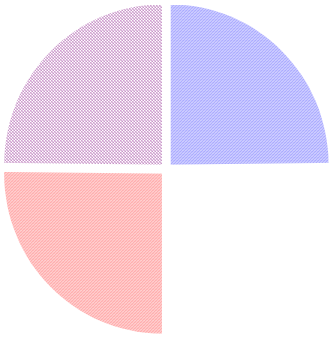

Westchester

Prevention Needs Assessment - 2003

Prepared for

Westchester County Department of Health

Submitted by: Partnership for Community Health, Inc.
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FOREWORD

- ***Every two days, another Westchester County resident is diagnosed with AIDS.***

- ***Every six days, another Westchester County resident dies from AIDS.***

- ***Of the 57 counties in New York State excluding New York City, Westchester has the largest number of AIDS and HIV cases.***

These facts paint a frightening picture for the social and economic fabric of Westchester County. Yet, AIDS is preventable: it is within the grasp of every Westchester resident not only to avoid becoming HIV-infected, but also to help to stop the spread of this devastating disease.

The Westchester County Department of Health hopes, through this report, to send out a call to action to key stakeholders and community partners to join us in a renewed effort to prevent the spread of HIV/AIDS.

The HIV/AIDS epidemic began almost a quarter century ago. As a county, we need to take a fresh look at our current portfolio of prevention services and incorporate new strategies and approaches into a countywide coordinated prevention plan that will enable us to halt the spread of HIV infection.

The Westchester County Department of Health commissioned the Partnership for Community Health to conduct an HIV Prevention Needs Assessment. That assessment, which follows, concluded that current prevention efforts may be reaching the general public but may not be sufficiently reaching other critical groups of people (such as people at high risk of contacting HIV, HIV negative people, HIV positive people and partners of HIV positive people). Opportunities for action exist in increasing funding and realigning services.

Based on our research, the following five recommendations are offered. We have divided the recommendations into three for our community to address and two as the responsibility of the health department.

1. The community, with leadership from the Westchester County AIDS Council, should continue to encourage and support the initiation and expansion of prevention programs that target sex- and needle-sharing partners of HIV positive individuals.

2. The community, with leadership from the Westchester County AIDS Council, should create a forum where funding opportunities for HIV prevention may be discussed and, as appropriate, coordinated.

3. The community, with leadership from the Westchester County AIDS Council and support from the Westchester County Department of Health, should consider key gaps in programs and in services to targeted populations, to identify providers who could offer more tailored programs to specific populations or communities and to identify interventions that address those gaps.

4. The Westchester County Department of Health will work with funded training centers and the AIDS Institute to help providers to enhance their communication skills when discussing sensitive issues with clients, in order to more effectively assess risk and to provide more appropriate support.

5. The Westchester County Department of Health will develop a more detailed inventory of HIV prevention outreach programs in the county that will include a listing of actual locations and days/times of service to identify specific gaps in services and to help to guide future planning.

We hope that every community stakeholder will take the time to review this report to identify ways to contribute toward the collective achievement of our recommendations. The Westchester County AIDS Council and the Westchester County Department of Health look forward to continuing our strong partnerships with our community in the fight to prevent the spread of HIV/AIDS in Westchester County.

The fight continues.

Joshua Lipsman, M. D., M.P.H.
Commissioner of Health
Westchester County Department of Health

Larry Hilton
Co-Chair
Westchester County AIDS Council
Executive Director, HIV/AIDS Programs
Urban League of Westchester County, Inc.

Wilfredo Morel
Co-Chair
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Director, Hispanic Health
Hudson River Community Healthcare, Inc.

EXECUTIVE SUMMARY

Introduction

Despite the efforts over the past twenty years, the HIV epidemic still poses a significant public health risk and expense. With the growing number of people living longer with HIV/AIDS and the fact that the number of new infections has remained fairly constant, a larger and larger reservoir of optional infection may be forming. Given this reality, coupled with the disease continuing to disproportionately affect blacks and Hispanics, the Westchester County Department of Health (WCDH) continues to work to stop the spread of HIV infection. WCDH in 2003 commissioned an HIV prevention needs assessment that was conducted by the Partnership for Community Health (PCH), a not-for-profit technical assistance agency. Designed to review the status of prevention activities in the County, the needs assessment encompassed the following components:

- developing a Continuum of Prevention Services (CPS),
- reviewing best models and practices for delivering HIV prevention services,
- conducting an inventory of local HIV prevention initiatives, and
- making recommendations to address identified gaps in prevention efforts.

The CPS considers the delivery of prevention services targeted to six constituent groups: (1) high-risk populations, (2) individuals who know they are HIV negative, (3) individuals who know they are the HIV positive, (4) partners of HIV positive persons, (5) providers of services, and (6) the general public. For each of these groups there are specific expected outcomes and objectives.

Data Collection Activities

PCH in consultation with WCDH developed a survey form that would identify HIV prevention services being offered by local community-based agencies in Westchester County. For each target group in the CPS, a list of possible activities that might be delivered to each of the six target groups was prepared. In total, 49 distinct service components were included on the survey form. The form was distributed in April 2003 to 56 service providers that receive direct prevention or Ryan White funding and agencies in contact with high-risk populations. Thirty-four (61%) of the 56 agencies completed surveys, indicating the provision of HIV prevention services.

Findings

The 34 agency respondents indicated providing a total of 398 types of prevention services within Westchester County. When further examining the data by the actual number of services offered in the continuum to all groups except providers, the largest percentage of services were identified as being provided to high risk populations (34.2%) followed by

the general public (22.1%). Roughly 40% of the services identified by respondents are being directed to those with a "known" HIV status, that is, 21.9% of services to HIV positives and 18.8% to HIV negatives. In contrast, only 3.0% of prevention services reported by respondents were being provided to partners of HIV positive persons. High risk populations are being targeted by the greatest number of agencies (N=30) and partners of positives are being targeted the least often (N=9). The remaining groups are each being targeted by 23-26 agencies.

While the efforts may be at varying levels, the data show that respondent agencies are engaged in activities that are designed to reach all the various groups of the continuum. When looking at those activities that are solely directed to the five categories of non-providers, half of the agencies indicated targeting at least four of those target groups. Nearly one-quarter of the agencies (23.5%) indicated providing at least one service to all five target groups in the continuum, compared to 14.7% of agencies indicating services being offered to only one target group. Four was the most frequent number of groups served by providers.

When examining the location or service area of prevention services being delivered, the data show that geographic communities with the highest prevalence of AIDS are more likely to be targeted for prevention services.

As the survey was not intended to measure the magnitude of effort or the actual staffing level dedicated to delivering each service, the data presented provide no more than a preliminary catalogue of prevention services available in Westchester County. Additional data collection and analysis are warranted to better understand the scope and diversity of services provided.

Given that certain types of prevention efforts have been shown to be more effective than others, it is important to understand the types of actual interventions being directed to the target groups. Summarized below for each target group are the top two service types most frequently offered by respondents in Westchester, along with the number of agencies offering the service.

High Risk:

Health education and risk reduction	(21)
Condom distribution	(18)
One-to-one contact	(18)
HIV testing	(18)

HIV Negative:

One-to-one counseling	(18)
Skill building workshop	(13)

HIV Positive:

Counseling	(19)
Monitoring HIV Status	(13)

Partners of Positives:

Offer programs for partners	(5)
Develop partner agreements	(3)

Providers:

Training to providers/workers	(17)
Consumer Satisfaction	(13)

General Public:

Group education interventions	(19)
Public service announcements	(13)

Another component of the provider survey examined barriers associated with delivering HIV prevention services. The top barrier cited by over 80% of the providers was consumers' difficulty following instructions followed by 74% citing the lack of funding. Additionally, seventy percent reported that consumers did not know the services offered, and 67% of providers equally rated transportation, loss of client contact and consumers being in a state of denial as barriers.

Providers interviewed further explained that the diversity of consumers, their inability to understand the information presented, and their different cultural perspectives on HIV/AIDS made providing prevention services in group settings difficult.

Providers added that awareness of services tended to be low, particularly among those who recently tested positive. They noted a general inability of newly infected clients to find their way through a referral system or to travel to locations where services were offered. While providers reported trying their best to inform the population of services available, most felt the majority of the public remained unaware of available prevention services.

The high level of "no-shows" is significant, providers said, when they were trying to maintain contact with people following testing as well as with newly diagnosed individuals. Over half the providers said that a barrier to providing prevention services was that consumers did not keep appointments. The lack of ability to keep appointments was attributed to several reasons, including lack of transportation and childcare, as well as to denial of infection and/or physical health.

The application of best models and practices suggests a need to tailor prevention methods and strategies to each specific population.

This report fills in missing information about prevention needs, and resources in Westchester County. If the report foments discussion and contributes to a consensus about the County approach to HIV prevention, then it has played an important role.

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Abbreviations

AI	AIDS Institute of the New York State Department of Health
API	Asian Pacific Islander
Bl/Bl	Blood/Blood products
B.I./B.P.	Blood Infusion/Blood Products
CBO	Community-based organization
CDC	Centers for Disease Control and Prevention
CSW	Commercial sex worker
CPS	Continuum of Prevention Services
EMA	Eligible Metropolitan Area
HERR	Health Education Risk Reduction
IDU	Intravenous drug user
MSM	Men-who-have-sex-with-men
PCH	Partnership for Community Health
PLWH/A	Person living with HIV/AIDS
PSA	Public service announcement
PLWA	Person living with AIDS
STD	Sexually transmitted disease
TB	Tuberculosis
WCDOH	Westchester County Department of Health

ACKNOWLEDGEMENTS

This Prevention Needs Assessment has benefited from the collaboration of many persons and organizations. The support of Westchester County AIDS Council was essential in implementing this project. Commissioner of Health, Dr. Joshua Lipsman supported and showed continued interest in this project, culminating in the sponsorship of a World AIDS Day event that featured findings from this Needs Assessment.

Several individuals at the Westchester County Department of Health (WCDOH), including Ms. Renee Recchia, Dr. Julie Lehane, Mr. Tom Petro, Mr. Basil Reyes, and Mr. Owen Borda were helpful in providing secondary sources of information and feedback on drafts of the report.

The project had the input from a Project Advisory Committee. In addition to those from the WCDOH noted above, members included:

- Mr. Joe Longwood (Deceased), PLWA, member of Westchester County AIDS Council, member of State PPG
- Mr. Wilfredo Morel, Director of Genesis Project, Hudson River Health Care
- Mr. Larry Hilton, Executive Director of HIV/AIDS Programs (including the needle exchange program) at Urban League of Westchester County, Inc.
- Ms. Trina Hiemcke, Director of Education and Prevention at the AIDS Related Community Services (ARCS)
- Ms. Sheila Lacey, (Former) Director of HIV Services at Open Door Family Health Center.

The information forms completed by 34 providers were critical in presenting the current HIV prevention environment in Westchester County. We further acknowledge those who participated in various other studies and tracking tools used for secondary analysis, such as the Regional Prevention Gap Analysis conducted by the Urban League of Westchester, Inc. for the AIDS Institute.

INTRODUCTION

Despite the drumbeat of government-sponsored prevention education messages since the early 1980s when HIV transmission routes became clear, and despite all the skills-building and behavioral trainings conducted over the past two decades, and despite the relatively widespread use of successful antiretroviral drugs introduced in the mid-1990s, in the year 2003, the HIV and AIDS epidemic still presents a significant public health risk and expense. According to the Centers for Disease Control, over 40,000 new HIV infections still occur nationally in the U.S. each year. At the end of 2002, some 385,000 persons in the U.S. were known to be living with AIDS and an estimated additional 500,000 with HIV. These figures have been particularly troubling to public health agencies at all government levels.

Under a new Department of Health and Human Services strategy, implemented largely through the Centers for Disease Control which conducts surveillance of HIV and AIDS epidemiological trends and the Health Resources Services Administration which administers the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, larger-scale prevention initiatives originally directed at those who are HIV-negative are being re-focused instead on the HIV positive and their partners.

With a growing number of people living longer with HIV and AIDS, primarily a result of the antiretrovirals, combined with a steady rate of new infections, a larger and larger wellspring of potential infection may be forming. Research has indicated that general HIV testing drives are less effective at identifying those with the virus than campaigns targeted at the sexual partners of people with HIV/AIDS. Public health agencies, therefore, are stepping up efforts to meld prevention and direct services into a more integrated and complementary system of health care to stem the further spread of HIV.

In Westchester County – with a population of just over 923,000 – there are over 1,700 people (excluding inmates) living with AIDS, the largest county AIDS caseload in New York State outside of New York City. The county with the next highest number of living cases has a population approaching 1.5 million, but an AIDS caseload 350 less than Westchester's.

Over the past decade Westchester County, along with its sister counties of Rockland and Putnam (together the "Tri-County region"), has benefited from federal funding allocated under Title I of the Ryan White CARE Act. Westchester County Department of Health was designated the Title I administrative agency for Tri-County which falls within the New York City Title I eligible metropolitan area. In the current Title I fiscal year, the WCDOH has administered $4.6 million to support a comprehensive continuum of HIV care spanning health and social services, but only indirectly addressing prevention.

In 1992, the Westchester County AIDS Council was established as an advisory board to the County Executive. The mission of the AIDS Council continues to include:

- Educating the public concerning HIV/AIDS in an effort to reduce the occurrence of the disease in Westchester;
- Assessing existing prevention efforts;

- Developing future community-wide prevention initiatives based on statistical data; and
- Providing a forum for community based organizations' input and local resource development.

Over the years the AIDS Council has supported such programs as needle exchange and currently is spearheading countywide efforts to extend this program into all high-need Westchester communities.

With the disease now disproportionately affecting residents from communities of color, the leadership of the Westchester County AIDS Council is working to address the changing needs dictated by evolving trends in AIDS epidemiology to stop the spread of HIV. Revised prevention action plans need to be developed to meet the emerging education and prevention needs of the community by targeting interventions where they are needed most. To this end, the Council teamed up with the Westchester County Department of Health and provided guidance for the development and administration of this countywide HIV prevention needs assessment.

The Partnership for Community Health (PCH), a not-for-profit technical assistance agency, was contracted by the Westchester County Department of Health (WCDOH) to conduct the 2003 HIV Prevention Needs Assessment. In conducting the needs assessment, PCH: 1) developed a Continuum of Prevention Services (CPS), 2) reviewed best models and practices, 3) conducted an inventory of local HIV prevention initiatives and 4) made recommendations to address identified gaps in prevention efforts for target populations and/or geographic regions.

CONTINUUM OF PREVENTION SERVICES

What is a Continuum of Prevention Services (CPS)?

A CPS is a coordinated system of HIV prevention services including a comprehensive range that address six constituencies: 1) the general public, 2) high-risk populations, 3) individuals who know they are HIV negative, 4) individuals who know they are HIV positive, 5) sexual partners – both same HIV status and different HIV status, and 6) providers and funders.

Why have a formal CPS?

When a CPS system is formalized it helps identify:

- Clear prevention goals for the system.
- An agreed upon array of coordinated services for PLWH/A.
- Clear eligibility and standards for services that are easily understood.
- Quantifiable outcomes that can be measured.

Creating a formal CPS is a process that gives health planners and providers an opportunity to create a vision for HIV prevention. This vision informs the allocation of resources for maintaining needed services, adding anticipated services, and shifting resources as the need for some services increase and others decrease.

Goals of a CPS

A CPS identifies the linkages between a full range of cost-effective prevention services. These address both the need for improved general public knowledge and support of HIV prevention and targeted interventions to those at risk for becoming infected and those at risk of spreading HIV infection. It ensures that all persons at risk for HIV disease, regardless of race/ethnicity, gender, or income, are served by a system that provides a comprehensive Continuum of Prevention Services that prevents transmission. It assures that services are:

- Available throughout communities at risk for HIV infection.
- Accessible to those eligible for services.
- Affordable to those eligible for services.
- Appropriate to the cultural norms of the community and to the cognitive abilities of the recipients of services.
- Accountable to the funders of prevention programs.

