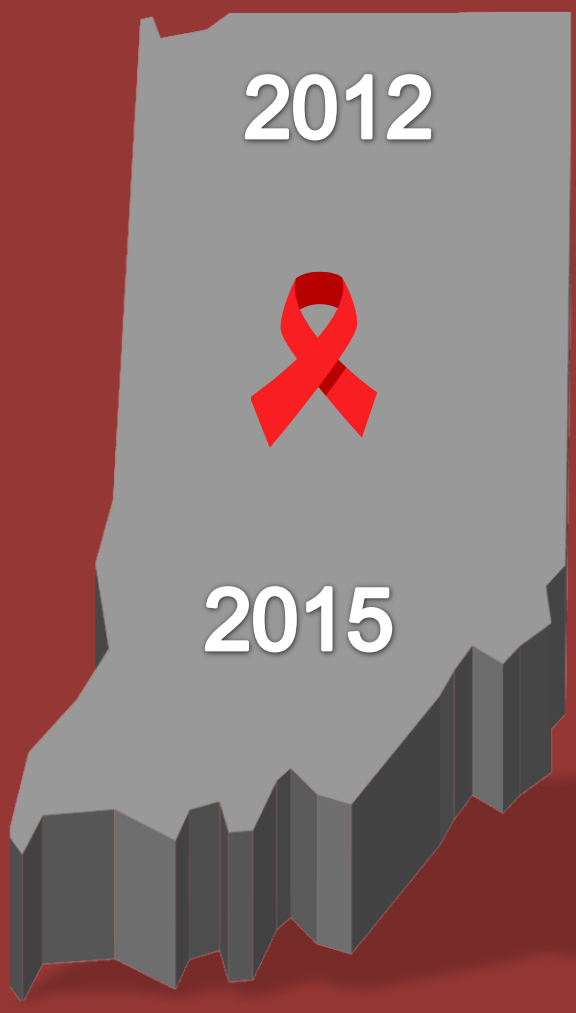
Indiana Statewide HIV Prevention Plan



ACKNOWLEDGEMENT

The Indiana HIV Prevention Community Planning Group (CPG) would like to take this time to remember and acknowledge all members who have lost their lives to HIV/AIDS since the group began in 1994. We would also like to thank those individuals currently on the CPG as well as those not serving on this body that unselfishly devote their lives to preventing the spread of HIV in the state of Indiana. Lastly, we want to thank everyone for their contribution no matter how large or how small to the information encompassed within these pages.

We are extremely proud of how the Indiana Statewide HIV Prevention Community Planning Group came together with the Indiana State Department of Health (ISDH) to create this comprehensive, statewide HIV Prevention Plan. We remain united in the struggle for healthy communities and are hopeful that that spirit of unity is reflected within these pages. We are fortunate to have a good working relationship, an honest and open dialogue, and a healthy respect for each other's strengths and weaknesses. This partnership has allowed us to adapt to the many changes in HIV prevention, ISDH staff and community planning membership.

The Indiana Statewide HIV Prevention Community Planning Group remains highly optimistic that a shared commitment by ISDH and the community to aggressively strengthen and modify the various components of the community planning process contained within this Plan will only serve to strengthen HIV prevention efforts statewide.

A newly revised HIV Prevention Planning Guidance for Health Departments and their Partners is expected from the Centers for Disease Control and Prevention and, when it is received, this Plan will be reviewed for consistency of content. Modifications, updates, and/or revisions will be made as needed.

It has been our honor to work with members of the community and State Government who are so passionate, committed and concerned about the plight of others that they dedicate their time, energy and skills to make a positive difference.

Sincerely,

Ramon R. Morton
Community Co-Chairperson

Andrea Perez
State Co-Chairperson

EXECUTIVE SUMMARY

The 2012-2015 Indiana Statewide HIV Prevention Plan is designed to establish the roadmap for prevention services that will have the most impact on communities with highest risk for acquiring and/or transmitting HIV/AIDS. In keeping with the goals and recommendations set forth by the Centers for Disease Control and Prevention (CDC), the Indiana State Department of Health (ISDH), in partnership with current members of the Indiana HIV Prevention Community Planning Group (CPG), has worked diligently on the recruitment of members from the community that are most heavily impacted by the disease to assist and provide input during the planning process and the finalization of this prevention plan. The thoroughness, specifications, and transparency of the work that was dedicated to producing this plan are documented throughout these pages.

The complete HIV Prevention Plan contains approximately 60 pages of information related to the HIV prevention needs in Indiana. This Executive Summary provides a synopsis of the complete plan. Multiple data sources were evaluated and analyzed to create this document. The plan includes the following: 1) the ISDH HIV Prevention Programs; 2) description and history of the Indiana HIV Prevention CPG; 3) CPG committee descriptions/narratives; 4) composition of the present Indiana HIV Prevention CPG; 5) Epidemiologic Profile Executive Summary; and 6) Prevention Resources for the State of Indiana.

Indiana State Department of Health HIV Prevention Programs

The HIV prevention program utilizes several methods to reach the goal of increasing public understanding of, involvement in, and support for HIV prevention, thereby reducing the number of new HIV infections in the state. This goal is met by administering the following programs: 1) Viral Hepatitis Prevention; to include perinatal hepatitis B; 2) Capacity Building; 3) Counseling, Testing, and Referral Services; 4) Comprehensive Prevention with HIV-positive Individuals; 5) Evidence-based HIV Prevention Interventions for HIV-negative Individuals; 6) HIV Prevention Community Planning Group; 7) Perinatal HIV Prevention; and 8) Training and Development. The above listed programs are implemented statewide through designated health departments and community-based organizations (CBOs).

HIV Prevention Community Planning Group

The Indiana HIV Prevention CPG is a Centers for Disease Control and Prevention (CDC) mandated advisory group that is comprised of persons throughout the state of Indiana who are either infected or affected by HIV/AIDS. The CPG works in partnership with the ISDH Division of HIV/STD/Viral Hepatitis (Division) to create this statewide prevention plan that best represents the needs of various communities at risk for or infected with HIV. The Indiana HIV Prevention CPG allows for a membership of 25. Applications are accepted throughout the year with new members selected on an annual basis, during the month of October. Technical advisors are provided by the Division and recruited from associated fields. The CPG meets bi-monthly at the ISDH. All meetings are open to the public as required by Indiana's "Sunshine Law". Tasks are completed through a committee structure. In addition to the executive committee, there are five standing committees and three Ad Hoc committees. The committees are as follows: 1) Epidemiology/Populations Committee; 2) Evaluations Committee; 3) Interventions Committee; 4) Membership Committee; 5) Needs Assessment Committee; 6) Sexually Transmitted Disease

Ad Hoc Committee; 7) Public Policy and Procedures Ad Hoc Committee; 8) Advocacy Ad Hoc Committee. These committees were created in order to complete the following tasks: 1) review of the Epidemiological Profile; 2) community services assessment; 3) prioritization of target populations; 4) identification of appropriate science-based prevention activities/interventions specific to the targeted populations; 5) creation of a comprehensive prevention plan; 6) creation and submission of the letter of concurrence/non-concurrence/concurrence with reservations; and 7) evaluation of planning activities.

CPG Committee Descriptions/Narratives *(in alphabetical order)*

Epidemiology/Populations Committee:

This committee is charged with the development, definition, and prioritization of targeted populations. Beginning in February of 2010, this committee began the development of the prioritization process that was eventually carried out in September of 2011. The methodology that was utilized in ultimately prioritizing the targeted populations for 2012 was a six (6) step process that incorporated risk behaviors, demographics, factors including, but not limited to AIDS and HIV incidence, prevalence, and rate; the difficulty of meeting the needs of certain populations; and the existing barriers to reaching certain populations. In both May and June, the committee convened to apply the methodology, calculate scores, and finalize the priority populations. Once a final score was tallied for each population, the committee ranked the populations from highest to lowest. During the September full body CPG meeting, the committee recommended and the full CPG approved the following priority populations:

1. **People Living with HIV/AIDS**
2. **Black Men who have Sex with Men (MSM)**
3. **White Men who have Sex with Men (MSM)**
4. **Hispanic Men who have Sex with Men (MSM)**
5. **Black Heterosexual Women**

Evaluations Committee:

This committee exists in order to implement an evaluation of the CPG process as mandated by the CDC with the goal of providing direction to the CPG regarding evaluation of prevention efforts in general. This section of the plan contains detailed information on the several methods that are implemented throughout the year in efforts of evaluating the CPG process as a whole. In this narrative, the committee describes the following tools used: 1) bi-monthly group assessment; 2) member self performance review survey; 3) exit surveys/interviews; 4) CPG knowledge assessment; and 5) annual evaluation survey. These tools help support the monitoring and evaluation of progress toward the goals and objectives of the HIV prevention community planning body and documents ways to constantly improve the group's work.

Interventions Committee:

It is the role of the interventions committee to identify appropriate interventions for the set targeted priority populations as well as to keep the full CPG updated on any and all information regarding newly created or revised interventions. In this plan, the interventions committee details the process of selecting the interventions that are thought to be the most feasible and effective for the state of Indiana. This narrative includes a table for each targeted priority population that lists and details the recommended intervention for each. This section also

describes the four (4) public health strategies that have been recommended by the CDC as other techniques used to assist in the prevention of HIV transmission. Additionally, this portion of the plan also includes an area that assists agencies in selecting a best fit intervention for their organization.

Membership Committee

The membership committee fully details their role in the planning process for Indiana. The committee makes great strides in the recruitment of members that accurately reflect the HIV/AIDS epidemic in Indiana. This portion of the plan describes the recruitment and selection process for members, as well as the orientation, participation, and inclusion of all CPG members.

Needs Assessment Committee

This committee is charged with working closely with the Division in assessing the needs of the community as it relates to HIV prevention in Indiana. In the past three years, the needs assessment committee has created or assisted in the creation of several documents that have assisted both the CPG in their work as a planning body and the ISDH in their efforts for HIV prevention. This portion of the plan details the establishment of *Moving Forward Together: A Needs Assessment Research Agenda for HIV Prevention in Indiana* which was designed to encourage Indiana communities, planning coalitions, and research partners to focus on one or more of the listed priorities in order to help shape a more comprehensive understanding of HIV in Indiana. This section also provides details regarding the 2011 HIV Test Visitors Project: Seeing with New Eyes, The Black Men's Health Study, the 2010 MSM needs assessment, and the 2009 HIV prevention gap analysis.

The 2012-2015 Indiana Statewide HIV Prevention Plan is the culmination of work that has spanned more than two years. This document represents the vigorous efforts of all members of the CPG, Division staff, and countless others who have made significant contributions. It is expected that this plan will be a living document, which can be revised as its content is updated and new information is available.

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CPG KNOWLEDGE ASSESSMENT SURVEY

Indiana HIV Prevention Community Planning Group

Community Planning Group Co-Chairs as of September 2011

Community Co-Chair	**State Co-Chair**
Ramon Morton	Andrea Perez

Community Planning Group Membership as of September 2011

Jonathan Balash Spencer, IN Region 7	Marissa Miller Indianapolis, IN Region 5
Emily Brinegar Bloomington, IN Region 7	Ramon Morton Gary, IN Region 1
Candace Florence Terre Haute, IN Region 7	Andrea Perez Indianapolis, IN Region 5
Angela Goode Indianapolis, IN Region 5	Brian Revalee Evansville, IN Region 8
Latorya Greene South Bend, IN Region 2	Nathan Rush Indianapolis, IN Region 5
Gregory Knight Merrillville, IN Region 1	Denice Trulley Crown Point, IN Region 1

Division of HIV/STD Staff Technical Advisors

Alicia Anderson HIV Prevention	John Hon STD Program
Rupert Arceo Perinatal Hepatitis B	Brenda Mason Perinatal Hepatitis B
Cena Bain HIV Prevention	Susan Newton HIV Prevention
Darin Foltz HIV Services	Amanda Writt HIV Prevention
Dan Hillman Surveillance	

HIV Prevention Community Planning Group Technical Advisors

Michael Exom Disease Intervention Specialists	Sue Henry HIV/STD Prevention Program Coordinator Indiana Department of Education (DOE)
Rochelle Feldheiser HIV Counselor/Disease Intervention Specialists	Anita Ohmit Epidemiologist
Tony Gillespie HIV Prevention	

Indiana State Department of Health
HIV Prevention Programs (in alphabetical order)

HIV prevention is the best strategy for reducing the human and economic toll from HIV/AIDS. Comprehensive HIV prevention is a broad term that incorporates tracking the epidemic through HIV/AIDS Surveillance system; research to identify causes and solutions; implementing effective, evidence based prevention intervention programs; building capacity of state and local programs; and program evaluation and policy development.

The goals of the Indiana HIV Prevention Program are to increase public understanding of, involvement in, and support for HIV prevention and through those efforts, reduce the number of new infections. The focus is on eliminating racial and ethnic disparities in new infections and prevention with HIV positives. Programs are implemented statewide through designated health departments and community-based organizations (CBOs). These agencies provide education and information to initiate modification of behavior patterns or practices that put persons at risk of HIV infection. Targeted populations include teenagers, men who have sex with men, women at risk (including pregnant women), substance users, needle sharers, prisoners, and individuals from racial and ethnic populations which are disproportionately affected by HIV Disease, and others at risk.

Adult Viral Hepatitis Prevention

The mission of this program is to decrease transmission of hepatitis viruses, increase hepatitis A & B immunizations among adults and those at increased risk, increase resources to identify and treat persons with chronic hepatitis, increase identification of those living with viral hepatitis, and increase awareness among healthcare providers and laboratories of their role in prevention, detection, management, and treatment of hepatitis.

The Indiana **Perinatal Hepatitis B Prevention Program (PHBPP)** is a resource for the surveillance and control of perinatal hepatitis B infection. The primary goal of the program is to prevent perinatal transmission of hepatitis B infection by identifying and providing case management to HBsAg-positive pregnant women to ensure initiation of post-exposure prophylaxis to their newborns.

Capacity Building

The Capacity Building Assistance (CBA) Program within the Division of HIV/STD strives to improve the performance of Indiana's HIV prevention workforce. This is done by assisting community-based organizations and local health departments by increasing and sustaining their ability to deliver effective HIV prevention services. The program's goal is to improve the performance of Indiana's HIV prevention workforce in the following areas: Strengthening Organizational Infrastructure, Strengthening Interventions for HIV Prevention, Strengthening Community Access to and Utilization of HIV Prevention Services, and Strengthening Community Planning for HIV Prevention. Upon needs being identified, program staff initiates assistance for local and national providers to assist with meeting their capacity building needs.

Counseling, Testing, and Referral Program

The mission of this statewide program is to provide and facilitate disease intervention and prevention. This is accomplished through counseling, testing, and client referrals to other service needs. This program also serves to promote early detection of HIV infection and facilitate access to health care.

HIV Prevention Community Planning Group (CPG)

This program is a Center for Disease Control and Prevention (CDC) mandated advisory board that is comprised of persons either infected or affected by HIV/AIDS. The CPG works in partnership with the Indiana State Department of Health (ISDH) to design this comprehensive statewide prevention plan that best represents the needs of various communities at risk for, or infected with HIV.

Perinatal HIV Project

"One Test Two Lives"

The "One Test Two Lives: Prevent HIV Indiana," campaign is an effort of multiple partners to increase awareness and promote practices that will result in prevention of HIV transmission from mothers to their babies. The mission of this statewide educational campaign is to alert care providers along with the general public of the importance of testing and treatment in the prevention of mother-to-child-transmission. The campaign is a multi-pronged outreach designed for those who provide care to and interact with women of childbearing age and the general public to make sure everyone is knowledgeable regarding mother-to-child-transmission. In addition to providing this education firsthand to those that the campaign has the ability to reach, it is also an objective to ask those who receive this important message to join in the prevention efforts.

Training and Development Program

This program initiates, coordinates, and provides trainings regarding HIV prevention. These trainings are provided by program staff as well as collaborations with national providers. The program holds monthly Counseling Certification Training for employees and volunteers of community partners.

Initiating HIV Prevention Community Planning

In 1993, CDC issued a directive for *"states and localities"* to receive special funds for HIV prevention to assist in the creation of HIV Prevention Community Planning Groups (CPG). Prior to 1993, communities were involved in carrying out HIV prevention services, but were not involved in the planning of comprehensive state and local prevention programs. Decisions regarding HIV prevention were either mandated by Congress or administered by the CDC through its Cooperative Agreement with State Health Departments regulating their grantees to adhere to CDC mandated criteria. Community Planning was developed to reflect the belief that it would bring state and local health departments down to community level and assist them with a more realistic point of view for determining how best to respond to local HIV prevention priorities and needs. Community Planning also assists in giving these entities a vehicle to determine how the CDC's mandates and initiatives could be best carried out through local community decision making.

Initiating HIV Prevention Community Planning in Indiana

In 1994, pre-planning groups were established by the state of Indiana to review the state's previous HIV planning experience before Community Planning was decreed into existence, to ascertain how closely this prior planning experience and how it fit into the mandate for community planning established by CDC. After much research and discussion these *"framework builders"* of the Indiana CPG decided that it was best for the state of Indiana to have one (1) statewide planning body that would have a member capacity of as many as thirty-two (32). Today the CPG Charter mandates a capacity of twenty (20) to twenty-five (25) members. Eighteen (18) to twenty-three (23) members sought through nominations from around the state of Indiana and two (2) members that are nominated from the services planning body the Comprehensive HIV Services Planning and Advisory Council (CHSPAC). These two (2) members provide the services planning perspective to the CPG as well as answer any questions that may arise regarding their services expertise during the course of a bi-monthly meeting. These two (2) members are held to the same standards and criteria as other members in the group.

Importance of HIV Prevention Community Planning

CDC expects HIV prevention community planning to improve HIV prevention programs by strengthening the: 1) scientific basis, 2) community relevance, and 3) population-based or risk-based focus of HIV prevention interventions in each project area. The basic intent of the process has been threefold: to increase meaningful community involvement in prevention planning, to improve the scientific basis of program decisions, and to target resources to those communities at highest risk for HIV transmission/acquisition.

Purpose of the Comprehensive HIV Prevention Plan

The Centers for Disease Control and Prevention (CDC) position is, ***"The primary task of the Community Planning Group is to develop a Comprehensive HIV Prevention Plan for the state of Indiana that includes prioritized target populations and a set of prevention activities and interventions for each targeted population."*** Target populations need to be prioritized and prevention activities and interventions need to be selected based on their ability to prevent as many HIV infections, as possible. The Community Planning Group is required to develop at least one Comprehensive HIV Prevention Plan at a minimum of every five years. The Indiana HIV Prevention Community Planning Group has chosen to implement the state's three-year funding cycle into their planning cycle and create a plan every three years, and update their existing plan annually or as needed.

The purpose and objective of the Comprehensive HIV Prevention Plan is to serve as a guide on how HIV prevention programs across the state of Indiana should respond to the HIV epidemic in implementing HIV prevention community planning, counseling, testing and referral/partner counseling referral services (CTR/PCRS), HIV prevention health education and risk reduction, capacity building, evaluation, and other health department activities conducted under the Program Announcement for HIV Prevention Projects.

The Indiana CPG Process

The Academy for Educational Development defines participatory planning as, ***"an ongoing process which state and local health departments share responsibility for developing a Comprehensive HIV Prevention Plan with other governmental and non- governmental agencies, and representatives of communities and groups at risk for HIV infection or those already infected."*** The Indiana HIV Prevention CPG uses this form of planning in identifying needs and making decisions through the broad-based involvement of a wide range of viewpoints, wherein differences in background, perspective, and experience are essential and valued.

Goals of the Community Planning Group Process

In the *"HIV Prevention Community Planning Guidance"* the CDC has set three (3) major goals for HIV Prevention Community Planning. The three (3) goals of the HIV Prevention Community Planning group process are as follows:

Goal One: HIV community planning is required to support broad-based community participation in HIV prevention planning.

The CPG must be inclusive and involve the participation of individuals infected with and affected by HIV. CPG must accomplish broad-based community participation in HIV planning. The Indiana CPG takes great strides in ensuring that this goal is met by focusing on CPG representation, inclusion, and parity through its membership and orientation process.

Representation

According to the HIV Prevention Community Guidance, representation is defined as the act of serving as an official member reflecting the perspective of a specific community. The guidance further states that a representative should truly reflect that community's values, norms, and behaviors. With that said, throughout the year the active members of the Indiana CPG work diligently with the leadership of the membership committee in accessing gaps in membership and recruiting from regions and populations who may lack representation on the advisory board. Prospective individuals are asked to apply to the advisory for consideration. Each application is received by the CPG Liaison. Once received, a profile is created for each eligible applicant, with all names and organization information removed, and provided to the membership committee for nominations. Committee members of the membership committee carefully review each profile, making nomination decisions based on demographic information, to include, but not limited to; race, ethnicity, gender, gender identity, sexual orientation, age, expertise, abilities, and experiences. Once nominated, the membership committee presents all selected nominees to the full CPG for final approval.

Inclusion

The HIV Prevention Community Guidance defines inclusion as meaningful involvement of members in the process with an active voice in decision making. Indiana attempts to maintain an inclusive planning process by recruiting potential applicants who match the epidemiology of the disease within the state of Indiana. CPG members maintain an open recruitment process throughout the year, selecting new members annually, during the month of October. Additionally, the CPG has created by-laws and policies that assist in assuring an inclusive planning process.

