV/AIDS epidemic approaches its third decade as one of the world's foremost public health concerns, developing innovative HIV prevention programming is more important than ever. In the United States, prevention programs work in an environment of diminishing resources, increased accountability and ever-advancing technological and behavioral interventions. In addition, data collection currently allows us to know more about the epidemic than we ever have before.

Planning groups, health departments and service providers

must all strategically plan for the efficient and effective use and distribution of limited prevention resources.

The Chicago HPPG does this by engaging in a process to set priorities every three years. These priorities represent guidelines that CDPH will follow in order to have the greatest impact on the city's HIV epidemic. To set their priorities in 2005, HPPG considered three areas:

- Populations
- Interventions
- Gap Analysis

When HPPG analyzes populations it examines individual groups who are most affected by HIV in a certain geographic area. When HPPG analyzes interventions it identifies methods to effectively reach those populations in order to interrupt the spread of HIV from person to person. Finally, HPPG performs

Prioritize

a gap analysis by assessing the HIV prevention needs of particular populations and areas and creates an inventory of existing resources serving those populations and areas. Ultimately, a Gap Analysis identifies met and unmet needs of a population, that is, a gap exists when a prevention need is not met.

OVERVIEW OF THE PROCESS

In 2005, the HPPG examined those key areas mentioned above. To organize these efforts, the HPPG divided into four committees:

- Populations/Interventions;
- Special Projects;
- Gap Analysis; and
- Finishing Committee.

The Populations/Interventions Committee had the following three tasks:

- Identify specific high-risk population groups, including both high-risk HIV-negative individuals (including those with an unknown status) and high-risk HIV-positive individuals;
- Identify science-based interventions that are most effective at reducing HIV transmission among high-risk HIV-negative and HIV-positive population groups; and
- Identify geographic areas with the highest number of new HIV cases.

The Special Projects Committee's primary task was to identify projects to supplement HIV prevention programs.

The projects fell into the following three categories:

- Special Concerns Populations Projects;
- Special Initiatives; and
- Structural Interventions.

The Gap Analysis Committee assessed the needs of Chicago communities by performing a resource inventory and a social barriers inventory. Using data from these inventories the committee determined where gaps exist in Chicago, and, ultimately, recommended a course of action to fill these gaps.

The Finishing Committee reviewed findings and recommendations from the other three committees throughout the year. The co-chairs from each of the four committees presented their findings to the full HPPG to give every member the opportunity to understand and, ultimately, to own the HPPG's final recommendations.

The 2005 priority-setting process differed from models used by HPPG in prior years. The following reasons led to this change.

Population Data

In the 2005 process, the Populations/Interventions Committee considered only epidemiological data in their process, rather than combining the epidemiological data with co-factor data. This allowed the committee to focus on the geographic areas and populations most impacted by the epidemic. Data on co-factors, like substance abuse and mental health, which may contribute to the HIV epidemic, were used in the Gap Analysis process to completely analyze the social barriers to receiving HIV prevention services.

New CDC Guidelines

In 2003, CDC released the *Advancing HIV Prevention* (AHP) initiative. The AHP revised the guidelines for setting HIV prevention priorities. Briefly, two highlights included: 1) requiring that people living with HIV/AIDS (PLWH/A) be the highest priority population; and 2) no longer requiring community planning groups to prioritize interventions.

Data Availability

HIV data and AIDS data were handled as two distinct data sets. AIDS data has been collected since the disease was identified in 1981, while HIV data collection did not begin until 1999. The 2005 priority-setting process represents the first year that HPPG was able to exclusively use HIV data for priority setting. Prior to 2005, HIV data were too new to analyze properly. This allowed the Populations/Interventions Committee to examine the characteristics of newly diagnosed individuals. Ultimately, this allowed the HPPG to develop priorities that most accurately reflect the Chicago epidemic in 2005.

POPULATIONS

The Populations/Interventions Committee concentrated on four basic questions:

- Who are those most at risk for acquiring HIV infection?
- Who are those most at risk for transmitting HIV?
- What interventions are most effective at reducing these individuals' risk for acquiring/transmitting HIV?
- Where are cases of new HIV diagnoses occurring in the City?

To begin answering these questions, the CDPH Office of HIV/AIDS Surveillance (OHAS) worked closely with the committee to ensure that all mem-

bers understood the epidemiological data. With the help of OHAS, the committee reviewed both HIV and AIDS data to understand the **incidence** and **prevalence** of HIV and AIDS in Chicago. Incidence is the rate of new cases of HIV being diagnosed over a specified period of time. Prevalence is the percentage of a population that is affected with a particular disease at a specific point in time. The committee also examined data on sexually transmitted diseases (STDs), data from the National HIV Behavioral Surveillance system and data on late HIV testers (see "Monitor and Research" for more information).

High-Risk Negatives

In order to discover "Who are those most at risk for acquiring HIV?" the committee displayed HIV incidence by:

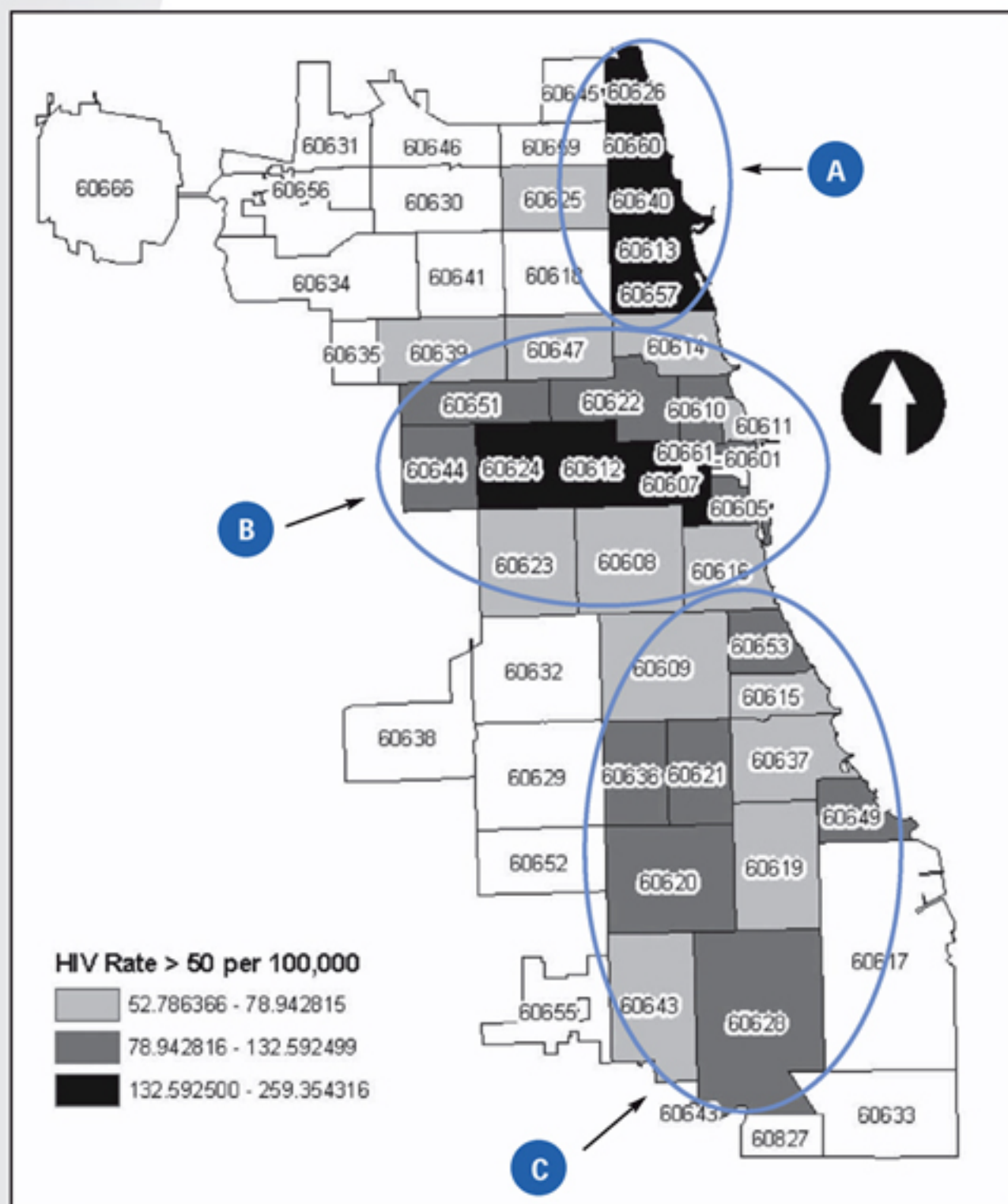
- Zip Code,
- Gender,
- Race/Ethnicity,
- Age, and
- Mode of Transmission.

The overview of HIV cases by zip code revealed three clusters of high HIV-incidence areas in Chicago, which the committee labeled A, B and C. Within each cluster, the committee identified populations with the highest HIV incidence organized by gender, race/ethnicity, age and mode(s) of HIV transmission. "High HIV incidence" was defined as incidence greater than the city average.

Prioritize

[HIV INCIDENCE MAP]

Zip Codes with high rates of HIV,
Chicago 2002-2003 (as of 12/27/2004)



High-Risk Positives

In order to discover “Who are those most at risk for infecting others with HIV?” the committee used data on the number of people living with HIV or AIDS (PLWH/A) in Chicago. These data revealed that people who are already living with HIV/AIDS are an older cohort than those who have recently been diagnosed with the virus. From this the committee determined that PLWH/A under 25 years could only account for a small number of new HIV infections and so were not identified as a priority population. The committee then sought to explore the risk behaviors of HIV positive populations. The committee used two “risk hierarchy charts” to help them with this effort (see Appendix B for these charts).

These charts revealed that male-to-female sexual transmission and male-to-male sexual transmission both significantly contribute to new HIV infections, whereas female-to-male sexual transmission and female-to-female sexual transmission do not. Consequently, the HPPG only prioritized male populations living with HIV. Female high-risk heterosexuals (HRH) living with HIV/AIDS were not prioritized as a population at risk for transmitting HIV.

The committee summarized their work into the following table and forwarded it to the Gap Analysis and Finishing Committees.

ZIP CODES			TARGET POPULATIONS	
Cluster A	60613 60625 60626 60640	60657 60660	High-Risk Negatives: 1. AA MSM 25-50+ 2. Hispanic MSM 25-39 3. White MSM 25-50+	People Living with HIV/AIDS: 1. HIV+ AA MSM 25-50+ 2. HIV+ Hispanic MSM 25-39 3. HIV+ White MSM 25-50+
Cluster B	60601 60605 60607 60608 60610 60611 60612 60614 60616	60622 60623 60624 60639 60644 60647 60651 60661	High-Risk Negatives: 1. AA/H/W IDU Male & Female 2. AA MSM 25-50+ 3. AA MSM 13-24 4. Hispanic MSM 25-50+ 5. White MSM 25-50+ 6. AA Female HRH 25-50+ 7. AA Female HRH 13-24	High-Risk Positives: 1. HIV+ AA/H IDU Male & Female 2. HIV+ AA MSM 25-50+ 3. HIV+ Hispanic MSM 25-50+ 4. HIV+ White MSM 25-50+
Cluster C	60609 60615 60619 60620 60621 60628	60636 60637 60643 60649 60653	High-Risk Negatives: 1. AA IDU Male & Female 2. AA MSM 25-50+ 3. AA MSM 13-24 4. AA Female HRH 25-50+ 5. AA Female HRH 13-24	High-Risk Positives: 1. AA IDU Male & Female 2. AA MSM 25-50+

Prioritize

INTERVENTIONS

Recruitment and Focused Interventions

The committee reviewed and adopted the existing model for interventions devised by the 2002 HPPG body. That model included two categories of interventions—recruitment and focused. Recruitment interventions move clients into one or more of the focused interventions. Focused interventions seek to change behaviors, attitudes and beliefs and increase knowledge about HIV within target populations. As in 2002, the Populations/Interventions Committee recommended that all projects couple at least one recruitment intervention with at least one focused intervention.

The following is a list of interventions organized by type (see Appendix C for detailed descriptions of each intervention).

Recruitment:

- Outreach (OR)
- Health Communication/Public Information (HC/PI)
- Community Level/Social Marketing (CL/SM)

Focused:

- Individual Level Intervention (ILI)
- Group Level Intervention (GLI)
- Prevention Case Management (PCM)
- Needle and Syringe Exchange Programs (N/SEP)

Needle/Syringe Exchange Programs

The committee decided that N/SEP serve IDU populations more effectively than any other intervention. Even though the committee understood that N/SEP are not the only intervention to target IDU populations, the committee was confident that N/SEP would have the greatest impact on new HIV infections among IDUs.

Diffusion of Effective Behavioral Interventions (DEBIs)

The committee reviewed information for several DEBIs and selected four that would best serve the identified population groups and also compliment CDPH's current HIV prevention portfolio. The following DEBIs were selected:

- Community PROMISE,
- Many Men, Many Voices,
- Popular Opinion Leader, and
- Real AIDS Prevention Project.

Community Level/Social Marketing

The committee determined that CL/SM was much more complex than the other recruitment interventions. Furthermore, the committee realized that certain DEBIs and other interventions could sufficiently serve the purpose of social marketing projects and, thus, did not recommend CL/SM as a priority intervention.

HIV Counseling and Testing

The committee recommended HIV Counseling and Testing as an intervention appropriate for all identified population groups to increase the number of people who know their HIV status.

SPECIAL PROJECTS

The Special Projects Committee was charged with identifying projects that significantly reduce HIV transmission/acquisition that are not or may not be adequately covered by other HIV prevention priorities or by services that are currently available. These projects include Special Concerns Populations Projects, Special Initiatives and Structural Interventions.

Special Concerns Populations Projects

Since 1999, the HPPG has paid special attention to HIV prevention efforts targeting Special Concerns Populations. These are populations that are not captured by surveillance data but that research suggests are at high risk for contracting HIV. The HPPG acknowledged that these populations are only minimally represented in other high-risk groups like MSM and HRH. Furthermore, Special Concerns Populations have specific needs associated with their HIV risk behaviors that are not adequately addressed in traditional HIV prevention projects. The committee identified a list of potential Special Concerns Populations and criteria to help guide their decision-making process.

Proposed Special Concerns Populations

- *High-Risk Youth*—Youth who are disenfranchised, e.g., drop-outs, wards of the state, homeless, runaway and engage in high-risk behaviors.
- *Homeless Individuals*—Individuals who are homeless or at risk of being homeless and engage in high-risk behaviors.
- *Individuals Involved in the Sex Trade*—Individuals who trade sex for money, drugs, shelter or other needs.
- *Individuals who are 50+*—Individuals who are 50 years old or older and engage in high-risk behavior.
- *Men who have Sex with Men and Women*—Men who have sex with both men and women and engage in high-risk behaviors.
- *Non-English/Non-Spanish Speaking Individuals*—Individuals who use a language other than

English and Spanish and engage in high-risk behaviors.

- *People with Disabilities*—Individuals who are living with a physical or developmental disability and engage in high-risk behaviors.
- *Transgender Individuals*—Individuals who are transgender and engage in high-risk behaviors.

Special Concerns Populations Criteria

- The Special Concerns Population is not/may not be adequately covered in other priority recommendations.
- Limited or no public health data exists on the Special Concerns Population, and limited or no services are currently available for that population.
- The Special Concerns Population is known to engage in high-risk behavior(s)¹
- The Special Concerns Population is known to be disproportionately represented in other categories of health disparity, such as substance use/abuse, STDs, and mental health problems
- The Special Concerns Population has known HIV risk co-factors, such as poverty, history of childhood sexual abuse, incarceration, unstable housing and trading sex for survival.
- The Special Concerns Population has a need for specialized services that address specific issues uniquely associated with that population.
- There exists no other system to handle the HIV prevention needs of the Special Concerns Population.

¹For the purposes of this document, high risk behavior is defined as one or more of the following: 1) having 3 or more sex partners in the past year and not using condoms; 2) using intravenous drug; 3) having been diagnosed with a sexually transmitted disease in the past 12 months; 4) exchanging sex for money or drugs; 5) having unprotected anal intercourse. (NYC DOHMH).