Based, in part, on the Centers for Disease Control and Prevention's (CDC) HIV Prevention Strategic Plan Through 2005, the objectives and outcomes of a typical CPS are shown in Table 1:

Table 1 Objectives and Outcomes for CPS

OBJECTIVE	OUTCOME
A. Increasing public awareness of the risk of HIV infection	1. Improving public support for prevention services. 2. Individual assessment of risk for HIV infection.
B. Outreach to at-risk populations	1. Knowledge of serostatus through recent testing. 2. Knowledge of related co-morbidities. 3. Increased safer behaviors (condom and needle use). 4. STD treatments and lower rates of STDs. 5. Abstinence from illicit drug use / sex.
C. Prevention services to HIV negative	1. Maintain negative status. 2. Risk reduction through adopting and maintaining safer sex and needle use activities. 3. STD treatments and lower rates of STDs. 4. Abstinence from illicit drug use / sex
D. Prevention services to HIV positive	1. Risk reduction through adopting and maintaining safer sex and needle use activities. 2. Linkages to, initiating, and maintaining health care. 3. Adherence to drug regimens, if applicable.
E. Prevention services to partners (sexual and needle exchange)	1. Adopt and maintain safer behaviors. 2. Commitment to safer sex and needle use strategies.
F. Provider and support services	1. Increase capacity to provide effective prevention services. 2. Accountability of funds and services to consumers and funders. 3. Improvement of services.

Process Outcomes of a CPS

The process outcomes for a comprehensive coordinated CPS include:

1. Community centered: At-risk communities must have input into defining their needs, assessing services, and modifying/changing services to meet their needs. This is achieved by assuring the:
   1.1. Participation of at-risk communities in the planning process.
   1.2. Feedback from at-risk communities through needs assessments and consumer satisfaction surveys and an accessible grievance procedure.

2. Proactive: The State and local Prevention Planning Groups, HIV Care Councils and providers must anticipate the changing needs of at-risk communities and the system has to be flexible to meet new needs. It will anticipate the growing rates of infection among women, heterosexuals, and communities of color, and the need to reach PLWH/A who engage in behaviors that would transmit HIV infection.

3. Comprehensive: A comprehensive CPS often includes more than prevention services funded by the State through CDC or Ryan White Care Act funds. It includes other programs with an impact on the spread of HIV infection by promoting risk reduction through use of condoms, clean needles, and promotion of other safer sex and drug use behaviors including abstinence of drug use and unprotected sex. For example, STD and TB prevention services, family planning, substance abuse programs, law enforcement, and sex education curriculum might be included in a CPS. A comprehensive system:
   3.1. Encourages the general public to provide continuing support to PLWH/A through public and private programs that provide prevention services.
   3.2. Promotes awareness of HIV status to those at risk of becoming infected or infecting others. With this acquired awareness, those at risk can adopt appropriate prevention behaviors.
   3.3. Includes services directed toward compatible goals such as STD prevention, family planning, substance prevention and treatment services, law enforcement services directed toward commercial sex work and illegal substance use, and faith based efforts to build community.

4. Evidence Based: Programs and services should be based on practices that have been proven scientifically.

5. Dynamic: The system should suggest movement of persons from one service to another. Consumers access services depending on their needs.

6. Accountable: The CPS should have internal systems that are in place to monitor, reinforce, and, if indicated, change their plan.

Continuum of Prevention Services

As seen in Figure 1, the CPS has been designed as a six-track system. The first five tracks move those at risk of becoming infected and transmitting infection to different services. The sixth track assures that the needs of consumers are included in the planning process, the quality of services are measured, and that there is technical assistance to assure the system has the expertise and capacity to provide services.

Each track has a starting point with objectives, and an ending point that has different outcomes. The starting point of each track defines the key-identifying factor for the consumer. For example, for those on the general public track, the qualification is that all individuals in the community are eligible. The services on this track should lead to the outcomes of improved public support for prevention services and an assessment by the general public of its own risk and need for HIV testing.

Those eligible for the prevention outreach track engage in high-risk behaviors or are members of high-risk populations (e.g. MSM, IDUs, "party-drug" users, bath-house patrons, heterosexuals with IDU partners, sexually active heterosexuals in high incidence areas, incarcerated, and those recently released from incarceration.) The main services on this track are counseling and testing, and the outcome is knowledge of HIV status and related co-morbidities.

There are three tracks for those who know their serostatus. Those who know they are HIV negative access a variety of individual and community-based services to assure that they maintain their negative status. Those who know they are HIV positive access a number of services to assure that they do not spread HIV infection or become re-infected. Because infection is spread by activities with sexual and needle sharing partners, certain prevention services are directed to negative, positive, and discordant (one partner negative, one partner positive) partners. These prevention strategies allow them to negotiate safer practices, with the outcome being a commitment to using safer practices.

In order to assure prevention services are effectively implemented, providers should be trained and have the organizational skills to provide services. Consequently, there are infrastructure development and training services to increase provider capacity to provide services. An effective CPS provides a feedback mechanism for assuring the system is self-adjusting and dynamic. This involves the assessment and evaluation of services to assure that prevention services are accountable and to modify services to better meet the needs of consumers.

Figure 1 Continuum of Prevention Services

A. GENERAL PUBLIC

SERVICES

- Place advertisements / PSAs in mass and small media, bill boards, brochures, and leaflets
- Write articles & editorials advocating HIV/AIDS prevention.
- Circulate newsletters
- Conduct group educational intervention such as HIV/AIDS prevention curriculum, drama or theater presentation, World AIDS day presentation
- Have a hotline or other type of information exchange, etc.
- Organize rallies, public meetings, write-in campaigns
- Use advocacy / educational volunteers or interns
- Provide advocacy / educational training
- Solicit financial support for HIV/AIDS prevention advocacy

OUTCOMES:
1. Improving public support for prevention services and 2. Individual assessment of risk for HIV infection

B. HIGH-RISK POPULATIONS

SERVICES

- Health education and risk reduction through targeted group and community level interventions including schools, street outreach, house parties, health fairs, public sex venues such as parks or bathhouses, bars, STD and health care clinics, etc.
- Conduct 1-1 contact with high–risk individual
- Operate a mobile van
- Exchange needles
- Distribute bleach kits
- Distribute condoms
- Offer HIV Testing and Counseling
- Offer STD testing
- Offer TB testing
- Offer Substance Abuse treatment, detox, methadone maintenance
- Offer 12-step and other abstinence
- Offer care at neonatal and other women's clinics
- Offer family planning to populations at high risk for HIV infection

OUTCOMES:
1. Knowledge of serostatus, 2. Knowledge of co-morbidities, 3. Risk reduction through increased safer behaviors (condom and needle use), 4. STD treatments and lower rates of STDs, and 5. Abstinence from illicit drug use / unsafe sex

	C. HIV NEGATIVE	D. HIV POSITIVE	E. PARTNERS of HIV POSITIVE
SERVICES	Offer HIV/AIDS re-test	Provide adherence programs Monitor HIV status	Develop partner agreements Partner notification
	Offer 1-1- counseling / prevention case management		
		Provide partner negotiation Partner counseling and referral	
	Provide skill building workshops (condom use, needle cleaning, partner negotiation) Conduct behavioral modification programs Provide peer education / support Circulate newsletters Offer support groups		
OUTCOMES:	1. Maintain negative status 2. Risk reduction through adopted and maintained safer behaviors (condom and clean needle use) 3. Obtain treatments and lower rates of STDs 4. Abstinence from illicit drug use / unsafe sex	1. Adopt & maintain safer behaviors 2. Linkages to, initiating, and maintaining health care 3. Adherence to drug regimen	1. Adopt & maintain safer behaviors 2. Commitment to safer behaviors

F. PROVIDERS

SERVICES

- Training
- Infrastructure support
- Program development
- Newsletters
- Program monitoring
- Needs assessment
- Consumer satisfaction

OUTCOMES
1. Increase capacity to provide effective prevention services
2. Accountability of funds and services to consumers and funders
3. Improvement of services

EPIDEMIOLOGICAL REVIEW

Snapshot of the Epidemic

The epidemiology of HIV and AIDS in Westchester County is changing dramatically due to the success of prevention and medical treatment efforts. In order to better understand the current needs of the community of Westchester it is necessary to review the current stage of the HIV/AIDS epidemic. When estimating the actual number of HIV cases, CDC estimates that on a national basis, up to 25% of those infected have not been tested and do not know their status. This report describes the trends in newly diagnosed HIV and AIDS cases and provides an in-depth profile of those living with HIV and AIDS at the end of 2001. The basic statistics through 2001 for Westchester are shown in Table 2.

Table 2 HIV/AIDS Statistics for Westchester*

Living with AIDS in Westchester in 2001	1,726
Estimated living with HIV (not AIDS)	2,500 – 2,800
Estimated number of Persons Living With HIV/AIDS (PLWH/A)	4,226 – 4,526

* *As reported by Westchester County Department of Health, excluding pediatric and inmate cases.*

In the next section, the trends for the yearly AIDS diagnosis and persons living with AIDS are reviewed from 1995 to 2001[1]. Following that, additional demographic and risk group information is presented for those living with AIDS and HIV in 2001[2].

Trends for People Diagnosed with AIDS Each Year

As an outcome of successful anti-retroviral and prophylactic treatments, many HIV infected persons are not progressing to AIDS as rapidly as in the past. As seen in the table at the bottom of Figure 2, in 1995, 393 persons were diagnosed with AIDS in Westchester County, while in 2001, less than half of that amount, 153 persons were diagnosed, representing a decline of about 61%. At the same time, as seen in Figure 2, between 1999 and 2000, there was an increase in AIDS cases in New York State. The downward trend in the State resumed after 2000. However, in Westchester County there has been a continual downward trend.

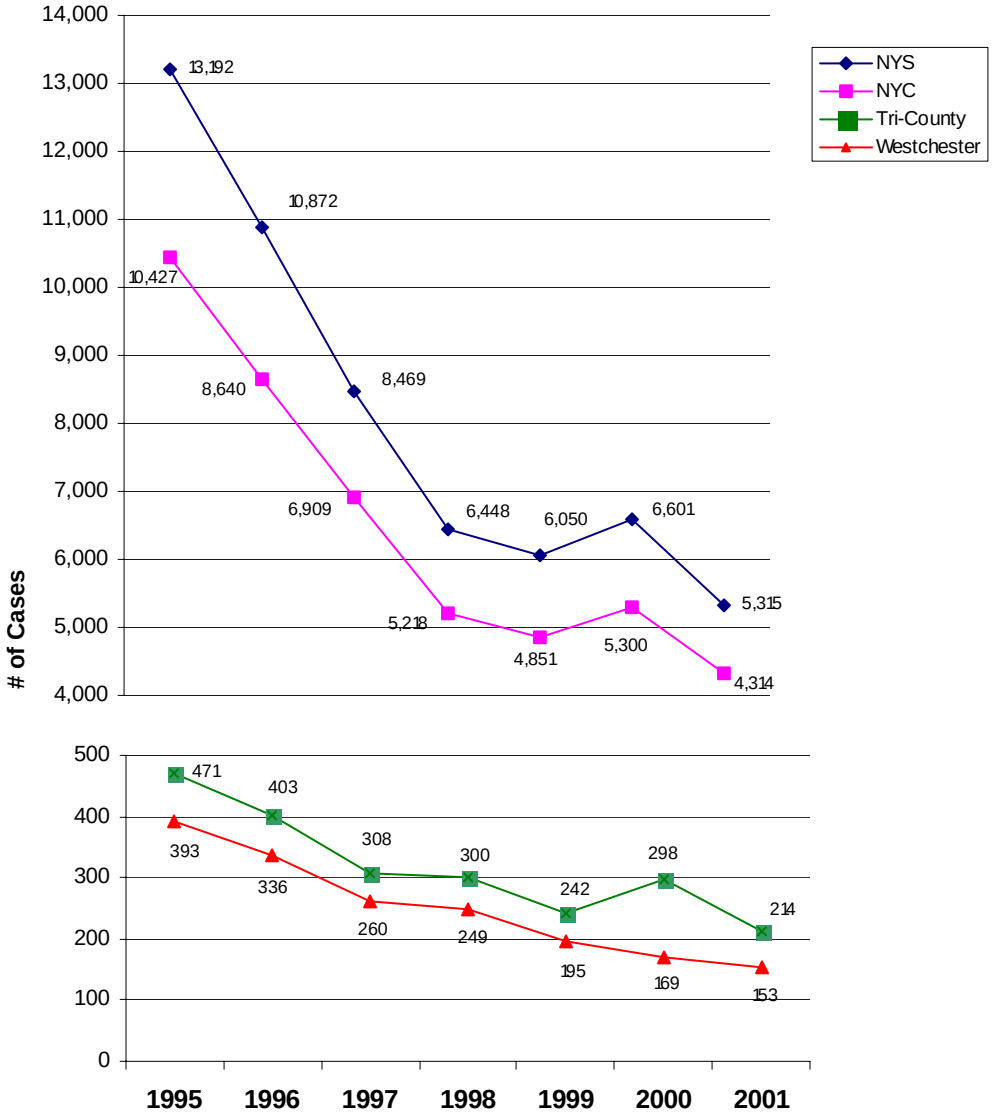
Westchester is influenced by the epidemic in New York City that reports an estimated 143,000 PLWH/A. While the proportion of New York City AIDS cases has slightly increased over the past seven years, the proportion of newly diagnosed AIDS cases in Westchester County has remained relatively constant, accounting for about three percent of the cases in the State. Similarly, while the proportion of new cases in the Lower Hudson region[3]relative to the State, as increased, the proportion of cases in Westchester relative to the Tri-county region has decreased.

[1] New York Sate Department of Health – Bureau of HIV/AIDS Epidemiology, Confirmed AIDS Cases (excluding pediatric and inmate cases) for 2001. Due to a lag in reporting all AIDS cases, trends are reported through 2001.

[2] The most accurate data to report for PLWA is the latest cumulative figures. Consequently, cumulative PLWA figures through 2001 are used.

[3] The Lower Hudson region is synonymous with the Tri-county region and includes Putnam, Rockland, and Westchester Counties.

Figure 2 AIDS Cases by Year of Diagnosis for Westchester County, New York City and NYS



	1995	1996	1997	1998	1999	2000	2001
NYS	13,192	10,872	8,469	6,448	6,050	6,601	5,315
NYC	10,427	8,640	6,909	5,218	4,851	5,300	4,314
Tri-County	471	403	308	300	242	298	214
Westchester	393	336	260	249	195	169	153

As seen in Figure 3, there has been about a 60% drop in the number of AIDS cases annually diagnosed for New York State between 1995 and 2001, with a slightly higher rate of decline in Westchester County (61%).