In addition, the CPG provides lodging for applicable members along with travel and meal reimbursement. In addition, the CPG has created policies that assist members with child care needs in order to have meaningful involvement with the CPG.

Parity

Parity is defined by the HIV Prevention Community Guidance as the ability of members to equally participate and carry-out planning tasks/duties,. Indiana maintains parity by first mandating that all returning and newly selected members attend an all day orientation. With technical assistance from the Academic for Educational Development (AED), the Indiana CPG has created an orientation that provides a background on community planning, details the roles and responsibilities of each key player in the planning process, provides information pertaining to the key products and activities that are needed for creating a comprehensive HIV Prevention Plan, describes the group process, and provides guidance on evaluating the CPG process.

To ensure that all members of the CPG are equally contributing to the planning process, the consensus style of decision-making is utilized as the basis of all CPG activities. Under this style of decision making, all members continue to discuss all issues until all points of views are incorporated prior to the final decision. For the Indiana CPG consensus means the following: 1) all members contribute to the discussion. 2) all members are able to state the issue/problem in their own words. 3) everyone is given reasonable opportunity and time to express their opinion about the issue/problem. 4) members who continue to dissent will agree to support the group decision. 5) all members agree to take responsibility for the implementation of a decision. Consensus does not mean that a vote is unanimous; it results in every member's first choice, every member agrees, and conflict or resistance will be overcome. If consensus cannot be reached by the group then the co-chairs will use the publication, "Robert's Rules of Order" to reach a final decision.

Goal Two: Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

A set of priority populations and intervention(s) for each identified target population is gathered through a logical and evidence based process utilizing a gap analysis, needs assessment, and an epidemiological profile. Each tool is described below:

Needs Assessment

The needs assessment is the process of obtaining and analyzing findings to determine the type and extent of unmet needs in a particular population or in a community. The duties and accomplishments of the Needs Assessment committee are presented in further detail beginning on page 48.

Gap Analysis

A gap analysis is used to identify and describe the gaps in services for defined high-risk populations determined by the needs assessment. A gap analysis is usually conducted following any needs assessment activities that have taken place. The needs assessment committee then utilizes this document in order to make recommendations to the state of Indiana.

Epidemiological Profile
The epidemiological profile is a description of the current status, distribution, and impact of an infectious disease or other health related condition in a specified geographic area. The epidemiology and populations committee utilizes this document when prioritizing the populations for the state of Indiana. The epidemiological profile for the state of Indiana is completed by the state's epidemiologists at the State Department of Health in partnership with Luther Consulting, LLC. Prior to public release, the profile is presented and viewed by the Indiana HIV Community Planning Group for thoroughness, comprehension, and approval.

Once prioritized target populations are presented and approved, interventions are selected that match those prioritized target populations. Decisions and the selections of specific interventions are explained in further detail beginning on page 28.

Goal Three: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

This goal is achieved by collaboratively working with the state health department in identifying target populations, targeting interventions, and compiling the HIV prevention plan. Once the plan is finalized and disseminated, this plan is to act as a roadmap to prevention services across the state of Indiana. According to the HIV Prevention Community Guidance, it is the role of the CPG to review the health department application to CDC for federal prevention funds, including the proposed budget, and develop a written response that describes whether the health department application does or not does not, and to what degree, agree with the priorities set forth in the comprehensive plan. This is often referred to as the concurrence/non-concurrence process.

Letter of Concurrence
If the full CPG agrees with the entire health department application for federal prevention funds, including the proposed budget, a letter of concurrence will be attached to the application.

Letter of Concurrence with Reservations
If the full CPG mostly agrees with the health department application for federal prevention funds, but has some concerns in various areas, a letter of concurrence with reservations will be developed, in which the state department of health must address the issues in an attachment to the application.

Letter of Non-Concurrence
If the full CPG disagrees with most or all of the application because it does not reflect the recommendations set forth in the comprehensive plan, a letter of non-concurrence will be submitted on behalf of the CPG. If the application that is submitted by the health department does not match the recommendations set forth in the plan, the health department must submit a letter of explanation as to why public health would be better served by funding HIV prevention activities that are different from those set forth in the prevention plan.

HIV Prevention Community Planning Group
Committee Descriptions

Executive/Budget Committee
The Executive Committee is made up of the two co-chairs, the chairs of each standing committee and one at-large member. The Executive Committee functions as the leadership of the Community Planning Group by providing directional and functional guidance. The executive committee keeps the CPG informed on the status of the annual CPG budget process and prior to the end of the year to propose a budget for the upcoming year.

Epidemiology/Populations Committee
It is the mission of the Epidemiology/Population Committee to develop, define and prioritize populations in order to have the process and final product approved by the full Community Planning Group, utilizing the following process:

1. Develop and define a list of populations through the use of epidemiological data and other pertinent information.
2. Determine a method for prioritization of populations and present the method to the CPG for final approval.
3. Implement the approved prioritization process and submit the outcome to full CPG for approval.
4. Continue to keep abreast of changes in trends of epidemiologic information relating to populations.

Interventions Committee
It is the mission of the Interventions Committee to develop the appropriate interventions for the priority populations set forth by the epidemiology/populations committee. In order to have the process and final project approved by the full Community Planning Group, the interventions committee then utilizes the following process:

1. Determine a method for prioritization of interventions for each population and present the method of the CPG for final approval.
2. Implement the approved prioritization process and submit the outcome to the full CPG for approval.
3. Continue to keep CPG updated on information and issues regarding interventions.

Needs Assessment Committee
It is the mission of the Needs Assessment Committee to work with the Division of HIV/STD to assess the needs of the community as it relates to HIV/AIDS prevention. This mission is met through the following functions:

1. Act as advisors to the Division on the focus and implementation of needs assessments.
2. Provide input as it relates to the development and updating of a resource inventory.
3. Review the needs assessment and resource inventory, provide input into a gap analysis report, and submit the outcome for full CPG for approval.

Membership Committee
The mission of the Membership/Evaluation committee is to work with the Community Planning Group and HIV Program Staff to address the needs of membership for representation, retention, and functioning within the Community Planning Group process. The committee also assures community input and access to the community planning process by maintain parity, inclusion, and representation as defined in the CDC Guidance for the Community Planning Groups.
This mission is met through the following functions:

1. Recruit members for the CPG with help of the ISDH
2. Ensure members of CPG reflect the diversity of the epidemic and regional areas.
3. Address retention and participation issues.
4. Replace members as vacancies occur
5. Recommend new members to the CPG.
6. Meet as needed to conduct the above business.
7. Review and revise application form as needed.
8. Develop and implement orientation procedure.

Evaluation Committee
The Evaluation Committee is to implement an evaluation of the CPG process as mandated by the CDC to provide direction to the Community Planning Group regarding evaluation prevention efforts in general. This mission is carried out in the following functions:

1. Working with Division staff and consultants to develop/update a survey tool and/or other methodologies to evaluate the community planning process.
2. Assist when necessary with implementing the evaluation process.
3. Report back to CPG the results and recommendations based on the evaluation.
4. Keep abreast of the evaluations methodology being utilized for the local funded prevention projects and national trends regarding evaluation.
5. Provide input through the CPG regarding evaluation methodology of funded prevention projects.

Sexually Transmitted Disease Ad Hoc Committee
It is the mission of the STD Ad Hoc Committee to act as an advisory body and provide input to the STD program regarding its activities as it relates to collaborations with HIV/AIDS prevention. This mission is carried out in the following functions:

1. Identify the means to coordinate prevention activities of HIV and STDs.
2. Maintain and promote awareness of relationships between HIV/STDs including new prevention detection and treatment technologies.
3. Recommend statistical comparisons between STD/HIV.
4. Collaborate with STD program manager to determine unmet STD intervention needs throughout the state.

Public Policy & Procedures Ad Hoc Committee
It is the mission of the Public Policy-Policy/Procedure Ad Hoc Committee to keep the CPG informed on the local, state, national, and international policies affecting the issue of HIV/AIDS/STD prevention and to make recommendations of policies and procedures to facilitate the planning and implementation process of the CPG. The expectations of this committee are as follows:

1. Recommend to the IN CPG, endorsement of position papers on HIV/AIDS/STD issues, and promote awareness among CPG membership of such issues.
2. Develop press releases as they pertain to all issues on HIV/ATD/STD, and the CPG.
3. Monitor any HIV/AIDS/STD activity, in an effort to keep the CPG updated and informed.
4. Solicit CPG co-chairs, committee chairs for immediate and/or future needs of Policy and Procedure needs.
5. Work with other appointed Committees (as needed by appointed committee) on compiling a draft recommendation for the Executive Committee.
6. Create new policy and procedures for recommendations to the CPG executive committee for preliminary approval.
7. Compile and disseminate draft policies and procedures to the CPG Executive Committee for preliminary approval.
8. Maintain and revise all necessary CPG policies and procedures.

Advocacy Ad Hoc Committee
The Advocacy Ad Hoc Committee is responsible for researching, identifying and disseminating policies and strategies to slow the spread of HIV, meet the needs of HIV positive people, and facilitate systematic and funding changes that are needed to improve the response to the HIV/AIDS epidemic in Indiana.

Indiana HIV Prevention Community Planning Group Composition

Collected and Results Compiled by Cena Bain, CPG Liaison

As of October 2011
Total Number of Voting Members: 12
Total Number of Non-Voting Members: 11

Age (voting members only)	**Number**
< 19	0
20-24	1
25-29	1
30-49	9
50 +	1
Unknown/Not Reported	

Gender (voting members only)	**Number**
Male	5
Female	6
Transgender	1

TABLE 1: Racial/Ethnic Representation on the CPG

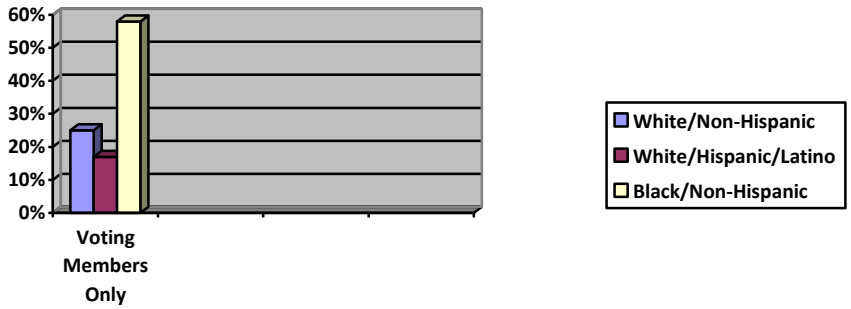


TABLE 2: Indiana Community Planning Group versus the Epidemic in the State of Indiana by Race and Ethnicity *(voting members only)*

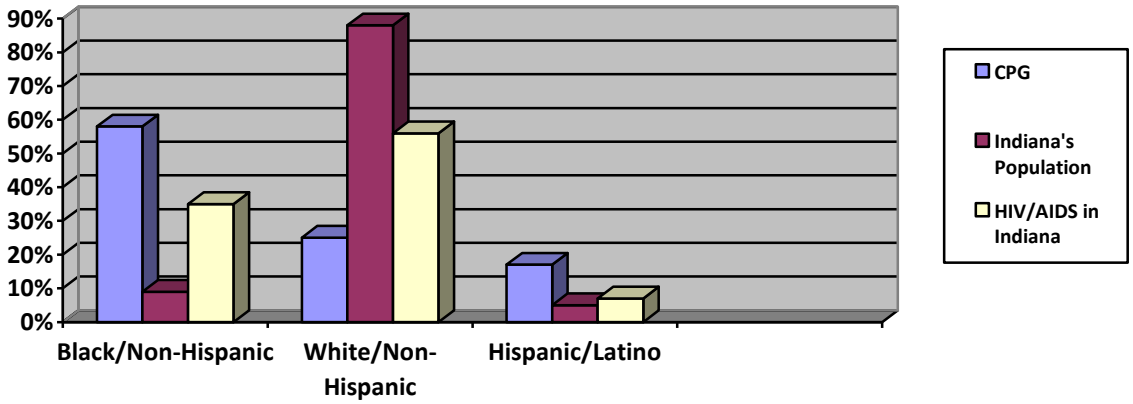


TABLE 3: Indiana Community Planning Group versus the Epidemic in the State of Indiana by Gender *(voting members only)*

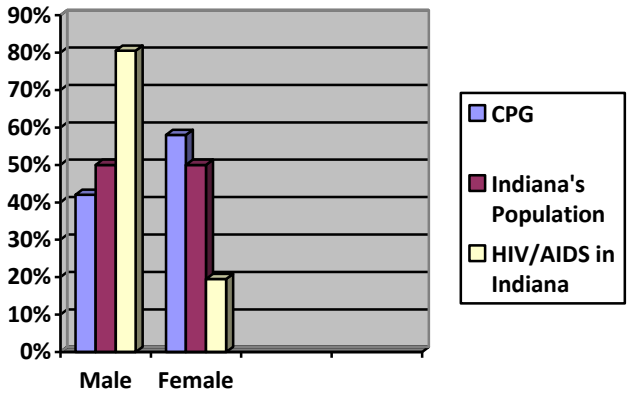
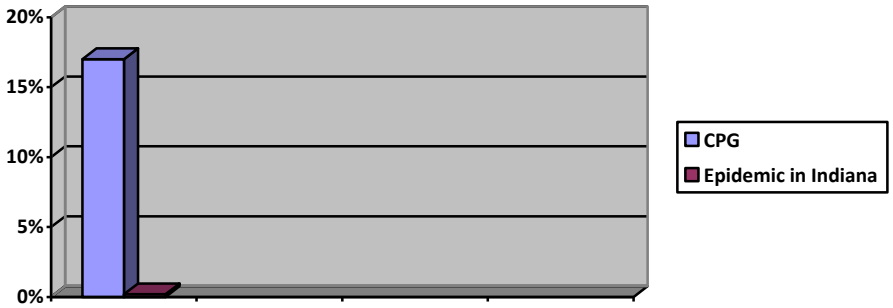


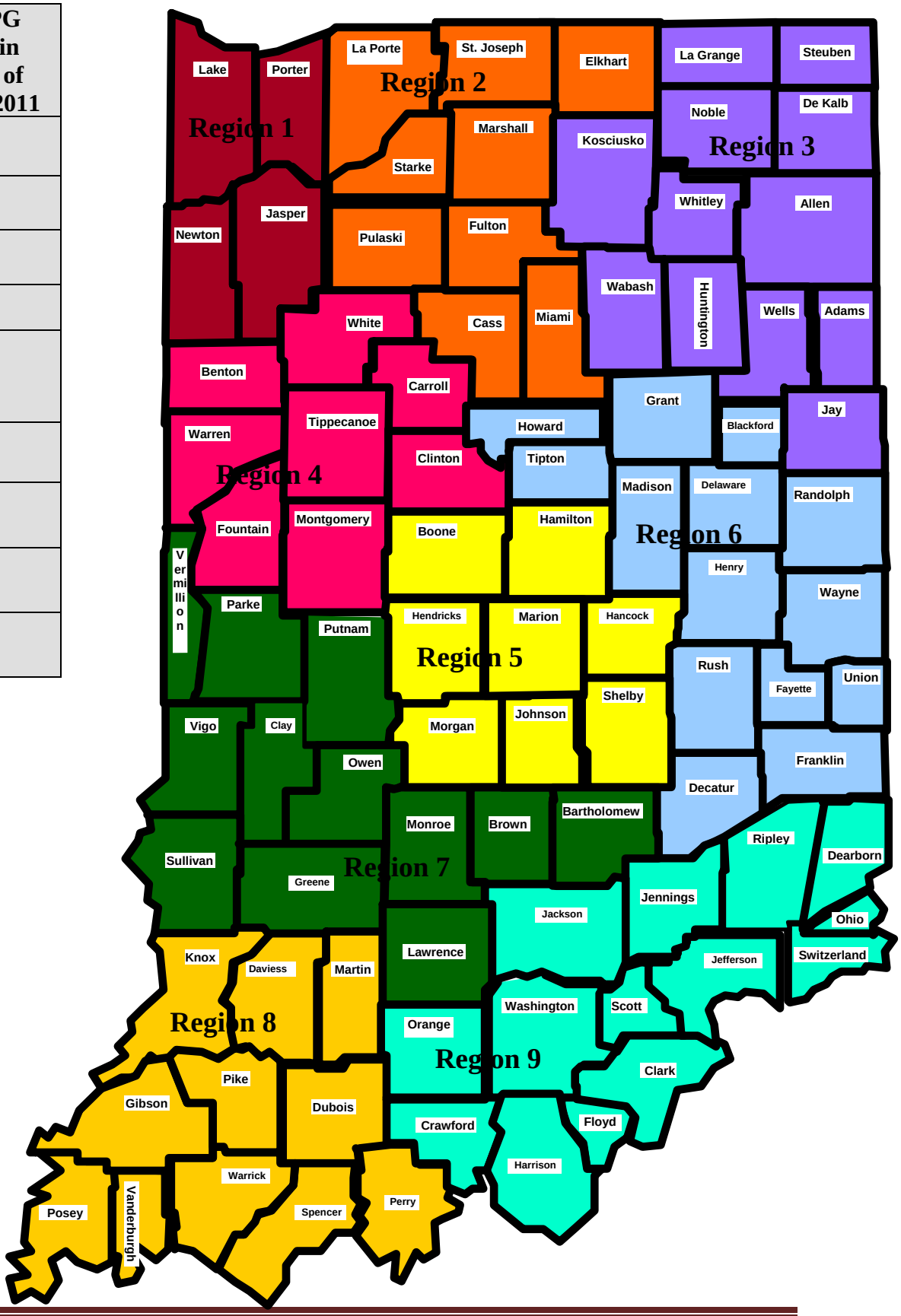
TABLE 4: Indiana self reported HIV positive CPG members versus the Epidemic in the State of Indiana *(voting members only)***.**



Note: Numbers in graph provided by the Epidemiologic Profile 2009 and the CPG Member Survey

HIV PREVENTION REGIONAL MAP

Region	Voting CPG Members in Region, as of September 2011
1	3
2	1
3	0
4	0
5	4
6	0
7	3
8	1
9	0



Community Planning Group 2011
Committee Member List

Executive/Budget Committee
Emily Brinegar (Member at-large)
Angela Goode (Needs Assessment Chair)
Latorya Greene (Membership Chair)
Ramon Morton (Community Co-Chair)
Andrea Perez (State Co-Chair, ISDH)
Nate Rush (Interventions Chair)
Cena Bain (CPG Liaison)

Epidemiology/Populations Committee
Jonathan Balash
Candace Florence
Gregory Knight
Angela Goode
Tony Gillespie (Technical Advisor)
Dan Hillman (Technical Advisor)
Anita Ohmit (Technical Advisor)
Cena Bain (CPG Liaison)

Evaluation Committee
Ramon Morton (Community Co-Chair)
Andrea Perez (State Co-Chair)
Brian Revalee
Cena Bain (CPG Liaison)

Interventions Committee
Nate Rush (Committee Chair)
Marissa Miller
Denise Trulley
Mike Exom (Technical Advisor)
Amanda Writt (Technical Advisor)
Sue Henry (Technical Advisor)
Darin Foltz (Technical Advisor)
Cena Bain (CPG Liaison)

Membership Committee
Latorya Greene (Committee Chair)
Rochelle Feldheiser (Technical Advisor)
Susan Newton (Technical Advisor)
Cena Bain (CPG Liaison)

Needs Assessment Committee
Angela Goode (Committee Chair)
Emily Brinegar (Committee Co-Chair)
Brian Revalee
Andrea Perez (State Co-Chair)
Tony Gillespie (Technical Advisor)
Anita Ohmit (Technical Advisor)
Cena Bain (CPG Liaison)

Sexually Transmitted Disease Ad Hoc Committee
Mike Exom (Technical Advisor)
John Hon (Technical Advisor)
Cena Bain (CPG Liaison)

Public Policy & Procedure Ad Hoc Committee
Ramon Morton (Community Co-Chair)
Jonathan Balash
Cena Bain (CPG Liaison)

Advocacy Ad Hoc Committee
Angela Goode
Ramon Morton (Community Co-Chair)
Tony Gillespie (Technical Advisor)
Cena Bain (CPG Liaison)

Technology Ad Hoc Committee
Cena Bain (CPG Liaison)

EPIDEMIOLOGIC PROFILE EXECUTIVE SUMMARY

Prepared By: Dan Hillman

Introduction:

This statewide profile describes the epidemiology of HIV, AIDS and other STD's in Indiana, mainly through December 2009, the last date of surveillance information available. The report describes the distribution of HIV disease (HIV and AIDS) by geography, age, sex, race, ethnicity, and associated risk categories. The purpose of this profile is to assist in the development of a comprehensive HIV/AIDS prevention and care plan by providing the necessary data that can aid in designing and implementing prevention and care services, as well as pointing out the dimensions of unmet needs for infected persons throughout the state of Indiana.

Strengths and Limitations of Profile:

Data collected through the Indiana HIV/AIDS surveillance system is collected through:

1. Required reports of persons with HIV infection and AIDS diagnosed or treated by physicians and hospitals, and
2. By laboratories that test for HIV, indicators for HIV, an antigen of the virus, or antibodies to that virus. Indiana reporting is designed such that the surveillance system receives multiple reports on each diagnosed person as the disease progresses and as various health care providers serve the person.