Prioritize

Using the criteria, the committee developed a rating system to rank the proposed Special Concerns Populations. Committee members rated each proposed Special Concerns Population for each identified criterion and aggregated those ratings to determine a final score. The following table shows the outcomes:

SPECIAL CONCERNS POPULATIONS	RANKING (SCORE)
Transgender Individuals	1 (244)
Individuals Involved in the Sex Trade	2 (241)
Individuals with Physical and Developmental Disabilities	3 (237)
Individuals who are 50+	4 (233)
Non-English/Non-Spanish Speaking Individuals	5 (229)
Homeless Individuals	6 (212)
High-Risk Youth	7 (204)
Men who have Sex with Men and Women	8 (194)

Special Initiatives

Special Initiatives address HIV prevention needs of high-risk populations in non-traditional ways. Special Initiatives complement the existing HIV prevention projects in Chicago's HIV prevention portfolio. The committee identified a list of potential Special Initiatives and criteria to help guide their decision-making process.

Proposed Special Initiatives

- **Capacity Building/Organizational Development**—The Capacity Building/Organizational Development initiative proposes to support organizations for specific fiscal, management and development support for HIV prevention programs.
- **Corrections**—The Corrections initiative proposes to reduce HIV infection/transmission among individuals who are incarcerated or recently released from a correctional facility.
- **Faith-Based**—The Faith-Based initiative intends to build the capacity of the faith community to reach high-risk populations who do not identify themselves at risk for HIV and/or who are unlikely to be reached through traditional HIV prevention services.
- **Female Empowerment**—The Female Empowerment initiative intends to reduce HIV infection among women by reducing gender inequality and associated vulnerabilities.
- **Integrating HIV and Other Prevention into HIV Primary Medical Care Settings**—The Integration of Prevention into Care initiative intends to deliver HIV prevention interventions and co-morbidity (hepatitis, substance abuse, etc.) prevention/intervention to people living with HIV/AIDS in primary medical care settings, both HIV-specific and non-HIV-specific.
- **Prevention of Crystal Methamphetamine Use and HIV Infection/Transmission**—This initiative intends to deliver interventions that will simultaneously prevent the use of crystal methamphetamine and prevent HIV infection/transmission among populations known to engage in high-risk behaviors and who use crystal methamphetamine.

- **Internet-Based Settings**—The Internet-Based Settings Initiative intends to deliver HIV prevention interventions on the Internet to populations who are known to use the medium to facilitate high-risk behaviors that can lead to HIV infection/transmission.
- **Performing Arts**—The Performing Arts Initiative intends to deliver HIV prevention interventions through performance, e.g., music, dance, theater, to youth who engage in high-risk behaviors and who do not access traditional HIV prevention services.
- **School-Based**—The School-Based Initiative intends to deliver HIV prevention interventions to middle- and high-school-aged youth who engage in high-risk behaviors and who do not access traditional HIV prevention services.
- **Social Marketing**—The Social Marketing Initiative intends to deliver HIV prevention interventions to target populations who engage in high-risk behaviors through social marketing, e.g., video, Internet, or print.
- **STD Clinic Waiting Room**—The STD Clinic Waiting Room Initiative intends to deliver HIV prevention interventions to individuals who present for STD screening, testing and/or treatment at CDPH STD clinics.

Special Initiatives Criteria

- The Special Initiative offers the potential to effectively prevent and/or identify new HIV infections.
- The Special Initiative provides services that are currently not provided or are provided in a limited way by other systems.
- The Special Initiative is conducted in non-traditional settings such as bars, parks, mobile units or beauty/barber shops.
- The Special Initiative targets high-risk populations such as MSM, IDU, HRH and PLWHIV, and/or high-risk environments like jails/prisons, STD clinics and bathhouses.
- The Special Initiative has a history of proven effectiveness in promoting positive change.
- The Special Initiative initiates or enhances collaboration between public and/or private partners.
- The Special Initiative serves to reduce barriers to accessing HIV prevention services.

Prioritize

Using the Special Initiatives criteria, the committee developed a rating system to rank the proposed Special Initiatives. Committee members rated each proposed Special Initiative for each identified criterion and aggregated those ratings to determine a final score. The following table shows the outcomes:

SPECIAL INITIATIVES	RANKING (SCORE)
Corrections	1 (272)
STD Clinic Waiting Room	2 (237)
Crystal Methamphetamine	3 (236)
Female Empowerment	4 (194)
Social Marketing	4 (235)
Integrating Prevention and Care	6 (234)
Internet	7 (226)
School-Based	8 (225)
Performing Arts	9 (218)
Faith-Based	10 (206)
Capacity Building/Organizational Development	11 (196)

The Special Projects Committee decided that Special Initiatives should be used to support the development of innovative and locally grown HIV prevention programs. Therefore, the committee redefined the Special Initiatives as Special Projects of Innovative Significance, or SPInS. The committee charged the Gap Analysis and Finishing Committees with setting guidelines for this recommendation.

Structural Interventions

The HPPG considered Structural Interventions for the first time ever in 2005. Structural Interventions aim to alter the public health context by identifying barriers and inefficiencies in the social, economic and/or political environments that play a role in an individual's HIV risk behaviors.

Structural Interventions Outcomes

Throughout their process, the Special Projects Committee kept a running list of potential circumstances in which structural intervention could be useful. Given time constraints, the committee referred its list to the HPPG Public Policy and Procedures (PPP) Committee for completion. The PPP Committee reviewed the work of the Special Projects Committee, further researched possible structural interventions and forwarded a final set of recommendations to the Finishing Committee. The final list included:

- Hepatitis Integration
- Corrections
- Substance Abuse
- Aging Populations
- Schools
- Public Sex Environments

Assess

[IN THIS SECTION]

- Social Barriers Analysis
- Resource Inventory Analysis
- Data Limitations
- Findings
- The Future of Gap Analysis

[COMMUNITY PLANNING]

Performing a gap analysis is a necessary component of any HIV Prevention Comprehensive Plan. During a priority-setting year, the HPPG analyzes the needs, barriers and assets in a community to determine where gaps in service exist. A gap in service often means that individuals are not receiving prevention messages and interventions that can help them reduce their risk for being infected with HIV or infecting others.

[CDPH]

CDPH uses the results of the gap analysis to assess the current allocation of resources. Once assessed, CDPH can maintain, initiate or redirect resources to ensure that high-risk communities receive appropriate HIV prevention services.

[SERVICE PROVIDERS]

Service providers can use the information gathered from the gap analysis to focus its resources where they are most needed and to help fill gaps that currently exist in Chicago's HIV prevention portfolio.

The goal of performing a gap analysis is to discover whether HIV prevention needs match the amount of services offered to Chicago communities. The Gap Analysis Committee did this in 2005 by performing a resource inventory and a social barriers inventory. Using data from these two inventories as well as data from surveillance activities and census information, the committee determined where gaps exist in Chicago, and ultimately recommended a course of action to the Finishing Committee.

To ensure a holistic approach to the definition of an HIV prevention need, the Gap Analysis Committee considered the connections between *social barriers*—like high rates of poverty, crime and substance abuse—to the spread of HIV. The committee used the concept of *syndemics* (see “Discover” for more information) to highlight these connections rather than examining each social ill independently.

The committee described two types of needs—needs for additional HIV prevention services and needs for large-scale efforts to combat multiple social ills. A population has a need when recent HIV infections and/or social barriers are disproportionately high relative to other populations. A gap exists within a community when the amount of services needed exceeds the amount of services provided.

SOCIAL BARRIERS ANALYSIS

The committee began by creating a list of possible social barriers in Chicago and organized it by general topic headings. They reviewed each social barrier heading to determine its significance to HIV prevention services. Furthermore, in order to visualize the affect of these barriers on communities, the committee overlaid certain data sets onto a map of Chicago.

RESOURCE INVENTORY ANALYSIS

The resource inventory collected HIV prevention programming data on the following:

- Funding source
- Target population
- Intervention
- Region served

The committee received responses detailing more than 250 services and 120 programs in Chicago. This information provided the committee with a keen understanding of the breadth and distribution of services in relation to the distribution of new HIV cases. The committee produced a map of Chicago, which combined data from the resource inventory and data from the epidemiological profile, and performed two analyses. The first was for HIV services targeting high-risk negative populations. The second was for HIV services targeting PLWH/A.

Data Limitations

Regarding the resource inventory, there were three primary data limitations. First, because many funders require agencies to serve multiple populations with the same funding allocation, the committee could not determine exact dollar amounts that are used to target specific populations. Similarly, the committee could not determine exact dollar amounts that are

used to perform specific interventions. Second, data across agencies were not always comparable since different funders require different interventions to various populations. Third, the committee could not determine expiration dates of programs within communities. This was due to variations in how agencies interpreted the question about expiration dates.

Regarding the social barriers inventory, there were three primary data limitations. First, not all data sources were organized by the same geographic boundaries (i.e., some data sources were available for census tract areas, others by zip codes and others still by community areas). This made it difficult to draw conclusions across data sets. Second, different research sources differ on which co-factors are most closely tied to the HIV epidemic. Finally, the social barriers analysis reveals many needs that are beyond HPPG's scope and so could not be analyzed more fully. Further analysis could reveal other avenues for exploration.

FINDINGS

The resource inventory analysis revealed gaps among and within the currently funded regions in Chicago. Proportionately, MSM receive fewer services in the north, west and near south regions relative to other populations. In the west region, PLWH/A experience disproportionate service gaps. Analysis of the social barriers data revealed that the north side experiences fewer social barriers compared to the other regions.

The Gap Analysis Committee forwarded their recommendations to the Finishing Committee for their review. For the Gap Analysis Committee's actual recommendations please see the following chapter which also discusses the Finishing Committee's response.

THE FUTURE OF GAP ANALYSIS

The committee made recommendations for future priority-setting processes based on their experiences. The primary concern involved the limitations of available data. They noted that more specific research and analysis would be needed in future years. The committee recommended that future priority setting processes:

- Analyze the quality and effectiveness of HIV prevention services in order to assess the impact of prevention services on sustaining behavior change and reducing the number of HIV infections;

- Continue to enhance the resource inventory to further assess the prevention needs of Chicago communities;
- Attempt to discover more accurate estimates on the size of the MSM population in Chicago;
- Attempt to assess the impact of stigma on high-risk behavior, health care access and HIV.

For a complete report on the Gap Analysis Committee findings, please see Appendix D or contact the CDPH HIV prevention team at [312-745-7679](tel:312-745-7679).

Recommend

[IN THIS SECTION]

- Reviewing the Gap Analysis End Report
- The Final 16 Recommendations

[COMMUNITY PLANNING]

The HPPG process for setting HIV prevention recommendations entails a three-year cycle. The first year (2004) of the cycle is spent gathering information and educating the members of the HPPG about the current state of the epidemic in Chicago. During the second year (2005) of the cycle, the HPPG convenes specific committees to use the information from year one to set priorities. The priority recommendations in this chapter are a result of the work conducted in the second year of the process. The HPPG spends the final year (2006) monitoring the implementation of those priorities.

[CDPH]

CDPH, in partnership with HPPG, supports the priority-setting process by providing data and information and guiding the HPPG in their decision-making process. Once finalized, CDPH takes the HPPG recommendations and uses them to fund projects in the community.

[SERVICE PROVIDERS]

Service providers can look to this chapter as an overview of the future goals of HIV prevention in Chicago. Service providers that do not receive funding from CDPH can use these recommendations to guide their own HIV prevention programs.

The Executive Committee of the HPPG took the role of finalizing the set of recommendations that would ultimately be given to CDPH. During the priority-setting process in 2005, the Executive Committee was known as the Finishing Committee. The membership remained the same—HPPG co-chairs, committee co-chairs and certain liaison and governmental members. Throughout the year, the Finishing Committee reviewed past priority-setting processes in addition to the ongoing work of each committee.

As each committee completed their work, the co-chairs presented the reports to the Finishing Committee.

REVIEWING THE GAP ANALYSIS END REPORT

The first task for the Finishing Committee was to address the Gap Analysis committee recommendations (see the previous chapter for background information). The Finishing Committee reviewed each recommendation individually and integrated concepts as appropriate. The Finishing Committee also provided justifications whenever they did not accept one of the recommendations. Gap Analysis recommendations are in quotation marks.

[A] “Appropriately allocate resources to ensure services are available to high-risk populations in those geographic areas with highest rates of HIV incidence.”

The Finishing Committee revised the language of the original Gap Analysis recommendation to read “appropriately allocate” rather than “shift.” Furthermore, the committee determined that this recommendation was adequately addressed in the Populations/Interventions Committee recommendations, which detail the high-risk clusters.

- [B]** "HIV prevention services should be targeted to those at highest risk in each region. This is not the case in many regions, especially with regard to MSM."

The Finishing Committee agreed with this recommendation and determined that it was adequately addressed in the Populations/Interventions recommendations, which detail high-risk populations.

- [C]** "Social barriers should be taken into account when allocating resources across the region. There should be enhanced services in geographic areas where there are more social barriers. These enhanced services should not focus on HIV prevention alone; they should work in conjunction with non-traditional HIV prevention providers. Enhanced services can be developed with collaborations, referral systems or other 'in house' programs."

The Finishing Committee agreed with this recommendation and made the following determinations: 1) all priority recommendations should address social barriers; 2) the SPInS should specifically address social barriers; and 3) CDPH and CDPH-funded delegates should be aware of social barriers when providing internal services.

- [D]** "Appropriately allocate resources to ensure social barriers are addressed in those geographic areas with the highest rates of HIV infection."

The Finishing Committee responded to this recommendation by ensuring that the SPInS explicitly address social barriers and that the majority of SPInS target Clusters B and C, the two clusters that the committee determined to be disproportionately affected by social barriers.

- [E]** "Within each region, services should be included for those populations that might fall into the 'other' category. We used

epidemiological data and our experiences to determine which populations were included in this category. Some of these populations are found in the Special Projects recommendations, while others emphasize those already found to be at highest risk. In the Far South and Near South regions, these populations included Hispanic MSM, African American MSM, and IDUs of all races. In the West region, these populations included Hispanic and African American MSM, HRH (both male and female), and IDUs (both male and female). In the North region, these populations include African immigrants, Asian/Pacific Islanders, HRH females, and youth who are homeless and/or sex workers."

The Finishing Committee reviewed the recommendations from the Populations/Interventions and Special Projects committees and determined that the majority of the populations falling in the "other" category were already covered by those recommendations.

- [F]** "Interventions should be used following the Populations/Interventions recommendations, with one concern. The entire spectrum of risk for an IDU is not adequately addressed by just using Needle Exchange programs. Programs should be able to use Needle Exchange alone or in conjunction with more focused interventions like Individual Level Interventions and Prevention Case Management. HIV prevention services targeted to IDU should also be expanded to include methadone treatment service providers."

The Finishing Committee recognizes that N/SEPs should be comprehensive, and must include some other HIV prevention intervention in conjunction with the needle exchange. Furthermore the Finishing Committee agreed that methadone providers who do not offer comprehensive N/SEPs should either partner with N/SEPs programs or apply for prevention resources targeting other populations who engage in high-risk sexual behaviors.

Recommend

[G] “HPPG should perform a resource inventory annually to update and further understand the resources available.

The Finishing Committee supported this recommendation by affirming that 1) the resource inventory will be an ongoing project; 2) the resource inventory will not be repeated during this priority-setting process and 3) new resource inventory data and new epidemiological data will inform the annual revision of the comprehensive plan.

[H] “Each year there should be a small amount of money for the full body to research an issue. These issues can vary from program effectiveness to uncovering populations not evident in epidemiological research. HPPG should have the flexibility to explore emerging issues the full body finds important. Because of many different funding constraints, there are few resources available to do such.”

The Finishing Committee confirmed this Gap Analysis recommendation by creating and allocating resources to a new research initiative (see recommendation #1 below).

THE FINAL 16 RECOMMENDATIONS

The Finishing Committee reviewed the end reports of the Populations/Interventions Committee and the Special Projects Committee as well as the end recommendations of the Gap Analysis Committee and devised the final set of recommendations. The following is a list of the sixteen priority recommendations with supplements as appropriate. This list was voted on by the HPPG in November 2005 and passed on to CDPH soon thereafter. Please see the next chapter, “Implement,” for a description of how these recommendations become reality.

RECOMMENDATION #1

Allocate approximately two percent of HIV prevention resources annually to research that explores issues impacting HIV prevention efforts in Chicago. In year one, research should explore the link between crack use and HIV risk. In year two, research should explore the link between non-identified MSM and HIV risk.

RECOMMENDATION #2

Accept the zip code clusters—A, B and C—as identified by the Populations/Interventions Committee and confirmed by the Finishing Committee.

Supplement to Recommendation #2:

Appendix E displays a chart showing the approximate community areas for each cluster. This chart is included for reference only.