Figure 3 Percentage Change in Number of AIDS Cases 1995-2001

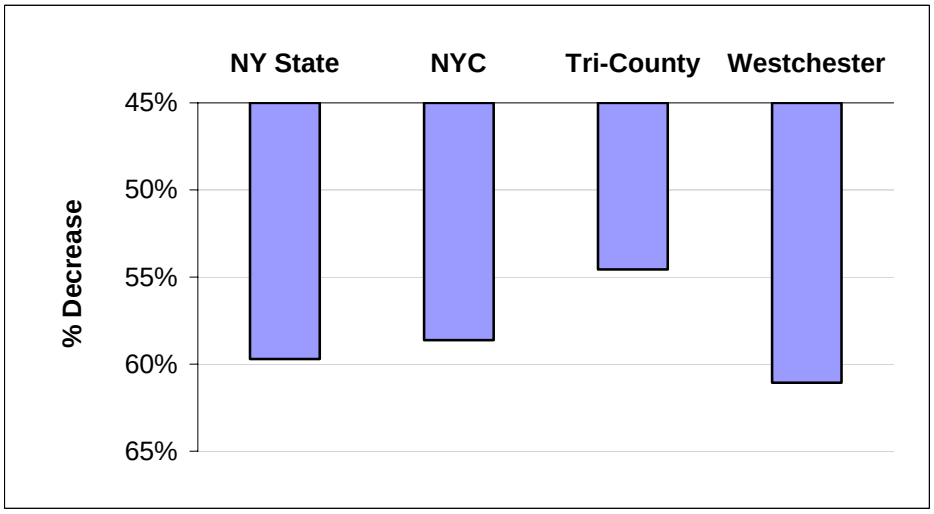
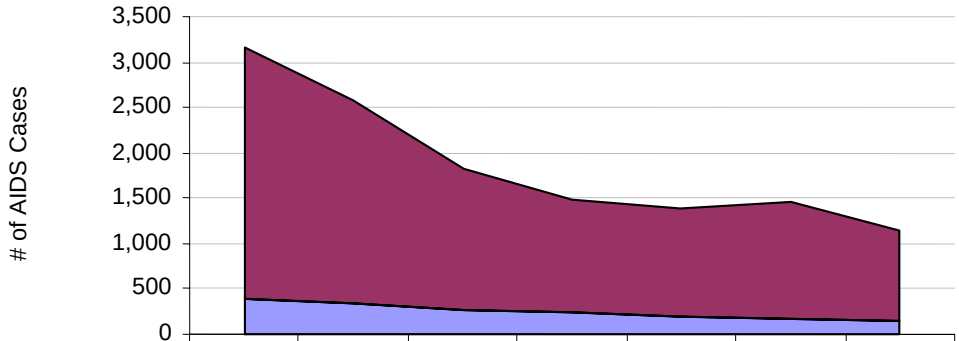


Figure 4 shows the trend in newly diagnosed AIDS cases in Westchester County versus the rest of the State, excluding New York City. It shows that the proportion of AIDS cases in Westchester County compared to the rest of the State has increased, with a high of over 20% in 1998. In 1995, Westchester County accounted for about 14% of all the newly diagnosed cases in upstate New York and by 2001 this proportion has increased to above 15%.

Figure 4 AIDS Cases by Year of Diagnosis: Westchester County and NYS (excludes NYC)



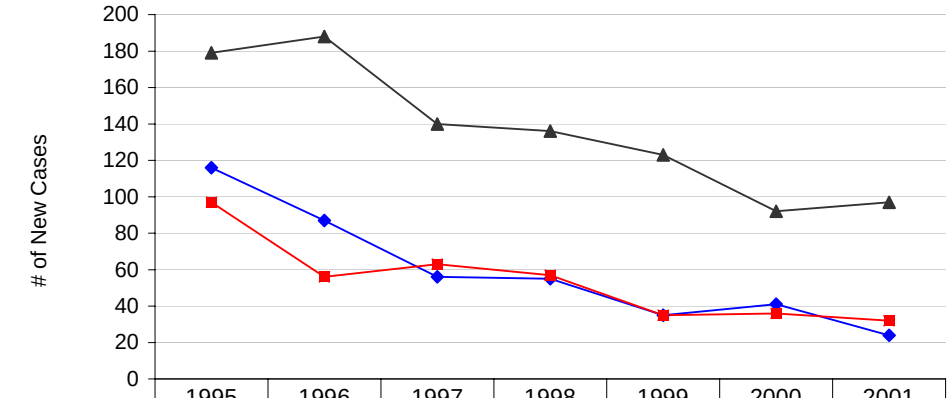
	1995	1996	1997	1998	1999	2000	2001
NYS (exc.NYC)	2,765	2,232	1,560	1,230	1,199	1,301	1,001
Westchester	393	336	260	249	195	169	153
% of NYS	14.3%	15.1%	16.7%	20.2%	16.3%	13.0%	15.3%

Figure 5 shows that there was a decline in AIDS cases in Westchester County from 1995 to 2000 among all ethnic populations, with a particularly large drop among whites. Hispanics, while having considerably fewer new cases of AIDS diagnosed in 2001 compared to 1995, have shown a less consistent trend compared to whites. In terms of absolute numbers, blacks have had, by far, the greatest number of newly diagnosed AIDS cases since 1995, and in 2001 blacks had more than three times the number of new cases than that of Hispanics and four times that of whites.

Figure 6 further indicates that the number of newly diagnosed AIDS cases among males continues to decline from a high of 280 new cases in 1995 to 87 reported in 2001, a 69% decline in newly diagnosed cases among males. The number of newly diagnosed AIDS cases among females has also decreased from 113 cases in 1995 to 66 cases in 2001, but at a slower rate of 42%. While women accounted for about 29% of new AIDS cases in 1995, in 2001 they account for more than 43%, in large part due to the more rapid decline in newly diagnosed AIDS cases among males.

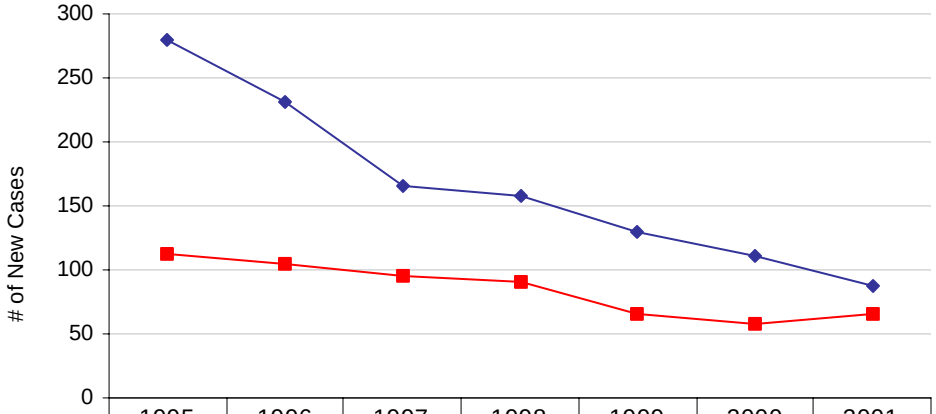
Figure 7 shows an unequal decline in diagnosed AIDS cases by risk group. Persons who reported being infected through IDU accounted for more than half of the newly diagnosed AIDS cases in 1995. By 2001, they account for about 26% of the newly diagnosed cases. On the other hand, while heterosexuals accounted for less than 16% in 1995, they represent more than 31% of the new cases in 2001. Transmission by MSM and MSM/IDU have shown an inconsistent pattern from 1995 to 2001, yet, MSM have consistently accounted for about 17% to 21% of new cases since 1995.

Figure 5 AIDS Cases by Year of Diagnosis by Race/Ethnicity, Westchester County



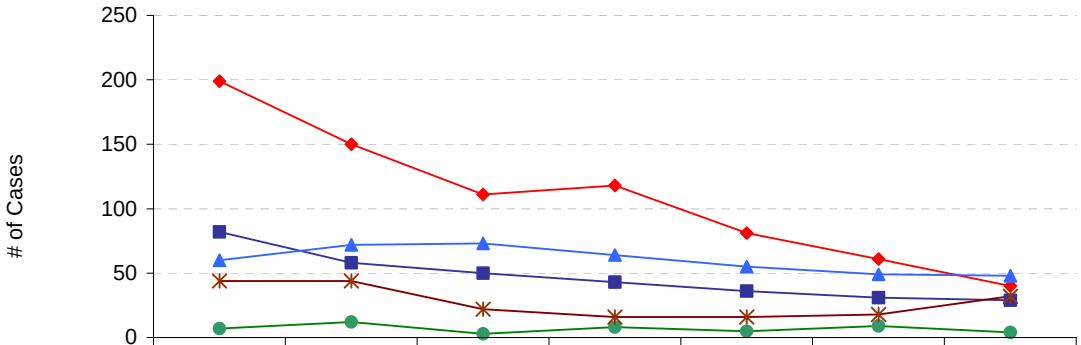
	1995	1996	1997	1998	1999	2000	2001
Total	392	331	259	248	193	169	153
Black	179	188	140	136	123	92	97
White	116	87	56	55	35	41	24
Hispanic	97	56	63	57	35	36	32

Figure 6 AIDS Cases by Year of Diagnosis by Gender, Westchester County



	1995	1996	1997	1998	1999	2000	2001
Total	393	336	260	249	195	169	153
Male	280	231	165	158	129	111	87
Female	113	105	95	91	66	58	66

Figure 7 AIDS Cases by Year of Diagnosis by Risk Group, Westchester County

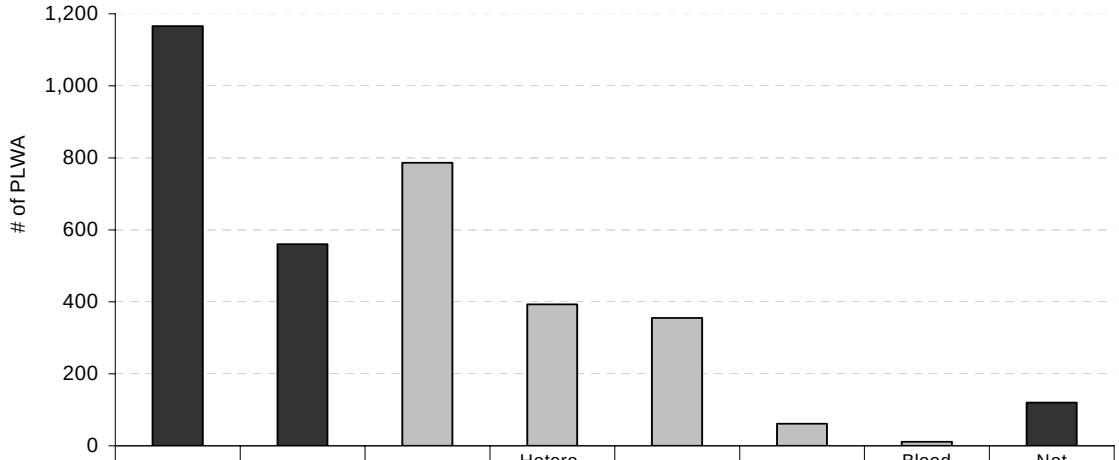


	1995	1996	1997	1998	1999	2000	2001
MSM	82	58	50	43	36	31	29
MSM/IDU	7	12	3	8	5	9	4
IDU	199	150	111	118	81	61	40
Het	60	72	73	64	55	49	48
Not Classified	44	44	22	16	16	18	32
Total	392	336	259	249	193	168	153

People Living with AIDS in 2001

The profile of PLWA is detailed below for 2001. The total number of living AIDS cases in Westchester County at the end of the 2001 was 1,726[4]. Gender and risk group are shown in Figure 8.

Figure 8 PLWA through 2001 by Gender and Risk Group, Westchester County



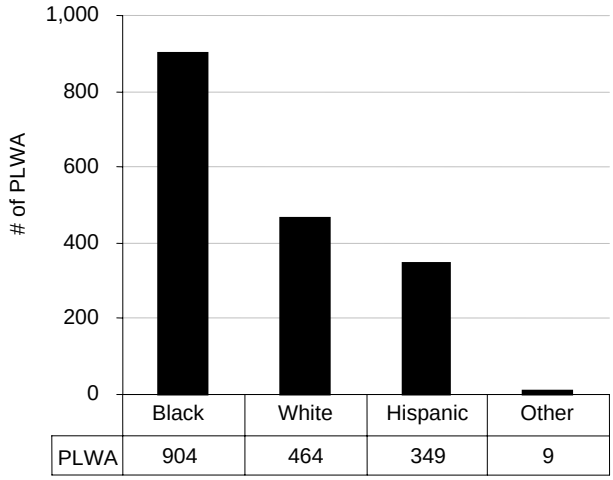
	Male	Female	IDU	Hetero-sexual	MSM	MSM-IDU	Blood Products	Not Classified
PLWA	1,166	560	786	393	355	61	11	120

[4] New York Sate Department of Health – Bureau of HIV/AIDS Epidemiology, Confirmed AIDS Cases (excluding pediatric and inmate cases) 2001.

In 2001, about 68% of the cases are male, representing 1,166 cases, and some 46% of the PLWA are IDU. About 32% are female, representing 560 cases. About 24% of the PLWA are attributed to MSM, 355 MSM and 61 MSM/IDUs, and 23% (393) to heterosexuals.

Figure 9 indicates that the 904 blacks living with AIDS constitute about 52% of all those living with AIDS, followed by 464 whites (27%). Blacks are disproportionately impacted by AIDS in Westchester County. The proportion of black non-Hispanics living with AIDS (52%) is dramatically higher than the proportion of black non-Hispanics in the general population (14%). White non-Hispanics on the other hand, while accounting 64% of the general population in Westchester, account for slightly over one quarter of the PLWA.

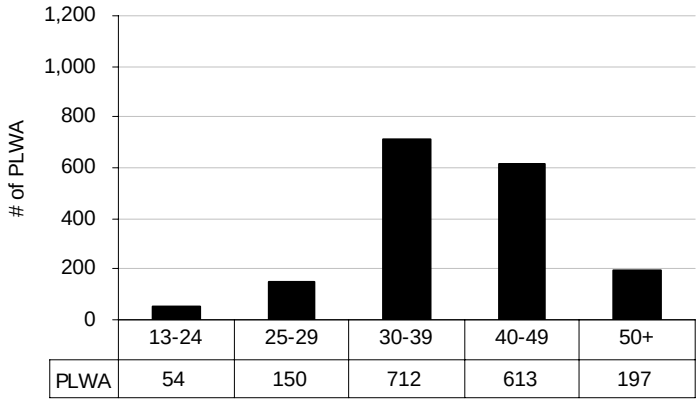
Figure 9 PLWA through 2001 by Race/Ethnicity, Westchester County



	Black	White	Hispanic	Other
PLWA	904	464	349	9

Figure 10 shows that the vast majority (77%) of those living with AIDS are between 30 and 49 years of age. As the mortality rate declines, there will be a growing number of persons over 50 living with AIDS. In 2001, about 11% of the PLWA are over 50.

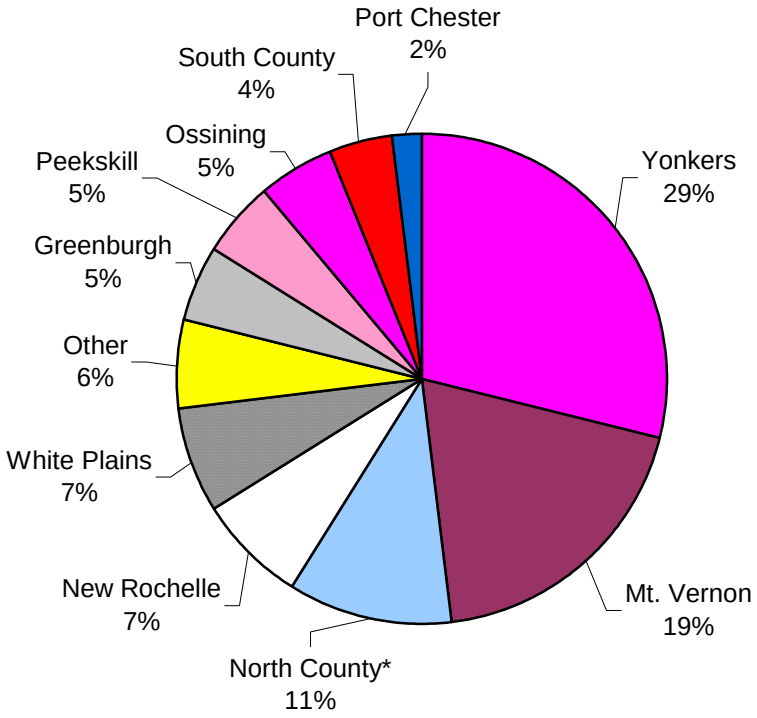
Figure 10 PLWA through 2001 by Age Group, Westchester County



	13-24	25-29	30-39	40-49	50+
PLWA	54	150	712	613	197

Within Westchester, as seen in Figure 11, the largest number of living AIDS cases are in the city of Yonkers (29%), followed by Mt. Vernon (19%). New Rochelle and White Plains each report 7% of living AIDS cases in Westchester County.

Figure 11 PLWA by Selected Municipalities in 2001, Westchester County



*The North County is a less densely populated area in the northeast section of the county comprised of 32 zip codes.