AIDS case reports are the only HIV-related data consistently available on a population-wide basis in all states by sex, race/ethnicity, age, and mode of HIV exposure (risk factor). Job Corps entrants and civilian applicants for military service are also tested for HIV and reported to the CDC as an aggregate. HIV and AIDS case report data represents those persons who:

1. Have confidentially tested positive for HIV,
2. Received medical care, and
3. Have been reported by the health care provider.

Demographics:

The demographic information for Indiana used throughout this report are based on the 2008 Census Bureau estimates, that extrapolate the census data from 2000 and provide periodic updates before the next population census is available in 2010. Indiana is a mostly rural state with several urban and metropolitan centers that had an estimated population of 6,376,792 people, as of July 2008. The majority of the population (88.0%) is White and Non Hispanic, followed by Blacks (9.1%). The rest is comprised of people of Asian/ Pacific Islander and American Indian/Alaskan Native origin. The population is predominantly Non Hispanic (94.8%), with a small, but fast growing Hispanic minority. According to the 2008 Census Estimates, 5.2% of the population selected Hispanic as their Ethnicity.

Prevalence:
By the end of December 2009, a total of 9,646 people were diagnosed with HIV/AIDS in the state of Indiana, up from 9,282 diagnosed people by the end of 2008. The disease continues to be male dominated, with the number of diagnosed males almost four times higher than that of females. The rate of infection was at 247.1 for males and 58.2 for females per 100,000 people of the general population. The majority of diagnosed persons are in their middle ages, ranging from 40 to 49 years of age by the end of 2009. However, the majority of people are diagnosed for the first time at the ages of 20 to 24 years of age. This is slightly lower than in 2008 when the majority of new cases were found among those 30 to 39 years of age. More than a third of all diagnosed people are Black (41.7%), while about five out of ten people with HIV/AIDS were White (47.9%). The gap between races continues to shorten as shown by the previous year, 2008 (34.8% Black vs. 55.9% White). Based on the smaller number of Blacks in the general population, the prevalence rate of that racial group (579.8/100,000) is exceeding the rate of the Hispanic (201.1/100,000) and White group (95.3/100,000). HIV/AIDS continues to affect Black males disproportionably more than their White counterparts.
Each diagnosed person is associated with a risk category of how they most likely were diagnosed with the disease. The overwhelming majority of risk categories were Men Having Sex with Men (MSM). Its rate of 152.6 per 100,000 people of the population is between 6 to 10 times higher than the other risk categories for all diagnosed people. It is the single largest category of risk for all race and ethnicity groups, and it is especially pronounced for Blacks. Heterosexual risk is the second highest risk category at 26.0 per 100,000 people.
Geographically, the vast majority of people that were diagnosed in Indiana are also living here (91.1%). Within the state of Indiana, most diagnosed people are concentrated in the urban areas of the state. The majority are living in Health Region 5, corresponding to Central Indiana and the Indianapolis Metropolitan area, with 271.3 per 100,000 diagnosed people. Other regions with large numbers of HIV/AIDS diagnosed people include Region 1 (169.1/100,000) and Region 2 (119.8/100,000) which corresponds to the northern part of the state adjacent to Chicago, and Region 7 (164.2/100,000) located in Southwestern Indiana.

New Diagnosis:
In 2009, the number of newly diagnosed persons in Indiana was 489, slightly up from 2008, which had 483 newly diagnosed persons. The diagnosis rate remained relatively the same in 2009 from 7.7 to 7.6 per 100,000 people in 2008. The highest rate of new diagnosis in 2009 occurred among males between the ages of 20 to 24 years of age. Males continue to outrank females more than three times. The male diagnosis rate of 12.1/100,000 in 2009 has increased from a rate of 11.9 in 2008. The female new diagnosis rate remained constant at 3.4/100,000 in 2009 and the previous year.
Among the new HIV/AIDS diagnosis in 2009, Blacks continue to have a rate (35.3) that is almost three times the rate of Hispanics (12.0), and more than seven times that of Whites (4.2). New diagnosis among males is predominant for all racial and ethnic groups. The rate of new diagnosis with HIV/AIDS among Black males (48.9) is especially high, compared to their Hispanic (20.0) and White (7.2) counterparts. The majority of new diagnosis can be found in the MSM risk category, with a diagnosis rate of 7.3 per 100,000 people. The main contributors are Whites (137), Blacks (74), and Hispanics (15). Heterosexual risk is the second highest category representing Blacks (40), Whites (20), and Hispanics (9).

Geographically, nearly five out of ten newly diagnosed persons live in Health Region 5 in Central Indiana, while regions 1, 2, and 7 come in close seconds of one another. Within the leading regions, Marion county and Lake county had the most new diagnosis in the reported time period.

Mothers with HIV:
The number of reported cases of children of HIV positive mothers in Indiana was 728, up from 698 in 2008. More than half of all children are Black (51.2%), less than one in three is White (31.1%), and the remaining is Hispanic (8.6%). In 2009, two new cases of pediatric diagnosis were reported. Of all the children that were born to diagnosed mothers, more than three fourths were exposed (80.1%), while 19.9% tested positive for HIV or were diagnosed with AIDS. Please note that these numbers are cumulative and include all children, including those that were born before medication to prevent the spread of the HIV virus from mother to child was available.

Mortality:
The number of people that died of HIV/AIDS-related complications in Indiana peaked around the year 1995 and started to drop sharply thanks to the widespread availability of antiretroviral medications. However, in 2007, the number of persons that were diagnosed with HIV/AIDS and that died was 210, up from 121 in 2006. The Office of Clinical Data and Research completed a death match in early 2008. The Vital Statistics department provides information on any deaths of persons for a given time period which is used to match against the surveillance data base to identify persons with HIV/AIDS that have deceased. This may account for the increase in deaths associated with persons that have HIV/AIDS. In 2008, the number dropped to 133 deaths. This decrease may in part be due to the development of a new Vital Records system established in early 2009. Many submitters were back logged with submittal of mortality reports. In 2009, it dropped even further to 119 deaths. It remains to be seen if 2007 is the beginning of a new trend towards rising mortality numbers or an exception to a trend. The majority of diagnosed people that died were males (77.3%). Among the racial and ethnic groups the death rate was highest for Blacks (1.4/100), followed by Whites (1.2/100), and Hispanics (0.8/100). The highest number of deaths occurred among persons aged 40 to 49 (absolute number of 43). The majority of deaths are connected to the MSM and Hetero risk group, with mortality numbers of 49 and 14 respectively. Geographically, the highest mortality numbers occurred in Regions 5 (Central Indiana) at 45 deaths.

Mobility:
Of the total number of diagnosed people in Indiana as of December 31, 2009, a relatively small number has migrated. At the end of 2009, a total of 774 persons that were diagnosed with HIV/AIDS in Indiana and were still alive had moved out of the state, compared to 632 in 2008. At the same time a total of 1,885 people had moved to Indiana that were diagnosed with the disease in another state and that were alive at the time of this report, compared to 1,664 persons in 2008. Of the diagnosed persons that moved into the state in 2009, the majority were White (54.4%), compared to 56.2% in 2008. Over one-third of all persons that moved to Indiana in 2009 were Black (34.0%), virtually unchanged from 33.4% in 2008. Diagnosed persons of Hispanic ethnicity remain stable as a percentage of all persons moving to Indiana. They comprised 7.8% in 2009, compared to 7.3% in 2008. Of those that moved to Indiana, more than a

third (39.1%) settled in central Indiana's Health Region 5, similar to the previous year. The rest was distributed more or less equally among the other health regions of the state.

Counseling and Testing:
In 2009, a total number of 31,826 HIV/AIDS tests were administered in Indiana by the state, federally funded sites, compared to 30,503 in 2008. Out of those 31,826 tests, 190 (0.5%) had a positive result, slightly lower than the numbers of 2008 (212 or 0.7%) and 2007 (222 or 0.7%). Slightly more tests were administered to males (56.3%) than to females (43.7%). In addition, twenty five tests were administered to Transgender persons in 2009. The positive test results for males (8.6/1,000) were almost three times the number of female test results (2.5/1,000). Blacks (6.2) had a similar positivity rate per 1,000 tests as compared to Whites (6.1) followed by Hispanics (4.6). The largest number of positives came from the 20-29 age groups (66) with 30-39 year olds (60) as runner-up.

Youth Risk Behavior Survey:
The Youth Risk Behavior Survey (YRBS) surveys the health-risk behaviors of young people every two years in six domains: (1) behaviors which facilitate unintentional injuries and violence, (2) tobacco use, (3) alcohol and drug uses, (4) sexual behaviors related to pregnancy and sexually transmitted diseases, (5) unhealthy dietary behaviors, and (6) physical inactivity and being overweight. The information gathered from the YRBS reveals that three-quarters of adolescents have used alcohol and over a third had used marijuana. Almost half of adolescents in Indiana (49.2%) have had sexual intercourse, while about a third is currently sexually active. An encouraging 89.6% of Indiana adolescents have been taught about HIV and AIDS infection in school, yet only 58.0% used a condom during the last sexual intercourse.

Behavioral Risk Factor Surveillance System:
In 2009, a survey was conducted to assess the indicators of risk for HIV/AIDS in Indiana. The survey asked specific questions to a representative group of Indiana residents. Approximately, 37.9% of all interviewees have ever been tested for HIV, up from 29.3% in 2006. Of those tests, the majority were done in a hospital or a drug treatment facility. Blacks have the largest share of HIV tests among all racial and ethnic groups with 58.5%. However, only 34.0% of men had been tested for HIV compared to 41.7% of women.

STD:
In 2009, Chlamydia continued to be the most frequently reported sexually transmitted disease in Indiana, with 21,759 reported cases, 21,744 cases in 2008, and 20,578 in 2007. Gonorrhea cases were reported at 6,812 cases in 2009 and 8,489 in 2008. Primary and Secondary Syphilis was reported to be 152 in 2009, up from 140 in 2008, and 53 reported cases the year prior. Females continued to outnumber males for both Chlamydia and Gonorrhea while Syphilis is more prevalent among males. Both Blacks and Whites make up the majority of all STD cases in the last year.
In 2009, Indiana had 63 cases of acute Hepatitis B, up from 58 in 2008. The total number of chronic Hepatitis C infections for the state was reported to be 7,066 cases in 2008. Finally, 118 cases of Tuberculosis (TB) were reported in Indiana in 2008, down from 129 in the previous year. Of those 118 TB cases four persons were also HIV positive.

Care Issues:

In the fiscal year that ran from April 1, 2009 to March 31, 2010, the funding for Title II of the Ryan White CARE Act added up to a total of $12,798,881. The majority of that budget (89.7%) financed the Health Insurance Assistance Programs (HIAP), while the rest was used for other medical and social services.

Of the 495 persons enrolled in the medical and social service programs called ADAP (AIDS Drug Assistance Program) in 2009, more than half (55.6%) were White. The share of Blacks among ADAP recipients grew from 29.0% in 2008 to 35.6% in 2009. The majority of recipients (64.0%) continued to select MSM as their main risk category. In 2009, 1,563 persons were enrolled and received assistance through the Health Insurance Assistance Program (HIAP), up from the year before, when 1,384 persons were enrolled.

As of March 31, 2010, Indiana had a prevalence of 9,704 persons living with HIV or AIDS (PLWHA). Annually, the HIV Care Services program uses the total PLWHA to estimate an Unmet Needs population. Unmet Needs are defined as service needs and gaps for diagnosed individuals who know their HIV positive status and are not receiving primary care. To calculate this estimation persons found to have a CD4 or viral load test between April 1, 2009 and March 31, 2010 were identified as receiving care based on records kept by the electronic HIV AIDS Reporting System (eHARS). Also, individuals found to have Medicaid service or antiretroviral drug claims within this time frame were determined to be in care. Persons with the requirements listed above were removed and as a result, 3,459 (35.6%) PLWHA were found to represent those with Unmet Needs. Demographically, Whites represented 49.0%, Blacks represented 40.0%, and Hispanics represented 8.0% of the Unmet Needs population. Most persons fell into the 40 – 49 age groups (42.0%). Of those with Unmet Needs, a higher percentage of persons identified as Homosexual (46%) while Heterosexual (16.0%) and IDU (6.0%) followed.

MEMBERSHIP COMMITTEE NARRATIVE

Prepared By: Cena Bain
Edited and approved by the Membership Committee

It is the mission of the membership committee to work within the Community Planning Group (CPG) to address the needs for representation, retention, and functioning within the community planning process. This committee also assures community input and access to the community planning process by maintaining parity, inclusion, and representation (PIR) as defined in the Centers for Disease Control and Prevention (CDC) Guidance for Community Planning Groups.

Recruitment and Selection

The membership committee makes great strides to recruit members that accurately reflect the epidemic of HIV/AIDS in Indiana. Applications are accepted throughout the year with new members selected on an annual basis. The membership committee works closely with the Indiana State Department of Health's HIV Epidemiologist to review the data and get a clear depiction of the epidemic for that particular year in order to determine the representation gaps and needs. The committee then carefully reviews current applications and recommends members that satisfy the existing vacancies. This process allows for the continuation of CPG functioning, and ensures new perspectives from various viewpoints.

In 2011, the executive/budget committee agreed to set aside funds for marketing to assist in the recruitment of potential CPG members. The committee is currently focusing on the recruitment of individuals from currently unrepresented geographic regions of the state as well as individuals aged from 13 to 24 years old, Hispanic Men who have Sex with Men (MSM), and persons aged 50 and older.

Orientation, Participation, and Inclusion

Orientation

In 2010, the membership committee worked closely with the Academy for Educational Development (AED) in developing a comprehensive orientation process for the Indiana CPG. To ensure that new members are clear on what is expected of them in their role on the Indiana CPG, their memberships are dependent on attending the two-day orientation that is held in January of each year. Each member is educated on the history of the CPG, his/her roles as a member, the roles of the department of health, CDC, and the shared responsibilities of each. Each new member is also presented with and educated on the Charter by-laws that the Indiana CPG has set along with policies and procedures that include, but are not limited to attendance and participation expectations.

Participation

It is the charge of the membership committee to ensure that each member is fulfilling his/her attendance obligation with regards to the full-body CPG meetings. These expectations and guidelines are clearly defined in the both the Charter by-laws and the policies and procedures given to each member at orientation. Ensuring active and continued participation allows the Indiana CPG to function with its original intent, making certain all tasks are being performed and that the board is in compliance with CDC's expectations.

Inclusion
Ensuring meaningful involvement of its members is crucial to the CPG process. To guarantee inclusion, the membership committee works to remove any and all barriers that may prevent a member from actively participating in the CPG process. The membership committee has worked diligently to identify any potential challenges to participation and create policies to address those, such as child care, travel, meal reimbursement and paid lodging.

Becoming a Member
Anyone interested in becoming a member should contact the Community Planning Group Liaison at 317-233-7483 at the Indiana State Department of Health.

EPIDEMIOLOGY / POPULATIONS COMMITTEE NARRATIVE

Prepared By: Cena Bain

Edited and approved by the Epidemiology/Populations Committee

In February of 2010, the Epidemiology/Populations Committee began to deliberate on the most appropriate way to proceed with the prioritization process. It was the collective decision of the committee to seek outside technical assistance from a Capacity Building Assistance Provider to help the committee better understand its role as a committee as well as educate the committee on best practices for the prioritization process. In July of 2010, the National Minority AIDS Council (NMAC) delivered a webinar to the full CPG that helped members understand what is expected of the committee, the importance of the process, and best practices in developing a methodology for that process.

In order to best prioritize populations in greatest need of HIV prevention services, in January 2011, the Epidemiology/Populations Committee began working diligently to develop a methodology for review and approval by the full body. In May 2011, the full CPG membership approved the methodology presented by the committee with the expectations that during the prioritization process, some adjustments may need to be made in order to accurately prioritize populations in need of services. Below is the process that was approved to use when selecting prioritized populations:

Step 1: The committee first identified and defined the target populations to be considered in the priority setting process. The populations were defined by risk behavior initially then by a combination of demographics such as age, race, ethnicity and gender.

Step 2: The committee then decided on the factors to be considered relevant when determining populations at highest risk for HIV infection. The following factors were selected and approved by the full CPG:

- AIDS incidence
- AIDS prevalence
- AIDS rate
- HIV incidence
- HIV prevalence
- HIV rate
- Riskiness of population behaviors
- Difficulty of meeting population need
- Barriers to reaching the population

Step 3: Once the factors had been chosen, the committee began determining the relative importance, or weight, of each chosen factor. By weighting each factor the committee was able to demonstrate the level of importance each factor carries in comparison to the other factors. A numeric scale was created from 1 through 5, with 1 being of least importance and 5 being of greatest importance.

The committee assigned weights to the factors as shown in the table below:

FACTOR	WEIGHT
AIDS incidence	3
AIDS prevalence	2
HIV/AIDS prevalence rate	3
HIV incidence	4
HIV prevalence	3
HIV/AIDS incidence rate	4
Difficulty of meeting population needs[1]	5
Barriers to reaching the population[2]	5
Riskiness of population behaviors	4

Step 4: This step required the committee to create a rating scale for assessing each factor and to rate each population according to the developed scale. This scale worked to ensure that the most important factors would have the most significant impact on the final score for each population. In addition to the epidemiological profile, the committee also utilized additional data sources such as past needs assessments, updated gap analyses, care/services data, and other various anecdotal data. Below are the listed factors with their final individual point scale:

AIDS incidence (*per case*)	Points
0 – 9	1
10 – 19	2
20 – 29	3
30 – 39	4
40 – 49	5
50 or above	6

AIDS prevalence (*per case*)	Points
Less than 100	1
101 – 200	2
201 – 300	3
301 – 400	4
401 – 500	5
501 or above	6

HIV/AIDS prevalence rate (*per 100,000*)	Points
0 – 25	1
26 – 50	2
51 – 75	3
76 – 100	4
101 – 125	5
126 or higher	6

HIV incidence (*per case*)	Points
0 – 9	1
10 – 19	2
20 – 29	3
30 – 39	4
40 – 49	5
50 or above	6

[1] Indicates populations that have never been reached.
[2] Indicates populations that has existing resources, but continue to have barriers that actually address population needs.

HIV prevalence (*per case*)	Points
Less than 100	1
101 – 200	2
201 – 300	3
301 – 400	4
401 – 500	5
501 or above	6

HIV/AIDS incidence rate (*per 100,000*)	Points
0 – 2	1
2.1 – 4	2
4.1 – 6	3
6.1 – 8	4
8.1 – 10	5
10.1 or above	6

Difficulty of meeting population needs	Points
Few or no resources	2
Moderate number of resources	1
Substantial number of resources	0

Barriers to reaching population	Points
Cultural barriers	1
Linguistic barriers	1
Stigma of behavior	1
Stigma of HIV/AIDS	1
Geographic barriers	1
Socio-economic barriers	1

When creating a point system for the factor *Riskiness of Population Behavior* it was determined that it was necessary to create an additional scaling system to accurately weight each factor. In addition to assigning a point system to the behavior, it was necessary to create a scale for the total Behavior Points relative to the points received when totaling the Behavior Risk Points. Below are the two (2) scales that were created for this factor:

Behavior Risk	Points
Sharing needles	10
Performing oral sex	2
Receiving oral sex	1
Insertive vaginal sex	3
Insertive anal sex	4
Receptive vaginal sex	7
Receptive anal sex	9

Total Behavior Points per population	Points
0 – 5	1
6 – 11	2
12 – 17	3
18 – 23	4
24 – 29	5
30 or above	6

Example: Population X receives 2 pts for Performing oral sex, 1 pt for receiving oral sex, and 3 pts for insertive vaginal sex for a total of 6 Behavior Risk Points. Therefore, Population X would receive 6 Total Behavior Points.

Step 5: Following the completion of all scales and point systems, the committee began to calculate final scores for each population. To assist in this process, the committee developed a table for each population. The following is an example of a completed scoring table for White MSM:

MSM-WHITE*				
FACTOR	**WEIGHT**	**RATING INFORMATION**	**RATING**	**SCORE**
AIDS incidence	3	19	2	6
AIDS prevalence	2	651	6	12
HIV/AIDS prevalence rate	3	41.2	2	6
HIV incidence	4	77	6	24
HIV prevalence	3	679	6	18
HIV/AIDS incidence rate	4	3	2	8
Difficulty of meeting population needs	5	1	1	5
Barriers to reaching population	5	0+0+1+1+1+1=**4**	4	20
Riskiness of population behaviors	4	2+1+0+4+0+9=**16**	3	12
**** Not actual numbers. For purposes of example only.***			**TOTAL**	**111**

Step 6: In both May and June, the committee convened to apply the methodology, calculate scores, and finalize the priority populations. Once a final score was tallied for each population, the committee ranked the populations from highest to lowest. During the September 2011 full body CPG meeting, the committee recommended and the full CPG approved the following priority populations:

1. **People Living with HIV/AIDS**
2. **Black Men who Have Sex with Men (MSM)**
3. **White Men who Have Sex with Men (MSM)**
4. **Hispanic Men who Have Sex with Men (MSM)**
5. **Black Heterosexual Women**

(Please note that all populations include individuals aged 13 years and older)

PRIORITY POPULATION DESCRIPTIONS

Priority Population is a term that refers to groups of people who are at increased risk for HIV transmission or acquisition because they engage in certain behavior(s), such as injection drug use and/or unprotected anal or vaginal sex, that have been demonstrated to transmit the virus. These groups are the focus of HIV prevention efforts because the behaviors correlate with high rates of HIV infection as evidenced in HIV epidemiologic data and reported by clients who are HIV positive. The following populations are at highest risk in Indiana:

Population One: People Living with HIV/AIDS (PLWH/A)
With the goal of reducing new infections, the Indiana CPG recognizes the importance of providing ongoing prevention support for persons living with HIV/AIDS. In order to achieve this goal, the behavior change, disclosure support, and needs related to social determinants of health of PLWH/A must be addressed. In recognition of this and in accordance with the goals set forth by the NHAS, PLWH/A have been selected as the top priority population. It is crucial that HIV positive persons are receiving prevention services that focus on changing high risk behaviors such as high-risk sexual practices and/or sharing injection equipment.