RECOMMENDATION #3

- (a) Integrate individuals who do not know their HIV status and are not in care into high-risk HIV-negative populations and rename the group as “individuals with HIV-negative or unknown status.”*
- (b) In order to reach those individuals at greatest risk of transmitting HIV, target PWP projects to populations with known HIV-positive status (who are or are not in care) and who face other challenges like substance use and homelessness.*
- (c) Of resources targeting high-risk populations, allocate approximately 10% to PWP projects with the explicit understanding that separate resources will cover HIV-positive individuals who are unaware of their status.*

Supplement to Recommendation #3:

The Finishing Committee devised recommendation #3 in three stages. First, the committee discovered two important facts about HIV transmission from the CDC. These are 1) 25% of HIV-positive individuals are unaware of their status, but they cause more than two-thirds (~67.5%) of all new infections and 2) the remaining 75% of HIV-positive individuals who are aware of their status cause less than one-third (32.5%) of new infections. As a result of this discovery, the Finishing Committee prioritized HIV-positive individuals who do not know they are positive very highly.

Second, the committee realized that individuals who face other significant challenges in life—like homelessness and substance use—are more likely to engage in behaviors that put others at risk, even if they are aware that they are HIV-positive. As a result of this discovery, the committee realized that not all HIV-positive individuals are equally at risk for infecting others.

Third, the committee utilized “Bob’s Life,” a model conceived by CDPH, to examine HIV at an individual level. Please see “Discover” for an explanation of this model. Together, those three components led to recommendation #3, above.

Recommend

RECOMMENDATION #4

Allocate approximately 25% of the resources targeting high-risk HIV-negative adult populations to their high-risk HIV-negative youth counterparts.

RECOMMENDATION #5

Following the allocation for adult PWP projects, allocate approximately 10% of resources targeting high-risk HIV-negative youth populations to youth PWP projects.

Supplement to Recommendation #4 and Recommendation #5:

The committee devised this recommendation based on a combination of epidemiological data and common sense. Youth represent only a small proportion of the current epidemic. Since the Populations/Interventions Committee used epidemiological data exclusively to make decisions, youth were not revealed as a high-risk population. However, the Finishing Committee recognized that youth are an important population for primary prevention activities, so the committee reviewed various scenarios for percent allocations to youth and recommended the final percentage of 25%, with 10% of that for HIV-positive youth.

RECOMMENDATION #6

- a) Accept the following interventions for high-risk HIV-negative/unknown HIV status and high-risk HIV-positive MSM and HRH: Individual Level Intervention, Group Level Intervention and Prevention Case Management (focused interventions); and Outreach and Health Communication/Public Information (recruitment interventions). At least one focused intervention must be coupled with at least one recruitment intervention.*
- b) Accept the following intervention for high-risk HIV-negative/unknown HIV status and high-risk HIV-positive IDUs: Comprehensive Needle/Syringe Exchange Programs.*

RECOMMENDATION #7

Accept HIVCT as an intervention appropriate for all identified high-risk HIV-negative/unknown HIV status population groups to encourage knowledge of HIV status.

RECOMMENDATION #8

- a) Include partner counseling and referral services (PCRS) as an intervention implemented by CDPH that targets HIV-positive individuals in order to identify new positives.*
- b) Encourage CDPH to enhance quality assurance efforts of PCRS services to ensure partners of newly identified positives are identified, counseled and tested.*

Supplement to Recommendation #8:

The Finishing Committee wanted to acknowledge the importance of PCRS programs. These programs aim to identify, counsel and test partners of individuals who are newly diagnosed with HIV. Partners of HIV-positive individuals represent one of the highest risk groups for HIV infection.

RECOMMENDATION #9

Accept the following three DEBI as interventions available to appropriate high-risk HIV-negative/unknown status and high-risk HIV-positive populations:

- *Community PROMISE*
- *Many Men, Many Voices*
- *Real AIDS Prevention Project*

Supplement to Recommendation #9:

Even though the Populations/Interventions Committee identified four DEBI, the Finishing Committee decided not to fund another Popular Opinion Leader (POL) project since two POL projects already exist in Chicago.

RECOMMENDATION #10

- a) Allocate resources to fund the following five Special Concerns Populations: Transgender, Sex Trade, Disabilities, NE/NS and Homeless.*
- b) Because Transgender populations were ranked significantly higher than other population groups, Transgender populations must receive approximately two times the resources available to each of the other SCP.*
- c) Allocate approximately 7.5 percent of HIV prevention resources to SCP projects.*

Supplement to Recommendation #10:

The Finishing Committee reviewed the full list of rated Special Concerns Populations. The committee questioned whether any of the identified populations could be adequately served in other priority recommendations. After deliberation, the committee determined that three Special Concerns Populations fit this description: Individuals who are 50+, High-Risk Youth and Men who have Sex with Men and Women. The committee, therefore, chose to not include these three in their final recommendation.

Recommend

RECOMMENDATION #11

- a) Allocate approximately 19% of HIV prevention resources to fund the following SPInS: Corrections (two projects with one addressing the link between corrections and crack use), STD Clinic Waiting Room, Crystal Meth and Female Empowerment.*
- b) To further address social barriers, target the SPInS to the following geographic clusters:*
 - *Corrections—populations residing in Clusters B and C*
 - *STD Clinic Waiting Room—populations residing in Clusters B and C*
 - *Crystal Meth—Populations residing in Cluster A*
 - *Female Empowerment—populations residing in Clusters B and C*
- c) Redirect the Social Marketing Initiative into the funded DEBI as it is already an integral part of each intervention.*
- d) Given recent findings published in Health Affairs (Cohen, et al. (2005), “Cost-Effective Allocation Of Government Funds To Prevent HIV Infection,” Health Affairs, 24: 915-926). that risk reduction videos in STD clinics had a low implementation cost and were cost-effective at preventing new HIV infections, incorporate the DEBI, Voices/Voces, into the STD Clinic Waiting Room SPInS.*
- e) Redirect the Internet initiative into the Crystal Meth SPInS.*
- f) Regarding Integration of Prevention and Care initiative, recommend that Title I and HOPWA explicitly include requirements for integration in their RFPs, as possible given grantee requirements.*
- g) Due to limited resources, the School-Based, Performing Arts, Faith-Based and Capacity Building/Organization Development Initiatives will not be recommended for funding.*

RECOMMENDATION #12

For all prioritized groups, require CDPH-funded agencies to provide the following as appropriate:

- *Hepatitis screening and testing, and/or*
- *Hepatitis vaccination, and/or*
- *Risk/harm reduction education on hepatitis transmission and prevention.*

RECOMMENDATION #13

Refer the following list of Structural Interventions to the 2006 HPPG Executive Committee. The Executive Committee, or its designee, will identify ways to intervene on a structural level for these arenas:

- *Substance Abuse*
- *Aging Populations*
- *Schools*
- *Mental Health*
- *Public Sex Environments*
- *Corrections*

Recommend

The following three recommendations (Recommendations #14, #15, and #16) outline the approximate percent allocations recommended for each specific high-risk population.

RECOMMENDATION #14

Allocate ~32% of the High-Risk Populations resources to Cluster A. Within Cluster A, allocate resources to high-risk populations as follows:

STATUS	RACE/ETHNICITY	MODE	GENDER	AGE	PERCENT OF CLUSTER A
HIV-Negative/ Unknown Status	African American	MSM	M	Adult	~12.42%
HIV-Negative/ Unknown Status	African American	MSM	M	Youth	~3.73%
HIV-Negative/ Unknown Status	Hispanic	MSM	M	Adult	~10.04%
HIV-Negative/ Unknown Status	Hispanic	MSM	M	Youth	~3.01%
HIV-Negative/ Unknown Status	White	MSM	M	Adult	~45.04%
HIV-Negative/ Unknown Status	White	MSM	M	Youth	~13.51
HIV-Positive	African American	MSM	M	Adult	~1.98%
HIV-Positive	Hispanic	MSM	M	Adult	~1.47%
HIV-Positive	White	MSM	M	Adult	~6.54%
HIV-Positive	ALL	MSM	M	Youth	~2.25%

RECOMMENDATION #15

Allocate ~37% of the High-Risk Populations resources to Cluster B. Within Cluster B, allocate resources to high-risk populations as follows:

STATUS	RACE/ETHNICITY	MODE	GENDER	AGE	PERCENT OF CLUSTER B
HIV-Negative/ Unknown Status	African American	MSM	M	Adult	~ 16.25%
HIV-Negative/ Unknown Status	African American	MSM	M	Youth	~ 11.35%
HIV-Negative/ Unknown Status	Hispanic	MSM	M	Adult	~ 12.84%
HIV-Negative/ Unknown Status	Hispanic	MSM	M	Youth	~ 3.85%
HIV-Negative/ Unknown Status	White	MSM	M	Adult	~ 15.26%
HIV-Negative/ Unknown Status	White	MSM	M	Youth	~ 4.58%
HIV-Negative/ Unknown Status	African American	HRH	F	Adult	~ 13.51%
HIV-Negative/ Unknown Status	African American	HRH	F	Youth	~ 9.15%
HIV-Positive	African American	MSM	M	Adult	~ 4.05%
HIV-Positive	Hispanic	MSM	M	Adult	~ 2.56%
HIV-Positive	White	MSM	M	Adult	~ 3.39%
HIV-Positive	ALL	MSM	M	Youth	~ 3.21%

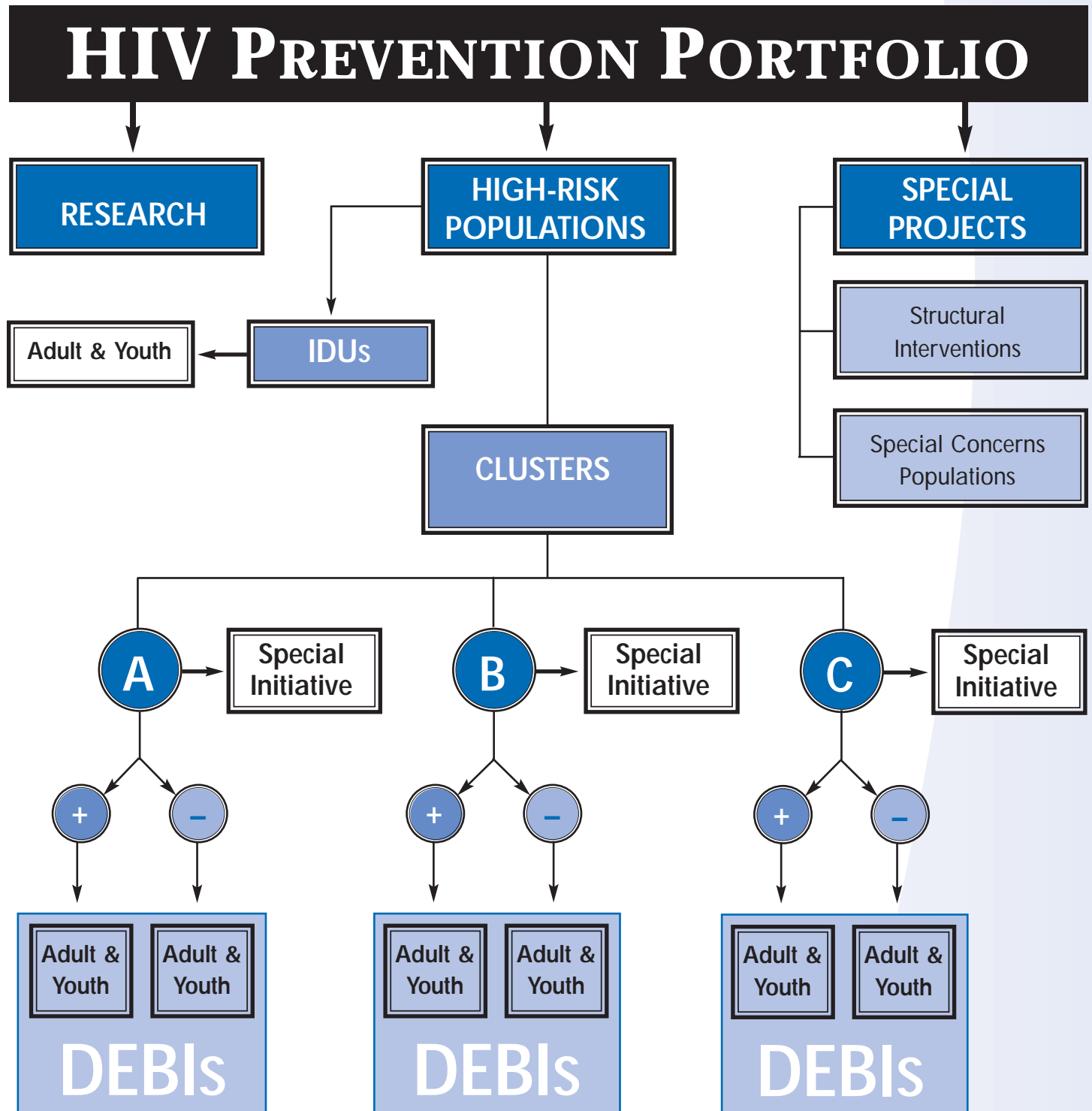
Recommend

RECOMMENDATION #16

Allocate ~31% of the High-Risk Populations resources to Cluster C. Within Cluster C, allocate resources to high-risk populations as follows:

STATUS	RACE/ETHNICITY	MODE	GENDER	AGE	PERCENT OF CLUSTER C
HIV-Negative/ Unknown Status	African American	MSM	M	Adult	~33.17%
HIV-Negative/ Unknown Status	African American	MSM	M	Youth	~21.14%
HIV-Negative/ Unknown Status	African American	HRH	F	Adult	~20.48%
HIV-Negative/ Unknown Status	African American	HRH	F	Youth	~11.58%
HIV-Positive	African American	MSM	M	Adult	~10.00%
HIV-Positive	African American	MSM	M	Youth	~3.64%

The following diagram shows how the projects are related and where each of the recommended projects will fall given the sixteen recommendations.



Implement

[IN THIS SECTION]

- Request for Proposals
- Structural Interventions
- CDPH Services
- Other Service Providers

[COMMUNITY PLANNING]

HPPG's priorities provide the foundation for CDPH's HIV prevention program, both internally through CDPH programs and externally through funded community-based organizations. HPPG, along with CDPH and other partners, also implements structural level recommendations to help influence change on a grander level.

[CDPH]

CDPH implements the priorities set by HPPG wherever possible into services that CDPH provides directly like HIV Counseling and Testing, Partner Counseling and Referral Services and outreach services.

[SERVICE PROVIDERS]

Service Providers apply for funding to provide community-based HIV prevention services from CDPH through a Request For Proposals. Service providers in Chicago that do not apply for funding from CDPH should still guide their services to be in line with the priorities set by HPPG.

There are four primary ways that priorities become implemented projects: CDPH distributes funding through a Request For Proposals (RFP), HPPG works with CDPH to influence structural changes, CDPH incorporates the recommendations into many of the services CDPH provides and finally all agencies, including non-funded agencies, may use the priorities to guide their work.

REQUEST FOR PROPOSALS

The 2006 RFP directly addressed the recommendations set by the HPPG in 2005. Eligible agencies may apply for funding through the RFP in order to see the HPPG recommendations in

action. When CDPH releases a RFP, agencies submit proposals to compete for funds dispersed by CDPH. The quality of those proposals determines which agencies receive funding and how much funding they receive. A service provider can receive help in constructing applications by attending one of the grant writing workshops hosted by CDPH. Please contact the Capacity Building, Training and Technical Assistance unit at [312-747-9665](tel:312-747-9665) for more information on these workshops.

STRUCTURAL INTERVENTIONS

Another way to implement the HPPG recommendations involves working with large-scale entities, such as governments, businesses or large churches. The goal of intervening at a structural level is to alleviate barriers to providing the highest quality HIV prevention services, to simplify processes or to improve the quality of services that already exist. For example, integrating Hepatitis prevention and treatment into HIV services is a structural intervention that focuses on government structures in order to improve the quality of HIV services in Chicago (see "Prioritize" for more information).

CDPH SERVICES

CDPH incorporates HPPG's recommendations into the direct services it provides. Whenever the HPPG prioritizes a recommendation involving HIV Counseling and Testing (HIVCT), Partner Counseling and Referral Services (PCRS) or outreach activities, CDPH makes appropriate adjustments to programming in Chicago.

OTHER SERVICE PROVIDERS

Service agencies that do not receive funding from CDPH will also find these recommendations useful to guide their work in Chicago. These agencies usually receive funding from other government sources, like the Illinois Department of Public Health or CDC. Other funding possibilities include funding from foundations, corporate donations and individual philanthropic support. Agencies that receive funding from non-CDPH sources to perform HIV prevention services are especially encouraged to align themselves with the HIV Prevention Comprehensive Plan.