People Living with HIV in 2001[5]

The time from initial infection with HIV until a person develops an AIDS-defining condition may span years, therefore, AIDS case reports do not always include those recently infected. HIV infection reports tend to identify more recently infected individuals than do AIDS case reports. For health professionals to follow the current trends of HIV disease and to develop care and prevention strategies, prompt identification and reporting of HIV infections is essential.

As new drug treatments stabilize, and in many instances improve, the health status of persons living with HIV, the usefulness of AIDS case data for determining need decreases. Consequently, in estimating need and unmet need the number and profile of persons living with HIV is essential. However the statistics on HIV are much less complete than those for AIDS because many persons living with HIV do not get tested and remain unidentified. HIV has only recently become a reportable disease, and anonymous testing is available making tracking and reporting of those cases difficult.

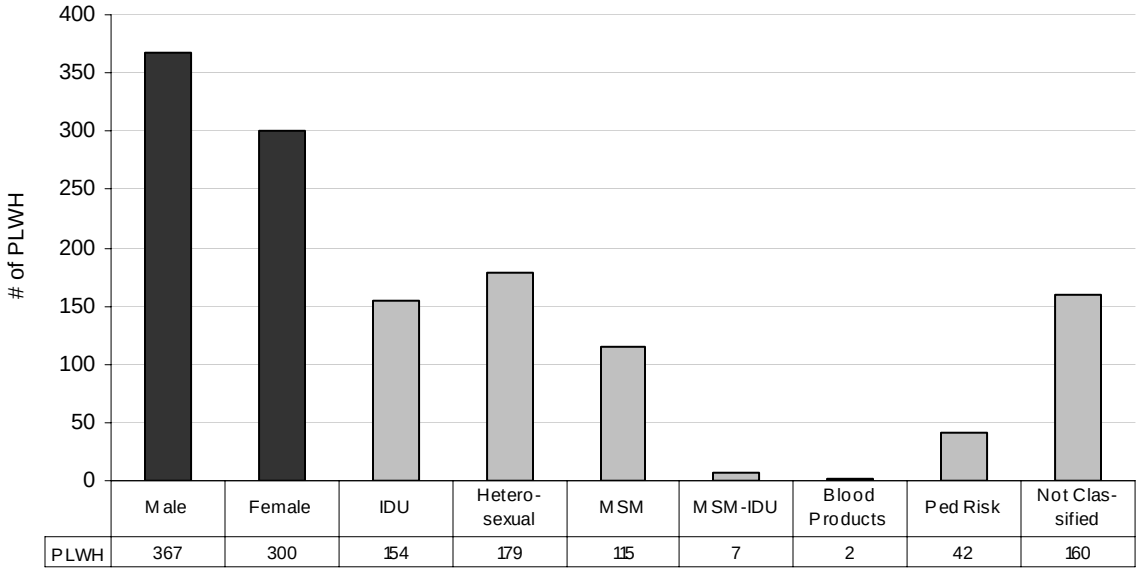
Given these caveats, below is the profile of PLWH for 2001. Currently the HIV data are most useful in determining the most current trends in HIV infection. Over time, as HIV reporting becomes more accurate, the data will be more useful in making estimates of the number infected with HIV.

For living HIV cases a stratified breakdown by gender, race/ethnicity, risk group, and age group was not available at the County level. Instead this section relies on Lower Hudson region data to present the proportional differences. The total number of reported living HIV cases in the Lower Hudson region at the end of 2001 was 668 with Westchester accounting for 87% or 578 cases. Westchester's living AIDS cases total 1,726. The two groups are mutually exclusive representing a total of 2,304 people reported living with HIV and AIDS. However, with NYSDOH estimating a range of 2,500 – 2,800 HIV cases in Westchester as of 2001, (i.e. including both reported and unreported cases) the likely number of those living with both AIDS and HIV is between 4,226 and 4,526.

The profile of reported PLWH is shown from Figure 12 – Figure 14. About 55% of the cases are male, representing 367 cases, and 45% are female, representing 300 cases. As shown in Figure 12, the risk group distribution of PLWH is almost equal among IDU, heterosexual, and unknown exposure, all accounting for about one quarter each. MSM ranks as the fourth largest group of PLWH in the Lower Hudson region in 2001, accounting for 17% of the cases.

[5] The data represent all cases, excluding incarcerated, reported from June 2000 through November 2002 for the Lower Hudson region, which included Westchester, Rockland, and Putnam.

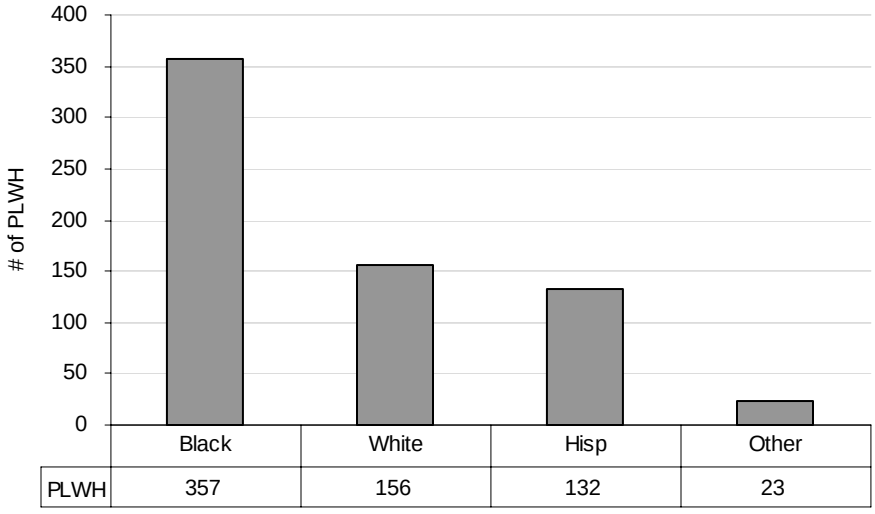
Figure 12 PLWH through 2001 by Gender,* Risk Group and Gender, Tri-County



*One case with sex unknown.

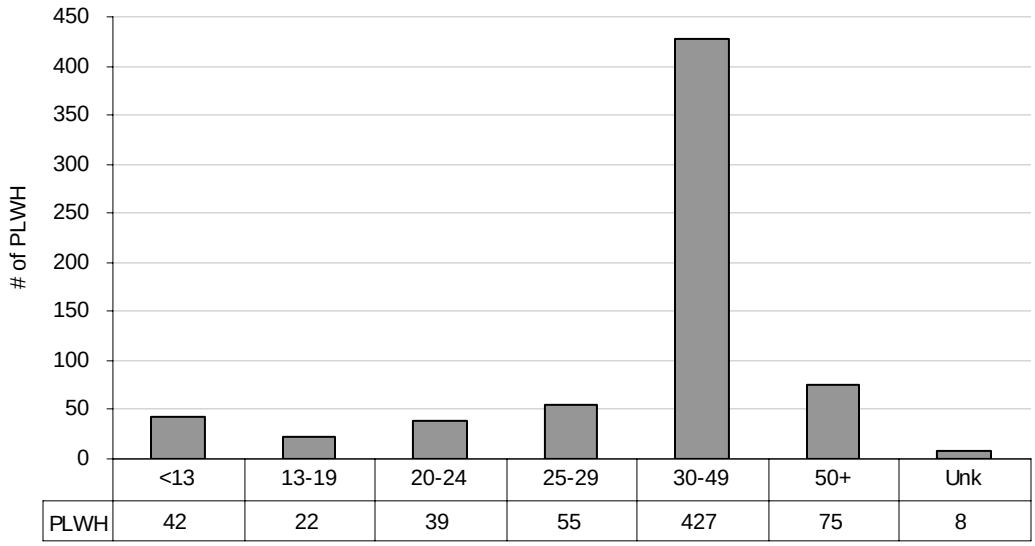
Figure 13 indicates that HIV has the greatest impact on communities of color. The 357 Blacks who report living with HIV constitute about 53% of all those reported living with HIV, followed by 156 Whites (23%), and 132 Hispanics (20%). Like Blacks living with AIDS, the proportion of Blacks living with HIV in 2001 is significantly greater than their 14% representation in the general population. The percentage of Hispanic HIV cases is slightly greater than their 16% representation in the general population. In contrast, Whites represent 70% of the general population but a much lower 23% of reported PLWH.

Figure 13 PLWH through 2001 by Race/Ethnicity, Tri-County



Like those living with AIDS, Figure 14 shows that the majority (64%) of those living with HIV are between 30 and 49 years of age. About 11% of the PLWH are over 50 and 24% are under 30. There are 42 children under the age of 13 living with HIV.

Figure 14 PLWH through 2001 by Age Group, Tri-County

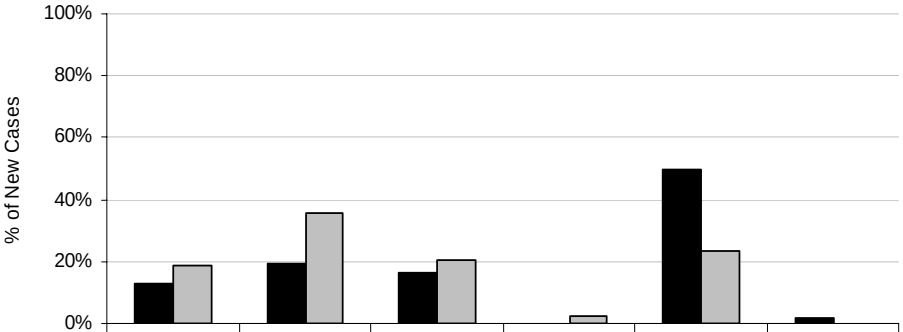


	<13	13-19	20-24	25-29	30-49	50+	Unk
PLWH	42	22	39	55	427	75	8

HIV Diagnosis Compared to AIDS Diagnosis

The comparison of the newly diagnosed HIV cases (total 109) and AIDS cases (total 172) diagnosed in 2001 reveals the current trend in the epidemic. The most striking finding in Figure 15 is that those reporting HIV are much more likely than those with AIDS to have their risk unclassified. The unclassified may fall into any of the categories, although they are likely to underreport the more stigmatized IDU and MSM categories.

Figure 15 Newly Diagnosed HIV and AIDS Cases through 2001 by Risk Group, Tri-County

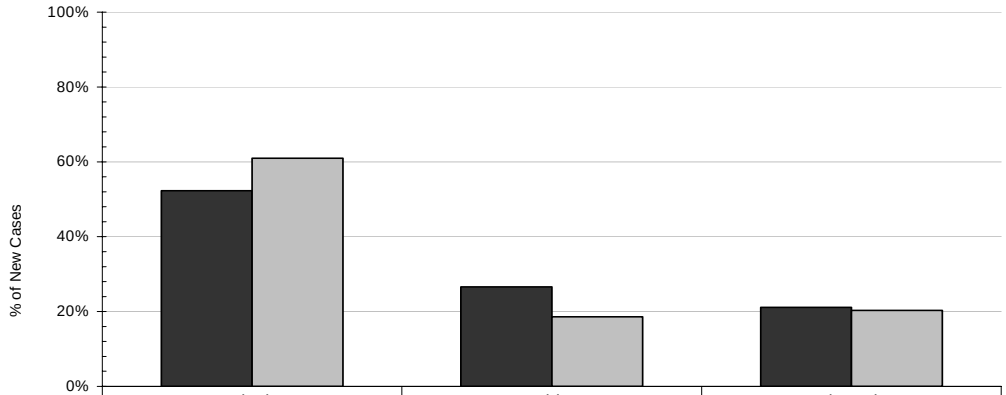


	IDU	Heterosexual	MSM	MSM/IDU	Not Classified	Pediatric risk
HIV	12.8%	19.3%	16.5%	0.0%	49.5%	1.8%
AIDS	18.6%	35.5%	20.3%	2.3%	23.3%	0.0%

Figure 16 shows that in 2001 blacks constitute the majority of new HIV and AIDS cases, but whites are more likely to be diagnosed with HIV than with AIDS. There are several possible explanations:

1. It may reflect the success in HIV treatment among whites, preventing the progression of HIV to AIDS.
2. It may suggest an increase in unsafe practices among whites that results in new HIV infection.
3. Given the large number of HIV cases that are unreported and undetected, it may reflect a lack of testing in communities of color.

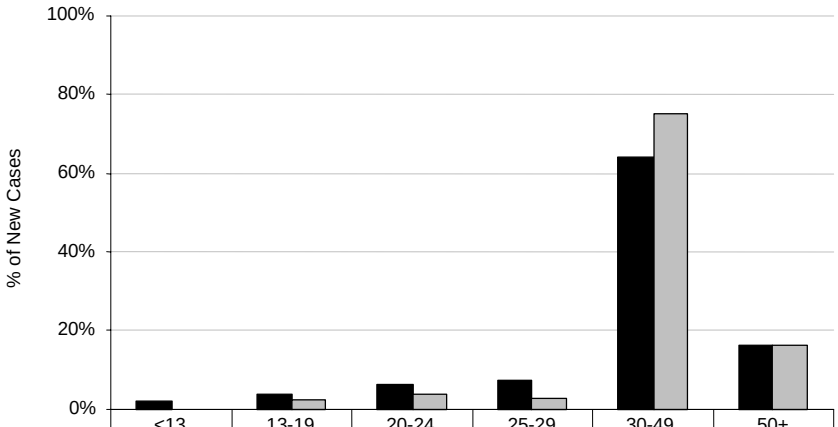
Figure 16 Newly Diagnosed HIV and AIDS Cases through 2001 by Race/Ethnicity, Tri-County



	Black	White	Hispanic
HIV	52.3%	26.6%	21.1%
AIDS	61.0%	18.6%	20.3%

As expected, Figure 17 shows that most of the new HIV and AIDS cases are among the 30-49 year olds. However, younger adults, i.e., under 30 years of age, are more likely to be diagnosed with HIV than with AIDS.

Figure 17 Newly Diagnosed HIV and AIDS Cases through 2001 by Age Groups, Tri-County



	<13	13-19	20-24	25-29	30-49	50+
HIV	1.8%	3.7%	6.4%	7.3%	64.2%	16.5%
AIDS	0.0%	2.3%	3.5%	2.9%	75.0%	16.3%

STDs

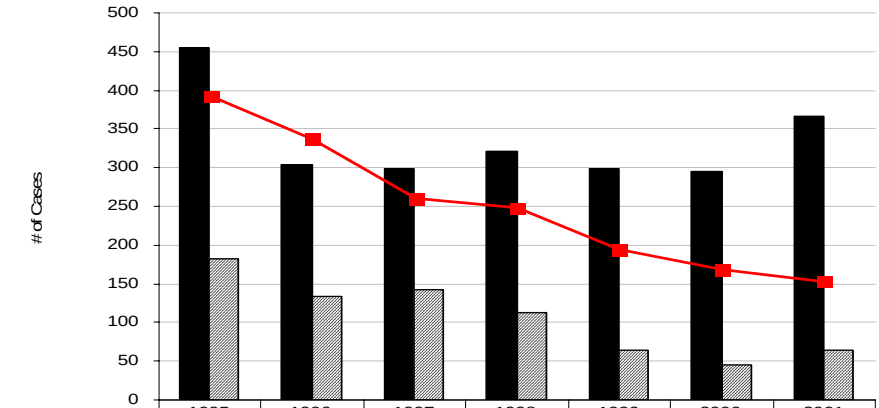
Based on STD rates in Westchester County there is a growing risk of HIV infection, particularly in the black community.

Gonorrhea and syphilis rates indicate the level of unprotected sexual contact and provide a potential early warning system for increased HIV infection. In addition to being an indicator of high-risk activity, it is also known that individuals who have a history of STDs are more vulnerable to HIV infection.

If HIV were accurately reported, a relationship between STDs and HIV might be apparent. However, HIV is not yet accurately reported, and, given the latency period of AIDS, at best, increases in STDs may indicate an increase in AIDS several years in the future. Other factors such as treatment of HIV and other medical factors make establishing a clear relationship between STD and AIDS difficult.