Population Two: Black Men who have sex with men (MSM)
Due to the excessively high HIV/AIDS incidence (26.6 per 100,000) and prevalence (406.1 per 100,000) rates among Black MSM aged 13 and up, that risk group was chosen as the second priority population. The culturally specific needs of that group, in addition to the disproportionately high prevalence and incidence rates, set them apart from MSM of other racial and ethnic backgrounds.

Population Three: White MSM
The HIV (1891) and AIDS (50) prevalence numbers among White MSM aged 13 and up garnered them the position as the third priority population in the state of Indiana. Each year this group continues to far outpace all others in terms of both current and new infections.

Population Four: Hispanic MSM
The HIV/AIDS incidence (8.4 per 100,000) and prevalence (143.1 per 100,000) rates, combined with the riskiness of population behaviors, and cultural/linguistic specific needs of Hispanic MSM aged 13 and up placed them as the fourth ranked priority population.

Population Five: Black Heterosexual Women
According to the 2010 Epidemiologic data for HIV/AIDS in Indiana, Black females have an HIV/AIDS prevalence rate (183.6 per 100,000) that is nearly four times higher than their Hispanic counterparts (53.7 per 100,000) and more than 11 times higher than their white counterparts (15.7 per 100,000). Additionally, the incidence (HIV=22, AIDS=8) and prevalence (HIV=262, AIDS=289) numbers for Black women are higher than both their Hispanic (HIV Incidence=3, AIDS Incidence=0, HIV Prevalence=31, AIDS Prevalence=51) and White counterparts (HIV Incidence=10, AIDS Incidence=3, HIV Prevalence=234, AIDS Prevalence=212). According to the Center for AIDS Prevention Studies (CAPS), women are less likely to use two methods of protection, for example using both birth control and condoms (2009). HIV among Black women is not simply about individual behavior, but a complex system of social, cultural, economic, geographic, religious and political factors that combine to affect health. Therefore, to maximize effectiveness, HIV prevention programs targeting Black women should include job training, couples counseling, food banks, housing assistance, mental health services, substance abuse treatment and family services.

POPULATIONS TO WATCH

As an adjunct to the Priority Populations, the Indiana CPG has identified the following Populations to Watch. These groups did not demonstrate the need to be ranked among the Priority Populations, however, their numbers are on the rise locally, they have been shown to be at extremely high risk elsewhere in the U.S., and/or they have particularly unique needs with regard to HIV prevention services. As a result, the following groups are being presented as potentially emerging populations worthy of attention (in alphabetical order):

Black Heterosexual Men

Black heterosexual men have shown to be of priority in this state. According to the 2010 Epidemiologic data for HIV/AIDS in Indiana, black males have a prevalence rate that is almost 3 times higher than their male counterparts. We have often confused the sexual behavior and the sexual identification of black men in Indiana. For example, if a black male admits to engaging in sexual activities with another male, he may or may not categorize himself as gay, bisexual, or MSM. Agencies must acknowledge the underlying cultural and social factors that exist within the black community when developing HIV prevention strategies that target black males. According to the Center for AIDS prevention Studies (CAPS), "*prevention programs should link with other programs such as drug treatment, violence prevention, scholastic enrichment, family planning, cultural strengthening and business organizations to help support Black men as a whole, working with the richness and complexities of modern Black male life*" (2004).

Commercial Sex Workers

Although exchanging sexual activities for money or goods is illegal in Indiana, the CPG recognizes that some individuals see sex work as a livelihood and often their only means of income. Given that sex work is illegal in Indiana, it is difficult to get an accurate depiction of the industry as it relates to HIV/AIDS. When developing programs that serve this population it is important to understand what force drove these individuals into the sex work industry. According to the UNAIDS technical update titled *Sex work and HIV/AIDS*, factors that appear to heighten sex workers' vulnerability to, and risk of HIV infection include: a) stigmatization and marginalization; b) limited economic options, in particular for women; c) limited access to health, social and legal services; d) limited access to information and prevention means; e) gender-related differences and inequalities; f) sexual exploitation and trafficking; g) harmful, or lack of protective, legislation and policies; and h) exposure to risks associated with lifestyle (e.g. violence, substance use, mobility) (2002).

Hispanic Women

In 2009, Hispanics showed an increase in the rate of persons living with HIV/AIDS (201.1 per 100,000). When looking at gender the average Hispanic male rate is 4 times higher than the Hispanic female rate (295.4 vs. 74.2 per 100,000). However, the increase in the HIV rate among Hispanics over time (2007-2009) is almost the same between genders (male=4% vs. female=3%). Additionally, due to infrequent HIV testing, Latinas are often diagnosed in a later stage of HIV infection and therefore progress to AIDS at a more rapid rate than that of white woman, following an HIV diagnosis. Given the strong culture aspects of both Hispanic men and women, safer sex strategies among Latinas may be quite difficult. The concept of *machismo* is significant in the Hispanic culture. The idea of machismo outlines the male responsibilities and rights. These responsibilities include providing economically for the family, defending its

welfare, and procreating children to carry out the family name. A man's rights include controlling the behavior of family members and having authority over them. Males are socialized to be sexually active and virile, and extramarital activity is considered a male prerogative. The female gender role known as *marianismo* is the cultural expectation of Latinas to be modest, pure, dependent, weak, and abstinent until marriage. This in return acts an obstacle to HIV prevention efforts.

Injection Drug Users (IDUs) and Other Substance Users

Sharing injection equipment to either inject or split drugs, including syringes, cookers, water and cotton is a high risk factor for persons with regard to the transmission and acquisition of HIV. Due to social, economic, and psychological factors, IDUs often struggle with multiple health risks. Persons with substance abuse issues, particularly those who inject drugs, face many daily challenges including, but not limited to: addiction, poverty, incarceration, homelessness, stigma, depression, mental illness and past trauma, leaving HIV low on the list of concerns.

The possibility of HIV transmission is plausible when an individual is a routine, occasional, or even a one-time substance user. When addressing the complicated effects of drugs, the following substances should be considered: 1) Heroin; 2) Cocaine; 3) Crystal methamphetamine; 4) Ritalin (as a stimulus in adults); 5) Talwin; 6) Anabolic steroids and other hormones; 7) "Club Drugs" (i.e. ecstasy, ketamine, GHB, and nitrates); 8) Marijuana; and 9) alcohol. Issues such as the behavioral effects of the drug, the equipment used to consume the drug, and the behaviors that drive the individual to drug use all have the potential to put a substance user at an increased risk for HIV infection. While under the influence of a drug, individuals may be less inhibited and be more likely to engage in risky behavior. Due to decreased inhibitions and less control of one's own surroundings, persons under the influence may engage in unsafe sex or improper use of condoms during intercourse.

Transgender Persons

As defined by CDC, transgender refers to those individuals whose gender identity, expression, or behavior is not traditionally associated with their birth sex. When providing services and reaching out to the transgender community it is very important to remember that there is distinction between ones biological sex, ones gender expression, and ones sexual orientation. Transgender persons may identify as heterosexual, bisexual, pansexual, or homosexual. Since transgender persons experience gender identity as incongruent with their anatomical sex, some may seek to undergo some or all of the following: sex reassignment surgery, hormonal intake, or other cosmetic procedures.

Although there are not a significant number of transgender persons documented to be HIV positive in Indiana, several behaviors continue to put them at risk. There have been several studies around transgender persons that suggest that risk factors include, but are not limited to: multiple sex partners, irregular condom use, unsafe injection practices (such as drugs and other substances including hormones and silicone), as well as lack of transgender-appropriate education and prevention activities. The stigma and discrimination continues to increase their risk for HIV, by contributing to low-esteem, depression and other mental health issues, and participation in behaviors that seemingly increase the likelihood of fitting into society.

INTERVENTIONS COMMITTEE NARRATIVE

Prepared By: Cena Bain
Edited and approved by the Interventions Committee

According to the Centers for Disease Control and Prevention (CDC), *HIV Prevention Community Planning Guide, 2003-2008*, an intervention is a specific activity (or set of related activities) intended to change the knowledge, attitudes, beliefs, behaviors, or practices of individuals and populations to reduce their health risk, that carries a distinct process and outcome objectives, and a protocol outlining the steps for implementation (43).

In late 2010, the interventions committee began researching and becoming familiarized with various evidence-based interventions. The committee utilized resources made available by the CDC known as the *Compendium of HIV prevention Interventions with Evidence of Effectiveness* along with the *Diffusion of Evidence Based Interventions* (DEBI) located at http://effectiveinterventions.org. Given that it is the role of the interventions committee to research and identify population specific interventions that correlate with the priorities set forth by the epidemiology/populations committee, it was crucial for the committee to educate themselves fully on all available interventions.

There are several evidence-based interventions that The **CDC** via **The HIV/AIDS Prevention Research Synthesis (PRS) Project** has identified through a series of efficacy reviews. (For more information go to http://www.cdc.gov/hiv/topics/research/prs/efficacy_overview.htm)
The current ongoing PRS efficacy review process has catalogued evidence-based interventions as best-evidence, good-evidence, or promising-evidence.

Following the approval of the priority populations recommended by the Epidemiology/populations committee, this committee began to examine and distinguish which interventions would be most feasible and most effective in Indiana. The committee extensively researched the following types of interventions, as defined by *Setting HIV Prevention Priorities: A Guide for Community Planning Groups* (2005):

Community-level interventions (CLI): Programs designed to reach a defined community and to increase community support of the behaviors known to reduce the risk for HIV infection and transmission by working with the social norms or shared beliefs and values held by members of the community. CLIs aim to reduce risky behaviors by changing attitudes, norms, and practices through community mobilization and organization, including community-wide events.

Group Level Interventions (GLI): Health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of carrying sizes. These use peer and non-peer models involving a wide-range of skills, information, education, and support.

Individual Level Interventions (ILI): Health education and risk-reduction counseling provided to one person at a time. ILIs assist clients in making plans to change individual behavior and to appraise regularly their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (i.e. substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV. Interventions also help clients plan to obtain these services.

Structural Interventions (SIs): Structural interventions aim at modifying the social, economic, and political structures and systems in which we live. These may affect legislation, media, health care, and the market place. Structural interventions directly alter the physical environments in which people live, work, play, and have sex, to help reduce risk.

Effectiveness Characteristics of Interventions other than DEBI's

While the Interventions Committee recognizes the effectiveness of EBI interventions, the viability of interventions other than DEBI's cannot be discredited. Therefore, the Interventions Committee recommends the following criteria be met for intervention other than DEBI's.

When providing **CLI's** and/or outreach, the goal and objectives should include the following:

- Provide HIV Prevention Educational Material in a language easily understood.
- Reach hard to access risks populations in their communities/environments at times when that population is readily accessible.

When providing **GLI's** the goal and objectives should include the following:

- Minimum four (two hour) sessions; may be expanded if access to target group available.
- Information on transmission; association of HIV to drugs and alcohol.
- Methods of prevention: condoms, abstinence, counseling and testing, mutual monogamy.
- Skills practice; assertive communication, sexual decision making, coping skills, condom use.
- Personal responsibility; developing social networks for sustained healthy behaviors.

When providing **ILI's** the goal and objectives should include the following:

- Minimum four (thirty minute) sessions.
- Assessing personal risk; referrals if necessary.
- Exploration of condom/abstinence attitudes; practice condom and assertiveness skills.
- Goal setting for risk reduction.
- Discussion of barriers and supports for behavior change.

INTERVENTIONS TABLE

PRIORITY POPULATION ONE: PEOPLE LIVING WITH HIV/AIDS (PLWH/A)

Title	Type of Intervention	Brief Description	Research Setting	Detailed Population
Choosing Life: Empowerment, Actions, Results (CLEAR)	Individual	An individual level intervention designed to both reduce sexual and substance use risk behaviors and improve mental and physical health. Intervention is delivered by a licensed therapists or clinical social worker in a total 18 sessions (6 sessions per module).	Coffee Shops, community agencies, private rooms at collaborating sites, parks, or participants' residents.	Young HIV-positive substance abusers
Directly Administered Antiretroviral Therapy (DAART)	Individual	An individual level intervention designed to improve adherence to antiretroviral therapy along with the virologic and immunologic responses to such. Delivered by a nurse or medical assistant in whom the nurse or medical assistant observes client consuming his/her HIV medications daily.	Methadone Clinic	HIV-positive injection drug users in treatment who are antiretroviral treatment experienced or naïve
Healthy Living Project (HLP)	Individual	An individual level intervention designed to eliminate or reduce sexual transmission and injection drug use risk behavior, and to improve health care practices and quality of life. Delivered by ethnically diverse, gender-matched female and male facilitators with experience as social workers, counselors, therapists, or community-based service providers with a total of fifteen 90-minute sessions delivered over 2 months.	Private settings in community-based organizations and clinics	HIV-positive persons at risk of transmitting HIV

Healthy Relationships	Group	Small group intervention designed specifically for men and women living with HIV/AIDS. Intervention found to be effective for men who have sex with men and heterosexual men and women. Based on social-cognitive theory with focus on skills building.	Room large enough to accommodate circular seating to enhance communication. 5-12 clients and members cannot join once groups are established.	People living with HIV
Partnership for Health-Medication Adherence	Individual	This individual intervention is designed to improve adherence to antiretroviral therapy for the purposes of achieving undetectable viral loads. Intervention is delivered by the client's primary care provider through brief discussion, printed materials, and problem solving.	HIV primary care outpatient clinics	HIV-positive clinic patients who are antiretroviral treatment-experienced.
Positive Choice: Interactive Video Doctor	Individual	An individual level intervention intended to eliminate or reduce sex risk behaviors and illicit drug use. Delivered through an interactive computer-based video while waiting to see his/her care coordinator.	Outpatient HIV clinics	HIV-positive clinic patients
Together Learning Choices (TLC)	Group	Group level intervention for young people living with HIV to identify ways to increase use of health care, decrease risky sexual behavior and drug and alcohol use, and improve quality of life. Intervention is delivered in 3 sequential modules, each containing 8 sessions.	Private area or room, to ensure confidentiality. Enough space and privacy for small groups of young people living with HIV.	Young (aged 13-29) HIV-positive persons

Seropositive Urban Men's Intervention Trial (SUMIT) Enhanced Peer-Lead Intervention	Community	This intervention is delivered to groups of gay or bisexual men living HIV in order to reduce risky sexual behavior. Intervention is delivered in 6 weekly 3-hour group sessions by two HIV-seropositive MSM peer facilitators.	Research Facility	HIV-seropositive MSM
Women Involved in Life Learning from Other Women (WiLLOW)	Group	A small group intervention intended to reduce HIV transmission risk behaviors, reduce sexually transmitted diseases (STDs), and enhance HIV-prevention psychosocial and structural factors. Intervention is delivered by a trained female health educator and female peer educator living with HIV in four 4-hour sessions delivered over 4 consecutive weeks.	A community site set up to deliver the intervention and an HIV service clinic.	Sexually-active, female clinic patients living with HIV.

POPULATION TWO: BLACK MSM

Title	Type of Intervention	Brief Description	Research Setting	Detailed Population
Community PROMISE	Community	Community level intervention to increase condom use with main and non-main partners and/or to increase disinfection of injection equipment for high-risk populations where there are established peer influences.	Street settings, public sex environment, and other community venues.	Persons or groups who practice HIV risk behaviors.
d-up: Defend Yourself!	Community	This intervention seeks to mobilize an existing social network of black men who have sex with men to support condom use and improve their sense of self worth. Specific social network members, called opinion leaders promote the benefits of consistent condom use and increase self-worth among their friends and acquaintances.	Locations and areas already frequented by opinion leader's friends and/or acquaintances.	Black MSM
Explore	Individual	This one-on-one intervention is designed to prevent the acquisition of new HIV infection and to reduce unprotected anal intercourse, serodiscordant unprotected anal intercourse, and serodiscordant unprotected receptive anal intercourse. Intervention is intended to establish rapport between the counselor and the participant, and to provide personalized risk assessments.	HIV prevention Trials Network sites, in the field or by telephone.	HIV-seronegative MSM

Mpowerment Project	Community	A community level intervention to reduce HIV risk behaviors. Intended for participants to bring about communitywide change by carrying out a set of 4 integrated activities that convey safer sex as the norm.	Mpowerment Center and other community venues where gay men congregate.	MSM aged 12-20
Personalized Cognitive Counseling (PCC)	Individual	A single-session counseling intervention designed to reduce unprotected anal intercourse. Consists of a 30-to-50 minute session that is part of the counseling component required in *Counseling, Testing, and Referral Services (CTRS)*.	HIV testing clinic	MSM who are repeat testers for HIV
Personalized Cognitive Risk-Reduction Counseling	Individual	A single counseling session delivered to clients during the 1-to2- week period between standard "pre-test" (risk-assessment) and "post-test" (results disclosure) HIV counseling. This intervention is designed to reduce high risk sexual behavior.	HIV testing clinic	MSM who are seronegative and have undergone repeat HIV testing
Popular Opinion Leaders (POL)	Community	A community level risk reduction program using casual, 1 on 1 conversation with peers in their own social network. Intervention to reduce high-risk behaviors. Program is based on affecting change to existing social norms about HIV prevention. Sessions can be from 4 - 90 minutes in length.	Well defined community venue. Weekly sessions held with opinion leaders in order to refine their skills and gain confidence in delivery of HIV prevention message to others.	MSM (can also be adapted for other populations)
Seropositive Urban Men's Intervention Trial (SUMIT) Enhanced Peer-Lead Intervention	Community	This intervention is delivered to groups of gay or bisexual men living HIV in order to reduce risky sexual behavior. Intervention is delivered in 6 weekly 3-hour group sessions by two HIV-seropositive MSM peer facilitators.	Research Facility	HIV-seropositive MSM

POPULATION THREE: WHITE MSM

Title	Type of Intervention	Brief Description	Research Setting	Detailed Population
Community PROMISE	Community	Community level intervention to increase condom use with main and non-main partners and/or to increase disinfection of injection equipment for high-risk populations where there are established peer influences.	Street settings, public sex environment, and other community venues.	Persons or groups who practice HIV risk behaviors.
Explore	Individual	This one-on-one intervention is designed to prevent the acquisition of new HIV infection and to reduce unprotected anal intercourse, serodiscordant unprotected anal intercourse, and serodiscordant unprotected receptive anal intercourse. Intervention is intended to establish rapport between the counselor and the participant, and to provide personalized risk assessments.	HIV prevention Trials Network sites, in the field or by telephone.	HIV-seronegative MSM

Mpowerment Project	Community	A community level intervention to reduce HIV risk behaviors. Intended for participants to bring about communitywide change by carrying out a set of 4 integrated activities that convey safer sex as the norm.	Mpowerment Center and other community venues where gay men congregate.	MSM aged 12-20
Personalized Cognitive Counseling (PCC)	Individual	A single-session counseling intervention designed to reduce unprotected anal intercourse. Consists of a 30-to-50 minute session that is part of the counseling component required in *Counseling, Testing, and Referral Services (CTRS)*.	HIV testing clinic	MSM who are repeat testers for HIV
Personalized Cognitive Risk-Reduction Counseling	Individual	A single counseling session delivered to clients during the 1-to2- week period between standard "pre-test" (risk-assessment) and "post-test" (results disclosure) HIV counseling. This intervention is designed to reduce high risk sexual behavior.	HIV testing clinic	MSM who are seronegative and have undergone repeat HIV testing
Popular Opinion Leaders (POL)	Community	A community level risk reduction program using casual, 1 on 1 conversation with peers in their own social network. Intervention to reduce high-risk behaviors. Program is based on affecting change to existing social norms about HIV prevention. Sessions can be from 4 - 90 minutes in length.	Well defined community venue. Weekly sessions held with opinion leaders in order to refine their skills and gain confidence in delivery of HIV prevention message to others.	MSM (can also be adapted for other populations)
Seropositive Urban Men's Intervention Trial (SUMIT) Enhanced Peer-Lead Intervention	Community	This intervention is delivered to groups of gay or bisexual men living HIV in order to reduce risky sexual behavior. Intervention is delivered in 6 weekly 3-hour group sessions by two HIV-seropositive MSM peer facilitators.	Research Facility	HIV-seropositive MSM