Evaluate & Assure Quality

[IN THIS SECTION]

- Developing Standards
- Types of Evaluation
- PEMS
- STD Related Evaluation
- HATU

[COMMUNITY PLANNING]

The community planning process relies on the evaluation tools to understand the current state of HIV prevention programming in order to devise the most effective recommendations to CDPH. Also, evaluation tools can assist HPPG in improving its internal processes. Ultimately, proper evaluation allows the HPPG and CDPH to feel confident that we are doing the most with the limited resources available.

[CDPH]

CDPH collects data from agencies to document program activities. CDPH uses this data to discover which populations are receiving services, where those services are offered and, ultimately, whether the programs are effective. The evaluation of HIV prevention programs demonstrates program accountability, effectiveness and value. Evaluation is necessary to ensure that HIV prevention programs provide the best services available and meet the needs of clients.

[SERVICE PROVIDERS]

Agencies benefit greatly from the systematic collection of data. Data specific to each service provider are essential to demonstrate program effectiveness to funders, board members and the community at large; guide the service provider's mission and long-term goals; and develop and improve programs.

The HPPG and CDPH use the findings from evaluations to improve planning, programming and service delivery regarding HIV/AIDS prevention programs. Furthermore, CDPH aims to help community-based agencies develop and enhance their own abilities to evaluate their programs, and analyze the results of that evaluation. Through a comprehensive evaluation program, agencies and CDPH can learn techniques and methods that best serve the communities of Chicago. The following highlights some recent planned quality assurance and evaluation activities in Chicago.

Developing Standards

Before formal evaluation can occur, standards must exist. CDPH will develop standards for all funded interventions. Currently, standards have been developed for HIVCT, rapid testing, and PCRS.

Creation of HIV Counseling and Testing Service Standards

The evaluation unit developed standards for HIV Counseling and Testing in 2004. The unit staff reviewed all available resources, including public health standards at the state, local and federal levels; held consensus groups with members of community-based organizations; and wrote, edited and printed the document. CDPH provides these standards to all agencies that perform HIV counseling and testing (HIVCT) so that all agencies can improve the quality of their programs in Chicago. Ultimately, documenting quality assurance guidelines allows CDPH to promote the duplication of successful HIV prevention projects. CDPH plans to revise these standards every two years. Please contact the CDPH Evaluation unit at [312-747-9869](tel:312-747-9869) to obtain a copy of these standards.



Evaluate and Assure Quality

Standards for Rapid Testing and PCRS

The evaluation unit also created standards for rapid testing and PCRS as part of a grant to discover whether rapid HIV testing decreases the spread of HIV and whether rapid testing can have a positive impact on PCRS outcomes. Any agency that currently performs rapid tests or that plans to offer rapid testing in the future is encouraged to attend trainings by the HIV/AIDS Training Unit learn the required protocols.

TYPES OF EVALUATION

Two types of evaluation are **process evaluation** and **outcome evaluation**. Process evaluation is the systematic collection of information to document and assess how a program was implemented and operated. Process evaluation aims to discover whether the intervention was delivered correctly, completely and to the target population. Outcome evaluation is the systematic collection of information to assess the impact of a program, present conclusions about the merit or worth of a program and make recommendations about future program direction or improvement. Outcome evaluation for HIV prevention programs seeks to know whether clients gained knowledge about HIV or STDs and whether clients actually changed their attitudes or behaviors.

PROGRAM EVALUATION AND MONITORING SYSTEM

The Program Evaluation and Monitoring System (PEMS) is a national web-based evaluation and monitoring tool that allows jurisdictions and agencies to assess and monitor HIV prevention services. Every HIV prevention program funded by CDPH will be required to document their programs using PEMS by the end of 2006. PEMS is an example of both process and outcome evaluation since PEMS documents all of the programs details and also asks

questions that will later be used to evaluate certain outcomes.

The ultimate goal of PEMS is to reduce the spread of HIV by providing consistent and comprehensive monitoring and evaluation of funded HIV prevention services. With the help of PEMS, jurisdictions around the country will enhance their efforts to provide the most appropriate interventions to specific populations. PEMS will enable CDPH to collect accurate and reliable prevention data from both internal CDPH clinics and external funded agencies in order to improve contract monitoring and program evaluation.

In April 2005, CDPH began to collect PEMS data from funded agencies. By the end of 2006, every funded agency will enter all data directly into a web-based platform for PEMS developed by the CDC. In addition, CDPH STD clinics and all agencies conducting HIV counseling and testing will collect client-level data using a new collection tool to comply with PEMS requirements.

SYPHILIS MEDIA CAMPAIGN EVALUATION

In 2000 and 2001 Chicago led the country in the number of syphilis cases. Surveillance data indicated a strong correlation of syphilis rates with HIV. Somebody who has syphilis is five to six times more likely to also have HIV. To address this concern, CDPH and other community partners led the formation of a coalition called the Syphilis Elimination Task Force (SETF). This coalition was formed to develop strategies to combat syphilis. The coalition used focus groups to create a multi-media advertising campaign. The task force found advertising space on the television, radio, restrooms and local public transportation. The task force also led the distribution of posters and palm cards.

Evaluate and Assure Quality

The SETF developed a street intercept survey tool in 2003 to evaluate this media campaign. The SETF ensured the survey's distribution through a random street intercept method as well as by placing the survey on the SETF website. The goal was to determine whether those who are at the highest risk for contracting syphilis in Chicago remembered seeing the campaign and whether any action was taken as a result of the campaign's messages.

Since syphilis has mostly affected men who have sex with men in recent years, campaign materials focused on encouraging syphilis testing among those populations. Intercept surveys were randomly administered to men. Results from the intercept survey indicate that 79% of respondents saw the campaign and 52% report seeking a syphilis test as a result of the campaign messages. The online survey was taken 284 times between March and June 2004. Eighty percent of online respondents had seen the campaign and 43% indicated a high probability of getting tested for syphilis because of the campaign messages. This evaluation led the SETF to conclude that health promotion messages are more effective when representatives of the most affected populations are actively involved in the design and dissemination of the campaign. The findings also helped to refine and develop subsequent phases of the campaign.

PROGRAM REVIEWS OF CDPH CLINICS

Each year, over 35,000 clients receive HIV testing, STD screening or primary care at a CDPH clinic. CDPH constantly seeks ways to improve the quality of those services by conducting quarterly program reviews. These reviews occur at every clinic as well as other locations where CDPH staff provide services,

such as the Cook County Jail, Stroger Hospital and Provident Hospital. A team of managers conducts the program reviews to assess case management activities conformity with confidentiality and HIPAA guidelines, field investigation activities and the physical environment of the clinics. The reviews also assess clinic registration and laboratory and clinical services.

PCRS CLIENT SATISFACTION SURVEYS

CDPH is currently developing a survey tool to assess how clients feel about partner counseling and referral services (PCRS) at CDPH. PCRS aims to identify and locate individuals who were exposed to HIV and provide them with diagnostic tests and other services, as appropriate. Specifically the surveys attempt to discover a client's comfort level with providing information about their sexual or needle-sharing partners to CDPH Disease Intervention Specialists. The results of the survey will be used to identify barriers of successfully implementing PCRS in Chicago and will guide CDPH to develop strategies for improving these services in the future. CDPH hopes to begin distributing these surveys by the end of 2006.

HIV/AIDS TRAINING UNIT EVALUATION

The HIV/AIDS Training Unit (HATU) distributes evaluation surveys at the conclusion of every training. The surveys seek to discover whether participants gained knowledge of the subject matter and whether they increased their ability to perform a specific prevention intervention. The survey also asks respondents to evaluate the appropriateness of course content as well as the skills of the instructors.

Assist & Improve

[IN THIS SECTION]

- Technical Assistance to Chicago HPPG Members
- Technical Assistance to Community Based Organizations (CBOs)
- CBTTA to External Primary Care Providers

[COMMUNITY PLANNING]

Community planning groups offer prime opportunities for capacity building, training and technical assistance (CBTTA) efforts because of the diversity of the members. CBTTA can come from any appropriate training source, either within the planning group, within the health department or from external community agencies.

[CDPH]

The CBTTA Unit at CDPH has provided some form of CBTTA since the early 1990s. The unit currently provides CBTTA to agencies and individuals throughout the city of Chicago. The unit also collaborates with CDC and other training centers when appropriate.

[SERVICE PROVIDERS]

CBTTA is important at the agency level to ensure staff have the skills and knowledge to do their jobs well. This assistance can come from any appropriate source including CDPH, universities and local or national agencies providing CBTTA.

Capacity building includes processes and/or activities that enhance a organization or individual's ability to perform. Technical assistance includes training and skills development opportunities that improve an individual's ability perform their job functions better.

TECHNICAL ASSISTANCE TO CHICAGO HPPG MEMBERS

HPPG provides ongoing capacity building to new and existing members. In January of every year, HPPG holds a one-day orientation for new members and a two-day retreat for both new and returning members. During the orientation, new members learn about the core principles and elements of HIV prevention community planning as well as the HPPG's major planning tasks and the expected outcomes of those tasks. During the annual retreat, all members review the previous work of the HPPG and then participate in team-building activities.

HPPG members also get priority for trainings held by the HIV/AIDS Training Unit (HATU), which provides trainings to agencies and individuals in Chicago. CDPH also provides presentations to the HPPG on topics ranging from interpreting epidemiological data to learning the details about interventions. In 2005, CDPH staff worked closely with the Populations/Interventions Committee to identify appropriate interventions for target populations.

Assist and Improve

Finally, HPPG also has access to national opportunities for CBTTA, like national conferences and CDC trainings.

TECHNICAL ASSISTANCE TO COMMUNITY-BASED ORGANIZATIONS (CBOs)

The CDPH Capacity Building Unit offers various services to CBOs, including:

- Individual consultation
- Skills building training and workshops in HIV prevention services
- Organizational development workshops
- Program enhancement workshops
- Monthly capacity building newsletter
- Coordinating with other organizations providing CBTTA opportunities

HIV/AIDS Training Unit

The HIV/AIDS Training Unit (HATU) provides training to community based organizations (CBO) on the HIV prevention interventions that are endorsed by the HPPG. The core training courses include HIV and Prevention Counseling, HIV Partner Counseling and Referral Services, HIV Prevention Case Management, Street and Community Outreach, American Red Cross Prevention and Group Education, Cultural Competency, Human Sexuality, Tuberculosis Prevention Education, Hepatitis Prevention Education, Sexually Transmitted Diseases Prevention Education and HIV/STD Medical Updates. The unit also provides other trainings such as informational trainings on violence prevention, harm reduction and alcohol and other drugs.

HATU strives to provide service providers with the information and skills to provide their communities with the best possible services. In 2005 HATU collaborated with the CDC and local capacity building agencies Providers to co-host trainings for DEBI projects that were identified by the HPPG.

Technical Assistance Project

The Technical Assistance Project (TAP) provides individuals and community-based organizations with the organizational development skills they need to deliver successful HIV prevention and care programs. Any organization that provides, or plans to provide, HIV prevention and/or care services in the greater Chicago region is eligible to receive these services. Specifically, TAP provides organization development workshops as well as one-on-one TA to delegate agencies.

In addition, TAP's staff conducts an annual CBTTA survey with all CBOs funded by CDPH to do HIV prevention activities. This survey assesses current capabilities as well as potential future training needs. CDPH uses the results from this survey to plan targeted training courses.

TAP also offers Continuous Education Unit credits on HIV/AIDS prevention trainings for front-line substance abuse treatment or counseling providers. Furthermore, TAP produces and distributes a monthly capacity building newsletter that provides a comprehensive listing of local, state and national CBTTA opportunities. The newsletter reaches over 750 individuals and CBOs in the greater Chicago region. To view the most recent newsletter on the web go to: http://egov.cityofchicago.org/webportal/COCWebPortal/COC_ATTACH/UpdateMarApr06.pdf. TAP staff evaluates all trainings to inform and modify future CBTTA activities; to identify new trends in CBO training needs; and to improve the annual CBTTA site visits.

Educational Resource & Information Center

The Educational Resource and Information Center (ERIC) project coordinates literature and condom pick-ups for over a hundred agencies. These agencies also receive technical assistance on relevant electronic technologies through ongoing workshops. Some of the topics include database development, Excel, PowerPoint, website development and Windows navigation. The skills agencies gain through these workshops enable them to provide streamlined services to high-risk population identified by the HPPG. Furthermore, ERIC connects agencies with services, materials, resources and information that also improve service delivery.

Prevention With Positives

The CBTTA unit at CDPH also works with service agencies that target PLWH/A to provide prevention, treatment and care services. The CBTTA unit provides trainings on skills development, resource development, consumer education, consumer advocacy and program monitoring. CBTTA staff also works with consultants who are living with HIV/AIDS to gain insight into the needs of services providers who target PLWH/A.

CBTTA to OraSure Agencies

CDPH supplies several agencies with an oral HIV test called OraSure. CDPH regularly provides these agencies with informal and formal capacity building and technical assistance. Informally CDPH is always available to answer questions regarding procedures and operations. Formally CDPH performs regular

site visits to review the agencies' counseling, testing and referral activities as well as their training needs. CDPH's HIVCT Unit further assesses and provides CBTTA to the OraSure agencies regarding their effectiveness through review of quarterly data reports generated for each site.

CBTTA to OraQuick Agencies

CDPH also supplies many agencies with supplies to run a rapid HIV test called OraQuick. In order to perform OraQuick test, an agency must have the proper training and certifications. CDPH staff regularly performs site visits to these agencies to ensure that all protocols are established correctly and consistently as well as to determine whether the agency staff needs additional training. CDPH staff also periodically holds booster trainings for these agencies to further ensure that their CBTTA needs are met.

CBTTA TO EXTERNAL PRIMARY CARE PROVIDERS

The medical staff at CDPH conducts a number of "grand rounds" or "lunch and learn" sessions each year. These sessions target primary care providers to present the latest information on STD treatment. The medical epidemiologist at CDPH also teaches a course on HIV Surveillance and Epidemiology at the University of Illinois at Chicago's School of Public Health. Finally, for over 10 years, CDPH has provided hands-on STD clinical training to doctors, nurses, physicians' assistants and medical students to ensure the quality of STD care provided throughout the great Chicago region. CDPH strives to train over a hundred clinicians each year.

Link & Coordinate

[IN THIS SECTION]

- Other Planning Bodies
- HIV Primary Care
- STD Prevention and Care
- CDPH Office of LGBT Health
- Education
- Corrections
- Hepatitis Integration
- Substance Abuse

[COMMUNITY PLANNING]

Community planning groups represent the ultimate form of linkages and coordination since they bring together so many different people with different backgrounds and in different professions. Linkages and coordination are essential tools for the HPPG to ensure that planning efforts are not duplicated. Furthermore these efforts add an extra dimension to the possibilities for planning in Chicago.

[CDPH]

CDPH forms linkages with other divisions and departments to ensure that no efforts are duplicated and to ensure that the most knowledgeable members of the community can contribute in positive ways to important projects.

[SERVICE PROVIDERS]

Every service provider must be aware of the other services in the community. Often service providers must refer clients to other agencies for services not offered in-house. Each organization must foster relationships in the community in order to ensure that clients feel safe and comfortable receiving services where they are offered.

A comprehensive plan for HIV prevention in Chicago would not be complete without a description of the programs and divisions that collaborate with HIV prevention programs on an ongoing basis. Linking and coordinating HIV prevention efforts allows CDPH and others to integrate HIV prevention services into a variety of settings. These linkages and collaborations increase the community's awareness of their own HIV risks and prevention strategies, while improving the quality of those services. Furthermore, they help eliminate service gaps by ensuring a wider distribution of resources and services across a variety of health-related services.

OTHER HIV PLANNING BODIES

HPPG collaborates with other HIV planning bodies in Chicago. These collaborations primarily ensure that the HPPG's efforts are not duplicated, but they also allow planning groups to share information about each group's planning process.

Ryan White Title I HIV Services Planning Council

The Ryan White Title I HIV Services Planning Council (Planning Council) plans for HIV care services in the Chicago Eligible Metropolitan Area. Collaborative activities include joint meetings, the sharing of information and cross-group training. In addition, both the Planning Council and HPPG approved cross representation of membership on each group. The retiring co-chairs of each planning body serve as active members on the other planning group for one year. In 2002 and 2003, joint training opportunities were available to members of both planning bodies.