Figure 18 plots the incidence of gonorrhea, syphilis, and AIDS from 1995 to 2001. There has been a long trend in declining syphilis rates, and this graph shows that generally the number of AIDS cases follows the trend in syphilis cases. However, the number of gonorrhea cases has remained more than double the syphilis cases since 1995. Also, of concern is the increase in gonorrhea and syphilis cases noted from 2000 to 2001. This increase sends a warning that there may be more unprotected sex that could result in a rise of HIV.

Figure 18 Gonorrhea, Syphilis, and AIDS



	1995	1996	1997	1998	1999	2000	2001
Gonorrhea	455	304	299	322	298	296	367
Syphilis	183	133	143	113	65	45	65
AIDS	393	336	260	249	195	169	153

Chlamydia is transmitted through unprotected vaginal, anal, or oral sex. It is the most prevalent STD and is known as the "silent epidemic" because 75% of women and 50% of men have no symptoms of disease. The increasing rates of chlamydia (Figure 19) are of concern as individuals with sexually transmitted diseases (STDs), both male and female, are believed to be three- to five-times as likely to acquire HIV if exposed to that virus.

Figure 19 shows the sharp increase in chlamydia cases since 1997, with some leveling-off from 2000 to 2001. This sharp increase may be a reporting artifact since mandatory reporting of chlamydia only started in 1999. Since 1998, chlamydia has been the most prevalent STD in Westchester County. In 2001, with 1,156 cases, the rate of chlamydia in Westchester was 125 cases per 100,000. Among women, this rate was over 200 cases per 100,000 and among black women this rate was as high as 609 cases per 100,000.

Figure 19 Chlamydia

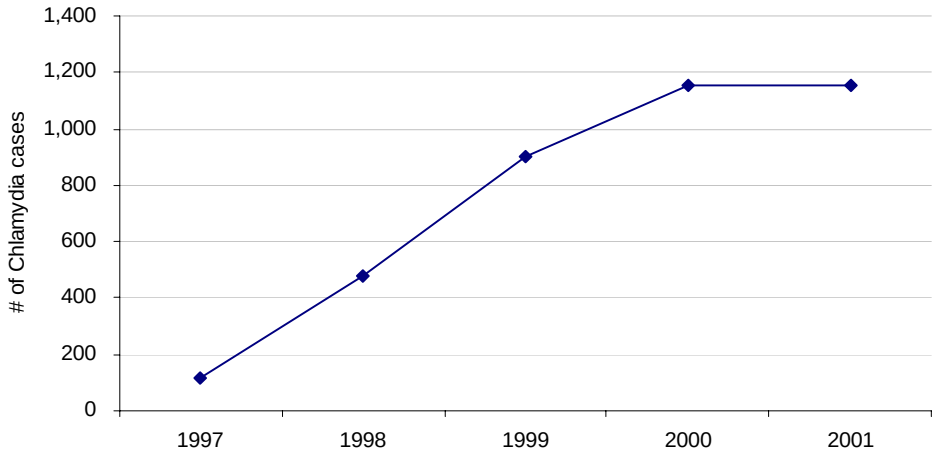
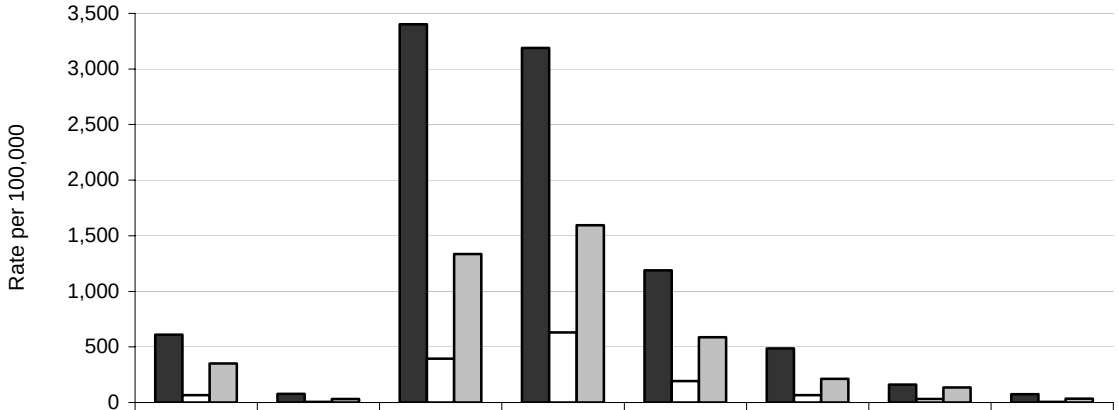


Figure 20 shows that among women of color between the ages of 15 and 24, chlamydia rates are alarmingly high, representing more than seven times the national rate of 435 cases per 100,000.

Figure 20 Rates of Chlamydia for Women by Age Group and Race/Ethnicity



	Total	Under 15	15-19	20-24	25-29	30-34	35-39	40+
Black	609.9	77.9	3,402.9	3,189.5	1,189.7	487.6	161.4	73.4
White	65.0	6.3	395.2	630.5	193.1	65.0	32.1	5.0
Hispanic	350.7	32.6	1,335.1	1,593.7	587.7	212.7	135.0	34.4

PROVIDER DATA COLLECTION ACTIVITIES

Currently Westchester County lacks a comprehensive inventory of HIV prevention services. To address this problem, a component of the 2003 Westchester Prevention Needs Assessment included the development and distribution of a provider information form which was designed to:

- Identify HIV prevention services currently offered by local community-based organizations with service descriptions, eligibility, and points of access.
- Identify the barriers that hinder providers delivering prevention services.

The information form was designed to quantify the Continuum of Prevention Services (CPS) presented earlier, and providers were asked to note the types of services they provided by the major categories in the CPS.

Methodology

The information forms were designed to identify the HIV prevention services currently offered and to measure the capacity for prevention services listed in the Continuum of Prevention Services (see Figure 1, page 4). The provider information form, shown in Attachment 1, was designed in close collaboration with WCDOH and finalized by mid-April 2003. PCH sent the information forms to the providers along with a cover letter from the Commissioner of Health to encourage a higher completion rate.

A team of Westchester County Department of Health (WCDOH) staff provided assistance in developing and reviewing drafts of the provider forms, providing the distribution list and maintaining contact with the community-based advisory committee. It was decided that the distribution of the forms should include agencies that currently receive Ryan White funds, those that receive any form of prevention funding, as well as other identified service providers who may come into contact with at-risk populations. These would include substance abuse treatment providers, youth programs, and family planning clinics. In total, the information forms were sent to 56 service providers. See distribution list in Attachment 2.

The form was designed to be self-administered and, initially, providers were asked to complete the information form and mail them to PCH within five weeks. To improve the initial low response rates and quality of the data the project staff changed the data collection strategy and shifted to one-on-one telephone interviews with the largest providers receiving the highest priority.

Data collection continued into August 2003. Of the 56 service providers who received the form, a total of 34 forms were completed (61%). Of the 27 providers who were identified as possibly providing prevention services, 23 were completed (85%). One provider said it did not provide prevention services. Over 70% of the completed forms were done over the telephone. Because all of the largest providers are included, the response rate is adequate to present a broad description of the types of prevention activities currently taking place in Westchester. The following descriptive analysis is a report of the provider information. Its

main use is to provide a snapshot of the quantity and types of prevention activities offered in the area. However, without specific information on funding amounts and actual number of clients served or units-of-service provided, it is not possible to estimate provider capacity and present a clear analysis of gaps in services.

Data Entry and Analysis

The data from the information form was entered into a Statistical Package for the Social Sciences (SPSS) data file by PCH staff. All data were checked for quality, and where necessary, providers were called to complete missing data. The data were analyzed using SPSS, Excel, and Access.

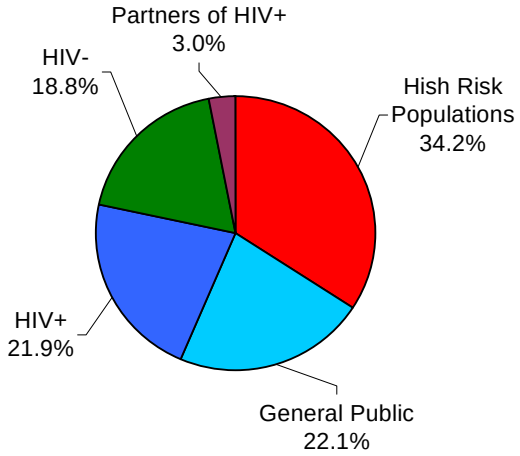
For each target group in the CPS a list of possible activities that might be delivered to each of the six target groups was prepared. In total 49 distinct service components were included on the survey form.

Findings

Distribution of Continuum of Prevention Services (CPS)

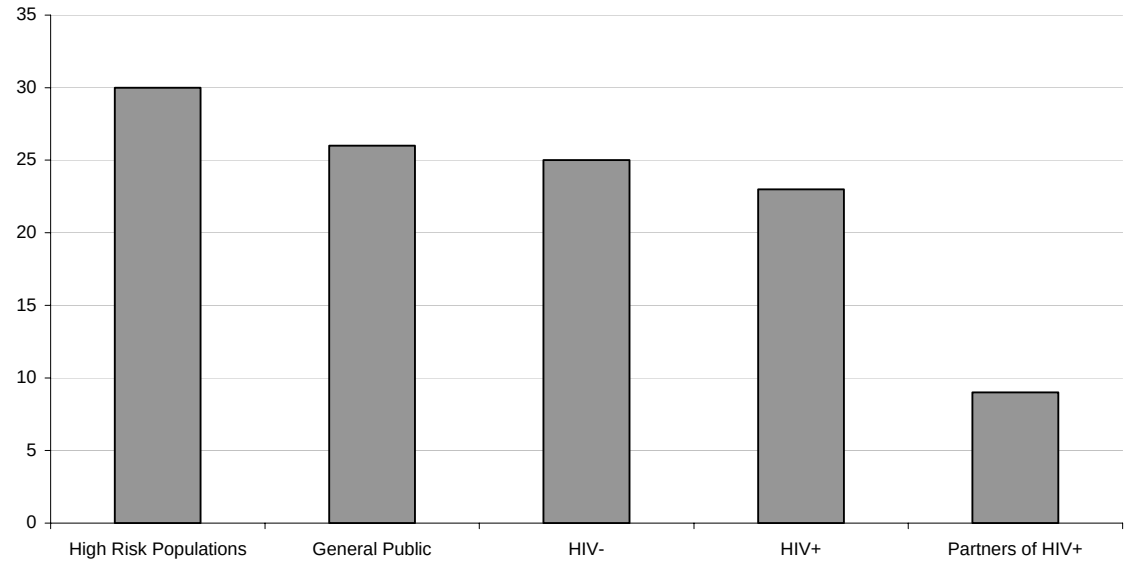
The 34 agency respondents indicated providing a total of 398 prevention services within Westchester County, excluding 106 services directed to providers. Figure 21 shows the distribution of these services for the five categories in the CPS that target individuals. When examining these data by the actual number of services offered in the continuum the largest percentage of services were identified as being provided to high risk populations (34.2%) followed by the general public (22.1%). Roughly 40% of the services identified by respondents are being directed to those with a "known" HIV status, that is 21.9% of services to HIV positives and 18.8% to HIV negatives. In contrast, only 3.0% of prevention services reported by respondents were being provided to partners of HIV positive persons.

Figure 21 Distribution of Services in CPS



Since for each target group the number of prevention services available for selection varied, ranging from thirteen services for high risk individuals to four services for partners of persons with HIV/AIDS, it is also important to review the data by groups most frequently targeted, regardless of the number of services offered by the respondent agencies. When examining from this perspective the results are fairly consistent as seen in figure 22 with high risk populations being targeted by the greatest number of agencies (N=30) and partners of positives being targeted the least often (N=9). The remaining groups are being targeted by 23-26 agencies.

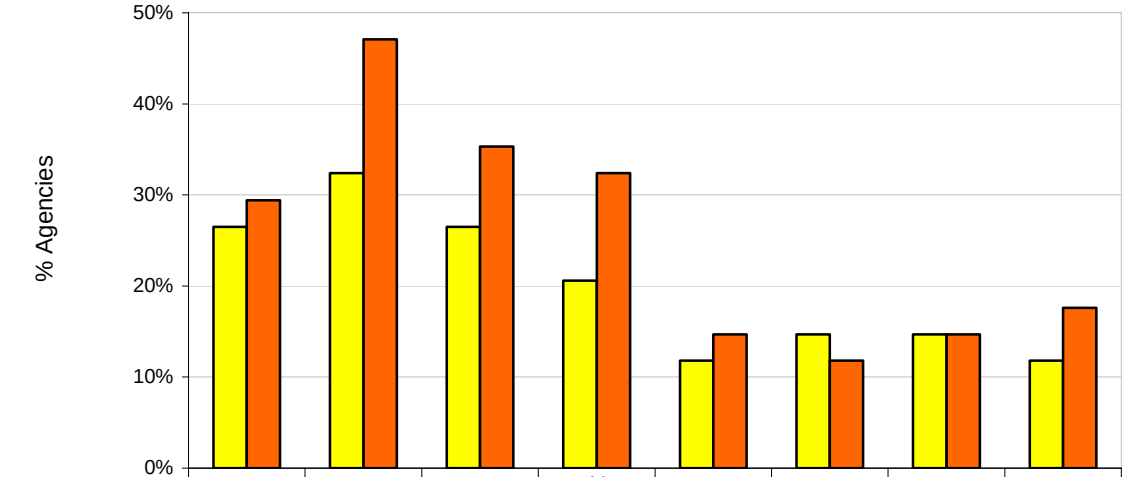
Figure 22 Distribution of Agencies in CPS



While the efforts may be at varying levels, the data show that respondent agencies are engaged in activities that are designed to reach all the various groups of the continuum. When looking at those activities that are solely directed to non-providers (5 groups), half of the agencies indicated targeting at least four target groups. Nearly one-quarter of the agencies (23.5%) indicated providing at least one service to all five target groups in the continuum versus 14.7% of agencies indicating services being offered to only one target group. Four was the most frequent number of groups served by providers.

Figure 23 shows that services to the general public and to high-risk communities is taking place in areas of high HIV incidence. However, less than 15% of the services targeting the general public and high-risk populations is taking place in Peekskill, an area with the second highest *rate* of PLWA.

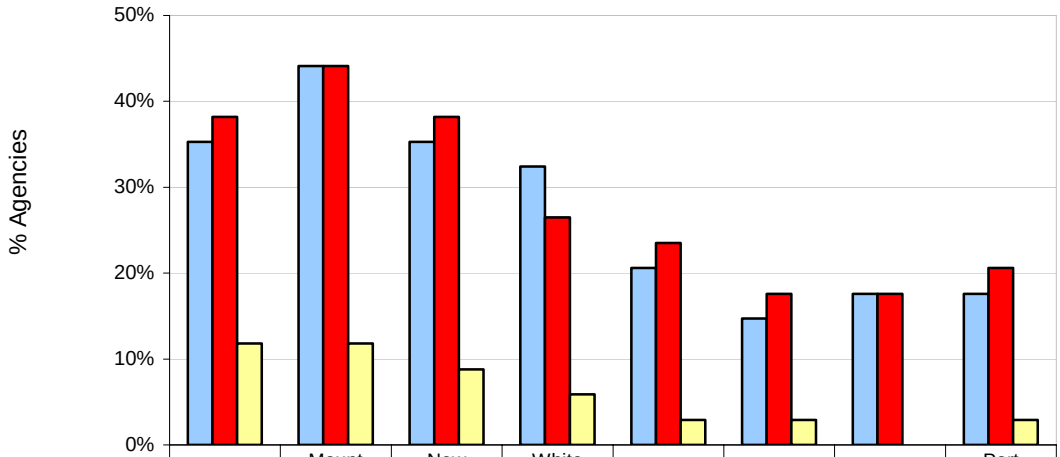
Figure 23 Percent of Agencies Delivering Programs Targeted to Selected Municipalities, Westchester County



	Yonkers	Mount Vernon	New Rochelle	White Plains	Greenburgh	Peekskill	Ossining	Port Chester
Public Advocacy	26.5%	32.4%	26.5%	20.6%	11.8%	14.7%	14.7%	11.8%
Outreach	29.4%	47.1%	35.3%	32.4%	14.7%	11.8%	14.7%	17.6%

Figure 24 shows that the areas with the highest prevalence of PLWA, i.e., Yonkers, Mount Vernon, and New Rochelle, are also the areas more likely to be targeted for prevention services for HIV positive individuals and although only a small percentage of agencies provide prevention for partners, these programs are more likely to be found in areas with high prevalence of AIDS.