POPULATION FOUR: HISPANIC MSM

Title	Type of Intervention	Brief Description	Research Setting	Detailed Population
Community PROMISE	Community	Community level intervention to increase condom use with main and non-main partners and/or to increase disinfection of injection equipment for high-risk populations where there are established peer influences.	Street settings, public sex environment, and other community venues.	Persons or groups who practice HIV risk behaviors.
Explore	Individual	This one-on-one intervention is designed to prevent the acquisition of new HIV infection and to reduce unprotected anal intercourse, serodiscordant unprotected anal intercourse, and serodiscordant unprotected receptive anal intercourse. Intervention is intended to establish rapport between the counselor and the participant, and to provide personalized risk assessments.	HIV prevention Trials Network sites, in the field or by telephone.	HIV-seronegative MSM
Mpowerment Project	Community	A community level intervention to reduce HIV risk behaviors. Intended for participants to bring about communitywide change by carrying out a set of 4 integrated activities that convey safer sex as the norm.	Mpowerment Center and other community venues where gay men congregate.	MSM aged 12-20
Personalized Cognitive Counseling (PCC)	Individual	A single-session counseling intervention designed to reduce unprotected anal intercourse. Consists of a 30-to-50 minute session that is part of the counseling component required in *Counseling, Testing, and Referral Services (CTRS)*.	HIV testing clinic	MSM who are repeat testers for HIV

Personalized Cognitive Risk-Reduction Counseling	Individual	A single counseling session delivered to clients during the 1-to2- week period between standard "pre-test" (risk-assessment) and "post-test" (results disclosure) HIV counseling. This intervention is designed to reduce high risk sexual behavior.	HIV testing clinic	MSM who are seronegative and have undergone repeat HIV testing
Popular Opinion Leaders (POL)	Community	A community level risk reduction program using casual, 1 on 1 conversation with peers in their own social network. Intervention to reduce high-risk behaviors. Program is based on affecting change to existing social norms about HIV prevention. Sessions can be from 4 - 90 minutes in length.	Well defined community venue. Weekly sessions held with opinion leaders in order to refine their skills and gain confidence in delivery of HIV prevention message to others.	MSM (can also be adapted for other populations)
Seropositive Urban Men's Intervention Trial (SUMIT) Enhanced Peer-Lead Intervention	Community	This intervention is delivered to groups of gay or bisexual men living HIV in order to reduce risky sexual behavior. Intervention is delivered in 6 weekly 3-hour group sessions by two HIV-seropositive MSM peer facilitators.	Research Facility	HIV-seropositive MSM

POPULATION FIVE: HETERSEXUAL BLACK FEMALE

Title	Type of Intervention	Brief Description	Research Setting	Detailed Population
Becoming a Responsible Teen (BART)	Group	This group level intervention is designed to increase information and skills to make sound choices, increase abstinence, and eliminate or reduce sex risk behaviors. Intervention is delivered in eight 90 to 120 minute sessions over 8 weeks by two co-facilitators.	A public health clinic serving low-income families.	African American Adolescents
CLEAR: Choosing Life: Empowerment! Action! Results!	Individual	CLEAR is a client-centered program delivered one-on-one using cognitive behavioral techniques to change behavior. This intervention is designed to provide the necessary skills to be able to make healthy choices for their lives. Intervention may be integrated into CRCS programs.	HIV testing clinic	African American females 16 and older.
Connect	"Couple"- level	This intervention is a six-session, relationship-based that teaches couples techniques and skills to enhance the quality of their relationship, communication, and shared commitment to safer behaviors.	Hospital outpatient clinic	Minority, inner-city heterosexual couples (can also be delivered to woman alone)

Female and Culturally Specific Negotiation Intervention	Individual	This intervention includes 4 individual sessions that focus on the social context of women's daily lives. It is designed to reduce HIV risk behaviors among African American women who use crack or inject drugs. These four 20 – to 40 minute sessions are delivered by female health interventionist and counselor over a 3-to-4 week time span.	HIV testing site, treatment housing, safe locations	Inner city, HIV-negative, heterosexually active, African American female drug injectors and crack cocaine smokers.
Female Condom Skills Training (FEMIT)	Individual and Group	This 4-session intervention is designed to increase knowledge about safer sexual practices, condom use skills, and ability to negotiate condom use. The four sessions are delivered over 6 weeks, including 2 individual and 1 group session ranging from 2 to 2.5 hours and a 30-minute telephone follow-up session.	Family Planning clinics	HIV-negative heterosexual women attending family planning clinics
Healthy Love	Group	Healthy Love is a single-session, small group intervention delivered to pre-existing groups of black women (e.g. friends, sororities) in settings of their choosing. This intervention is designed to increase consistent condom use and other latex barriers, reduce unprotected sex with male partners, reduce the number of sex partners, increase sexual abstinence, and promote HIV testing and receipt of test results.	Settings of participants choosing including their homes, college campuses, churches, and community centers.	Black Women.

Horizons	Group	This intervention is designed to reduce sexually transmitted diseases, increase condom use, increase communication with male partners about safer sex and STDs, and increase male partners accessing STD services. This intervention is delivered in two 4-hour group sessions on 2 consecutive Saturdays, followed by 4 (15-minute) telephone contacts approximately every 2.5 months over approximately 9 months.	Public community clinic	Heterosexually active African-American adolescent females seeking health services.
Motivational Interviewing-based HIV Risk Reduction	Individual	An individual level intervention designed to reduce HIV sex risk behavior, reduce HIV injection risk behavior, reduce intimate partner violence risk, and establish or improve life stability issues (food, housing, education, employment, legal services). Delivered up to 12 sessions, each consisting of 30 – 45 minute sessions over 3 consecutive months.	Client choice	Recently incarcerated, HIV-negative women at risk for HIV.
Real AIDS Prevention Project (RAAP)	Community	A community level intervention that consists of 2 phases: 1) community assessment, which involves finding out about the community and how to talk to women and their partners about their risk for HIV infection and 2) getting the community involved in a combination of risk reduction activities directed toward these women and their partners. This intervention is designed to help women and their partners reduce	Based on community.	Sexually active women of reproductive age and their male partners.

		their risk for HIV infection by increasing condom use by women and their partners, changing community norms so that practicing safer sex is seen as the acceptable norm, and involving as many people in the community as possible.		
Respect	Individual	An individual level, client-focused HIV prevention intervention, consisting of two brief interactive counseling sessions. Uses "teachable moments" to motivate a person to change her behavior. Can be easily incorporated into an HIV counseling/testing program.	STD and/or HIV testing clinics	HIV negative women
Safe in the City	Group	Safe in the City is a 23-minute HIV/STD prevention video for STD clinic waiting rooms aimed to increase condom use and other safer sex behaviors.	STD clinic waiting rooms	Women
Safer Sex Skills Building (SSSB)	Group	This group level intervention consists of 5 sessions, approximately 90-minutes each, designed to increase HIV.STD risk awareness, condom use, and partner negotiation skills of women attending community outpatient drug treatment programs.	Community-based methadone programs and outpatient psychological treatment programs.	Heterosexually active women in drug treatment.

Sisters Informing, Healing, Living, and Empowering (SIHLE)	Group	This peer-led, social skills training intervention is aimed at reducing HIV sexual risk behavior among sexually active African-American teenage females, aged 14-18. This intervention consists of four 3-hour sessions, delivered by two peer facilitators (aged 18-21) and one adult facilitator in a community-based setting.	Quiet, accessible meeting space for 10-12 women.	Sexually active African-American females aged 14-18
Sisters Informing Sisters about Topics on AIDS (SISTA)	Group	A peer-led small group social skills intervention to prevent HIV infection to African American women. Information is delivered in 5 sessions on 5 specific topics.	Quiet, accessible meeting space for 10-12 women.	African American Women

PUBLIC HEALTH STRATEGIES

Counseling, Testing, and Referral (CTR)

The CDC estimates that approximately 1.1 million adults and adolescents in the United States are living with HIV and many are unaware of their infection. The primary purpose of CTR is to increase clients' knowledge of their HIV status; encourage and support risk reduction; and secure needed referrals for appropriate services (medical, social, prevention, and partner services).

There are crucial activities that may be tailored to fit different agencies and at-risk populations. These are parts of the strategy that can be adapted to meet the needs of the organization or target population:

- Provide information and education about testing in 1 of 3 ways.
    - Individual face-to-face reason.
    - Small or large group sessions.
    - Brochures, handouts, videos, or audiotape, or other non-personalized information.
- Deliver client-focused counseling and test results in an individual, face-to-face session.
- Use a variety of specimen types and test types for HIV antibody testing, depending on the setting in which testing is conducted and the needs of the organization and the client.
- Provide service referrals to client's self-identified priority needs (increases likelihood that referrals will be completed), if possible.
- For clients whose test results are positive, place priority on referrals for medical care, ***partner services,*** and other prevention and support services.

Partner Services (PS)

The goal of PS is to notify the sex and/or needle-sharing partners, including spouses, of HIV-infected individuals of their possible exposure to HIV and to recommend that they seek health care to include counseling and testing. The goal of this is to help prevent HIV transmission and to ensure that partners have the opportunity to implement prevention strategies while gaining access to counseling, testing, and other services as appropriate.

Comprehensive Risk Counseling and Services (CRCS)

The goal of CRCS is to promote the adoption and maintenance of HIV risk-reduction behaviors by clients who have multiple, complex problems and risk-reduction needs. The ISDH has set the following guidelines for those individuals who should be referred to this public health strategy:

1. Any HIV- client who presents for repeated testing with no signs of change in behavior.
2. Any HIV+ client who demonstrates an unwillingness to adhere to the "duty to warn" law.
3. Any client who demonstrates an unwillingness to engage in some level of risk reduction behavior.
4. Any client who is in a serodiscordant relationship and expresses a desire to learn more about transmission prevention or is putting themselves or their partner at risk.

5. Any client who reports wanting or needing assistance or additional support to make behavior change associated with risk.

6. Any client who reports having been diagnosed with two or more sexually transmitted infections in the last 12 months.

This public health strategy provides several sessions of client-centered HIV risk-reduction counseling. CRCS helps clients initiate and maintain behavior change toward HIV prevention while addressing competing needs that may make HIV prevention a lower priority. This strategy addresses the relationship between HIV risk and other issues such as substance abuse, mental health, social and cultural factors, and physical health.

CRCS has the following 6 Core elements:

- Provide CRCS as intensive, client-centered HIV risk-reduction counseling, and include conventional case management services only when the client does not have access to those services.
- Base CRCS services on the premise that some people may not be able to prioritize HIV prevention when they face problems perceived to be more important and immediate.

For HIV +

- Focus on persons living with HIV who have multiple, complex problems and risk-reduction needs who are having, or are likely to have, difficulty initiating or sustain practices that reduce or prevent HIV transmission.

For HIV –

- Consider persons whose HIV status is negative or unknown to be eligible if they have a recent history (past 6 months) of 1 or more of the following:
    - unprotected sex with a person who is living with HIV.
    - unprotected sex in exchange for money or sex.
    - multiple (e.g., more than 5) or anonymous sex partners.
    - multiple or anonymous needle-sharing partners.
    - a diagnosis of a sexually transmitted disease.

- Recruit persons who expressed some degree of commitment to participating in ongoing risk-reduction counseling.
- Hire prevention counselors with the appropriate training and skills to complete the CRCS activities within their job description.
- Develop clear procedures and protocol manuals for the CRCS program to ensure effective delivery of CRCS services and minimum standards of care.

Routine HIV Testing in Medical Settings

In September 2007, Wishard and Methodist Hospitals, both urban inner city hospitals located in Indianapolis, began collaborating with MATEC (Midwest AIDS Training and Education Center). A combined task force comprised of hospital staff, including physicians, nurses, and representatives from community based organization were formed in an effort to implement an Emergency Department based routine HIV screening pilot project. Execution of routine HIV testing in the Wishard Emergency room became official in September of 2008. Since that time, Wishard has identified forty-five (45) new positives, 2 in 2008, 5 in 2009, 17 in 2010, and 19 in 2011. For more information surrounding routine testing in a medical setting or initiating a similar project in your area contact the Indiana State Department of Health, Division of HIV/STD/Viral Hepatitis.

SELECTING THE BEST INTERVENTION FOR YOUR AGENCY

In September of 2011, an interventions committee member had the privilege of attending a training that was hosted by the Denver STD/HIV Prevention Training Center. The course objectives of this two-day training were as follows:

- To describe how behavioral interventions work to change behavior.
- To list the four steps in selecting a behavioral intervention.
- To use the community assessment results to identify HIV risk factors and an intervention population.
- To examine intervention-specific behavior change logic models to assess interventions.
- To assess agency capacity for intervention-specific implementation plans.
- To match the results of community assessment, intervention examination, and agency capacity assessment to select an appropriate behavioral intervention.
- To identify resources for training and technical assistance.

Given that the committee members found this information helpful when recommending interventions for Indiana, the committee decided to provide organizations with the tools to assist them in selecting the best intervention for their agency. Any agency that is interested in implementing any of the above listed interventions should first decide the specific priority population(s) that your organization will be targeting. In addition to the population, agencies should also consider the following: Race, ethnicity, and age of the population, Specific community (i.e. northwest or southwest region), risk behaviors (i.e. sharing needles, unprotected sex), risk factors (i.e. unemployment, “sex parties”, low socio-economic status, multiple partners), and behavioral determinants[3] (i.e. social norms, attitudes and beliefs, intentions, values, knowledge, self-efficacy).

[3] Behavioral determinants that have been proven to influence behavior change. A definition of these factors is included as an attachment to this prevention plan.

Following both the population and additional factors selection your agency should consider the following factors regarding their organizations capabilities in executing an intervention.

Agency Strengths: Such as, but not limited to, is the agency "well established", maintains a good community reputation, provides HIV testing, trained staff, availability of counselors on site, staff buy-in, diversity, linguistics, equipment, data capabilities, collaborations with other agencies, availability of focus groups.

Agency Weaknesses: Availability of staff training to the specific intervention, experience with the targeted priority population, hesitation from staff members, location of agency.

Recruitments: Referral capabilities, advertisement availabilities, networking potentials, relationships with other local agencies.

Retainment: Completion certificates, client commitment agreements, social events, incentives.

NEEDS ASSESSMENT COMMITTEE NARRATIVE

Prepared by Cena Bain/Beth Meyerson
Edited and approved by the Needs Assessment Committee

It is the mission of the Needs Assessment Committee to work with the Division of HIV/STD/Viral Hepatitis to assess the needs of the community as it relates to HIV prevention. This mission is met through the following functions:

- Act as advisors to the Division on the focus and implementation of needs assessments.
- Provide input as it relates to the development and the updating of a resource inventory.
- Review needs assessment and resource inventory to provide input into a gap analysis report.

SEEING WITH NEW EYES: ESTABLISHING THE HIV PREVENTION RESEARCH AGENDA

In late 2009, the Indiana CPG Needs Assessment Committee convened to discuss potential assessment activities for Indiana. At that time it was determined that the CPG had not recommended, nor had the Division completed a comprehensive needs assessment for the state since 2002. Given that the epidemic was not changing in Indiana, and in order to leverage change in the health of populations impacted by HIV, a new strategy was necessary to change the way we think about and approach HIV prevention. For these reasons, in early 2010 the CPG convened a group of prevention partners, advocates, and researchers in HIV, STD, and Viral Hepatitis to evaluate the HIV prevention efforts in the face of continued increases in HIV incidence, particularly among sexual and racial/ethnic minorities.

Prior to fully developing the Research Agenda, the committee, in collaboration with external partners (Indiana Minority Health Coalition and Policy Resource Group, Inc.), began to review all existing needs assessments that were focused in Indiana (HIV and beyond) from the years 1998-2000. Additionally, the group reviewed states that were similar to Indiana in terms of geographicy, socio-demographics, HIV policy and available resources. After review of these documents and data, the committee found that past needs assessments were 1) asking the same people the same questions in the same ways; 2) based on unfounded assumptions(e.g. we already know how HIV is transmitted in Indiana, people identify themselves as we identify them, and preventing HIV has little to do with structural or co-occurring health issues); 3) often rushed; 4) studies that did not offer recommendations; and 5) sometimes presented, but did not allow for gap identification by the CPG process.

Following evaluation of the materials and conversation within the committee, *Moving Forward Together: A Needs Assessment Research Agenda for HIV Prevention in Indiana* was created. The research agenda was designed for the encouragement of Indiana communities, planning coalitions, and research partners to focus on one or more of the following priorities in order to help shape a more comprehensive understanding of HIV in Indiana:

STIGMA

Focus

Stigma about HIV and STDs, sexuality, sex talk, LGBT persons, disclosure about HIV or STDs, addiction, race and ethnicity, immigration status, depression, and health services access.

Learning Goals (e.g. *what do we want to know?)*

1. What are the expressions of stigma in Indiana? How are they different from place to place? Subject to subject? What is the experience of layered stigma?
2. What are the characteristics of internalized stigma among priority populations?
3. How is stigma (perceived and experienced) a barrier to prevention information, service access and healthy living?
4. What are the opportunities for social marketing intervention?
5. How should the health system change to reduce the expression of stigma and stigmatizing situations?

Sample (e.g. *who do we want to learn from?)*

1. Health providers (HIV specific providers; Non-HIV specific providers who are likely in the orbit of people at risk for or living with HIV)
2. People living with HIV, their family members, social networks
3. Religious communities
4. General public (distinct age group samples)
5. Community gatekeepers/leaders in African American communities, Hispanic communities, rural communities and immigrant communities

Methods (e.g. *how will we gather this information?)*

1. Utilize a community participatory research model
2. Focus groups and key informant interviews – to help define stigmas and their expression
3. Survey
   - PLWHA in care and providers of HIV related services: Partner with HIV Care planning partners (TGA and CHSPC) to add questions to consumer and provider surveys; construct survey for HIV and STD prevention services providers.
   - Youth in High Schools: Partner with YRBS to add questions to survey instruments 2013 and beyond.
   - Public and Gate Keepers – Street surveys? Online? Health fairs and expos? Leverage opportunities for rapid assessments.
   - Secondary analysis of select household surveys

PROVIDER BEHAVIORS

Learning Goals (e.g. *what do we want to know?)*

1. How do providers support the delivery of effective HIV prevention services to priority populations?
    - What provider behaviors enhance or inhibit HIV and STD prevention? (Access and use of services, consideration and adoption of healthier behaviors)
    - What prevention messages are providers communicating, and how are they communicated? (HIV and STD testing and services, access to health services, sex and sexuality)
2. How are providers striving to be culturally relevant to the populations they serve?
3. How do factors such as location and organization of services impact provider behavior? (e.g. rural, referral networks, organization of services – health clinics, emergency rooms, jails, treatment programs, etc.)

Sample (e.g. *who do we want to learn from?)*

1. HIV prevention and care funded providers
2. STD providers
3. Non-HIV specific health providers who are in the orbit of people who live with or are at risk for HIV/AIDS: long term care, women's health and family planning, urgent care/emergency room, alternative and traditional medicine, migrant health, jail and prison health, community health, substance abuse and mental health treatment

Methods (e.g. *how will we gather this information?)*

1. Utilize a community participatory research model
2. Focus Groups (Convenience: professional health conferences, health fairs)
3. Secondary analysis of Medicaid utilization and hospital discharge data to identify providers and related services
4. Review of ISDH prevention contract provider data (EvaluationWeb).
5. Survey
6. Gap testing by CPG members or others – related to structural gaps in the system of care, provider behaviors and messages
7. Health system users: PLWHA and priority populations

PERSPECTIVES AND BEHAVIORS OF SUB-POPULATIONS

Learning Goals (e.g. *what do we want to know?)*

1. Sexual practices, networks, partner histories, disclosure practices and beliefs
2. Construction of risk, sex, HIV and STDs, substance use, sexuality
    - Role of stigma in the construction of risk; experiences and perceptions of stigmas
3. Health Access: Knowledge, beliefs about/construction of health and treatment/services access and use
    - Experiences of treatment/service attempts or access for substance abuse, depression, partner violence
4. Social networks and cohesion (connectedness to family, friends, community)
5. Environmental experiences: rural life, life in jail or prison, housing transition

Sample (e.g. *who do we want to learn from?)*
Men who have sex with other men (all race/ethnicities; self identifying and those who do not self identify as gay or bisexual)
Black women (African American and Black African)
Heterosexual Black men
Heterosexual Hispanic men
Hispanic women
Injection drug users
People with substance use/abuse histories
Rural youth and adults, with oversampling of ethnic minorities
Youth and young adults, ages 13-20

Methods (e.g. *how will we gather this information?)*

1. Utilize a community participatory research model
2. Focus groups
3. Key informant interviews
4. Surveys (Youth in High Schools: add questions to 2013 YRBS survey instrument; MSM)

COMMUNITY INFRASTRUCTURE

Learning Goals (e.g. *what do we want to know?)*
What is the community health infrastructure and how does it support or hinder HIV and STD prevention?

Methods (e.g. *how will we gather this information?)*

1. Utilize a community participatory research model
2. Review community mapping and asset projects focused on Indiana communities (Wabash, minority health coalitions, etc.)
3. Conduct statewide community asset mapping
   - Enhance with data from Stigma study and from secondary analysis of Medicaid and hospital discharge data.

HEALTH SYSTEM OPPORTUNITIES & FAILURES

Learning Goals (e.g. *what do we want to know?)*

1. What are the opportunities for HIV prevention among PLWHA in care?
2. What are the experiences of treatment attempts or access for substance abuse, depression and partner violence among priority populations? (see perspectives and behaviors of sub populations)
3. What are the missed opportunities for prevention and other services?