The Illinois Prevention Community Planning Group

HPPG also has representation on the Illinois Department of Public Health's (IDPH) group called the Prevention Community Planning Group (PCPG). The PCPG includes representation from all state regions and plans for HIV prevention efforts for the entire state of Illinois, except Chicago. Monthly updates from the HPPG's PCPG representative ensure that the entire full body is aware of statewide efforts. IDPH sends a representative to serve on the HPPG as well.

CDPH HIV PRIMARY CARE

The HIV Primary Care Program at CDPH provides HIV primary care, mental health services and nutrition services to HIV-positive clients in three clinics throughout Chicago. The clinics contribute to the goal of preventing HIV infections by providing adherence counseling; condom and other risk reduction messages; and HIV testing for the partners of HIV-positive clients which all contribute to the program's success.

First, adherence counseling helps HIV-positive clients to consistently take their HIV medications. Studies suggest that PLWH/A are less likely to pass on the disease when they exhibit a lower viral load. Consistently taking medication helps reduce HIV viral load. Also, condom messages are part of every primary care visit, mental health counseling session or nutritional health session. These messages emphasize proper and consistent condom use with all sexual partners, but especially with partners who are HIV-negative or who have an unknown HIV status. Finally, testing the partners of HIV-positive clients ensures that the people at the highest risk of contracting HIV get easy access to counseling and testing services.

The Consumer Advisory Council allows HIV-positive clients to have a voice in their own care. The council is made up of CDPH clinical staff, administrative staff, as well as HIV-positive clients. The council makes recommendations to CDPH on how to improve services in Chicago. At council meetings, HIV-positive members can get more information on both drug adherence and condom usage.

SEXUALLY TRANSMITTED DISEASE (STD) PREVENTION AND CARE SERVICES

STDs and HIV are closely related. STDs can increase the likelihood of HIV infection by two to five times. STDs also pose a unique health risk to people with HIV/AIDS. An HIV-positive person may be more likely to contract STDs due to a weak immune system. When an HIV-positive person contracts an STD, his/her viral load usually rises. This means an HIV-positive person is more infectious and could transmit HIV more easily during a high-risk activity.

CDPH is the largest provider of STD services in Chicago including screening, treatment and partner referral services. CDPH also provides STD screening at Cook County Juvenile Detention Center, Illinois Youth Center, school based clinics and an emergency room. Timely and effective STD prevention and care services are effective strategies to reduce HIV transmission in a community. When appropriate, risk reduction counseling is also integrated into any STD/HIV services delivered to the public. Other recent accomplishments include integrating hepatitis programs, such as providing Hepatitis B vaccinations and Hepatitis C testing; providing rapid HIV testing at all clinics; and increasing the number of clients who get services by creating a triage system.

Link & Coordinate

The CDPH STD/HIV Prevention and Care Program intends to improve services by maintaining the capacity to provide STD prevention and care services in traditional and non-traditional settings; increasing the number of available trainings for health care providers; expanding the delivery of prevention education to all populations at risk; and continuing to raise awareness of STDs in the general public. Specifically, the program will educate the public about the signs and symptoms of STDs, the complications of untreated STDs, STD prevention strategies, and where to go for care and treatment.

CDPH OFFICE OF LGBT HEALTH **Chicago Black Gay Men's Caucus**

The Chicago Black Gay Men's Caucus is a coalition of public health officials, HIV/AIDS activists, business owners, party promoters, policy makers and clergy. The group formed in 2005 in direct response to high HIV infection rates among black gay men and non-gay-identified men who have sex with men (MSM). Its mission is to improve the lives and well being of black MSM in Chicago with a focus on reducing the spread of HIV/AIDS in that community. The Chicago Black Gay Men's Caucus will attempt to reduce the spread of HIV/AIDS among black MSM via the development of innovative and effective prevention messages, health events, assessment of current STD/HIV prevention and care programs for black MSM and outreach training. Goals and objectives will be achieved through the unique collaborative effort of leaders within the black MSM community.

The group meets every other month. For more information, or for meeting times and locations, please go to www.lovelthybrotha.com.

Chicago Crystal Meth Task Force and "Crystal Breaks" Campaign

The Chicago Crystal Meth Task Force is a group of concerned community members, community based organizations, public health advocates, business owners and governmental and law enforcement representatives dedicated to addressing crystal methamphetamine use among lesbian, gay, bisexual and transgender people in Chicago. The task force supports educational and social marketing initiatives that address the effects of using crystal methamphetamine (including the link to HIV and STDs); promotes compassionate and targeted services for those who use, abuse or are addicted to the drug (and those affected by others' use) and advocates for services and policies for the unique needs of lesbian, gay, bisexual and transgender people.

Numerous research studies around the country have identified crystal methamphetamine as a major contributor to rising HIV infection rates. Chicago's Crystal Meth Task Force directly addresses this link between crystal and HIV/STDs through a focused media campaign, "Crystal Breaks." Ultimately the campaign aims to enhance the health of Chicago's LGBT community by decreasing illegal drug use and decreasing the rate of HIV infection while empowering individuals to make healthy choices throughout their lives. The Crystal Meth Task Force depends on community support. To find out how to help support the effort to curb crystal use in Chicago, please go to www.crystalbreaks.org

Targeted Capacity Expansion— VOCES Project

Since 2001, the SAMHSA-funded VOCES program has provided services to African American and Hispanic men who both have sex with men and use opiates. This combination of risk factors for HIV makes VOCES a crucial intervention among these populations. VOCES directly confronts the link between substance abuse and dependence with HIV risk among MSM of color who use opiates. The project provides comprehensive support to these populations. The VOCES project includes street outreach to substance abusing MSM, linkages to substance abuse treatment and primary care at various community agencies and technical assistance to any substance abuse provider who serves MSM.

EDUCATION

Chicago Public Schools (CPS)

A representative on the HPPG has facilitated coordination since 1997. Beyond sharing information with both HPPG and CPS, this representative is an active member of the planning body serving as a committee co-chair in 2005 and 2006. Specifically, this representative shares reports on the CDC-funded Youth Risk Behavior Survey and CDPH's Faces of AIDS project remains part of the CPS health curriculum. Furthermore, the linkage extends to CDPH representation on CPS HIV Materials Review Committee for approving health materials in schools, and CPS representation on CDPH's community standards review panel. Finally CDPH offers direct services to many youth including STD screening, HIV education and referrals at all eight CPS high schools with school-based clinics.

Youth Participation in World AIDS Day Events

Every year CDPH hosts a daylong event on World AIDS Day. In 2005 youth were included in the

planning process for the first time. Twelve youth helped plan the event. These youth played a key role in determining how to focus education efforts to the hundreds of youth who attend the World AIDS Day event. In 2005 six hundred youth attended the event. Due to the success of youth involvement in the planning process, CDPH and CPS plan to include and expand youth participation in future event planning of World AIDS Day.

CORRECTIONS

Illinois Public Health and Corrections Task Force

Incarcerated populations suffer from a variety of diseases and health problems. Tuberculosis, HIV/AIDS and other STDs such as syphilis, gonorrhea, hepatitis and chlamydia are more common among those who are incarcerated than in the general U.S. population. Furthermore many inmates engage in high-risk sexual and drug using behaviors and also suffer from mental health problems.

The Illinois Public Health and Corrections Task Force represents a collaboration of multiple organizations including CDPH and the Cook County Department of Corrections, which are lead organizations. The task force has over 160 statewide members, including representatives from local health departments, county jails, faith-based organizations, policy makers, community-based organizations and five of Chicago's top universities. The goal of the task force is to improve the health status of incarcerated individuals as well as those who are recently released from a correctional facility by leveraging health-related resources throughout Illinois. Cermak Health Services collaborates with CDPH to provide ambulatory care services to Cook County Department of Corrections inmates including services for primary care, HIV counseling and testing, hepatitis vaccinations, tuberculosis screening and treatment, STD

Link & Coordinate

screening and treatment, discharge planning, mental health services and substance abuse treatment.

Illinois Public Health, Corrections and Community Initiative

The Illinois Public Health, Corrections and Community Initiative brought together service agencies from across Illinois to improve services for people who were recently released from correctional facilities. According to the U.S. Department of Justice approximately 95% of incarcerated individuals have sentences that make them eligible for release. This means that almost all individuals who are currently incarcerated will return to their communities. Furthermore the rate of HIV infection among those incarcerated is 5–6% higher than the general population.

HEPATITIS INTEGRATION

Anybody who is at risk for contracting HIV is also at risk for contracting the hepatitis A virus (HAV) and the hepatitis B virus (HBV). Injection drug users and anyone who received a blood transfusion prior to 1992 are at risk for contracting the hepatitis C virus (HCV). CDPH's hepatitis program serves these high-risk populations to provide trainings and referrals to appropriate services and/or clinics. The program also maintains hepatitis surveillance and monitoring systems. The integration of hepatitis prevention into HIV prevention programs will improve both programs through the re-enforcement of consistent prevention messages. HIV-positive individuals at risk for hepatitis can receive appropriate counseling to prevent themselves from getting HCV as well as referrals to clinics that provide HAV and HBV vaccinations. Conversely, HCV-positive individuals can understand how to stay HIV-negative and receive appropriate care if they do become infected with HIV.

Viral hepatitis will become integrated into prevention efforts across Chicago. Individuals at risk for HIV and/or hepatitis will become more aware of their risks and how to prevent dual infection. Individuals at risk will be screened, tested and/or referred for vaccinations. Individuals with a history of exposure to HCV will be identified and referred for follow up health care. Individuals with a history of exposure to HCV will be counseled to reduce the risk of transmission to others as well as the potentially increased risk of HIV infection. Furthermore, the program can link those who become infected with both hepatitis and HIV to the most appropriate treatment and primary care services.

Activities that will improve hepatitis integration include availability of additional hepatitis training through the HATU as well as continued intradepartmental collaboration to assure availability and potential expansion of resources such as HCV testing and HAV/HBV vaccinations.

SUBSTANCE ABUSE PREVENTION AND TREATMENT

Hepatitis C

The Substance Abuse, HIV and Hepatitis Prevention project is funded by a five-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The project aims to reduce the risk for contracting HIV, hepatitis and other STDs as well as to reduce the likelihood of using illegal substances. This program will provide prevention and risk reduction services that are tailored to the needs of individuals who reenter society after incarceration. The HCV program also provides access to rapid HIV testing and counseling and helps identify the needs of service agencies who are providing Hepatitis C services to uncover any potential service gaps.

Family Violence and Substance Abuse Prevention Program

Since 1998 the Family Violence and Substance Abuse Prevention Program has provided education on family violence and substance abuse in the public schools in the Roseland neighborhood. The program targets youth ages 10–17 who are at risk for abusing substances and who are at risk for committing violent acts. The program provides these youth with workshops that improve their knowledge and awareness of STDs, HIV, sexual abstinence, relationship building, communication skills, conflict resolution, anger management, peer mediation and goal setting.

Outpatient Methadone Maintenance Therapy

The sharing of syringes and other equipment used for drug injection contributes significantly to the transmission of HIV. Outpatient methadone maintenance therapy provides drug users (opiates) with a comprehensive program, including an assessment, individualized treatment planning, methadone thera-

py and counseling. HIV testing and counseling and access to twelve-step recovery groups are also commonly offered.

Encouraging injecting drug users to seek treatment is one of the ways to address the link between HIV/AIDS and substance use. As a result of this comprehensive approach, former needle users gain the skills needed for behavioral and life style changes. Outpatient methadone maintenance programs have helped participants achieve abstinence from drugs.

Crystal Clear

The Crystal Clear program began in 2005 to provide outpatient treatment services for methamphetamine users in the LGBT community. A community based health clinic performs this program, which addresses the medical, mental health and social service needs of the participants and also provides clients with specialized counseling. Although the program primarily targets members of the LGBT community, this is a citywide program that is available to any resident of the City of Chicago who abuses methamphetamine.

Monitor & Research

[IN THIS SECTION]

- OHAS Activities
- HIV Incidence Surveillance
- Drug Incidence Surveillance
- National HIV Behavioral Surveillance
- Special Studies

[COMMUNITY PLANNING]

Surveillance and research provide important new information and are critical to the HIV prevention community planning process. Data from these sources are essential to identify and set HIV prevention funding priorities for specific populations and interventions.

[CDPH]

Surveillance is a core public health function that CDC requires CDPH to perform. CDPH provides surveillance data updates to community groups, including the HPPG, as needed. CDPH also uses surveillance data when applying for additional grants.

[SERVICE PROVIDERS]

Surveillance data can be derived either for the entire city of Chicago or for specific community areas. Service providers are welcome to contact the Office of HIV/AIDS Surveillance (OHAS) for information about the state of HIV/AIDS in particular community areas.

Surveillance is the systematic ongoing collection, analysis and interpretation of client-level data. Some examples of the type of data collected include risk factors, exposure information and demographic information. Surveillance is essential to plan, implement and evaluate public health services. Research is scholarly or scientific investigation, either formal or informal, that contributes to the expansion of knowledge. Planning bodies, health departments and local providers can apply this knowledge to solve problems in the community.

The application or translation of scientific findings is at the core of HIV prevention planning. CDPH and HPPG make certain that the planning process incorporates current surveillance and research information that may have implications for HIV prevention planning in Chicago. The STD/HIV/AIDS Division is responsible for identifying and communicating surveillance and research activities to HPPG. HPPG is responsible for requesting the information they need to inform their decision-making. It is this continuous communication and sharing of information that ensures the linking of surveillance and research activities to prevention program strategies in this plan.

The remainder of this section is devoted to describing current CDPH surveillance and research activities within the Office of HIV/AIDS surveillance (OHAS) and the STD/HIV program. Results and information from these surveillance and research activities are incorporated into the planning process.

In addition to providing information in the form of routine reports, publications, presentations and responses to data requests, OHAS helps others

understand and correctly interpret the information and promotes the use of surveillance data for prevention planning. This type of technical assistance has become more crucial in recent years as new providers and members of community planning groups are identified and as the epidemic continues to grow and move into different communities.

During the planning and priority-setting process in 2005, the Populations/Interventions (PI) Committee was charged to determine populations at greatest risk, and hence, in need of prevention interventions to reduce the number of new HIV infections in the city. OHAS worked closely with the committee, by presenting HIV/AIDS surveillance data and applying epidemiological principles to address key questions. After five sessions of analyzing available data on HIV/AIDS and other sexually transmitted diseases, the committee had the information necessary to make a science-based recommendation on which populations were at greatest risk of becoming infected.

In this manner, OHAS data has been instrumental in bringing prevention, primary care and support services to Chicago and allocating them throughout the City. Additionally, OHAS provides information and technical assistance to community-based organizations, legislators, people infected with or affected by HIV/AIDS, HIV specialty clinics and the media. OHAS also disseminates information on the HIV/AIDS epidemic through the STD/HIV/AIDS Chicago newsletter, the Epidemiological Profile of HIV/AIDS in Chicago and HIV/AIDS Briefs, which can be found at: www.cityofchicago.org/health.

OFFICE OF HIV/AIDS SURVEILLANCE ACTIVITIES

Core HIV/AIDS Surveillance: Changes in Reporting

As of January 1, 2006, Illinois law requires that all new HIV diagnoses and people receiving HIV primary care be reported by name, rather than code. The reason for the transition is two-fold:

- continuing to use code-based HIV reporting would represent a loss of millions of dollars for the City and state in federal funding for HIV care and support services; and
- results from an evaluation conducted by IDPH found that the code-based system failed to meet all the evaluation criteria specified in the regulations for code-based reporting.

Another important change in HIV reporting is the addition of testing history information on the case-report form. This information will allow OHAS to measure and characterize recent HIV infection more accurately. This information will provide the information needed to effectively target prevention resources towards those at greatest risk of acquiring HIV.

Core HIV/AIDS Surveillance: Standard Practices

Primarily funded by the CDC, OHAS is responsible for the implementation of Core HIV/AIDS Surveillance activities including the following:

Monitoring report sources

To improve uniformity of case ascertainment, OHAS observes and records active case-finding methods for all persons who meet the criteria for HIV infection and AIDS. OHAS uses CDC standards to analyze

Monitor & Research

and document the proportion of cases originating from each source. This allows OHAS to monitor trends in report sources and to target efficiently case finding activities.

Active case finding

OHAS case surveillance includes cases obtained both from active and routine surveillance. Active case finding is vital to the completeness, accuracy and timeliness of Chicago's HIV/AIDS surveillance data. Epidemiologists conduct active case finding by routinely reviewing all HIV-related deaths certificates and obtaining discharge information from reporting facilities to identify potentially unreported HIV/AIDS cases. Active case-finding activities account for nearly 20% of HIV and AIDS cases diagnosed in Chicago in 2004.