Figure 24 Percent of Agencies Delivering Programs Targeted to Selected Municipalities, Westchester County



	Yonkers	Mount Vernon	New Rochelle	White Plains	Greenburgh	Peekskill	Ossining	Port Chester
Prevention to HIV-	35.3%	44.1%	35.3%	32.4%	20.6%	14.7%	17.6%	17.6%
Prevention to HIV+	38.2%	44.1%	38.2%	26.5%	23.5%	17.6%	17.6%	20.6%
Prevention to Partners	11.8%	11.8%	8.8%	5.9%	2.9%	2.9%	0.0%	2.9%

Summary Templates

This section presents information on services that represent the categories reflected in the Continuum of Prevention Services (CPS). Those categories include: 1) public advocacy, 2) outreach to high-risk populations, 3) prevention to HIV negative individuals, 4) prevention to HIV positive individuals, 5) prevention to partners, 6) provider and support services.

A one-page summary sheet is dedicated to each category, with the exception of training and assessment that have been combined into the "other services" category. Each category covers several individual services. For example, public advocacy includes nine different services and outreach to high-risk populations includes thirteen different services.

Each category is shown using the same page layout. The summary sheet, an example shown in Figure 25, details:

1. At the top left of each summary sheet is the name of the service.
2. Next to the track are the service outcomes or goals to be achieved based on the newly designed CPS.
3. The first table shown in the template presents the different services offered under each category, the number of agencies reporting having this service available, and the percentage of the 34 agencies responding to the information form that offer each specific service.
4. A summarized description of the service category and of the targeted populations based on information submitted by providers on the information form.
5. Finally, the table on the right shows all the municipalities within Westchester County and reflects the number of agencies offering the specific service category at each site. For example, public advocacy is offered by three agencies serving the Ardsley area. Note that the agency is not necessarily physically located at the particular municipality. Rather an agency program is designated to serve residents from that area.

Figure 25 Example of CPS Service Summary Sheet

❶ **Name of the service track.** ❷ **Outcomes**

❸ **Prevention Service**	**# of Agencies**	**% of All Reporting Agencies**
Xxxx	#	%
Xxxx	#	%

❹ **Description:**
Summary of text submitted by providers on Information Form
Target Population:
Summary of text submitted by providers on Information Form
Summary:
Comments and notes for each service category

❺ **Region/Municipality**	**# of Agencies Serving Area**
Ardsley	#
Bedford	#
.	#
.	#
.	#
	#
	#
	#
	#
	#
	#
	#
Yorktown	#

In addition, Attachment 3 presents a summary of the prevention services offered by the participating service providers. On the provider form, each agency was asked to check whether it provided a particular activity. Attachment 3 shows each of the agencies by name and the types of prevention programs available. For instance, there are nine activities listed under "Public Advocacy." Attachment 3 shows that ARCS provides four out of the possible nine activities.

Advocacy to General Public

Outcomes: 1. Public Support and 2. Individual risk assessment

Prevention Service	# of Agencies	% of All Reporting Agencies
Group educational interventions	19	55.9%
PSAs	13	38.2%
Educational training	12	35.3%
Newsletters	12	35.3%
Write-in campaigns	9	26.5%
Volunteers/interns educational	8	23.5%
Organize rallies include with write-in campaigns, articles, editorials	6	17.6%
Financial solicitation	5	14.7%
Hotline	3	8.8%

Description:

In addition to the programs and activities listed above, some of the specific public advocacy activities include:

- Annual fundraising events
- Community outreach
- Lobbying

Target Population:

Public advocacy activities are designed to reach the general population. Among the reporting agencies, most are targeting communities of color and are not gender or risk group specific. Some special populations reached include:

- Inmates (1 program)
- Adolescents (5 programs)
- Homeless populations (2 programs)
- Mentally ill (1 program)

Summary

Group education activities remain the preferred method of reaching a larger audience with HIV prevention messages. Several agencies reported having educational activities specifically targeting adolescents or young adults through youth or school programs.

Public advocacy programs targeting the general population are more likely to be found in Mount Vernon, New Rochelle, and Yonkers.

Region/ Municipality	# of Agencies Serving Area
Ardsley	3
Bedford	3
Briarcliff Manor	4
Bronxville	3
Buchanan	4
Cortlandt	4
Croton-on-Hudson	4
Dobbs Ferry	4
Eastchester	3
Elmsford	4
Greenburgh	4
Harrison	4
Hastings-on-Hudson	4
Irvington	3
Larchmont	3
Lewisboro	2
Mamaroneck	3
Mount Kisco	3
Mount Pleasant	3
Mount Vernon	**11**
New Castle	2
New Rochelle	**9**
North Castle	3
North Salem	3
Ossining	5
Peekskill	5
Pelham Manor	3
Pleasantville	3
Port Chester	4
Pound Ridge	3
Rye	3
Scarsdale	3
Sleepy Hollow	3
Somers	4
Tarrytown	3
Tuckahoe	3
White Plains	7
Yonkers	**9**
Yorktown	3

Outreach to High-Risk Populations

Outcomes: 1. Knowledge of serostatus, 2. Knowledge of co-morbidities, 3. Increased safer behaviors (condom and needle use), 4. STD treatment referrals and lower rates of STDs, and 5. Abstinence from drug use and sex

Prevention Service	# of Agencies	% of All Reporting Agencies
HERR	21	61.8%
Condom distribution	18	52.9%
One-on-one	18	52.9%
HIV testing	18	52.9%
STD testing	11	32.4%
TB testing	11	32.4%
Family planning	9	26.5%
Substance abuse treatment	8	23.5%
12 step alcohol anonymous program	7	20.6%
Bleach kit distribution	6	17.6%
Mobile van	4	11.8%
Neonatal clinic	3	8.8%
Needle exchange	1	2.9%

Description:

In addition to the programs and activities listed above, some of the specific outreach programs include:

- Education programs at schools
- AA group sessions
- Referrals to other services

Target Population:

Outreach activities are designed to reach high-risk populations Among the reporting agencies, most are targeting communities of color and are not gender or risk group specific. Some special populations reached include:

- Inmates (1 program)
- Adolescents (6 programs)
- Homeless (2 programs)
- Mentally ill (1 program)

Summary

Traditional outreach activities to high-risk populations include HERR, counseling and testing, and condom distribution. More than 50% of the service providers report offering these services.

Outreach to high-risk populations is more likely to be found in Mount Vernon, New Rochelle, White Plains, and Yonkers.

Region/ Municipality	# of Agencies Serving Area
Ardsley	2
Bedford	2
Briarcliff Manor	3
Bronxville	2
Buchanan	3
Cortlandt	3
Croton-on-Hudson	3
Eastchester	2
Elmsford	3
Greenburgh	5
Harrison	3
Hastings-on-Hudson	3
Irvington	2
Larchmont	2
Lewisboro	2
Mamaroneck	2
Mount Kisco	4
Mount Pleasant	2
Mount Vernon	**16**
New Castle	2
New Rochelle	**12**
North Castle	2
North Salem	2
Ossining	5
Peekskill	4
Pelham Manor	3
Pleasantville	2
Port Chester	6
Pound Ridge	2
Rye	3
Scarsdale	2
Sleepy Hollow	2
Somers	3
Tarrytown	3
Tuckahoe	3
White Plains	**11**
Yonkers	**10**
Yorktown	2

Prevention Targeted to HIV Negative Individuals

Outcomes: 1. Maintain negative status, 2. Adopt and maintain safer behaviors (condom and needle use), 3. Obtain treatments and lower rates of STDs, and 4. Abstinence from drug use and sex

Prevention Service	# of Agencies	% of All Reporting Agencies
One-on-one counseling	18	52.9%
Skills building workshop	13	38.2%
Behavior modification programs	8	23.5%
Partner negotiation	8	23.5%
HIV re-test	8	23.5%
Prevention case management	7	20.6%
Peer education	7	20.6%
Support group	5	14.7%

Description:

In addition to the programs and activities listed above, some of the specific prevention for HIV negative individuals programs include:

- Counseling groups for men
- Family/partner support groups

Target Population:

Among the reporting agencies, most are targeting communities of color and are not gender or risk group specific. Some special populations reached include:

- Inmates (1 program)
- Adolescents (7 programs)
- Homeless populations (1 program)

Summary:

Prevention for HIV negative individuals is designed for individuals that have already accessed the CPS, i.e., they've sought testing. More than half of the programs include one-on-one counseling and more than one third include skills building workshop to teach the individuals how to maintain their negative status.

Mount Vernon, New Rochelle, White Plains, and Yonkers account for 50 (24%) of the prevention to HIV negative individuals in the county.

Region/ Municipality	# of Agencies Serving Area
Ardsley	4
Bedford	4
Briarcliff Manor	5
Bronxville	4
Buchanan	5
Cortlandt	6
Croton-on-Hudson	5
Dobbs Ferry	5
Eastchester	4
Elmsford	5
Greenburgh	7
Harrison	5
Hastings-on-Hudson	5
Irvington	4
Larchmont	4
Lewisboro	3
Mamaroneck	4
Mount Kisco	6
Mount Pleasant	4
Mount Vernon	**15**
New Castle	3
New Rochelle	**12**
North Castle	4
North Salem	4
Ossining	6
Peekskill	5
Pelham Manor	5
Pleasantville	4
Port Chester	6
Pound Ridge	4
Rye	5
Scarsdale	4
Sleepy Hollow	4
Somers	5
Tarrytown	5
Tuckahoe	4
White Plains	**11**
Yonkers	**12**
Yorktown	5

Prevention Targeted to HIV Positive Individuals

Outcomes: 1. Adopt & maintain safer behavior, 2. Linkages to, initiating, and maintaining health care, and 3.Adherence to drug regimen, if applicable

Prevention Service	# of Agencies	% of All Reporting Agencies
Counseling	19	55.9%
Monitor HIV status	13	38.2%
Support groups	11	32.4%
Safer behavior workshops	11	32.4%
Behavior modification	10	29.4%
Adherence programs	9	26.5%
Partner notification	7	20.6%
Circulate newsletters	6	17.6%

Description:

In addition to the programs and activities listed above, some of the specific prevention for HIV positive individuals programs include:

- Case management programs
- Counseling and job training programs
- Transportation services
- Nutrition counseling
- Housing assistance
- Referrals

Target Population:

Among the reporting agencies, most are targeting communities of color and are not gender nor risk group specific. Some special populations reached include:

- Inmates (1 program)
- Adolescents (3 programs)
- Homeless populations (1 program)

Summary

Prevention for positives is one of the most commonly offered prevention services. This may reflect the service providers' greater capacity to report more structured services. Once a person tests positive, service providers appear to be better able to integrate the individual in the overall care system, and provide some prevention information. It is, however, not systematic and there are few guidelines and standards.

Mount Vernon, New Rochelle, and Yonkers account for 41 (18%) of the prevention to positive programs offered in the county

Region/ Municipality	# of Agencies Serving Area
Ardsley	4
Bedford	5
Briarcliff Manor	5
Bronxville	4
Buchanan	5
Cortlandt	7
Croton-on-Hudson	6
Dobbs Ferry	5
Eastchester	4
Elmsford	6
Greenburgh	8
Harrison	5
Hastings-on-Hudson	5
Irvington	4
Larchmont	4
Lewisboro	3
Mamaroneck	5
Mount Kisco	6
Mount Pleasant	5
Mount Vernon	**15**
New Castle	4
New Rochelle	**13**
North Castle	5
North Salem	5
Ossining	6
Peekskill	6
Pelham Manor	5
Pleasantville	4
Port Chester	7
Pound Ridge	3
Rye	5
Scarsdale	4
Sleepy Hollow	4
Somers	5
Tarrytown	5
Tuckahoe	5
White Plains	9
Yonkers	**13**
Yorktown	5

Prevention to Partners **Outcomes:** 1. Adopt & maintain safer behavior and 2. Commitment to safer behaviors

Prevention Service	# of Agencies	% of All Reporting Agencies
Other programs for partners	5	14.7%
Develop partner agreements	3	8.8%
Partner negotiation campaign	2	5.9%
Partner negotiation workshops	2	5.9%

Description:

In addition to the programs and activities listed above, some of the specific prevention for HIV negative individuals programs include:

- Counseling groups for men
- Family/partner support groups
- Partner notification

Target Population:

Among the reporting agencies, most are targeting communities of color and are not gender nor risk group specific. Some special populations reached include:

- inmates (1 program)
- adolescents (1 program)
- Gay, lesbian, bisexual, transgender (1 program)

Summary

Very few programs targeting partners are offered throughout Westchester County. Prevention for partners is the least popular prevention category. While more than half of service providers offer prevention services to individuals of known HIV status, whether positive or negative, very few target or include their partners.

Region/ Municipality	# of Agencies Serving Area
Ardsley	
Bedford	
Briarcliff Manor	1
Bronxville	
Buchanan	1
Cortlandt	1
Croton-on-Hudson	1
Dobbs Ferry	1
Eastchester	
Elmsford	
Greenburgh	1
Harrison	1
Hastings-on-Hudson	1
Irvington	
Larchmont	
Lewisboro	
Mamaroneck	
Mount Kisco	1
Mount Pleasant	
Mount Vernon	**4**
New Castle	
New Rochelle	**3**
North Castle	
North Salem	
Ossining	
Peekskill	1
Pelham Manor	1
Pleasantville	
Port Chester	1
Pound Ridge	
Rye	
Scarsdale	
Sleepy Hollow	
Somers	1
Tarrytown	1
Tuckahoe	
White Plains	2
Yonkers	**4**
Yorktown	

Services to Providers and Grantees

Outcomes: 1. Increase capacity to provide effective prevention services, 2. Accountability to consumers and funders, and 3. Improvement of services

Prevention Service	# of Agencies	% of All Reporting Agencies
Training to providers/ workers	17	50.0%
Consumer satisfaction	13	38.2%
Program monitoring	11	32.4%
Needs assessment	10	29.4%
Program development	8	23.5%
Infrastructure support	7	20.6%
Newsletters	3	8.8%

Description:

In addition to the programs and activities listed above, other services for providers and program assessment/evaluation

- Adherence and cultural training
- Education courses
- Information sharing and networking w/ other agencies
- Quarterly program assessments
- Written pre/post surveys at educational sessions

Target Population:

- Outreach staff (1 program)
- Probation/prison officials (1 program)

Summary

- "Other Services" are designed to support and enhance service delivery. These are services offered to or by service providers and/or grantees. The most common organizational development service is training for staff. Consumer satisfaction and pre/post test surveys, and assessments are also used to improve quality of services.
- The areas most active in providing services to the community are also the areas most likely to offer organizational and capacity building services.

Region/ Municipality	# of Programs
Ardsley	3
Bedford	3
Briarcliff Manor	4
Bronxville	3
Buchanan	4
Cortlandt	5
Croton-on-Hudson	4
Dobbs Ferry	4
Eastchester	3
Elmsford	4
Greenburgh	6
Harrison	4
Hastings-on-Hudson	3
Irvington	2
Larchmont	3
Lewisboro	2
Mount Kisco	4
Mount Pleasant	2
Mount Vernon	10
New Castle	2
New Rochelle	9
North Castle	3
North Salem	3
Ossining	4
Peekskill	4
Pelham Manor	4
Pleasantville	3
Port Chester	5
Pound Ridge	3
Rye	3
Scarsdale	2
Sleepy Hollow	2
Somers	3
Tarrytown	3
Tuckahoe	3
White Plains	9
Yonkers	9
Yorktown	4

EVIDENCE BASED – OUTCOME BASED STRATEGIES

The purpose of this section is to present a list of effective HIV prevention strategies and interventions identified as effective programs that may be applied in whole or in part in Westchester County.