Methods (e.g. *how will we gather this information?)*

1. Utilize a community participatory research model
2. Survey
   - PLWHA in care and providers of HIV related services: Partner with HIV Care planning partners (TGA and CHSPC) to add questions to consumer and provider surveys
   - Priority populations – experience of prevention service providers
3. Review of select epi data: delayed HIV testing (health at first HIV+ test); out of care for

HIV; STD, HIV and Hepatitis co-occurrence or shared history (e.g. co-occurrence or history of STDs and Hepatitis among those who are newly diagnosed with HIV).

CONTINUOUS REVIEW OF THE POLICY ENVIRONMENT

Key policies for review and further study:

1. HIV testing: rapid and routine
   - What is the need for rapid and routine HIV testing?
   - What is the impact of routine and rapid HIV testing on early diagnosis?
2. Availability and use of substance abuse treatment
   - Modeling: how might the expansion of substance abuse treatment impact HIV risk behaviors and health services utilization in priority populations?
3. Availability of treatment for depression
   - How would the expansion of treatment for depression impact risk for HIV and access of health services?
4. Access to comprehensive sex and sexuality education
   - What is the status of comprehensive sex and sexuality education in Indiana? (Existence, availability, evaluable outcomes)
   - How are stigmas expressed in the available curricula?
   - What are the missed opportunities for STD, HIV and pregnancy prevention?
5. Syringe access and harm reduction
   - What are the opportunities for the expansion of syringe access, overdose prevention and harm reduction programming among injection drug using communities?
6. Heath Care Reform –What are the implications and opportunities for STD, HIV and Hepatitis prevention and treatment?

FOLLOW-UP and MOVING FORWARD WITH INDIANA'S RESEARCH AGENDA

It is the goal of the Indiana CPG and the ISDH to disseminate the research agenda to various governmental entities, as well as AIDS Service and Community Based Organizations in order for them to assess and review research priorities and potentially assist in funding some additional needs assessment activities. The CPG encourages collaborations and partnerships with other organizations outside of the HIV/AIDS/STD arena. For example, collaborations with the Indiana Department of Correction, Division of Mental Health and Addiction, and Indiana Housing Authority are just a few examples of agencies that have the potential to benefit HIV prevention services throughout the state.

ACCESSING THE AGENDA

Anyone interested in additional information or obtaining a copy of the *Moving Forward Together: A Needs Assessment Research Agenda for HIV Prevention in Indiana,* should contact the Community Planning Group Liaison at 317-233-7483 at the Indiana State Department of Health or click on the following:

Moving Forward Together_HIV Prever

2011 HIV TEST VISITORS PROJECT: SEEING WITH NEW EYES

In response to the research agenda priorities, the ISDH began planning a provider assessment in January of 2011. The project consisted of 30 HIV-negative community researchers who were reflective of the demographics and experiences of target populations selected to serve as HIV testing visitors at the 33 sites funded by the ISDH. In March 2011, each site received at least one (1) visit, with many receiving two (2) or more from different community researchers over a three week period. Community researchers evaluated the following: messaging and provider community (including stigmatization), access to services (cultural/linguistic, availability, setting, appropriate, referrals), and whether they would return for a future test. Phone follow up of any referrals offered provided a random assessment of the referral network as well.

FINDINGS/RESULTS

In May 2011 the Needs Assessment Committee presented its findings to the full CPG. All ISDH funded sites were visited, most of which were visited by three (3) community researchers, with 5 sites only visited by only one (1) person due to recruitment challenges. Of the 33 ISDH funded sites, 33.3% of sites were categorized as "strong" sites. Strong sites were those that received a positive review by all who visited the site. Characteristics of a strong site included 1) a positive access experience (to include flexible scheduling, easy phone access, availability of provider, welcoming front desk staff/receptionist); 2) respectful, welcoming, kind, open, and listened well; 3) knowledgeable provider, educated client well; 4) space and provider respected confidentiality; 5) efficient, clean and organized site; 6) rapid test was an option; 7) regardless of initial negative experience, a strong/positive testing provider negative experiences were reduced.

In addition to the 33.3% of sites that were categorized as strong, testers reported that at 42% of the sites they reported to have had experienced confidentiality issues, testers reported that they would not return to 48% of the sites for various reported reasons, and testers also reported that they did not receive a test, despite attempts and request at 33.3% of the sites visited/contacted.

Following these findings, it is the goal of the HIV Prevention Program to address each issue that was reported within the study as a whole to all funded by the ISDH. In addition, by the end of 2012, the HIV Prevention Program will visit all sites, address specific issues individually and determine if any additional training or capacity building activities are needed.

ACCESSING THE FULL REPORT

Anyone interested in additional information surrounding the 2011 HIV TEST VISITORS PROJECT: SEEING WITH NEW EYES should contact the Community Planning Group Liaison at 317-233-7483 or the HIV Prevention Program Manager at 317-233-7840 both located at the Indiana State Department of Health.

BLACK MEN'S HEALTH SURVEY

During the gathering of data related to the HIV research agenda, it was concluded that there was insufficient data to determine appropriate and effective HIV prevention services for Heterosexual Black Men. As a result, during the summer of 2011 the Indiana Minority Health Coalition (IMHC) began to prepare and conduct a black men's health study. The study is a community based participatory research project designed to assess the general health of black men, including sexual health such as HIV and STD's.

Currently, IMHC is analyzing the results and preparing to release a final report in early 2012. Additionally, meetings are being held around the state with project research teams to discuss the preliminary results. Upon completion, an addendum will be filed to this prevention plan.

2010 HIV/STD/VIRAL HEPATITIS PREVENTION AND MEN WHO HAVE SEX WITH MEN (MSM) NEEDS ASSESSMENT

In 2008, the HIV Prevention Program was awarded competitive supplemental funding from the Centers for Disease Control and Prevention to conduct an HIV/STD/Viral Hepatitis Prevention Needs Assessment for Men who have Sex with Men (MSM). This funding was designated for states to assess the strengths and weaknesses of existing prevention services and resources that target MSM and to identify barriers that impede MSM access to these services and resources. The primary goal of this study was to guide ISDH officials in efforts to devise new prevention measures and to revise and enhance existing services that would help reduce infection rates of HIV/STD/Viral Hepatitis among MSM communities in the state of Indiana.

The study was conducted in the following five (5) highest incidence counties of Indiana for MSM: Marion, Lake, Allen, St. Joseph, and Vanderburgh. Activities included both survey questions and focus groups. Survey questions focused mainly on demographic, gender identity, sexual practices, and sexual orientation information, while focus groups primarily centered on the knowledge of HIV and HIV status, barriers that MSM face, prevention knowledge and access to services, stigma surrounding MSM, HIV, and testing.

FINDINGS/RESULTS

General findings included strong associations between socio-economic status and HIV positivity rates. Overall themes included strong stigma associated with sex, HIV, and other STDs, barriers to accessing general prevention information, barriers to receiving testing, and a lack of comprehensive prevention information that focuses on risk reductive sexual practices. To address some of these issues the following was recommended:

1. Development of social marketing campaigns that normalize sexuality as a part of sexual health and to incorporate sex positive representations of MSM.
2. Development of partnerships between ISDH officials, sexual education consultants, prevention workers, care providers, and grade school teachers to develop a comprehensive sex education curriculum.
3. Training of health care providers in adopting a risk reductive, sex positive approach to service provision and care for MSM clients.
4. Transient, audience intended prevention messaging/social marketing.
5. Development of appropriate culturally based interventions and prevention messaging.
6. Development of comprehensive HIV testing sites to include both free HIV and STD tests.
7. Development of prevention methods and/or interventions that focus on risk reductive practices.

ACCESSING THE FULL REPORT

Anyone interested in obtaining the 2010 HIV/STD/Viral Hepatitis Prevention and Men who have Sex with Men (MSM) Needs Assessment Report should contact the Community Planning Group Liaison at 317-233-7483 at the Indiana State Department of Health.

2009 HIV PREVENTION GAP ANALYSIS

In early 2009, the Indiana CPG and the ISDH conducted a gap analysis focused on organizations that provide HIV prevention services to those populations at greatest risk for HIV infection. The analysis covered a 10-county geographic region area which included Elkhart, St. Joseph, Delaware, Henry, Jay, Randolph, Wayne, Marion, Monroe, and Vigo Counties. Service providers in these areas were contacted via telephone and asked a series of questions related to available programs, services, and referral processes within their organizations.

FINDINGS/RESULTS

Attempts were made to contact a total of 85 agencies with successful contacts occurring at only 56 (66%). The biggest obstacles were determined to be that of the automated phone systems and unreturned voice mail messages. For agencies that were successfully contacted, answers to the questions were found to be ambiguous and formulaic, with some respondents who were unfamiliar with terminology used in the HIV/STD field. Additionally, when referrals were given, many individuals were sent to organizations located in another county.

ACCESSING THE FULL REPORT

Anyone interested in obtaining the 2009 Gap Analysis Report should contact the Community Planning Group Liaison at 317-233-7483 at the Indiana State Department of Health.

EVALUATION COMMITTEE NARRATIVE

Prepared by Cena Bain, CPG Liaison
Edited and approved by the Evaluation committee

Evaluation of the community planning process is implemented through several methods. Those methods include:

Bi-Monthly Group-Assessments:
The CPG has utilized a bi-monthly group-assessment since its inception. Over the years, minimal changes have been made; however, in 2009 the assessment form was reformulated and downsized from 35 questions to 10 in hopes of receiving more detailed and accurate information from members. The purpose of the group assessment is to allow members to provide an opportunity for input of the process and policies on how the bi-monthly meetings are governed. The form is distributed to and completed by all members and technical advisors of the CPG at each meeting. The results are compiled by the CPG staff, reviewed by the Co-Chairs as well as the Executive Committee and then presented to the full body at the following meeting. The comments and suggestions are taken into account when determining meeting format, agendas, training needs, etc. A copy of this assessment is included as an attachment to this plan.

Member Self Performance Review Survey:
In 2009, the evaluation committee created a self performance review sheet that was first disseminated and completed in November of 2010. The purpose of this review sheet is for members to self examine their personal role, contribution, and understanding of the planning process and rate themselves on a Likard Scale. Members are then asked to list all achievements from the previous year, set goals for the upcoming year, recognize their strengths and weaknesses and list an areas for both personal and group developments. The completed surveys are then re-examined mid-year by the evaluation committee. A copy of this assessment is included as an attachment to this plan.

Exit Surveys/Interviews:
In 2009, the evaluation committee created a written exit interview form that is distributed to all members who voluntarily make the decision to remove themselves from the CPG.
Former members are asked about their service on CPG including why they are leaving, what negative and positive experiences occurred, their willingness to serve in the future and whether or not they would recommend CPG to other members of the community, etc. The intent of this survey is to better improve retention within CPG membership and improve in areas that former members find to be problematic or potential impediments to the process.

Evaluating the Process:
In 2010, the evaluation committee sought the help of outside technical assistance in evaluating the community process in terms of meeting the goals and objectives, including the key attributes that have been set by the Centers for Disease Control. As this had never been done before, at least in Indiana, the committee was at a loss on where to even begin on the process. After working closely with the Academic of Educational Development (AED), the committee developed a template that allowed the committee to review all pertinent information, determine if evidence exists, if a relevant indicator is being fulfilled, and document and summarize that data on the template. Once compiled, the committee was able to examine the completed form and determine what objectives and/or indicators are not being fulfilled within the planning process in the state of Indiana.

CPG Knowledge Assessment:
In September 2011, the evaluations committee collectively decided to assess the knowledge of the CPG members to determine any ongoing training and/or educational needs. The CPG assessment consisted of ten (10) general knowledge questions pertaining to issues such as the goals, mission, roles and responsibilities, by-laws and policies and procedures guidelines of the planning process. Of the 14 present voting and non-voting CPG members, 10 completed the assessment. A copy of this assessment is included as an attachment to this plan, additionally; the results of the assessment are as follows:

Question Number	Correct	Partial	Incorrect
1	80%	0%	20%
2	20%	40%	40%
3	80%	0%	20%
4	40%	10%	50%
5	40%	20%	40%
6	40%	20%	40%
7	40%	10%	50%
8	60%	10%	30%
9	20%	10%	70%
10	50%	10%	40%

After compiling the findings it was determined that some additional educational sessions may be necessary throughout the year to ensure understanding and purpose of all members assisting with the planning process. Additionally, while providing the correct responses of the assessment to the members, it was evident that some by-laws and/or policies and procedures needed to be revisited and adjusted on a bi-annual basis to ensure PIR.

Annual Evaluation Survey:
A more comprehensive survey is distributed on an annual basis. This survey is facilitated and distributed by the CPG Liaison. Participants are given time during the meeting to complete the survey to assure a higher number of completed surveys. CPG members are asked in-depth about their CPG membership including experience, opinions, concerns, needs, etc. Members are asked specific questions regarding gender, race, ethnicity, employment, and sexual orientation. Participants are also asked to answer questions regarding CPG's monetary and human resources, policies and procedures, influences of outside and health department technical staff, advocacy issues, and the handling of actionable items. This survey allows the health department to better complete their required Annual and Interim Progress Report that is mandated by the Centers for Disease Control as well as ensure that Parity, Inclusion, and Representation (PIR) is being met. A copy of this assessment is included as an attachment to this plan.

ANNUAL EVALUATION SURVEY RESULTS

Collected and Results Compiled by Cena Bain, CPG Liaison

Between the dates of October 18th and October 28th, 2011 the annual evaluation survey was distributed to both voting and non-voting CPG members. Of the 23 members of the CPG, 18 members completed the survey. Below are the findings of the survey:

Are you a voting member?		
Yes– 61% (all voting members completed the annual evaluation survey)	No –28%	Unanswered–11%
Age:		
(13-24) – 5%	(25-29) – 0	(30-39) – 45%
(40-49) – 34%	(50+) – 11%	Unanswered – 5%
Gender:		
Male – 40%	Female – 55%	Transgender – 5%
Sexual Orientation:		
Heterosexual – 72%	Heterosexual (but have had sex with men) – 0%	Gay – 23%
Lesbian – 5%	Same Gender Loving (SGL) – 0%	Other – 0%
Race:		
White – 45%	Black or African-American – 55%	American Indian or Alaska Native – 0%
Asian – 0%	Hawaiian/Pacific Islander – 0%	Other – 0%
Ethnicity:		
Hispanic or Latino/a – 11%	Non-Hispanic or Non-Latino/a – 78%	Unanswered – 11%

Are you Employed by or personally represent any of the following Organizations? (check all that apply)		
Health department – 39%	Community-Based Organization (CBO) – 39%	Health Care Provider – 0%
Academic Institution – 11%	Correctional Facility – 0%	Other Government Agency (other than health department) – 5%
Other –	Unanswered – 17%	
Does your Organization receive HIV prevention funding from the ISDH?		
Yes – 44.5%	No – 11%	Not Applicable – 44.5%
Including this term, how many terms have you served on the CPG (One term equals 24 months)?		
Average Term for the 18 members – 2		
On average, how many hours do you spend on all CPG activities per month?		
Average hours spent on CPG – 7.5		
The CPG has sufficient human resources to conduct tasks of community planning.		
Strongly Agree – 27%	Somewhat Agree – 39%	Unsure – 17%
Somewhat disagree – 17%	Strongly Disagree – 0%	
The CPG has sufficient monetary resources to conduct tasks of community planning.		
Strongly Agree – 50%	Somewhat Agree – 39%	Unsure – 5.5%
Somewhat disagree – 0%	Strongly Disagree – 5.5%	
The CPG brings the necessary skills and abilities to the table to effectively conduct community planning activities.		
Strongly Agree – 44.5%	Somewhat Agree – 44.5%	Unsure – 5.5%
Somewhat disagree – 5.5%	Strongly Disagree – 0%	
The CPG follows its' own policies and procedures.		
Strongly Agree – 50%	Somewhat Agree – 50%	Unsure – 0%
Somewhat disagree – 0%	Strongly Disagree – 0%	
The CPG receives adequate information from ISDH to perform required tasks.		
Strongly Agree – 56%	Somewhat Agree – 38.5%	Unsure – 0%
Somewhat disagree – 0%	Strongly Disagree – 5.5%	
The CPG is focused on community planning outcomes.		
Strongly Agree – 44.5%	Somewhat Agree – 44.5%	Unsure – 5.5%
Somewhat disagree – 0%	Strongly Disagree – 5.5%	
CPG members who are NOT Health Department staff have more influence on the CPG than Health Department staff.		
Strongly Agree – 28%	Somewhat Agree – 33.5%	Unsure – 11%
Somewhat disagree – 22%	Strongly Disagree – 5.5%	
CPG members who ARE Health Department staff have more influence on the CPG than members who are not Health Department staff.		
Strongly Agree – 11%	Somewhat Agree – 17%	Unsure – 22%
Somewhat disagree – 44.5%	Strongly Disagree – 5.5%	

CPG members from organizations that receive Health Department funds have more influence on the CPG than other members.		
Strongly Agree – 0%	Somewhat Agree – 17%	Unsure – 22%
Somewhat disagree – 33%	Strongly Disagree –28%	
During the past year, the role of the CPG has been quite clear to me.		
Strongly Agree – 27%	Somewhat Agree – 62%	Unsure – 5.5%
Somewhat disagree – 5.5%	Strongly Disagree – 0%	
During the past year, MY role of the CPG has been quite clear to me.		
Strongly Agree – 11%	Somewhat Agree – 17%	Unsure – 22%
Somewhat disagree – 44.5%	Strongly Disagree – 5.5%	
Some CPG members advocate their own agenda more than for the agenda of the CPG.		
Strongly Agree – 22%	Somewhat Agree – 44.5%	Unsure – 11%
Somewhat disagree – 17%	Strongly Disagree – 5.5%	
The CPG is culturally sensitive.		
Strongly Agree – 39%	Somewhat Agree – 55.5%	Unsure – 0%
Somewhat disagree – 5.5%	Strongly Disagree – 0%	
The CPG is a well organized group.		
Strongly Agree – 22%	Somewhat Agree – 67%	Unsure – 5.5%
Somewhat disagree – 5.5%	Strongly Disagree – 0%	
The amount of time for conducting all community planning activities is adequate.		
Strongly Agree – 33.5%	Somewhat Agree – 50%	Unsure – 0%
Somewhat disagree – 11%	Strongly Disagree – 5.5%	
The Health Department's HIV funds have been distributed fairly.		
Strongly Agree –39%	Somewhat Agree – 33.5%	Unsure – 11%
Somewhat disagree – 16.5%	Strongly Disagree – 0%	
CPG meetings are conducted in a way that allows for maximum participation of participants.		
Strongly Agree – 33.5%	Somewhat Agree –50%	Unsure – 0%
Somewhat disagree – 11%	Strongly Disagree – 5.5%	
I feel safe in speaking freely at CPG meetings.		
Strongly Agree – 72%	Somewhat Agree – 17%	Unsure – 0%
Somewhat disagree – 0%	Strongly Disagree – 11%	
I clearly understand language and terminology used during CPG meetings.		
Strongly Agree – 44.5%	Somewhat Agree – 44.5%	Unsure – 0%
Somewhat disagree – 11%	Strongly Disagree – 0%	
The Co-Chairs of the CPG do an effective job keeping members on task according to meeting agendas.		
Strongly Agree – 56.5%	Somewhat Agree – 39%	Unsure – 0%
Somewhat disagree – 5.5%	Strongly Disagree – 0%	
The CPG advises and makes recommendations to the state.		
Strongly Agree –67%	Somewhat Agree – 22%	Unsure –11%
Somewhat disagree – 0%	Strongly Disagree – 0%	

The state follows up on recommendations made by the CPG.		
Strongly Agree – 17%	Somewhat Agree – 50%	Unsure – 22%
Somewhat disagree – 11%	Strongly Disagree – 0%	
Materials for CPG meetings are adequately prepared and in advance of meetings (agendas, minutes, materials to complete meeting objectives).		
Strongly Agree – 83%	Somewhat Agree – 17%	Unsure –0%
Somewhat disagree – 0%	Strongly Disagree – 0%	
When the CPG has follow-up action items, it is clear how these items will be handled.		
Strongly Agree – 17%	Somewhat Agree – 61%	Unsure – 11%
Somewhat disagree – 5.5%	Strongly Disagree – 5.5%	
Meeting times work well with my schedule.		
Strongly Agree – 67%	Somewhat Agree – 27.5%	Unsure – 0%
Somewhat disagree – 5.5%	Strongly Disagree – 0%	
Location of meetings is convenient for me.		
Strongly Agree – 61%	Somewhat Agree – 39%	Unsure – 0%
Somewhat disagree – 0%	Strongly Disagree – 0%	
Given the money and time that has been put into community planning in my jurisdiction, I am satisfied with what has been accomplished.		
Strongly Agree – 22%	Somewhat Agree – 67%	Unsure – 11%
Somewhat disagree – 0%	Strongly Disagree – 0%	

Additional Evaluations

On occasion, members wish to invite representatives from around the state to discuss or educate the CPG on various components of HIV Prevention. For this reason a "presentation request form" was developed for use by members and/or committees to request trainings and/or presentations on issues specific to HIV/STD prevention, community needs, the CPG process, etc. Additionally, a post-evaluation tool is used to assess the quality and effectiveness of the presentation.