Death registry matching for case finding and case completion

OHAS conducts an electronic match with the Chicago Real-Time Death System, the vital records registry, and in 2006, the National Death Index. Between 2001 and 2003, 10% of HIV/AIDS cases were ascertained through the vital registry match, underscoring the need for this process. Tuberculosis (TB) registry matching is conducted to identify possible unreported AIDS cases. Such matches also allow OHAS to verify accuracy and completeness of the data and for the TB surveillance registry to ensure that all known cases of co-infection of HIV/AIDS and TB are identified. Hepatitis B (HBV) and C (HCV) registry matching is conducted to identify possible unreported HIV/AIDS cases. The CDC estimates that 25% of persons infected with HIV are co-infected with HCV.

Pediatric surveillance

OHAS will be conducting enhanced perinatal HIV/AIDS surveillance to better understand perinatal transmission in Chicago and identify missed opportunities for HIV perinatal prevention and treatment. Enhanced perinatal surveillance in Chicago will include establishing and maintaining collaboration and support in data collection from the leading pediatric HIV/AIDS specialty clinics in Chicago. The data gathered through this project will help OHAS coordinate and evaluate the existing system of perinatal HIV prevention and care services. This data will also be useful to the Title I Planning Council's needs assessment for HIV-positive women and their children and allocation of resources.

Provider education

OHAS educates providers and case reporters throughout Chicago about reporting responsibilities of HIV/AIDS cases. All major reporters receive facility or provider-specific statistical summaries from OHAS, which provides feedback about the uses of surveillance data to promote public health, particularly HIV prevention. OHAS also responds to a variety of requests for additional summary data from providers and case reporters. Community requests have dramatically increased for educational sessions regarding the reporting of HIV infection. This is due to implementation of HIV reporting with a patient code number, regulatory changes, laboratory-based reporting and linking case reports with partner notification services.

Follow-up of laboratory-initiated HIV/AIDS cases

Laboratory-based reporting began July 1, 1999, requiring all laboratories in Illinois to report confirmed HIV-positive tests and CD4+ T-lymphocyte

counts less than 200 cells/ul or 14% of total lymphocytes to IDPH. HIV or CD4+ reports that do not match with a case reported in the statewide data registry are sent to the appropriate local health departments by IDPH. The local health departments must then investigate and complete a case report form.

Follow-up investigation of cases/populations of special epidemiologic significance, including Non-Identified Risk (NIR) cases

As part of ongoing education about reporting responsibilities, OHAS informs providers and case reporters of the importance of promptly notifying OHAS of any unusual cases or circumstances. The number of providers and facilities that need this information increased with the implementation of HIV surveillance. The NIR Coordinator is responsible for oversight of surveillance activities initiated to ascertain risk for cases reported as NIRs.

Use of case reports to facilitate voluntary prevention services

A new HIV/AIDS Case Report form was developed and implemented in Illinois. After discussions with IDPH and CDPH's Counseling, Testing, Referral and Partner Notification program staff, a system was developed to ensure the confidentiality of the patient requesting assistance with PN by having the provider obtain consent for PN from the patient and submit proper documentation to CDPH.

HARS/STD registry database matching

Presently, OHAS does not have any information in the CDC HIV/AIDS Reporting System (HARS) database concerning HIV and STD co-infection. To better describe the epidemic in a population with specific outcomes (i.e., HIV and STD co-morbidity), OHAS is proposing to conduct semi-annual registry matches between HARS and the STD Surveillance Registry,

which is maintained by the CDPH HIV/STD Prevention Program. This activity will supplement the HARS database by providing expanded risk information and identifying the percent of HIV and STD co-infections. It will also allow for monitoring of STD infections that occur before or after an HIV diagnosis. This information will help assess the effectiveness of prevention, counseling and testing programs by estimating the number of HIV cases that could have been prevented with effective counseling to those receiving an STD diagnosis. Likewise, tracking STD infections among those who are HIV positive serves to measure the effectiveness of the STD/ HIV/AIDS prevention programs.

Activities to evaluate core surveillance data

With the implementation of HIV surveillance and the recent clinical advances in treating people living with HIV or AIDS, evaluating the performance of the HIV/AIDS surveillance system and the data it yields is necessary in order to identify and correct any systematic errors; verify the completeness and accuracy of the database; better target surveillance efforts; and, ultimately, provide useful information for public health planning for prevention and care. One evaluation activity is the re-abstraction of a random sample of HIV/AIDS cases in the HARS registry. In 2001, OHAS collaborated with IDPH and CDC to develop a plan to evaluate HIV reporting. OHAS also worked with IDPH to obtain access to the Illinois Medicaid and AIDS Drug Assistance Program databases and evaluate trends at publicly funded HIV counseling and testing sites.

Medical Monitoring Project

The Medical Monitoring Project (MMP) is a new surveillance project designed to produce nationally representative data on people living with HIV/AIDS who are receiving care in the United States. In

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collaboration with CDC, National Institutes of Health (NIH) and Health Resources and Services Administration (HRSA), state and local health departments will implement the MMP in designated areas across the nation.

The MMP aims to gain a deeper understanding of health-related experiences and needs of people living with HIV/AIDS who receive HIV care in the U.S. The goals of the project are to: 1) provide a wide array of local and national estimates of behaviors and clinical outcomes of persons in care for HIV; 2) describe health-related behaviors; 3) determine accessibility and use of prevention and support services; 4) increase knowledge of the care and treatment provided; and 5) examine variations of factors by geographic area and patient characteristics.

Data from MMP will provide valuable local, state and national estimates of health care utilization, quality of care, severity of need and effectiveness of prevention messages. MMP data may help estimate resource needs for treatment and services for HIV-infected persons. To be effective, programs must meet the current needs of the population. MMP data will provide contextual information on prevention, care-seeking, treatment and risk behaviors, which will aid in the design and improvement of HIV programs.

HIV INCIDENCE SURVEILLANCE

Since the first case of AIDS in the early 1980s, the HIV/AIDS epidemic has been limited to monitoring people infected with HIV, with no measures of recent HIV infection. Understanding trends in new HIV infections is increasingly important so that public health officials can more effectively and completely monitor the epidemic, allocate resources and plan

and implement programs, particularly those designed to prevent the spread of HIV. Over the last few years, new serologic testing methods have become available that can distinguish recent from long-standing infections on a population level. The most studied of these methods is the serologic testing algorithm for recent HIV seroconversion, or STARHS. Once HIV diagnoses have been confirmed, STARHS can determine, on a population level, whether newly diagnosed HIV infections are likely to represent recent infections (within the last six to twelve months) or long-standing infections.

CDC-hosted consultation meetings with surveillance, statistics, infectious disease, ethics and laboratory experts agreed that HIV incidence surveillance be a part of standard core surveillance in order to derive the best possible method for obtaining a national HIV incidence estimate. Additionally, they recognized that information about individuals' HIV testing behaviors would be required to determine the likelihood that individuals were tested during the seroconversion period, i.e., during the period they began to produce antibodies in response to HIV antigens. Thus, persons newly diagnosed with HIV infection who tested confidentially (i.e., with name) would be reported to HARS per routine case reporting requirements which include demographic, clinical and risk factor information.

As of January 1, 2006, Illinois implemented HIV incidence surveillance following the general principals mentioned above as recommended by CDC. To arrive at a population-based estimate of HIV incidence, testing history data is collected through the HIV/AIDS case report form and remnant blood specimens from diagnostic HIV tests are submitted for STARHS testing.

DRUG RESISTANCE SURVEILLANCE Variant, Atypical and Resistant HIV Surveillance (VARHS) Overview

The purpose of VARHS is to incorporate surveillance of transmitted drug resistant HIV strains into routine HIV incidence and core surveillance activities in order to provide HIV drug resistance epidemiological data to assist local HIV prevention and treatment program planning and evaluation. VARHS evaluates the prevalence of HIV drug resistance and HIV-1 subtypes among individuals newly diagnosed with HIV in public health settings and settings collaborating with OHAS. Aliquots of remnant sera are set aside at participating provider sites in Chicago for HIV drug resistance testing from each blood specimen drawn for HIV diagnosis from eligible persons.

Monitoring Atypical HIV Strains Using Dried Fluid Spots (DFS)

OHAS and the CDC are currently evaluating the effectiveness of dried fluid spots (DFS) to perform HIV drug resistance testing. Using a very small amount of dried blood or serum collected on filter paper cards, rather than standard centrifuged and frozen plasma specimens will allow more providers to perform HIV drug resistance with fewer resources. The results of DFS could ultimately result in more patients who receive optimal treatment for their infection.

DFS in Chicago is a five-year project that began in 2005 and links with five community-based providers and two major hospitals to collect a very small blood specimen from people who have been newly diagnosed with HIV. The community-based providers collect whole blood specimens directly from clients at the time of an initial rapid HIV test. The hospitals collect serum from their HIV testing laboratories.

After the specimens dry, CDPH surveillance staff collect and ship them to Stanford University for HIV genotyping.² When CDPH receives the results, staff enters the data into a database and eventually will evaluate the information collected about specimen collection, processing, storage and testing. DFS contributes to the goal of reducing the spread of HIV by potentially enhancing HIV diagnostic tools through a less labor-intensive and more cost-effective procedure. If providers can test for drug resistance using dried fluid spots, then more sites will be able to provide superior service to clients and help them get placed on HIV medications that are not likely to fail.

Specifically dried fluid spots may be better than whole blood, serum or plasma specimens for a few reasons. First, non-specialists can collect dried fluid spots. Also, DFS requires less expensive equipment and less labor-intensive handling to store and transport the specimens. Furthermore, because an increasing number of agencies use rapid HIV testing and oral HIV testing, leftover blood specimens from laboratories will become scarce. DFS will allow sites to maintain participation in surveillance activities even while using these newer HIV testing methods. DFS also allows the number of diagnostic sites to expand, and provides alternative methods for obtaining specimens in Chicago.

In the near future, CDPH plans to add nine additional collection sites in 2006. In addition, CDPH plans to conduct a joint study with the Howard Brown Health Center to directly compare standard plasma specimens to dried fluid specimens from the same individual.

² Genotyping is the process of screening patients to identify the specific gene and the specific error (mutation) in a gene that causes a disease.

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Ultimately the goal is to estimate the prevalence of HIV drug resistance and HIV-1 subtypes among those newly diagnosed with HIV. Information gathered from the final report may enhance tracking of atypical HIV strains. CDPH also hopes that this information will also allow surveillance efforts to expand into a larger number of HIV testing sites. Finally, if DFS proves to be a successful method of testing for HIV drug resistance, more clients will be able to receive this testing at affordable costs.

NATIONAL HIV BEHAVIORAL SURVEILLANCE: PROJECT CHAT

National HIV Behavioral Surveillance (NHBS) is an ongoing behavioral surveillance system that collects data on populations at high risk for acquiring HIV. These include MSM, IDU and HRH. CHAT staff surveys the target populations in three-year cycles.

- 1) **Men who have sex with men**—In 2004 CHAT staff interviewed 1263 men aged 18 years or older selected from venues where MSM congregate (e.g., bars/clubs, churches, social organizations and street locations). All men 18 and over who were Chicago residents were eligible. These men were asked questions about their sexual and drug-use behaviors, HIV-testing behavior and use of HIV-prevention services.
- 2) **Injection drug users (IDUs)**—Between June 1, 2005 and December 31, 2005, CHAT staff interviewed 529 IDUs from the Chicago area.
- 3) **Heterosexuals at high risk**—Beginning in summer 2006, NHBS aims to interview 500 heterosexuals at high risk of acquiring HIV through heterosexual transmission. CHAT staff will perform interviews at venues in highly impoverished neighborhoods of Chicago where there have been high rates of heterosexual AIDS and adult female syphilis cases documented in the past three years.

For the first time, the 2006 cycle will include rapid HIV testing for participants. In addition, this cycle will attempt to recruit, survey and test at least 100 male sex partners of the female participants.

NHBS is an important tool for monitoring the impact of the HIV epidemic and informing prevention efforts. By monitoring HIV risk behaviors and the use of HIV testing and prevention services over time in community samples, NHBS can provide important data on changing trends and help inform the planning and prioritizing of citywide HIV prevention programs and the development of community-based HIV interventions.

Data from the 2004 and 2005 cycles of NHBS are being disseminated to Chicago community-based organizations, HIV planning councils and local researchers for their use in prevention and planning efforts.

CDPH will begin repeating this three year surveillance cycle in 2007. This will enable Chicago to detect changes in risk behaviors and the use of HIV testing and prevention services over time within each target population.

SPECIAL STUDIES

Project 1—Behavioral and Viral Characterization of Persons Recently Infected or Newly Diagnosed with HIV in Chicago

From September 2003 through December 2004, all persons receiving a new HIV diagnosis at CDPH clinics and two partner agencies were offered enrollment into the CDC-funded Project 1 research study. Project 1 staff administered a questionnaire to the participants that covered demographics, sex and drug risk behavior in the past year; use of HIV testing and prevention services; and utilization of health

care. Participants also received testing to ascertain whether their infection was recently acquired and whether their HIV is drug resistant in addition to standard CD4 and viral load testing.

A project like this, which targets research efforts to those who are newly infected, will provide the relevant information about changing behaviors and attitudes toward HIV infection. By evaluating why new infections are occurring, who is becoming infected and whether newly infected persons are receiving appropriate services, CDPH can discover crucial information that will help HPPG and CDPH prioritize populations and interventions in Chicago. In addition, if this study can reveal the proportion of infected individuals who have a drug-resistant strain, clinicians will have a guide to help them choose appropriate therapies for patients in Chicago.

Preliminary analysis of this project has revealed some dramatic differences in behaviors between those recently infected and those with long-standing HIV infection. Project 1 staff is currently distributing this data to HIV prevention planning groups, community based organizations and health department staff as well as the national public health community.

Context of HIV Infection Project

The Context of HIV Infection Project (CHIP) was conducted between December 2003 and February 2005. The results of this qualitative case-control study will help health officials, prevention and care planning groups, public health researchers and care providers to understand why some individuals who exhibit high-risk behaviors remain uninfected while others do not. Front-line HIV programs and community planning groups will be able to use information from CHIP to design new programs or improve existing programs to reduce, eliminate or neutralize the

adverse effects of HIV risk factors identified by CHIP. Participants were recruited to CHIP through a separate study protocol if they were recently infected with HIV. CHIP staff administered a semi-structured qualitative interview to the participants to identify the most relevant risk factors associated with the risk of recent infection and, ultimately, to identify any missed prevention opportunities.

Data collection for this project ended February 18, 2005. On March 1, 2006 CDPH researchers received the cleaned and approved data from the CDC. Analysis of this data will continue through 2006. CDPH will release preliminary findings from this data to HIV prevention planning groups, community based organizations, health department staff and the national public health community by the end of 2006.

Project 1—Anonymous Unlinked HIV Serosurvey

A serosurvey is a surveillance tool that can provide a picture of the state of HIV within a population. Performed in 2004, this anonymous serosurvey used HIV diagnostic specimens for all people testing for HIV at eleven testing centers in Chicago (n=17,010 tests). Using the STARHS technology, researchers were able to identify recent infections in order to provide better estimates of HIV incidence in Chicago. This is important to more accurately identify those at highest risk for becoming infected with HIV in Chicago. Results from this project have provided the first estimates of HIV incidence in Chicago. Monitoring HIV incidence is crucial to assess the current state of HIV transmission and to identify who is most at risk for contracting the disease.

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Preliminary analysis has revealed some dramatic differences in incident HIV infection rates by subgroup. For example, in Chicago, MSM of color, and particularly those under 30 years old, most likely have higher HIV incidence rates. These communities may need targeted intervention and prevention efforts to curb this rise in incidence. HIV prevention planning groups, community based organizations and health department staff will receive data from this project as it becomes available.

Rapid Testing and PCRS

The Rapid HIV Testing and Partner Counseling and Referral Services Project began in 2003 as a research project to discover whether rapid HIV testing could improve PCRS outcomes. CDPH collaborates with CBOs, CDC and OraSure Technologies, Inc. to:

- Implement rapid testing widely in Chicago
- Collect and analyze survey data;
- Provide quality assurance and technical assistance; and
- Ensure compliance with all local, state and federal laws and guidelines.

The research component of this project seeks first to discover whether rapid HIV testing decreases the spread of HIV and, second, to discover whether rapid testing can have a positive impact on PCRS outcomes. Since this project was implemented, 8,400 rapid tests have been performed and the positivity rate among rapid testers has been higher than conventional testers. There has been an increase of testing in the number of partners who were notified due to rapid testing at CBOs. Finally one result of this project is that nearly 100% of all clients who test with OraQuick Advance receive their preliminary HIV result.