Using the prevention continuum as a reference, PCH conducted a literature review of evidence-based models of HIV prevention strategies and programs. According to the Centers for Disease Control and Prevention (CDC), evidence-based interventions are science-based interventions that have rigorous study methods with demonstrated evidence of effectiveness in reducing sex- and drug-related risk behaviors or improving health outcomes. Consequently, most of the programs that are included in this review have been scientifically assessed. However, in this review, some innovative or promising prevention programs were included to address specific constituencies or target populations.

As a further guide to suggesting programs, CDC identifies seven types of interventions in its guidance on evaluation. These include individual-level interventions, group-level interventions, outreach, prevention case management, partner counseling and referral services, health communications/public information, and other interventions. Table 3 shows prevention intervention types identified by CDC and a brief description of each.

Table 3 HIV Prevention Intervention Types

Intervention Type	Description
Individual-level Interventions (ILI)	Consist of health education and risk-reduction counseling provided to one individual at a time. These interventions assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. ILIs also provide linkages to services in both clinic and community settings in support of behaviors and practices that prevent transmission of HIV.
Group-level Interventions (GLIs)	GLIs consist of health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. The intervention may be delivered by a peer or a non-peer, and programs usually include information about condom use, negotiation of safer sexual behaviors and risk reduction strategies. Interventions that focus on groups as a target for HIV prevention and education may be structured to encourage the initiation and maintenance of safer behaviors, to provide interpersonal skills training, and/or to sustain appropriate behavior change.
Outreach	Outreach is generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate (e.g. bars, parks, shooting galleries). Outreach usually includes distribution of condoms, barriers, bleach and educational materials. Includes peer opinion leader models. Outreach workers – who may be trained peers or non-peers -- also provide referrals to prevention, substance abuse or early intervention programs. Needle exchange programs are a form of outreach intervention used to reduce the transmission of HIV among injecting drug users and their sex partners.

Intervention Type	Description
Prevention Case Management (PCM)	This is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is a hybrid of HIV risk-reduction counseling and traditional case management. It provides an ongoing, sustained relationship with the client in order to assure multiple-session, individualized HIV risk reduction counseling that provides intensive, support, and referrals to other services. The goal of PCM is to assist persons to remain seronegative or to reduce the risk for HIV transmission to others by those who are HIV positive.
Partner Counseling and Referral Services (PCRS)	PCRS provides a systematic approach to notifying sex and needle-sharing partners of HIV infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.
Counseling and testing (CT)	CT refers to the voluntary process of HIV testing accompanied by client-centered, interactive information-sharing in which an individual is made aware of the basic information about HIV/AIDS, testing procedures, and how to prevent the transmission and acquisition of HIV infection.
Health Communications/ Public Information (HC/PI)	This includes the delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. May include electronic or print media, hotlines, clearing houses, presentations, or lectures.
Community Level Interventions and other Interventions	This category includes community-level interventions (CLI), i.e., interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups.

The Continuum of Prevention Services (CPS) is designed to incorporate these levels of prevention services. Table 4 shows how different intervention types can be part of the various components of the CPS.

Table 4 CPS Objectives and Intervention Types

CPS Objective	CDC Intervention Type
Public advocacy and risk assessment	Largely HC/PI and CLI. Other interventions may be used for fundraising
Outreach to at-risk populations	All levels except ILI, PCRS, PCM
Prevention services to HIV negative	All levels
Prevention services to HIV positive	
Prevention services to partners (sexual and needle exchange)	
Prevention services to providers and grantees	Largely individual and group level trainings

Several “best practice” documents have been compiled and were reviewed for this report. The documents reviewed are listed below and web page links or citations are provided in Attachment 4.

- The New York City HIV Prevention Plan, Volume V, 2000
- The Institute of Medicine’s “AIDS and Behavior”

- The United States Conference of Mayors' "HIV Prevention and Outreach Strategies", 2001
- The Compendium of HIV Prevention Interventions with Evidence of Effectiveness from the CDC's HIV/AIDS Prevention Research Synthesis Project – revised in August 2001.
- "Bright Ideas - Innovative or Promising Practices in HIV Prevention and HIV Prevention Community Planning" - National Alliance of State and Territorial AIDS Directors (NASTAD), March 2002.

The majority of programs that have been assessed are individual and group level interventions and counseling and testing. The programs reviewed have measurable indicators and rely on the rational decision-making or modeling behavior theory. These theories include concepts from the health belief model, social learning theory, social cognitive theory, reasoned action theory, and/or the transtheoretical model of change (or stages of change model). Attachment 5 presents a brief summary of these theories highlighting their key assumptions and constructs. A key limitation in most of these models is their failure to address structural or environmental factors that may influence the decision making process.

There are almost no reviews of the interventions whose goal is strengthen infrastructure or focus on other structural features of the continuum of care.

Adopting any of these programs to Westchester requires an understanding of the particular needs of the County. In assessing the different programs, the nine criteria listed below were used for selecting the recommended strategies:[6]

1. Does the program meet the objectives of the Westchester HIV Prevention program (as defined in the Continuum of Prevention)?
2. Is it culturally appropriate?
3. Is it effective in meeting its objectives?
4. Is it efficient in meeting its objectives?
5. What are the necessary cost and resource allocations?
6. What are the political and social consequences?
7. How does the program interface with existing programs?
8. Is there likely to be organizational support of the program?
9. Is the target population receptive to the program?

With these caveats and conditions, Table 5 presents a spectrum of interventions that can be enhanced or adopted in Westchester County based on the best practice review and the profile of the AIDS epidemic in Westchester. Where possible they are theory based, and target an epidemic that predominantly impacts communities of color, particularly Blacks and Hispanics, and has most recently affected IDUs more than any other group. The recommendations acknowledge a current shift in the increased rate of infection among heterosexuals.

[6] For more details see Dr. Cohen's article, "Adopting an HIV/AIDS Program: Tried and True or Tried and Tired", published in the Technical Assistance Newsletter of the National Minority AIDS Council, 1997.

Table 5 Potential HIV Prevention Interventions

Public Advocacy & Risk Awareness			
Target Group	**Intervention Type – Findings**	**Model Program**	**Implementation Considerations**
General public (Personal risk assessment)	• Recently the CDC has recommended that general population campaigns are not efficient in having at-risk persons self-identify.	Not applicable (NA)	NA
General public advocacy	• In conjunction with other interventions, public campaigns can have an impact on raising community awareness.	Public Information Campaign: ***AIDS: It Ain't Over Yet*** Extracted from the "HIV Prevention & Outreach Strategies" The United States Conference of Mayors Best Practices, June 2001.	The campaign, entitled "AIDS: It Ain't Over Yet," was a collaborative effort among the Boston Public Health Commission, AIDS Action Committee and Better World Advertising, and was designed to counter the impression that the AIDS epidemic was over or that HIV was a treatable disease. The advertising campaigns featured photographs of members of target population groups, including gay men, transgenders, teens, young women, and Intravenous Drug Users (IDUs). The prevention messages included abstinence, condom use, and not sharing works. These images were placed on billboards, posters - including subway posters, buttons, postcards, and cards for public rest rooms.
Politicians and policy makers	• Although no programs were reviewed in the evidenced based documents, the efficacy of educating and involving politicians and policy makers is known to be effective.	NA	NA

High-Risk Populations			
Target Group	**Intervention Type – Findings**	**Model Program**	**Implementation Considerations**
Heterosexuals	• Small group interventions are more effective than individual level interventions. • While these intervention tend to reach more women than men, interventions are not generally separated by gender.	Community PROMISE: Peers Reaching Out and Modeling Intervention Strategies for HIV/AIDS Risk Reduction in their Community (#2 - refers to Attachment 4 references)	Community PROMISE is a community-level intervention to promote progress toward consistent HIV prevention through community mobilization and distribution of small-media materials and risk reduction supplies, such as condoms and bleach. The program is derived from the AIDS Community Demonstration Projects. The program is based on several behavioral theories, including the Transtheoretical Model of Behavior Change, the Theory of Reasoned Action, and Social Cognitive Theory.
MSM	• Individual, group, and community level interventions are similarly effective. • Interpersonal skills include sexual negotiation, disclosure, and communication. Interpersonal skills training is more effective in reducing risk than other types of skills building or self-esteem enhancement. • Sustained training and interventions are more effective than 1-time trainings.	The Mpowerment Project: A Community-Level HIV Prevention Intervention for Young Gay Men (#4)	The Mpowerment Project is a community-building program designed to reduce the frequency of unprotected anal intercourse among young gay and bisexual men. Developed through an intensive social marketing process with young gay men, the Mpowerment Project is based on an empowerment model in which young gay men take charge of the project. The project draws on the theory of diffusion of innovations. The Mpowerment Project is run by a "core group" of 10-15 young gay men from the community and paid staff. The young gay men from the core group, along with other volunteers, design and carry out all project activities.
Substance Users – IDUs	• Most interventions that were reviewed were individual level interventions.	Informational and Enhanced AIDS Education (#2)	The goal of the intervention is to determine the effects of small group Informational and Enhanced Education interventions on drug- and sex-related HIV risk behaviors.

High-Risk Populations			
Target Group	**Intervention Type – Findings**	**Model Program**	**Implementation Considerations**
Substance Users – IDUs	• In general, interventions with drug users were effective in reducing sexual risk behaviors.	CDC AIDS Community Demonstration Projects Research Group (2)	This community-level intervention was based on the Transtheoretical Model of Behavior Change (stages of change theory). The intervention aimed to modify attitudes and beliefs about prevention methods among the community members by providing models of successful risk-reduction strategies adopted by members of the target population. The intervention took place over 3 years in Dallas, Denver, Long Beach, New York City, and Seattle. Volunteers from each target community were trained to carry out the intervention, drawing attention to and reinforcing identification with and acceptance of the intervention messages.
Women	• More effective interventions need to be developed for women.	Real AIDS Prevention Project (RAPP): A Community-Level HIV Prevention Intervention for Inner-City Women (#5)	RAPP is a community mobilization program designed to reduce risk for HIV and unintended pregnancy among women in high-risk communities by increasing condom use. The program is based on the multi-site HIV Prevention in Women and Infants Demonstration Project. RAPP is based on the Transtheoretical Model of Behavior Change. The program also is supported by theories of social learning and diffusion of innovations.
Youth	• Higher effectiveness in risk reduction was observed among groups in which all participants were of the same Race/Ethnicity.	Street Smart : Reducing HIV Risk Among Runaway and Homeless Youths (#8)	Street Smart is a multi-session, skills-building program designed to help groups of runaway and homeless youth reduce unprotected sex, number of sex partners, and substance use. The program is based on social learning theory.

High-Risk Populations			
Target Group	**Intervention Type – Findings**	**Model Program**	**Implementation Considerations**
Youth		BE Proud! Be Responsible! (#2)	The intervention consisted of one 5-hour session held on a Saturday morning in a local school in Philadelphia, Pennsylvania. The session was led by African-American men and women with backgrounds in human sexuality education, nursing, social work, and small group facilitation. The intervention included information about risks associated with injection drug use and specific sexual activities. The intervention used videos, games, exercises, and other culturally and developmentally appropriate materials to reinforce learning and to encourage active participation.
Blacks	• Interventions should be culturally appropriate; include multiple sessions; and include skills training.	VOICES/VOCES: Video Opportunities for Innovative Condom Education and Safer Sex (#7)	VOICES/VOCES is a single-session, video-based HIV/STD prevention program designed to encourage condom use and improve condom negotiation skills. The program is based on the theory of reasoned action. VOICES/ VOCES is grounded in extensive formative research exploring the culture- and gender-based factors that can facilitate behavior change. An evaluation of the intervention showed that VOICES/VOCES is effective when delivered at a "teachable moment," for instance when a visit to an STD clinic may motivate a person to change behavior.
Blacks		A Randomized Controlled Trial of an HIV Sexual Risk-reduction Intervention for Young African-American Women (#2)	Social Cognitive Theory and theories of gender and power were used as models to guide the development of this social skills intervention. The intervention consisted of five weekly 2-hour group sessions led by trained African-American peer educators in the Bayview-Hunter's Point community of San Francisco, California. Each session had a specific topic and planned activities for modeling and assessing

High-Risk Populations			
Target Group	**Intervention Type – Findings**	**Model Program**	**Implementation Considerations**
Hispanics	• Interventions should be culturally appropriate; include multiple sessions; and include skills training.	VOICES/VOCES: Video* Opportunities for Innovative Condom Education and Safer Sex (#7)	See above.

HIV Negative Individuals			
Target Group	**Intervention Type – Findings**	**Model Program**	**Implementation Considerations**
Heterosexuals and Communities of Color		Project RESPECTS (#2)	The Enhanced and Brief Counseling interventions were based on the Theory of Reasoned Action and Social Cognitive Theory. Sessions were interactive and designed to change factors that could facilitate condom use, such as self-efficacy, attitudes, and perceived norms. The study was conducted in Baltimore, Denver, Long Beach, Newark, and San Francisco. Health department staff, trained to conduct HIV counseling, delivered the intervention. The Enhanced Counseling intervention consisted of 4 sessions, a total of 200 minutes, and was completed in 3-4 weeks.

HIV Positive Individuals			
Target Group	**Intervention Type – Findings**	**Model Program**	**Implementation Considerations**
	• There are several jurisdictions that are conducting their own intervention for Positives. However, there are very few published interventions or articles evaluating the efficacy of the programs.	"HIV Stops With Me Prevention for Positives Demonstration Project" (#6)	The demonstration project, known as HIV Stops With Me, combines multiple strategies to help HIV positive persons in San Francisco gain and use the skills necessary to prevent new HIV transmissions. These strategies include: media efforts, support groups, social events, community forums, provider training and outreach.
			The AIDS Policy Research Center, Center for AIDS Prevention Studies, and UCSF AIDS Reach Institute have produced a report on "Designing Effective Programs for People Living with HIV." See: **http://ari.ucsf.edu/pdf/PrimaryPrevention.pdf**

HIV Positive Individuals			
Target Group	**Intervention Type – Findings**	**Model Program**	**Implementation Considerations**
Women (partners of substance users)		15-month Follow-up of Women Methadone Patients Taught Skills to Reduce Heterosexual HIV Transmission (#2)	The goal of the intervention is to determine the effects of a small group intervention to reduce sexual risk behavior and HIV transmission by increasing AIDS knowledge, sexual negotiation skills, and safer sex practices. Women who participated in the intervention significantly increased frequency of condom use with their partners compared with women in the comparison condition.

Partners			
Target Group	**Intervention Type – Findings**	**Model Program**	**Implementation Considerations**
	None reviewed for scientifically based efficacy.		

Barriers

This section discusses barriers reported by the providers who completed the provider information form. Providers were asked to identify barriers and rate the severity of the barriers the general community experiences in seeking prevention services (see question Section II in Provider Information Form, Attachment 1). A barrier is considered something that prevents the service provider from delivering a prevention service. Twenty-seven out of 34 service providers responded to the barrier section of the provider information form and identified barriers that prevented their clients from obtaining services.

Table 6 lists the barriers and rates the magnitude of their effects on prevention service delivery. The first column presents the number of providers who indicated the barrier is a problem. Column two lists the percentage of providers who experience the barrier as having an effect on their ability to deliver prevention services. The third column indicates the degree to which each barrier the provider perceived is having an effect on HIV prevention activities in Westchester County.