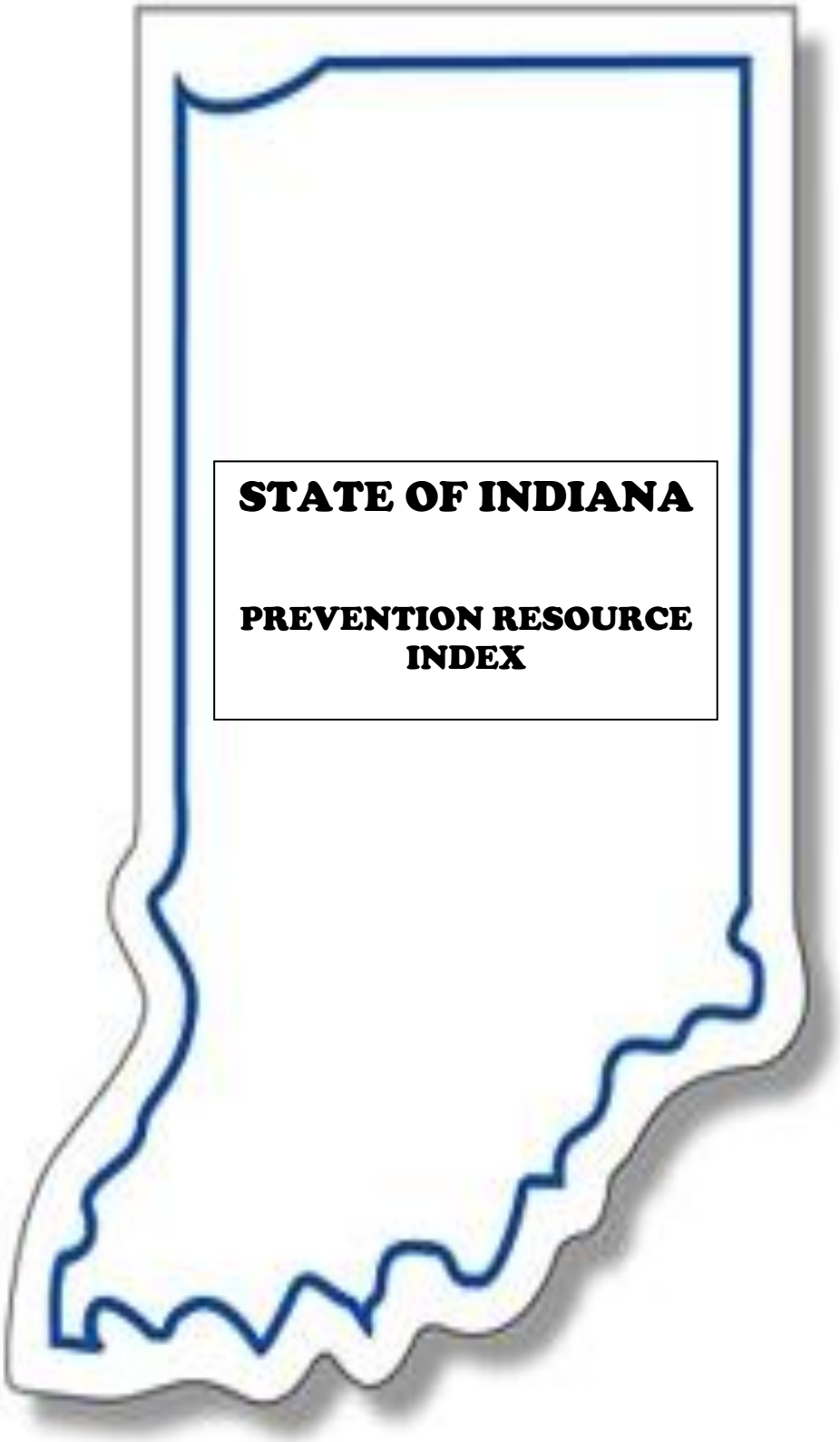
REFERENCES

Center for AIDS Prevention Studies. Retrieved September 28, 2011 from http://www.caps.ucsf.edu/

Center for Disease Control and Prevention. (1999). *Compendium of HIV prevention Interventions with Evidence of Effectiveness*. Atlanta, GA

Center for Disease Control and Prevention. (2003). *HIV Prevention Community Planning Group Guide.* Atlanta, GA.

UNAIDS. (2002). Technical Update [Electronic version]. *Sex Work and HIV/AIDS.*



STATE OF INDIANA

PREVENTION RESOURCE INDEX

2010-2012 HIV Prevention Directly Funded Sites

Agency	Region (s)	Counties Served	Population (s) Served	Intervention (s)
African Communities Inc.	1, 5	Allen, Marion	Heterosexual African Females	CTR
AIDS Ministries/AIDS Assist	2	St. Joseph	African American MSM, African American Females	CTR and Outreach
AIDS Resource Group	8	Vanderburgh, Warrick, Knox, Dubois, Gibson	People Living with HIV/AIDS	CTR, Outreach, and CRCS
AIDS Task Force-Ft. Wayne	3	Allen, Dekalb, Kosciusko, LaGrange, Noble, Steuben, Wabash, Whitley	Heterosexual African American Females and Males	Street Smart, Group Level Intervention, and Outreach
The Aliveness Project	1	Lake, LaPorte, Porter	MSM, African American Females, IDU, Youth, People Living with HIC/AIDS, African American MSM	CTR and CRCS
The Bethlehem House	5	Marion	African American MSM, People Living with HIV/AIDS, IDU, Youth	Healthy Relationships
Brothers United	5	Marion	African American Gay, Lesbian, Bi, Transgender	CTR, CRCS, and Outreach
Clark County Health Department	9	Clark, Crawford, Dearborn, Floyd, Harrison, Jackson, Jefferson, Jennings, Ohio, Orange, Ripley, Scott, Switzerland, Washington	Youth	CTR
The Damien Center	5	Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Shelby	Youth	CTR and CRCS
Elkhart County Health Department	2	Elkhart, Kosciusko, Noble, St. Joseph	Youth, MSM, People Living with HIV/AIDS, African American females	CTR and Outreach
Fort Wayne-Allen County Health Department	3	Adams, Allen, DeKalb, Huntington, Jay, Kosciusko, LaGrange, Noble, Steuben, Wabash, Wells, Whitley	MSM, Heterosexual African American Females, High Risk Males and Females, People Living with HIV/AIDS	CTR and CRCS
Hispanic/Latino Health Coalition of Elkhart County	2	Elkhart, Kosciusko, LaGrange, Noble	Latino MSM, Heterosexual Latina Females, Youth	CTR and Outreach
Imani Unidad	2	Elkhart, St. Joseph	People Living with HIV/AIDS, High Risk Males and Females	CRCS
Indianapolis Urban League	5	Marion	Youth	I Need you to Listen, Hear, Understand Me
Madison County Health Department	6	Delaware, Grant, Madison, Wayne	African American Females, MSM ages 20-49	Voices, POL

Positive Link, A Program of IU Health Bloomington	7	Bartholomew, Brown, Greene, Lawrence, Monroe, Owen	MSM	CTR, MPowerment, and CRCS
Step-Up, Inc.	5	Boone, Delaware, Hamilton, Hancock, Hendricks, Henry, Howard, Johnson, Madison, Marion, Morgan	African-American MSM, Latina Females, Youth	POL, SISTA, Youth Outreach "Understanding Risk Sessions"
Wayne County Health Department	6	Wayne	MSM, Heterosexual African American Female, Youth, IDU	CTR and Outreach

Prevention Interventions

CRCS - Comprehensive Risk Counseling and Services
CTR - Counseling Testing & Referral
Outreach
GLI - Group -Level Intervention

HIV COUNSELING AND TESTING SITES
DIVISION OF HIV/STD/VIRAL HEPATITIS
INDIANA STATE DEPARTMENT OF HEALTH

Indiana HIV counseling and testing sites provide confidential and anonymous testing for the HIV virus. There is no charge for the HIV test; however, a few sites may have a minimal charge for service. Please call your local site (see the following list) for more information.

ADAMS COUNTY (*See Allen County)*

ALLEN COUNTY

Allen County Health Department
4813 New Haven Avenue
Ft. Wayne, IN 46803
260-449-7504
Monday and Thursday
Be Present at 8:00 a.m. to Receive Confidential Only Test

AIDS Task Force
525 Oxford Street
Ft. Wayne, IN 46806
260-744-1144
Mondays
3:00 p.m. to 6:00 p.m.

Prevention Clinic
2700 South Lafayette Street
Ft. Wayne, IN 46806
260-399-6461
3rd Wednesdays of every month
5:00 p.m. to 7:00 p.m.

Women's Bureau
3521 Lake Avenue, Suite #1
Ft. Wayne, IN 46805
260-424-7977
Wednesdays
11:00 am to 1:00 pm

BARTHOLOMEW COUNTY

Bartholomew County Health Department
Nursing Division
1971 State Street
Columbus, IN 47201-6965
812-379-1555
By Appointment Only

BENTON COUNTY (*See Tippecanoe County)*

BLACKFORD COUNTY (*See Delaware County)*

BOONE COUNTY

Boone County Health Department
116 West Washington Street, B201
Lebanon, IN 46052-2147
765-482-3942

BROWN COUNTY (*See Positive Link -- Monroe County)*

CARROLL COUNTY (*See Clinton or Montgomery)*

CASS COUNTY (*See Tippecanoe County)*

CLARK COUNTY

Clark County Health Department
Southeast Regional Office
1301 Akers Ave
Jeffersonville, IN 47130
812-288-2706 or 1-800-828-5624
Monday thru Friday
By Appointment Only
$10 fee
STD Clinic, Tuesdays ID Required
$10 fee

CLAY COUNTY (*See Vigo County)*

CLINTON COUNTY (*See Tippecanoe County)*

CRAWFORD COUNTY (*See Perry County)*

DAVIESS COUNTY (*See Knox County)*

DEARBORN COUNTY (*See Wayne County)*

DECATUR COUNTY

Decatur County Health Department
801 North Lincoln Street
Greensburg, IN 47240
812-663-8301
By Appointment Only
$10 fee

DEKALB COUNTY (*See Allen County)*

DELAWARE COUNTY *(See Madison or Henry County)*

DUBOIS COUNTY (*See Vanderburgh County)*

ELKHART COUNTY

AIDS Ministries/AIDS Assist
201 S. William Street
Elkhart, IN 46601
574-234-2870
Monday thru Thursday
9:00 a.m. to 4:00 p.m.
Fridays
9:00 a.m. to 1:00 p.m.
Walk-ins welcomed
See also www.aidsministries.org

Northern Indiana Hispanic Health Coalition
323 Stocker Ct.
Elkhart, IN 46516
574-522-0966
By appointment only

Elkhart County Health Department
608 Oakland Avenue
Elkhart, IN 46516
574-523-2128
Monday-Friday 8:30 a.m. to 4:00 p.m.
Appointment Preferred
Walk-ins welcomed
For Alternative Testing Options
contact 574-523-2125

FAYETTE COUNTY (*See Rush County)*

FLOYD COUNTY (*See Clark or Washington County)*

FOUNTAIN COUNTY (*See Warren, Tippecanoe, or Montgomery County)*

FRANKLIN COUNTY (*See Fayette County)*

FULTON COUNTY (*See St. Joseph County)*

GIBSON COUNTY (*See Knox or Vanderburgh County)*

GRANT COUNTY (*See Madison, Howard, or Delaware County)*

GREENE COUNTY (*See Positive Link – Monroe County)*

HAMILTON COUNTY

Hamilton County Health Department
18030 Foundation Drive, Suite A
Noblesville, IN 46060
317-776-8500
By Appointment Only

HANCOCK COUNTY (*See Henry, Madison, or Marion County)*

HARRISON COUNTY (*See Clark or Washington County)*

HENDRICKS COUNTY (*See Boone or Marion County)*

HENRY COUNTY

Henry County Health Department
1208 South 12th Street
New Castle, IN 47362
765-521-7060
Monday thru Thursday
8:30 a.m. to 4:00 p.m.
By Appointment Only

HOWARD COUNTY

Howard County Health Department
120 East Mulberry, Room 206
Kokomo, IN 46901
765-456-2402
Mondays
9:00 a.m. to 3:00 p.m

HUNTINGTON COUNTY (*See Allen County)*

JACKSON COUNTY (*See Monroe County)*

JASPER COUNTY (*See Monroe County)*

JAY COUNTY (*See Delaware County)*

JEFFERSON COUNTY (*See Scott County)*

JENNINGS COUNTY (*See Bartholomew County)*

JOHNSON COUNTY (*See Marion or Bartholomew County)*

KNOX COUNTY

Knox County Health Department
701 Dubois Street
Vincennes, IN 47591
812-882-8080
2nd Wednesday of every month
9:30 a.m. to11:00 p.m.
Appointment Preferred
Walk-ins welcomed

KOSCIUSKO COUNTY (*See Allen County)*

LAGRANGE COUNTY (*See Elkhart County)*

LAKE COUNTY

Lake County Health Department
2293 North Main Street
Crown Point, IN 46307
219-755-3655
By Appointment Only

Aliveness Project-Merrillville Office
5490 Broadway, Suite L3
Merrillville, IN 46410
219-985-6170
Monday thru Friday
8:30 a.m. to 4:00 p.m.

East Chicago Health Department
100 West Chicago Avenue
East Chicago, IN 46312
219-391-8467
Monday, Tuesday, and Wednesdays
9:00 a.m. to 12:00 p.m.
and 2:30 p.m. to 3:30 p.m.

LAPORTE COUNTY (*See Lake County)*

LAWRENCE COUNTY (*See Positive Link – Monroe County)*

MADISON COUNTY

Madison County Health Department
206 East Ninth Street
Anderson, IN 46016
765-646-9205
By Appointment Only

MARION COUNTY

African Community
3737 North Meridian Street, Suite 507
Indianapolis, IN 46208
317-927-9777
By Appointment Only

Bell Flower HIV Testing Clinic
1101 West 10th Street, 1st Floor
Indianapolis, IN 46202
317-221-8312
Monday
9:00 a.m. to 6:30 p.m.
Tuesday
11:30 a.m. to 3:30 p.m.
Wednesday
10:30 a.m. to 6:00 p.m.
Thursday
9:00 a.m. to 3:30 p.m.
Friday
9:00 a.m. to 12:30 p.m.
Same Day Appointments Only

Bell Flower STD Clinic
1101 West 10th Street, 1st Floor
Indianapolis, IN 46202
317-221-8300
Monday
7:40 a.m. to 6:10 p.m.
Tuesday
11:40 a.m. to 3:10 p.m.
Wednesday
10:40 a.m. to 6:10 p.m.
Thursday & Friday
7:40 a.m. to 3:10 p.m.
Same Day Appointments Only
Walk-ins Welcomed on
Monday, Thursday, and Friday at 7:00 a.m. Only

Casa Mateo
3745 W. Washington Street, Suite 1
Indianapolis, IN 46241
317-481-0110
By Appointment Only

Citizen's Health Center
1650 North College Avenue
Indianapolis, IN 46202
317-924-6351
By Appointment Only

Damien Center
26 North Arsenal Avenue
Indianapolis, IN 46201
317-632-0123
Monday
11:00 a.m. to 7:00 p.m.
Tuesday thru Friday
8:30 a.m. to 5:00 p.m.

HealthNet Care Barrington Health Center
3401 East Raymond Street
Indianapolis, IN 46203
317-781-4994
English, Spanish and Burmese Speaking
By Appointment Only

HealthNet Care Center at the Tower
1633 North Capitol Avenue, Suite 500
Indianapolis, IN 46202
317-962-5014
English, Spanish and Burmese Speaking
By Appointment Only

Blackburn Health Center
2700 Dr. Martin Luther King Jr. Street
Indianapolis, IN 46208
317-931-4300
Monday thru Friday
8:00 a.m. to 4:30 p.m.
By Appointment Only

Brothers United
3737 North Meridian Street, Suite 505
Indianapolis, IN 46208
317-931-0292
Monday thru Friday
10:00 a.m. to 6:00 p.m.
By Appointment Only

HealthNet Southwest Health Center
2202 West Morris Street
Indianapolis, IN 46221
317-488-2021
English, Spanish and Burmese Speaking
By Appointment Only

Life Care Program of Clarion Health
1633 North Capitol Avenue, Suite 700
Indianapolis, IN 46202
317-962-2700
Monday thru Thursday
8:00 a.m. to 4:30 p.m.
By Appointment Only

PACE/OAR
(Public Action in Correctional Effort/
Offender Aid and Restoration)
2855 N. Keystone Av., Suite 110
Indianapolis, IN 46218
317-612-6800
Monday thru Friday
9:00 a.m. to 4:00 p.m.
Walk-ins Welcomed
Testing is available for all ex-offenders and their families only.

HealthNet Martindale-Brightwood Health Center
2855 N. Keystone, Suite 100
Indianapolis, IN 46218
317-962-5014
English, Spanish and Burmese Speaking
By Appointment Only

HealthNet People's Health Center
2340 East 10th Street
Indianapolis, IN 46204
317-633-7360, Extension 151
English, Spanish and Burmese Speaking
By Appointment Only

HealthNet Southeast Health Center
901 South Shelby Street
Indianapolis, IN 46203
317-488-2040
English, Spanish and Burmese Speaking
By Appointment Only
Step-Up, Inc.
850 N. Meridian St, First Floor,
Indianapolis, IN 46204
317-259-7013
Check Web site calendar for current testing locations and times
www.stepupin.org

Substance Use Outreach Services
2951 E. 38th Street
Indianapolis, IN 46218
317-221-4618
Mondays
9:00 a.m. to 7:00 p.m.
Tuesday, Wednesday, Thursday, and Friday
9:00 a.m. to 5:00 p.m.
Walk-ins Only

Women in Motion, Inc.
8902 East 38th Street
Indianapolis, IN 46218
317-890-3288, Extension 119

MARSHALL COUNTY (*See St. Joseph County)*

MARTIN COUNTY (*See Dubois or Monroe County)*

MIAMI COUNTY (*See Grant or Madison County)*

MONROE COUNTY

Positive Link, A Program of IU Health Bloomington
333 East Miller Drive
Bloomington, IN 47401
812-353-3261

MONTGOMERY COUNTY (*See Tippecanoe County)*

MORGAN COUNTY (*See Marion or Monroe County)*

NEWTON COUNTY *(See Lake County)*

NOBLE COUNTY *(See Allen County)*

OHIO COUNTY *(See Clark or Wayne County)*

ORANGE COUNTY *(See Clark County)*

OWEN COUNTY *(See Monroe County-Positive Link)*

PARKE COUNTY *(See Montgomery or Vigo County)*

PERRY COUNTY

Perry County Health Department
Courthouse Annex Building, Room 16
Cannelton, IN 47520
812-547-2746
Monday thru Friday
8:00 a.m. to 4:00 p.m.
By Appointment Only

PIKE COUNTY *(See Vanderburgh County)*

PORTER COUNTY

Porter County Health Department
Portage Office
3560 Willow Creek
Portage, IN 46368
219-759-8239
Monday thru Friday
8:30 a.m. to 3:30 p.m.
By Appointment Only

Porter County Health Department
Valparaiso Office
155 Indiana Avenue
Valparaiso, IN 46383
219-465-3525
Monday thru Friday
8:30 am - 3:30 pm
By Appointment Only

POSEY COUNTY *(See Vanderburgh County)*

PULASKI COUNTY (*See Clinton or Montgomery County)*

PUTNAM COUNTY *(See Marion and Vigo County)*

RANDOLPH COUNTY *(See Wayne County)*

RIPLEY COUNTY *(See Jefferson or Decatur County)*

RUSH COUNTY

Family Health Services
201 Harcourt Way
Rushville, IN 46173
765-932-3699
Monday thru Friday
8:30 a.m. to 4:30 p.m.
By Appointment Only

ST. JOSEPH COUNTY

AIDS Ministries/AIDS Assist
222 South William Street
South Bend, IN 46601
574-234-2870
Monday thru Thursday
9:00 a.m. to 4:00 p.m.
Fridays
9:00 a.m. to 1:00 p.m.
Walk-ins welcomed
See also www.aidsministries.org

St. Joseph County Health Department
227 West Jefferson Boulevard, Room 825
South Bend, IN 46601-1870
574-235-9750

SCOTT COUNTY *(See Clark County)*

SHELBY COUNTY *(See Marion or Bartholomew County)*

SPENCER COUNTY *(See Perry County)*

STARKE COUNTY *(See Marshall County)*

STEUBEN COUNTY *(See Allen County)*

SULLIVAN COUNTY *(See Knox County)*

SWITZERLAND COUNTY *(See Jefferson County)*

TIPPECANOE COUNTY

Lafayette Planned Parenthood
964 Mezzanine Drive
Lafayette, IN 47901-1159
765-446-8078
By Appointment Only
Call for details

TIPTON COUNTY *(See Howard or Madison County)*

UNION COUNTY

Union County Health Department
6 West South Street
Liberty, IN 47353
765-458-5393

VANDERBURGH COUNTY

AIDS Resource Group
201 NW 4th Street, Suite B-7
Evansville, IN 47708
812-421-0059
By Appointment Only

Matthew 25 AIDS Services
100 Washington Avenue
Evansville, IN 47713
1-877-428-1231
Tuesday
9:00 a.m. to 11:30 a.m.
1:30 p.m.to 4:00 p.m.
Appointments Preferred

VERMILLION COUNTY *(See Vigo County)*

VIGO COUNTY

Health Connection – Wabash Valley
1724 North 7th Street
Terre Haute, IN 47802
812-234-0707
Monday, Wednesday, Thursday & Friday
8:15 a.m. to 4:15 p.m.
Tuesdays
10:15 a.m. to 6:15 p.m.
Call for an Appointment

Planned Parenthood
30 South 3rd Street
Terre Haute, IN 47807
812-238-2636
Mondays and Fridays
8:30 a.m. to 5:00 p.m.
Wednesday and Saturdays
8:30 a.m. to 1:30 p.m.
Tuesdays and Thursdays
10:30 a.m. to 7:00 p.m.
Call for an Appointment

WABASH COUNTY *(See Allen County)*

WARREN COUNTY *(See Tippecanoe County)*

WARRICK COUNTY *(See Vanderburgh County*

WASHINGTON COUNTY *(See Scott County)*

WAYNE COUNTY

Wayne County Health Department
203 East Main Street
Richmond, IN 47374-4288
765-973-9200
By Appointment Only

WELLS COUNTY *(See Allen County)*

WHITE COUNTY *(See Tippecanoe County)*

WHITLEY COUNTY *(See Allen County)*

Community Action Groups (CAG)

The CAG program is a statewide network of grassroots organizations that provide HIV education in their communities according to their specific needs and community standards. Step-Up provides technical assistance, training and resources to the 20 member CAGs. Each CAG must meet specific criteria to remain in good standing. Each quarter the CAGs educate an average of 35,000 individuals, distribute approximately 30,000 pieces of educational material and approximately 65,000 male condoms.