Appendix A: Social Determinant Factors and Variables

Group A: Crime and Violence

- Drug Crimes Arrests, CPD, 2000
- Index Crime Reports, CPD, 2003
- Prostitution Arrests, CPD, 2004
- Ex-Offenders relocation after release, Illinois Department of Corrections, 2003

Group B: Stigma

- Domestic Violence Reports, CPD, 2003
- Hate Crime Reports, CPD, 2003

Group C: Poverty

- Housing expenses more than 30% of annual income, Census, 2000
- Over 16 able to work without a job, Census, 2000
- People with income below the Federal Poverty Level, Census, 2000
- Adults over 25 with lower than a high school diploma, Census, 2000
- Number of privately owned vehicles, Census, 2000

Group D: Health Care Access

- Number of clinics, hospitals, Federally Qualified Health Centers, CDPH, 2002
- Number of CTA Train stops within 1/2 mile, CTA, 2005
- People over 5 yrs speaking English "not well" or "not at all" at home, Census, 2000

Group E: Undocumented Status

- People living in the US without any residency status or documentation, Census, 2000

Group F: Mental Health

- People reporting their mental health kept them from daily activities in the past six months, Census, 2000

Group G: STD/AIDS

- People living with AIDS, CDPH, 2004
- Chlamydia Cases, CDPH, 2004
- Gonorrhea Cases, CDPH, 2004
- Syphilis Cases, CDPH, 2004

Group H: Disability

- Physical, Sensory, Self-Care, Go Outside and Employment Disability, Census, 2000

Group I: Substance Use

- Patients Served by Division of Alcoholism and Substance Abuse Network, Illinois Department of Human Services, Division of Alcoholism and Substance Abuse, 2003

Appendix B: Risk Hierarchy Charts

Certain activities and behaviors transmit HIV from one person to another more efficiently than others. Riskiness of behavior data quantify an activity's/behavior's risk relative to other high risk activities/behaviors.

ACTIVITY	RELATIVE RISK
Sharing unsterile needles	12
Unprotected receptive anal intercourse	9
Unprotected receptive vaginal intercourse	3
Unprotected anal insertive intercourse	2
Unprotected insertive vaginal intercourse	1.5
Giving unprotected fellatio	1
Giving unprotected cunnilingus	0.5
Getting unprotected fellatio	0.1
Getting unprotected cunnilingus	0.1

From the 2000 Washington D.C. HIV Prevention Plan, p. 5.3 / 1997 San Francisco HIV Prevention Plan

ACTIVITY	RELATIVE RISK
IDU and MSM/IDU	5
MSM	4
HRH Female	3
HRH Male	2

From 2001–2003 State of Florida HIV/AIDS Comprehensive Plan, p. 94

Appendix C: Descriptions of Interventions

The primary goal of HIV prevention interventions is to reduce high-risk behaviors by increasing knowledge and promoting long-term changes in attitudes, beliefs and behaviors. Recruitment Interventions are intended to “recruit” high-risk individuals into more intensive interventions by providing basic HIV prevention information, distributing condoms and other materials and making referrals to HIV counseling and testing services. More intensive service activities, or Focused Interventions, are delivered to promote positive and sustainable behavior change and link individuals to other services that meet an individual’s HIV prevention needs. HIV prevention interventions should assess an individual’s risk for HIV and the circumstances/situations that place an individual at high risk. Further, interventions should address issues and needs unique to the target population being served.

RECRUITMENT INTERVENTIONS	DESCRIPTION & MINIMUM CRITERIA
Outreach (OR)	An intervention generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in neighborhoods or other areas where they typically congregate. This intervention is intended to introduce individuals to HIV prevention messages and recruit individuals into more intensive counseling interventions that seek to change attitudes, beliefs and high-risk behavior. Outreach usually includes distribution of condoms, sexual responsibility kits and other risk reduction materials. Outreach also provides referrals or facilitates linkages to other more intensive HIV prevention interventions, like counseling and testing, or other needed services.
Health Communication/ Public Information (HC/PI)	An intervention intended to reach the public at large with prevention messages through various means like electronic media, print media, hotlines, the Internet, clearinghouses and large group presentations/lectures. This intervention intends to change social/community norms by increasing STD/HIV prevention knowledge, building general support for safe behaviors, providing basic skills building techniques and informing the target audience of available prevention services. HC/PI also provides referrals or facilitates linkages to other more intensive HIV prevention interventions, like counseling and testing, or other needed services.

Appendix C: Descriptions of Interventions

FOCUSED INTERVENTIONS	DESCRIPTION & MINIMUM CRITERIA
Individual Level Intervention (ILI)	An intervention that provides one-on-one health education and risk-reduction counseling to an individual. ILI assesses client risk behavior and assists clients in making plans for individual behavior change including ongoing self-appraisals of behavior. This intervention also facilitates linkages to other more intensive HIV prevention interventions, like counseling and testing and other needed services that support behaviors and practices that prevent transmission of HIV.
Group Level Intervention (GLI)	An intervention that provides health education and risk-reduction counseling to groups of varying sizes over multiple sessions. Specific session activities provide information about HIV risk behavior and promote behavior change. Clients participate in a pre-determined number of sessions (at least three). GLI uses peer and non-peer models involving a wide range of skills, information, education and support.
Comprehensive Risk Counseling and Services (CRCS) <i>(Formerly Prevention Case Management)</i>	An intensive, on-going client-centered HIV prevention intervention with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. CRCS is a hybrid of risk-reduction counseling and traditional case management that provides intensive, ongoing and individualized prevention counseling, support and service brokerage. During the intervention, a risk assessment is conducted and a written service plan, outlining client risk and methods/strategies the client can undertake to reduce high-risk behavior or eliminate risk altogether, is developed.
Community Level Intervention	<p><i>NOTE: This intervention is only funded as a part of DEBI.</i></p> <p>CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is accomplished by attempting to alter social norms, policies or characteristics of the environment. Examples of CLI include community mobilizations, social marketing campaigns, community-wide events, policy interventions and structural interventions.</p>

Appendix D: Details of the Gap Analysis

Developing a Gap Analysis Model

The Needs Assessment/Gap Analysis Committee assessed gaps in two overarching areas: 1) distribution of HIV prevention services across the city and 2) the existing types of social barriers in communities impacting HIV risk. The presence of these barriers impedes the delivery of HIV prevention services and/or inhibits access to these needed services. A comprehensive understanding of the social, political and economic barriers to HIV prevention drove the development of the gap analysis model, methodology and outcomes. The following steps help to develop a gap analysis that assesses HIV prevention services and community social barriers in your jurisdiction.

Steps:

1). Define Gap Analysis Questions

Discuss and gather information on the components to be included in your gap analysis including a needs assessment, resource inventory and other socioeconomic or psychosocial factors. The following questions assisted the committee in identifying the types of data needed, data collection strategies and data analysis methods. Subsequent steps and their outcomes answer these questions. The HPPG plans for HIV prevention services across several geographic regions in Chicago that were defined by the HPPG. Only the South region is presented in this methods section. For the entire methodology please contact the Chicago Department of Public Health at 312-747-9667.

Guiding Questions:

- What types of HIV prevention services are offered in each region of the city?
- Are these services targeting those “at most risk” in each region?
- Are these services targeting youth or adult high-risk populations?
- When does funding for these services expire?

2). Discuss Social Determinant Factors Related to HIV Transmission.

The committee determined that socioeconomic issues like poverty and substance abuse are important factors impacting the HIV epidemic. These were included as components of the model (refer to Table 1). These types of variables are known as “social determinants.” While some variables may not have a direct effect on a person’s HIV risk, they do shape the social, economic and political environments in which people make decisions about high-risk sexual activity. The committee agreed that some variables have a direct effect on HIV risk, and others have an indirect effect.

The committee incorporated as many “social determinants” that could inhibit the effectiveness of HIV prevention services. Many of these inhibitive issues are quantified as variables in existing data sets: Census data, epidemiological reports, etc.

3). Collect Data on Each Variable

All the available quantitative factor variables were collected by Chicago zip code. Some variables were not zip code-based and the committee had to transform them using a basic formula for geographic proportional sum.

Appendix D: Details of the Gap Analysis

4). Collapse Variables into Factors

Once all variables were available by zip code, the committee researched each variable to determine its strength and relationship on HIV prevention. The committee then decided against using statistical measures for factor analysis. Through consensus, they grouped the variables into factors and voted on the weight to give each factor. The factor categories and their corresponding weights are listed in Table 1. The highest weight indicates a stronger relationship to HIV transmission.

Each variable was then indexed to combine them numerically into factors. The committee took great care to assure all values were indexed in the appropriate way. Some variables, such as high HIV incidence, were negative values; others, such as number of health clinics, were positive. The indexed formula was transposed accordingly. Once indexed and combined, the committee had eight factors for measurement to assess the presence of barriers inhibiting HIV prevention (Table 1).

The committee employed the use of geographic information systems to create maps identifying the areas of city with higher social determinants. The factor and final values for each zip code were transformed into ESRI shape files to map the values. The Social Determinant–All Variables map illustrates these values. The Poverty, Health Care Access and Crime and Violence factor category maps were also included to illustrate how these variables occur simultaneously in communities with high HIV incidence.

5). Conduct a Survey of Existing Resources

The resource inventory provided information on the number and types of HIV counseling, testing and education services by zip code in Chicago. The survey was distributed to over 120 HIV prevention service providers. An unduplicated number of services were documented from 73 agencies and 250 individual HIV prevention services being delivered to high-risk populations in Chicago. Refer to the HIV Prevention Services by Region and Far Southside Services charts at the end of this section. The charts illustrated the percentage of services delivered across the city and in South region as compared to recent HIV infection; the percentage of services targeted to the four priority populations; and the percentage of services targeted to persons living with HIV/AIDS. The service percentages were also charted for comparisons with the social barriers in each zip code to determine if HIV prevention services were targeted in areas with higher barriers to HIV risk.

Appendix D: Details of the Gap Analysis

Table 1. Social Determinant Factors

FACTOR CATEGORIES	DESCRIPTION	DATA SOURCES USED	INDEX WEIGHT
STD/AIDS	Directly related to HIV transmission. Individuals exposed to STDs, particularly syphilis, are more at risk for HIV infection/transmission. AIDS prevalence is also directly related to the spread of HIV.	CDPH Office of HIV/AIDS Surveillance Gonorrhea, Chlamydia, Syphilis Cases, CDPH, 2004; People living with AIDS, CDPH, 2004	2.00
Substance Abuse	Directly related to HIV transmission by increasing high risk sexual and needle sharing behaviors.	CDPH Office of Substance Abuse and Mental Health Mortality Data, 2002	1.79
Health Care Access	Indirectly related to HIV transmission and varies by race/ethnicity. Defining variables include insurance offered by an employer or through Medicaid or Medicare; number of cars/household with the number of bus/train stops in the community; number of hospitals and clinics in each of the four regions. Is also related to other factor variables including poverty, unemployment and immigration status and may result in poor access to health care.	Number of clinics, hospitals, CDPH Health Inventory, 2002; Number of privately owned vehicles, Census, 2000; Number of CTA Train stops within 1/2 mile, Chicago Transit Authority, 2005; Number and percentage of insured persons, Gilead Center; CDPH Community Area Profile Medicaid Medicare Mt Sinai Hospital Health Disparities Study, 2004	1.75
Poverty	Directly related to HIV transmission. Defining variables include income, housing, employment/unemployment and health care insurance. This factor is also related to other social determinant factors like crime and violence and substance abuse. Communities with higher prevalence for HIV are more likely to be impoverished. Poverty also results in poor access to HIV prevention and education services.	People with income below the Federal Poverty Level, Census, 2000; Adults over 25 with lower than a high school diploma, Census, 2000; Housing expenses more than 30% of annual income, Census, 2000; Over 16 able to work without a job, Census, 2000; other literature	1.71
Crime and Violence	Indirectly related to HIV and most other variables but may exist simultaneously with other social determinants like substance abuse and poverty. Defining variables include domestic violence data, drug and prostitution arrest data.	Domestic Violence Reports, Chicago Police Department (CPD), 2003; Drug Crimes Arrests, CPD, 2000; Ex-Offenders relocation after release, Illinois Department of Corrections, 2003; Prostitution Arrests, CPD, 2004	1.50

Appendix D: Details of the Gap Analysis

Table 1. Social Determinant Factors (continued)

FACTOR CATEGORIES	DESCRIPTION	DATA SOURCES USED	INDEX WEIGHT
Mental Health	Indirectly related to HIV transmission. Emotional well-being and psychological stability of an individual or population particularly influenced by social or environmental factors.	People reporting their mental health kept them from daily activities in the past six months, Census, 2000; CDPH Office of Substance Abuse Mental Health (SAMSA, OASA, etc.); Minority AIDS Initiative Data, 2002	1.29
Disability	Indirectly related to HIV transmission. Defining variables include physical disability data, blind and hearing impaired data. Disabilities may inhibit access to adequate health care, especially HIV prevention testing and education efforts that are not widely available to disabled populations.	Census, 2000	1.25
Stigma/Racism/Homophobia	Indirectly related to HIV transmission. Institutional/systematic racism impact health care access that contributes to transmission of HIV. Differences in how this variable impacts groups/populations. Related to most other variables that address or meet daily needs including housing, education, employment, securing entitlements, etc.	Hate Crime Reports, CPD, 2003; Index Crime Reports, CPD, 2003; other literature.	1.04
Undocumented Immigrant Status	Indirectly related to HIV transmission and other variables. Defining variables include English-speaking ability, documented residency and citizenship status. Individuals may have difficulty securing entitlements and resources to meet daily living needs for fear of deportation due to language barriers. Language barriers also make understanding prevention or general health care messages more difficult.	People over 5 yrs speaking English "not well" or "not at all" at home, Census, 2000; People living in the US without any residency status or documentation Census, 2000	1.00

Appendix D: Details of the Gap Analysis

Data, Analysis and Interpretation Limitations

There are several limitations to the data used in the committee's research on the HIV prevention resource inventory in Chicago. First, agencies were asked to indicate the amount and source(s) of funding for each target population served. Consequently, funding sources, particularly direct funding from Centers for Disease Control and Prevention (CDC), allow agencies to serve multiple populations using a combination of interventions. Therefore, it was impossible to determine the amount of funding targeted to a specific population. Additionally, there was no way to determine the amount of money spent on one intervention. In addition, funding entities such as the CDC required prevention programs to target populations and employ interventions that were not always congruent to other funding entities. For example, the CDC 04064 program announcement provided funds to two groups: high-risk populations from ethnic minority communities and high-risk groups regardless of race/ethnicity. These populations did not necessarily match those prioritized by the HPPG/CDPH, IDPH or other federal agencies. The third limitation of the resource inventory lay in the use of expiration dates for the programs. The survey asked for a date when prevention program funding expired. Some agencies provided a specific day when services would expire; others cited the month or year of the expiration. The survey also failed to probe about whether agencies would apply for continued funding from the same source or if funding would evaporate completely. Without this critical information, it is difficult to assess potential gaps in services at the time when new CDPH funding will be awarded (2007–2009).

There are also several limitations to the data on social barriers. While the data used to develop the social determinants model was useful and informative, it must be interpreted cautiously. The committee process to collapse variables that are indirectly or directly related to HIV was based on data that were readily available and anecdotal accounts. Additionally, some of the data was not available in the same geographic format. The committee used GIS to calculate the proportional sum of data, such as AIDS cases and STDs, not divided by zip code. The calculation of these social barriers was not an index of the likelihood of HIV in region. There is no direct link between the calculation of social barriers and HIV transmission. The social barriers index calculated barriers inhibiting clients from receiving all types of programs, not just HIV prevention programs.

The committee took these limitations into account as they planned future needs assessment and research activities.

Appendix D: Details of the Gap Analysis

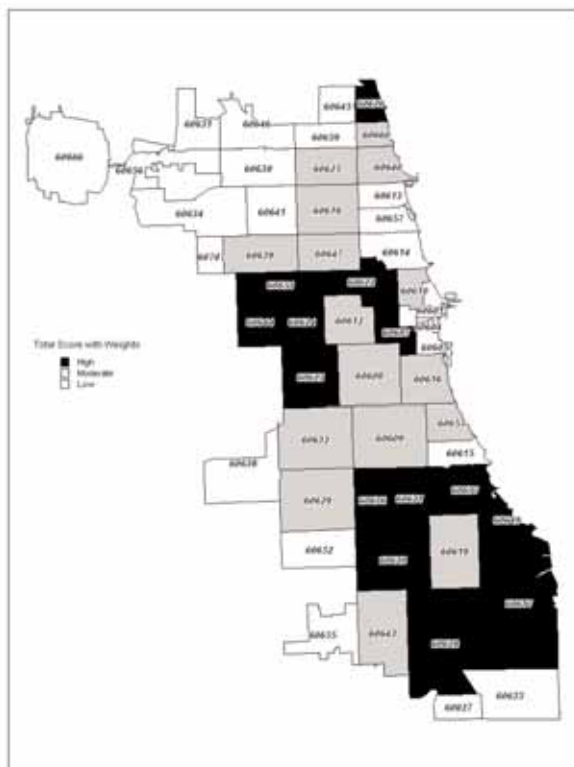
Social Determinant Analysis–All Variables



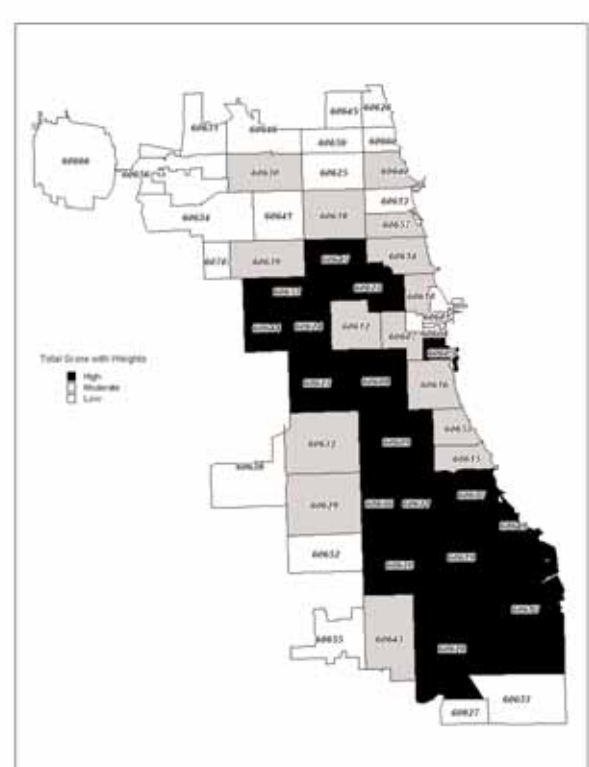
Group C: Poverty



Group I: Substance Use

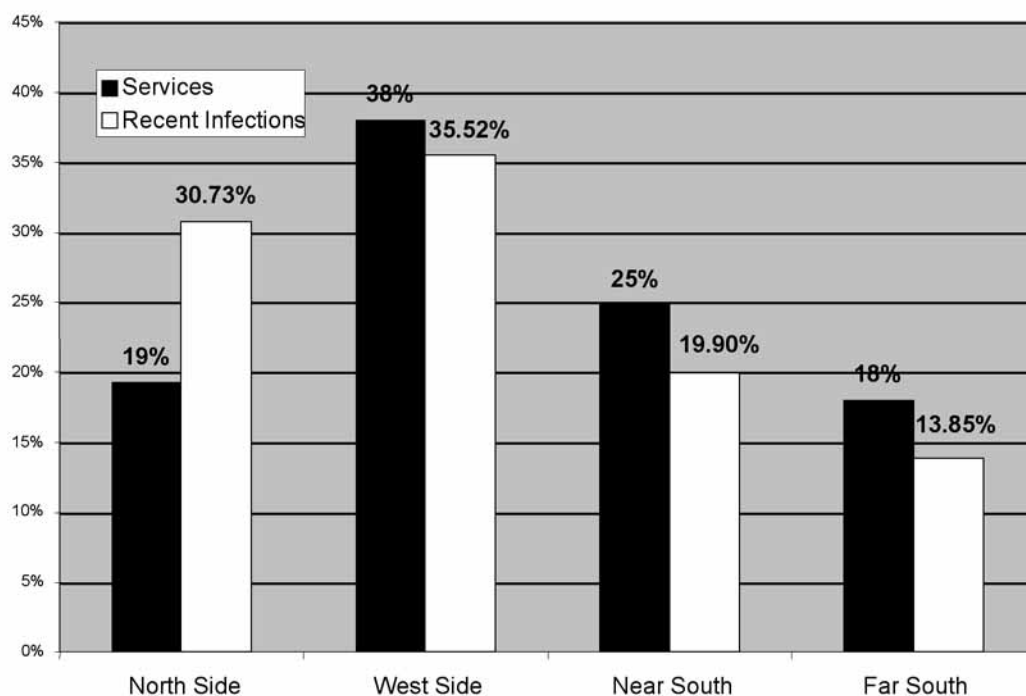


Group A: Crime and Violence

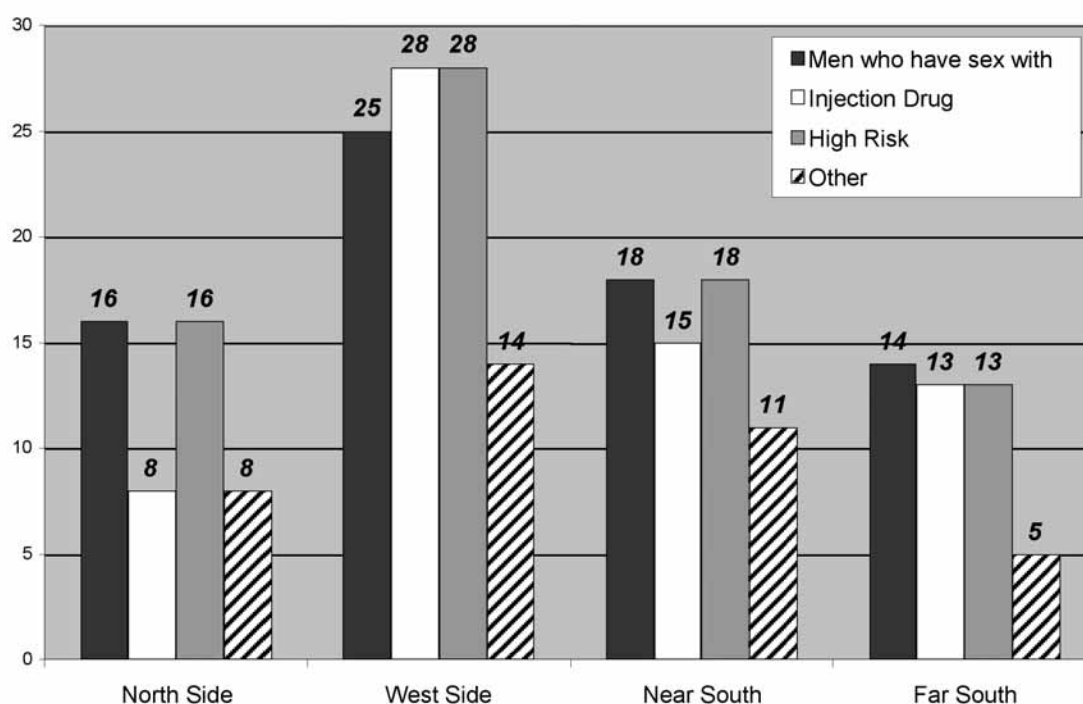


Appendix D: Details of the Gap Analysis

HIV Prevention Services by Recent Infections by Region

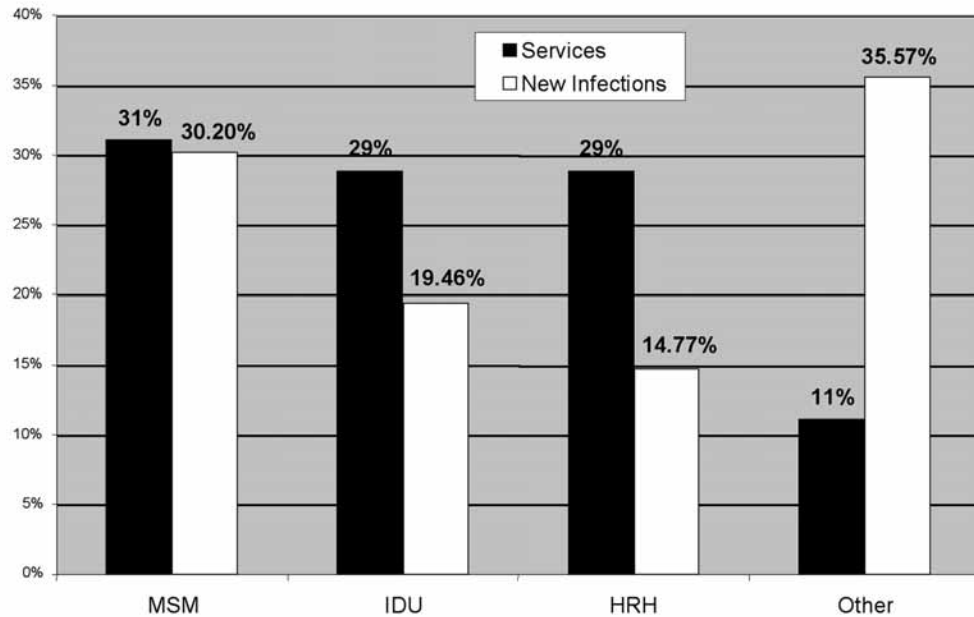


Services by Target Population by Region

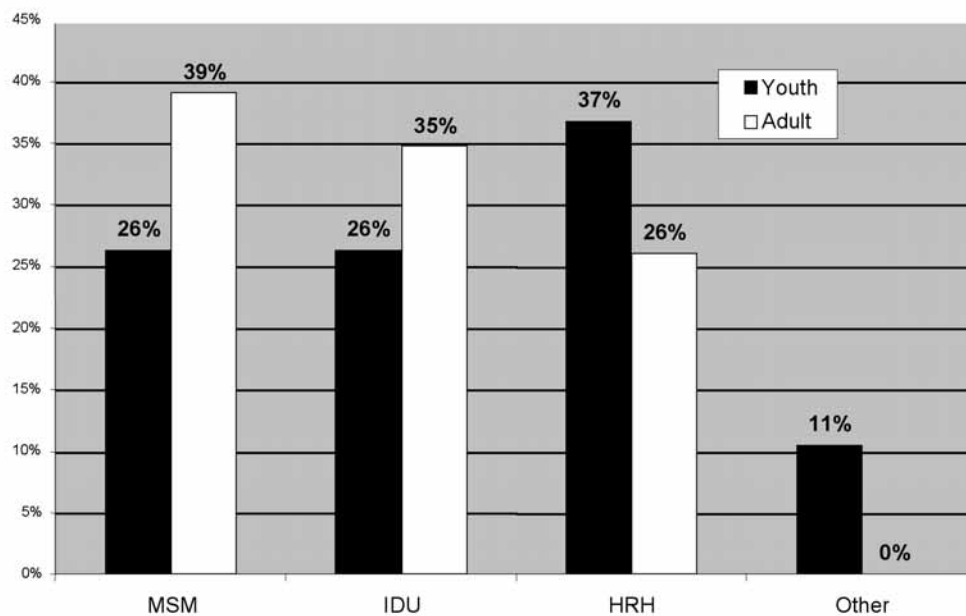


Appendix D: Details of the Gap Analysis

Far Southside: Services by New Infections by Target Population

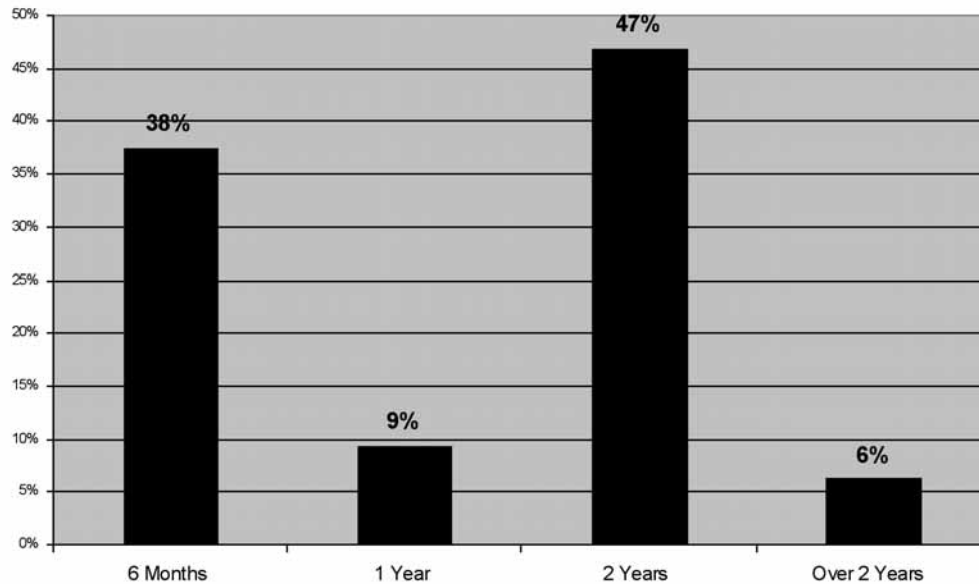


Far Southside: Percentage Services by Youth and Adult Target Populations

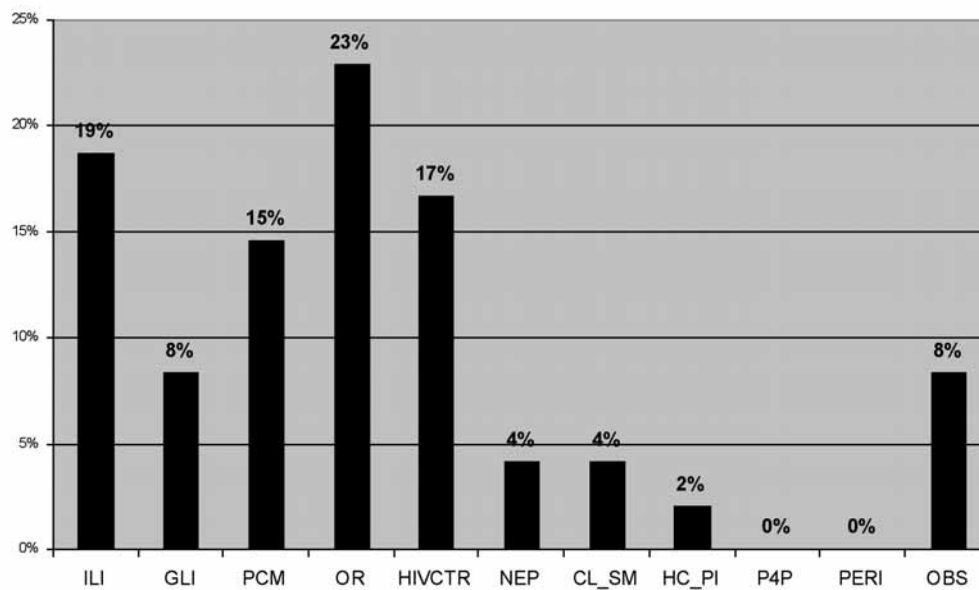


Appendix D: Details of the Gap Analysis

Far South: Expiration Dates of Programs



Far South: Use of Interventions



ILI = Individual Level Intervention

GLI = Group Level Intervention

PCM = Prevention Case Management

OR = Outreach

HIVCTR = HIV Counseling Testing and Referral

NEP = Needle Exchange Program

CL SM = Community Level/Social Marketing

HC PI = Health Communication/Public Information

P4P = Prevention for Positives

PERI = Perinatal

OBS = Organizational Development/Capacity Building

Appendix E: Zip Codes and Community Areas

CLUSTER	ZIP CODES		COMMUNITY AREAS		
Cluster A	60613 60625 60626 60640 60657 60660		Albany Park Edgewater Lakeview Lincoln Park Lincoln Square Rogers Park Uptown		
Cluster B	60601 60605 60607 60608 60610 60611 60612 60614 60616	60622 60623 60624 60639 60644 60647 60651 60661	Armour Austin Belmont Cragin Bridgeport Douglas East Garfield Park Hermosa Humboldt Park Logan Square	Loop Lower West Side Near South Side Near West Side North Lawndale South Lawndale West Town West Garfield Park	
Cluster C	60609 60615 60619 60620 60621 60628	60636 60637 60643 60649 60653	Auburn Gresham Avalon Park Beverly Bridgeport Burnside Chatham Douglas Englewood Fuller Park	Grand Boulevard Greater Grand Crossing Hyde Park Kenwood McKinley Park Morgan Park New City Oakland Pullman	Riverdale Roseland South Shore Washington Heights Washington Park West Englewood West Pullman Woodlawn