Paula French/Brad Gumbert
Step-Up, Inc.
850 North Meridian Street, 1st Floor
Indianapolis, IN 46204
Ph. 317-259-7013
Fx. 317-259-7034
pafrench@stepupin.org
bgumbert@stepupin.org

Allen County:
Kandace Kelly
ATF of Northeast Indiana
525 Oxford St.
Fort Wayne, IN 46806
Ph. 260-744-1144
Fax. 260-745-0978
kandace@aidsfortwayne.org

Clark Co:
Elaine Dailey
Dorothy Waterhouse
Hoosier Hills AIDS Coalition
1301 Akers Avenue
Jeffersonville, IN 47130
Ph. 812-283-2589 (Elaine Dailey)
Ph. 812-283-2586 (Dorothy Waterhouse)
Fax. 812-288-1474
elained@hotmail.com

Dubois Co:
Don Jones
Patoka Valley CAG
P.O. Box 411
Jasper, IN 47547
Ph. 812-482-1649
Fax. 812-482-1071
djdjdj5270@aol.com

Elkhart Co:
Jim Starkey
Elkhart Co. Health Dept.
608 Oakland Ave.
Elkhart, IN 46516
Ph. 574-523-2125
Fax. 574-523-2163
jstarkey@elkhartcounty.com

Floyd Co:
Jesse Floyd
Tri-County Health Coalition of S. Indiana
1222 State Street
P.O. Box 1580
New Albany, IN 47150
Ph. 812-944-7265
Fax. 812-945-3583
tchcosi@sbcglobal.net

Henry Co:
Sylvia Edwards
Henry County CAG
907 Lincoln Ave.
New Castle, IN 47362
Ph. 765-529-4381
Fax. 765-593-2510

Johnson Co:
Christina Bailey
3200 Sycamore Ct 2C
Columbus, IN 47203
812-376-0724
Christina.bailey@ppin.org

Lake Co:
Tammy Morris
Aliveness Project
5490 Broadway Suite L-3
Merrillville, IN 46410
Ph. 219-985-6170
Fax. 219-985-6097
tmorrisap@aol.com

Tony Gillespie
Brothers Uplifting Brothers
6111 Harrison Street
Merrillville, IN 46410
Ph. 219-985-2008
Fax. 219-887-1518
tgillespie@bubnwi.com

Madison Co:
Julie Foltz
Aspire Indiana Central (Elwood)
2020 Brown Street
Anderson, IN 46016
Ph. 765-552-5009
Fax. 765-552-8347
Julie.foltz@aspireindiana.org

Marion Co:
Jason Grisell
Circle City HIV/AIDS Coalition
The Health Foundation of Greater Indianapolis
429 E. Vermont Street, Suite 300
Indianapolis, IN 46202
Ph. 317-630-1805
Fax. 317-630-1806
jgrisell@thfgi.org

Byron Reynolds
Brothers United
3737 N. Meridian, Suite 505
Indianapolis, IN 46208
Ph. 317-931-0293
Fax. 317-931-0294
brothersunitedindy@sbcglobal.net

Pamela Goodwin
Women in Motion
6345 Old Barn Court
Indianapolis, IN 46268
Phone: 317-249-4223
Fax: 317-843-4895
Pamela.goodwin@womeninmotioninc.org

Monroe Co:
Jill L. Stowers, MSW
Bloomington Hospital Positive Link
333 E. Miller Dr.
Bloomington, IN 47401
Ph. 812-353-3250
Fax. 812-353-3226
jstowers@bloomingtonhospital.org

St. Joseph Co:
Debra M. Stanley
IMANI UNIDAD
914 Lincolnway West
South Bend, IN. 46616
Ph. 574-234-2870
Fax. 574-232-2872
wuzuwuzu@aol.com

Tippecanoe Co:
LaQuita Marshal
Aspire Indiana West (Lafayette)
133 N. 4th Street, Suite 409
Lafayette, IN 47901
Ph. 765-742-4402
Fax. 765-429-5914
LaQuita.Marshal@aspireindiana.org

Vanderburgh Co:
Wally Paynter
Tri-State Alliance
P.O. Box 2901
Evansville, IN 47728
Ph: 812-480-0204
wallypaynter@aol.com

Brian Revalee
AIDS Resource Group
Old Courthouse, Suite B7
201 NW Fourth Street
Evansville, IN 47708
Ph: 812-421-0059
Fax: 812-424-9059
Brev928@yahoo.com

Wayne Co:

Erin Holbert
Aspire Indiana Southeast (Richmond)
1119 ½ NW 5th Street
Richmond, IN 47374
Ph. 765-962-8778
Fax. 765-962-8347
Erin.holbert@aspireindiana.org

Indiana State Department of Health - Division of HIV/STD/Viral Hepatitis

Amanda Writt, Project Liaison
2 N. Meridian Street
Section 6-C
Indianapolis, IN 46204
Ph. 317-234-2360
Fax. 317-233-7663
awritt@isdh.in.gov

STATE OF INDIANA

ATTACHMENTS

HIV/AIDS Acronym Reference Guide

AAC	AIDS ADVISORY COUNCIL, AIDS ACTION COUNCIL
AAF	AIDS ACTION FOUNDATION
ACAPS	AGENCY CLAIMS AND ADMINISTRATION PROCESSING
ADA	AMERICANS WITH DISABILITIES ACT
ADAM	ARRESTEE DRUG ABUSE MONITORING
ADAP	AIDS DRUG ASSISTANCE PLAN
ADMS	ADMINISTRATIVE DATA MANAGEMENT SYSTEM
AED	ACADEMY FOR EDUCATIONAL DEVELOPMENT
AESOP	AIDS EVALUATION OF STREET OUTREACH PROJECTS
AETC	AIDS/HIV TRAINING AND EDUCATION CENTER
AIDS	ACQUIRED IMMUNODEFICIENCY SYNDROME
AMA	AMERICAN MEDICAL ASSOCIATION
AMFAR	THE AMERICAN FOUNDATION FOR AIDS RESEARCH
ANAC	ASSOCIATION OF NURSES IN AIDS CARE
APG	AIDS POLICY GROUP
APHA	AMERICAN PUBLIC HEALTH ASSOCIATION
ARC	ADVOCACY, RESPONSIBILITY, COUNSELING
ASAP	AIDS SUBSTANCE ABUSE PROGRAM
ASD	ADULT/ADOLESCENT SPECTRUM OF DISEASE STUDY
ASO	AIDS SERVICE ORGANIZATION
ASTHO	ASSOCIATION OF STATE TERRITORIAL HEALTH OFFICIALS
AZT	ZIDOVUDINE
BRAT	BEHAVIORAL RISK ASSESSMENT TOOL
BRFSS	BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM
CAB	CONSUMER ADVISORY BOARD
CADR	CARE ACT DATA REPORT
CAG	COMMUNITY ACTION GROUP
CARE	COMPREHENSIVE AIDS RESOURCE EMERGENCY (ACT)
CBA	CAPACITY BUILDING ASSISTANCE
CBC	CONGRESSIONAL BLACK CAUCUS
CBO	COMMUNITY BASED ORGANIZATION
CBR	CODE-BASED REPORTING
CC	CARE COORDINATION
CD4	T-HELPER CELL (TYPE OF TEST)
CDC	CENTERS FOR DISEASE CONTROL
CDR	CLINICAL DATA AND RESEARCH
CHIP	CONTEXT OF HIV INFECTION PROJECT
CHSPAC	COMPREHENSIVE HIV SERVICES, PLANNING, AND ADVISORY COUNCIL
CIDUS	COLLABORATIVE INJECTION DRUG USERS STUDY
CIRBC	CENTRAL INDIANA REGIONAL BLOOD CENTERS
CMS	CENTERS FOR MEDICARE AND MEDICAID SERVICES
CMV	CYTOMEGALOVIRUS

COC	COMMUNITIES OF COLOR
CPG	COMMUNITY PLANNING GROUP
CSTE	COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS
CTR	COUNSELING, TESTING, REFERRAL
CTRPN	COUNSELING, TESTING, REFERRAL, AND PARTNER NOTIFICATION PROGRAM
CY	CALENDAR YEAR
DASH	DIVISION OF ADOLESCENT AND SCHOOL HEALTH
DAWN	DRUG ABUSE WARNING NETWORK
DHAP	DIVISION OF HIV/AIDS PREVENTION (CDC)
DIS	DISEASE INTERVENTION SPECIALIST
DOC	DEPARTMENT OF CORRECTION
DOE	DEPARTMENT OF EDUCATION
DRP	DENTAL REIMBURSEMENT PROGRAM
DSS	DIVISION OF SERVICE SYSTEMS
EHRAP	EXPANDED HIV RISK ASSESSMENT PROJECT
EIA	ENZYME IMMUNOASSAY (EIA TST)
EIP	EARLY INTERVENTION PLAN
ELDAR	ELECTRONIC LABORATORY DATA ANALYSIS REPORT
ELISA	ENZYME-LINKED IMMUNOSORBENT ASSAY
EMA	ELIGIBLE METROPOLITAN AREA
FDA	FOOD AND DRUG ADMINISTRATION
FSSA	FAMILY AND SOCIAL SERVICES ADMINISTRATION
FY	FISCAL YEAR
GISP	GONOCOCCAL ISOLATE SURVEILLANCE PROJECT
GLAAD	GAY AND LESBIAN ALLIANCE AGAINST DEFAMATION
GLBTQ	GAY, LESBIAN, BISEXUAL, TRANSGENDER AND QUEER
GMHC	GAY MEN'S HEALTH CRISIS
HAART	HIGHLY ACTIVE ANTI-RETROVIRAL TREATMENT
HARS	HIV/AIDS REPORTING SYSTEM
HAB	HIV/AIDS BUREAU
HBV	HEPATITIS B
HCFA	HEALTH CARE FINANCING ADMINISTRATION
HCV	HEPATITIS C
HERS	HIV EPIDEMIOLOGIC RESEARCH STUDY
HE/RR	HEALTH EDUCATION/RISK REDUCTION
HHS	HEALTH AND HUMAN SERVICES (DEPARTMENT OF)
HIAP	HEALTH INSURANCE ASSISTANCE PLAN
HIPAA	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY
HITS	HIV TESTING SURVEY
HIV	HUMAN IMMUNODEFICIENCY VIRUS
HMO	HEALTH MAINTENANCE ORGANIZATION
HOLIDS	HIV ONLINE LABORATORY INFORMATION DELIVERY SYSTEM
HOPWA	HOUSING OPPORTUNITIES FOR PEOPLE WITH AIDS

HOPS	HOSPITAL OUTPATIENT SURVEY
HRSA	HEALTH RESOURCES AND SERVICES ADMINISTRATION
HUD	HOUSING AND URBAN DEVELOPMENT
ICD	INTERNATIONAL CLASSIFICATION OF DISEASES
ICES	INDIANA CLIENT ELIGIBILITY
ICHIA	INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION
IDEP	INTERSTATE DUPLICATION EVALUATION PROJECT
IHFA	INDIANA HOUSING FINANCE ASSOCIATION
IMHC	INDIANA MINORITY HEALTH COALITION
IND	INVESTIGATIONAL NEW DRUG
IPHA	INDIANA PUBLIC HEALTH ASSOCIATION
IPHC	INDIANA PRIMARY HEALTH CARE ASSOCIATION
ISDH	INDIANA STATE DEPARTMENT OF HEALTH
IV	INTRAVENOUS
IDU	INJECTION DRUG USER
JAMA	JOURNAL OF MEDICAL ASSOCIATION
KAB/KABB	KNOWLEDGE, ATTITUDE, BELIEF/BEHAVIOR
KS	KAPOSI'S SARCOMA
LHD	LOCAL HEALTH DEPARTMENT
MAI	MINORITY AIDS INITIATIVE
MATEC	MIDWEST AIDS TRAINING AND EDUCATION CENTER
MI	MINORITY INITIATIVES
MMWR	MORBIDITY AND MORTALITY WEEKLY REPORT
MSA	METROPOLITAN STATISTICAL AREA
MSM	MEN HAVING SEX WITH MEN
MSP	(ISDH) MEDICAL SERVICES PROGRAM
NAIC	NATIONAL AIDS INFORMATION CLEARING HOUSE
NAPWA	NATIONAL ASSOCIATION OF PEOPLE WITH AIDS
NASTAD	NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS
NCHSTP	NATIONAL CENTER FOR HIV, STD, AND TB PREVENTION (CDC)
NHIS	NATIONAL HEALTH INTERVIEW SURVEY
NHSDA	NATIONAL HOUSEHOLD SURVEY DRUG ABUSE
NIDA	NATIONAL INSTITUTE ON DRUG ABUSE
NIH	NATIONAL INSTITUTES OF HEALTH
NIMH	NATIONAL INSTITUTE OF MENTAL HEALTH
NIR	NO IDENTIFIED RISK
NMAC	NATIONAL MINORITY AIDS COUNCIL
NNIP	NATIONAL NEIGHBORHOOD INDICATOR PROJECT
NPIN	NATIONAL PREVENTION INFORMATION NETWORK
NNR	NO REPORTED RISK
NTC	NAME-TO-CODE
OASIS	OUTCOME ASSESSMENT THROUGH SYSTEMS OF INTEGRATED SURVEILLANCE
OI	OPPORTUNISTIC INFECTION

ORS	OTHER REPORTING SYSTEM
OSHA	OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION
PCP	PNEUMOCYSTIS CARINII PNEUMONIA
PCRS	PARTNER COUNSELING REFERRAL SERVICES
PGL	PERSISTENT GENERALIZED LYMPHADENOPATHY
PHI	PUBLIC HEALTH INFORMATION
PHI	PUBLIC HEALTH INVESTIGATION OR INVESTIGATOR
PI	PUBLIC INFORMATION
P.I.	PROTEASE INHIBITOR
PLWA/H	PEOPLE LIVING WITH AIDS/HIV
PPA	PLANNED PARENTHOOD ASSOCIATION
PRAMS	PREGNANCY RISK ASSESSMENT MONITORING SYSTEM
PSA	PUBLIC SERVICE ANNOUNCEMENT
PSD	PEDIATRIC SPECTRUM OF DISEASE
PWA	PERSON WITH AIDS
RARE	RAPID ASSESSMENT AND RESPONSE AND EVALUATION
RFP	REQUEST FOR PROPOSAL
RNR	REPORTING (HIV) NOT REQUIRED
RWCA	RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY (ACT)
SAMHSA	SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
SHAS	SUPPLEMENT TO HIV/AIDS SURVEILLANCE
SHDC	SURVEY OF HIV DISEASE AND CARE
SIDA	AIDS ACRONYM IN SPANISH
SPSP	SPECIAL POPULATIONS SUPPORT PROGRAM
SPNS	SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE
SSDI	SOCIAL SECURITY DISABILITY INSURANCE
SSA	SOCIAL SECURITY ADMINISTRATION
SSI	SUPPLEMENTAL SECURITY INSURANCE
SSVRS	SENTINEL SURVEILLANCE OF VARIANT AND DRUG-RESISTANT STRAINS
STARHS	SEROLOGIC TESTING ALGORITHM FOR RECENT HIV SEROCONVERSION
STD	SEXUALLY TRANSMITTED DISEASE
STDMIS	SEXUALLY TRANSMITTED DISEASE MANAGEMENT INFORMATION SYSTEM
SWCAB	INDIANA STATEWIDE HIV CONSUMER ADVISORY BOARD
TB	TUBERCULOSIS
TTY	TELE-COMMUNICATION DEVISE FOR THE DEAF
WB	WESTERN BLOT (CONFIRMATORY BLOOD TEST)
WHA	WORLD HEALTH ASSOCIATION
WHO	WORLD HEALTH ORGANIZATION
YMS	YOUNG MEN'S SURVEY
YRBSS	YOUTH RISK BEHAVIORAL SURVEILLANCE SYSTEM

HIV PREVENTION COMMUNITY PLANNING GROUP
ASSESSMENT FORM

The purpose of this self-assessment is to provide an opportunity for planning members to provide input to the process and the policies that govern meetings. The results are distributed to all members at the following planning meeting. Your input is important to the successful and efficient functioning of the planning group. **Thanks!**

Directions: Please indicate your response to the statements below that best represents your experience on the planning group. It is preferred that you keep your responses **anonymous,** so **please do not indicate your name.**

PLEASE USE COMPLETE SENTENCES AND PLEASE BE SPECIFIC!

#s	Questions	Strongly Agree	Somewhat Agree	Unsure	Somewhat Disagree	Strongly Disagree	Comments Please use additional space at end of form if needed. Please provide details and examples for clarification.
1	CPG has sufficient human resources to conduct tasks of community planning.						
2	CPG has sufficient monetary resources to conduct tasks of community planning.						
3	CPG bring the necessary skills and abilities to the table to effectively conduct community planning activities.						
4	CPG follows its' policies and procedures.						
5	CPG receives adequate information from ISDH to perform required tasks.						
6	CPG is focused on community planning outcomes.						

7. **What do you believe was/is the most positive/productive part of the planning process?**

_____

_____

_____

8. **What changes would you suggest to make the planning group more effective?**

_____

_____

_____

9. **What suggestions would you like to make to help implement the changes or correct any problem stated previously?**

_____

_____

_____

10. **What would you like to see addressed at future planning meetings?**

_____

_____

_____

_____

PLEASE USE THIS PAGE TO PROVIDE FURTHER IN DEPTH EXPLANATION OF YOUR SUGGESTIONS TO MAKE THE CPG PROCESS A BETTER ONE.

_____

_____

_____

_____

INDIANA HIV PREVENTION PLANNING GROUP

MEMBER SELF PERFORMANCE REVIEW

CPG MEMBER

Name:

Review period: **to**

EVALUATION

	(1) = Poor	(2) = Fair	(3) = Satisfactory	(4) = Good	(5) = Excellent
Knowledge of CPG Guidance	☐	☐	☐	☐	☐
Comments:					
Knowledge of CPG Charter	☐	☐	☐	☐	☐
Comments:					
Sharing of Ideas and Information	☐	☐	☐	☐	☐
Comments:					
Sought Help from Others as Needed	☐	☐	☐	☐	☐
Comments:					
Worked Well with the Group	☐	☐	☐	☐	☐
Comments:					

Achievements, Contributions:

Goals for 2010 Planning Year:

Strengths:

Area for Development:

Member Signature: _____ Date: _____

Indiana HIV Community Planning Group Knowledge Assessment

The purpose of this questionnaire is to assess your general knowledge of the information needed to be a conscientious and committed member of the Indiana HIV Community Planning Group (CPG). This assessment will be used to design orientation and training materials for both new and continuing members of the CPG. At future CPG meetings, part of the time will be used to present training modules on different topics the group needs more information about. All questions within this assessment are taken from the information contained in the CDC's HIV Prevention Community Planning Guidance (2003-2008) along with the Charter By-laws and Policies and Procedures that have been set by the CPG. Each member of the CPG should have a copy of these basic materials as the information contained in the guidance is essential to your qualified, informed, and intelligent participation in the CPG. If you do not have these materials, please contact Cena N.F. Bain, CPG Liaison, immediately.

Please write your answers beneath each question. Please be sure to write legibly.

Name: _____ Date: _____

1. Please name two (2) of the three (3) goals of HIV Prevention Community Planning.

2. What do the acronyms PIR represent? Please define each term.

3. What is the primary task of the Indiana HIV Community Planning Group?

4. How should group conflicts or disagreements be handled?

5. What is the role of the Executive Committee?

6. As a member of the CPG, name two (2) responsibilities you must fulfill.

7. What is the role of the Indiana State Department of Health in the community planning process?

8. What does the word accountability mean and how does it relate to your responsibilities as a member of the CPG?

9. What is CPG's process for decision-making?

10. According to the CDC Guidance for Community Planning, when does a conflict of interest occur?