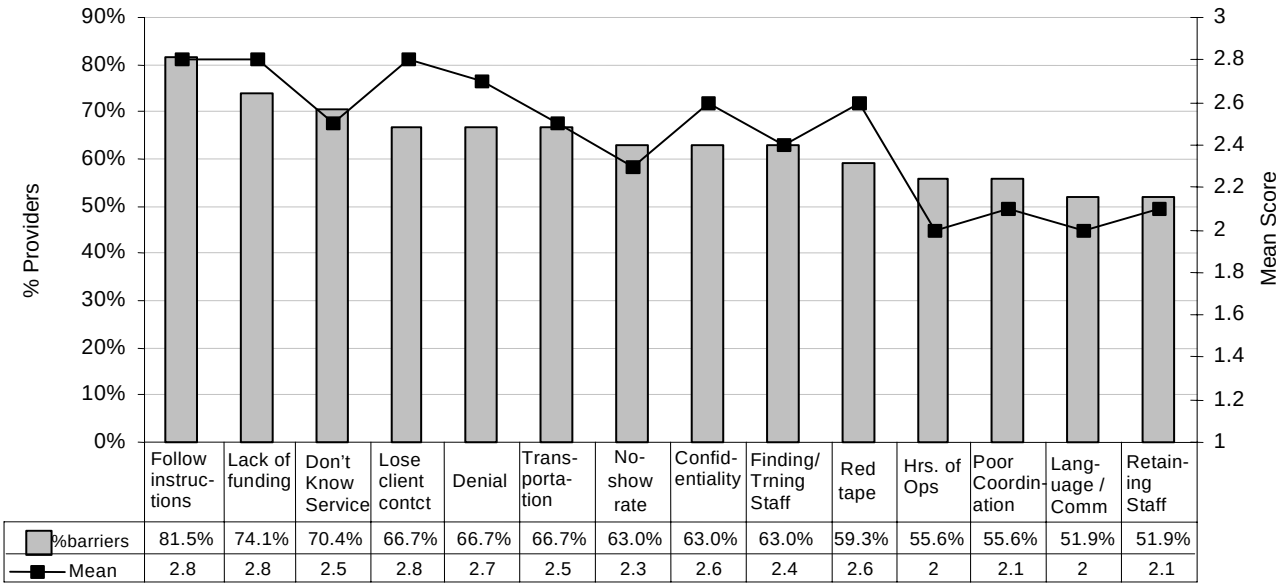
Table 6 Provider Barriers to Prevention

Barriers to Prevention	# Reporting Problem (N=27)	% Reporting Problem	Average Barrier Score*
Consumers inability to follow instructions	22	81.5%	2.8
Lack of funding for the service	20	74.1%	2.8
Consumers do not know what services are available	19	70.4%	2.5
Loss of contact with client	18	66.7%	2.8
Consumer's denial	18	66.7%	2.7
Lack of transportation to service sites	18	66.7%	2.5
High no-show rate	17	63.0%	2.3
Clients' fear of loss of confidentiality	17	63.0%	2.6
Difficulty finding/training qualified staff, volunteers, subcontractors	17	63.0%	2.4
Red tape	16	59.3%	2.6
Hours of operation	15	55.6%	2.0
Poor coordination among organizations/programs	15	55.6%	2.1
Not being able to communicate in consumer's language	14	51.9%	2.0
Difficulty retaining qualified staff, volunteers, subcontractors	14	51.9%	2.1
Clients' health	13	48.1%	2.0
Location or physical limitations of the building	13	48.1%	1.9
No childcare available for the service	12	44.4%	2.4
Organizational issues or infrastructure development	12	44.4%	2.0
Long waiting list for services (ie high demand)	11	40.7%	1.8
Cultural diversity issues	10	37.0%	1.7
Cost of service to consumer (ie insufficient insurance coverage)	8	29.6%	1.6
Rules and regulations regarding HIV reporting	7	25.9%	1.5
Not knowing where to refer a client for another service	6	22.2%	1.4

** Average mean scores: 1=No Barrier 2=Small Barrier 3=Moderate Barrier 4=Big Barrier*

Figure 26 compares the percent of agencies who indicated that the barrier affects their program and the degree to which the barrier interferes with HIV prevention service delivery. The gray bar in Figure 26 illustrates the percentage of providers who indicated the barrier to be a problem (barriers wherein greater than 50% of the providers listed it as a problem are presented in the figure). The black line indicates the relative impact that the barrier is having on the delivery of services. All the barriers fall between a moderate barrier, "3", and a small barrier, "2".

Figure 26 Barriers for Providers



	Follow instruc-tions	Lack of funding	Don't Know Service	Lose client contct	Denial	Trans-porta-tion	No-show rate	Confid-entiality	Finding/ Trning Staff	Red tape	Hrs. of Ops	Poor Coordin-ation	Lang-uage / Comm	Retain-ing Staff
%barriers	81.5%	74.1%	70.4%	66.7%	66.7%	66.7%	63.0%	63.0%	63.0%	59.3%	55.6%	55.6%	51.9%	51.9%
Mean	2.8	2.8	2.5	2.8	2.7	2.5	2.3	2.6	2.4	2.6	2	2.1	2	2.1

Barrier Summary

Among the top ten barriers noted as problems by providers, five were related to consumer problems. Over 80% of the providers said that consumers did not have the ability to follow instructions. Seventy percent (70%) reported that consumers did not know the services offered, and 66% said consumers were in a state of denial, and about the same percent reported that consumer fear about being identified was a barrier.

Providers interviewed on the phone further explained their rationale for these barriers. Several noted that the diversity of consumers, their inability to understand the information presented, and their different cultural prospective on HIV, AIDS, and illness made providing prevention services in group setting difficult.

Providers added that awareness of services tended to be low, particularly among those who recently tested positive. They noted a general inability of newly infected to find their way through a referral system or travel to locations where services were offered. Providers said they tried their best to inform the population of services available to them, either through literature, television, the Internet, or through street task forces. Yet most felt the majority of the public remained unaware of available prevention services. Most providers felt that there could never be too much outreach to the community. They felt the community continued to need to be informed and educated about prevention and available services.

To address the issue pertaining to consumers' ability to follow instructions, providers report they are taking time to teach consumers about the "system" through one-on-one counseling where staff explain processes to getting service when necessary. At selected agencies, staff often accompany clients through the system or to appointments if the procedure is too complicated for them. In general, providers say they try to simplify things as much as possible.

Added to these top barriers, providers noted that many of the people coming to their agencies seem to be in denial about the risks of contracting HIV, the importance of testing, and the need for treatment services. Some providers connected this denial with stigma about HIV and refusal by people to admit that they could be "the type of person" that would be infected. Providers noted that many people are still concerned about their privacy despite reassurances of confidentiality from providers.

Over half the providers said that a barrier to providing prevention services was that consumers did not keep appointments. The high level of "no-shows" is significant, providers said, when they were trying to maintain contact with people following testing as well as with newly diagnosed individuals. The lack of ability to keep appointments was attributed to several reasons, including lack of transportation and childcare, as well as denial of their infection and/or physical health. One provider suggested in the interview that no-show rates are not indicative of a lack of demand for service, instead it's an organizational barrier that they are trying to address by opening up a drop-in center to service clients who cannot make their appointments or prefer to drop in as a way of protecting their confidentiality. Notably, 55% of the provider noted that the hours of operation of the agencies was a barrier, but they did not rank it as a particularly high one.

Three of the top fifteen barriers were organizational. While the majority of top barriers were centered on the consumer, two of the top barriers were based on the system of care. The second most frequent barrier noted by providers was a lack of funding. Over 60% of the providers noted that as a result of limited and competing funding, they often could not offer competitive salaries to hire new staff. In addition over half of the providers noted that they had a difficult time retaining experienced workers, and that was, in part, due to a low salary scale.

Another barrier noted by a relatively large number of providers was red tape that consumers had to work through to obtain services. About 60% of the providers reported red tape and said that City, State and/or County requirements changed every year and agencies had to comply. In addition to adding to consumer burden, more paperwork translated into more work for staff, taking away time from providing actual services to the consumer.

Access to care was also mentioned as significant structural barriers by providers. Over two-thirds said that they felt that lack of access to transportation was a big barrier for consumers.

They added that Westchester County is geographically diverse with limited public transportation for those seeking HIV prevention services. Providers report that demand for

transportation services exceeds their capacity to provide it, and lack of funding limited the amount of services they could deliver. In addition, services that clients needed, such as childcare and transportation, had to be cut in recent years due to discontinued funding. Some providers say they have sought out funding sources for transportation and childcare without success. Some agencies do provide transportation but there is high unmet demand.

About 56% of the providers said that poor coordination between prevention services and losing contact with clients created a barrier for consumers who wish to maintain services. To avoid losing contact with clients and to better coordinate services several providers have improved their tracking systems and tried to obtain additional tracking information from consumers. Selected agencies reported that their staff will follow-up by seeking out clients who have moved or cannot come in for services in person due to physical health.

WESTCHESTER PREVENTION GAP ANALYSIS

There are several gaps that might be measured in a gap analysis.

First, there is the gap between needed services and those provided. This requires a documented and agreed upon need and the knowledge of how well the current and projected need is met. Usually needs are determined for different populations.

Based on the epidemiology, provider information forms, the literature review, and input from the project advisory group, Table 7 reflects PCH's synthesis regarding high risk for HIV infection. Those with a high risk have the highest need for services in the CPS.

Table 7 Priority Target Groups*
(H=high, M=medium, L=low ?=not sufficient information

Race/Ethnicity ***Risk Group***	**General Pop**	**White**	**Black**	**Hispanic**
MSM	M	M	**H**	M
Young gay men	**H**	**H**	**H**	**H**
IDU	M	M	**H**	M
Het / Bisexual	M	L	**H**	M

Special Populations	
Adolescents sexually active / drug users	M
Seniors	L
Mentally Ill	?
Inmates	**H**
Homeless	M
Women	M
Commercial sex workers (CSW)	?
Immigrants/Migrants	?

*The ratings in this Table are based on an assessment of available information by PCH.

The perceived prevention needs of providers and consumers are a second source of input into a gap analysis. Although no representative quantitative data has been collected, the recent Regional Gap Analysis conducted by the Urban League of Westchester, Inc. for the AIDS Institute in February 2003 reports on the perceived needs for providers and consumer who attended group sessions and workshops. The key populations that should to be addressed include IDUs, immigrants and migrants, women, MSM, men of color, and adolescents. Subpopulations and their needs as determined by the participants in the Gap Analysis process are shown in Table .

Table 8 Lower Hudson Region Prevention Gap Analysis Recommendations*

1.	**IDU**
	1.1. Commercial Sex Worker
1.1.1.	Peer-based education and outreach at STD clinics
1.1.2.	Counseling and testing
1.1.3.	Referral to drug treatment
	1.2. Immigrants/Migrants
1.2.1.	Mental health and substance abuse counseling
1.2.2.	Culturally and language specific education and outreach
1.2.3.	Peer programs delivered through mobile vans at work sites
	1.3. Women
1.3.1.	Family-based drug treatment
1.3.2.	Counseling and testing and partner notification
1.3.3.	Skills building/skills acquisition counseling
2.	**MSM**
	2.1. Young MSM
2.1.1.	Community outreach at shopping malls, STD clinics, barber shops
2.1.2.	School-based prevention and education, including condom distribution particularly at alternative schools
2.1.3.	Teen specific internet sites
	2.2. MSM/Substance Abusers (non IDU)
2.2.1.	Targeted outreach at bars, clubs and meeting places
2.2.2.	Print/radio/television campaign in Spanish soap operas, radio
2.2.3.	Media campaign in magazines, gyms, billboards
	2.3. Non gay identified MSM
2.3.1.	Media campaign on billboards, rest stops, Metro North stations
2.3.2.	Internet outreach on chat rooms
2.3.3.	Education campaign
2.3.4.	Targeted outreach at rest stops, bathrooms, and meeting places
3.	**Women of Color of Child Bearing Age**
3.1.1.	Peer-based community outreach expanded at prenatal centers and child care
3.1.2.	Family-based drug treatment at detox facilities
3.1.3.	Prevention case management at CBOs and expand at medical facilities and mental health programs
3.1.4.	Skills building
4.	**Men of Color**
4.1.1.	Community outreach parks (soccer games), bars and at CBOs
4.1.2.	Needle exchange expanded
4.1.3.	Skills building counseling expansion at residential facilities and through criminal justice system
5.	**Adolescents**
5.1.1.	Peer programs with targeted outreach at malls and on the street, expand at schools
5.1.2.	Skills acquisition building expansion at youth centers and residential treatment and shelters
5.1.3.	Referrals for substance abuse treatment through the courts, schools, and CBOs

*Information from the Regional Gap Analysis conducted by the Urban League of Westchester, Inc. for the AIDS Institute

In addition the Gap Analysis identified provider services that were under- or un-met. They are listed in Table 9.

Table 9 Provider Prevention Needs - Gap Analysis*

Unmet Needs
Review prevention messages
Co-location of psychiatric/mental health staff at CBOs
Reduced documentation
Expanded hours of services
Under Met Needs
Better coordination and linkages
PLWA advocacy
More funding
Transportation
Mobile vans
Better salaries and benefits to improve staff retention
Consumer involvement

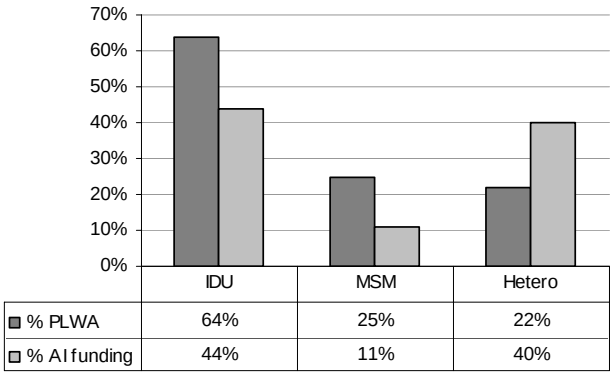
*Information from the Regional Gap Analysis conducted by the Urban League of Westchester, Inc. for the AIDS Institute

The Gap Analysis also noted the need to expand prevention services to include community efforts to break down institutional barriers like poverty, racism, homophobia, and stigmatization which directly impact the effectiveness of different services and interventions.

A third factor is determining the resources allocation. The AIDS Institute (AI) is the main funder for prevention activities and the distribution of their funds is discussed below. There is, however, a need for a more complete resource directory that includes funding in the future.

As noted in the 2003 Gap Analysis, in 2002 about 95% ($2.4 million) of all AI prevention funds allocated to the Lower Hudson region is used for the provision of services to high-risk individuals. Figure 27 shows how these are distributed to the different risk groups, and suggests that prevention funding does not follow the epidemiology of the epidemic. Heterosexuals receive a disproportionate amount of the AI prevention funding, while the proportion of funding for IDUs and MSM falls below their estimated incidence of living with AIDS.

Figure 27 Funding of Prevention Services - Lower Hudson Region*



	IDU	MSM	Hetero
% PLWA	64%	25%	22%
% AI funding	44%	11%	40%

*Information from the Regional Gap Analysis conducted by the Urban League of Westchester, Inc. for the AIDS Institute

It would be useful to determine the amount of resources that go to each of the prevention services in the CPS and the number of units of each service it provides, but obtaining and analyzing those data is beyond the scope of this project.

A final input into the gap analysis is the capacity of the system. This was obtained by the provider information form discussed earlier in this report. Using the CPS as reference, a summary for each track is noted in Table 10.

Table 10 Summary of the Most Frequent Prevention Programs

Public Advocacy and Risk Awareness
Group session
PSAs
Educational training
Newsletters
High-Risk Populations
HERR
Condom distribution
HIV testing
HIV negative
One-on-one counseling
Skill building
HIV positive
Counseling
Monitoring HIV status
Support groups
Safer sex workshops
Partners
No largely diffused program. Three for partner agreements
Provider and Grantee
Training workshops
Consumer satisfaction tracking
Program monitoring
Needs assessments

For all programs, the areas where services are most available are Mt Vernon, New Rochelle, White Plains, and Yonkers.

Common Themes

Certain common themes and needs that help pinpoint those services that have the largest gaps have been identified from the epidemiological data, provider information forms, gap analysis, and best practices review. Using the CPS as a referent, they are:

<u>Public Advocacy and Risk Awareness</u>

1. Targeted education programs and advocacy to politicians, policy makers, private business, and community leaders at the municipal and state level are needed to assure continued

funding for HIV prevention. With the new CDC directives and funding for Ryan White, Westchester County should assure that it receives its fair share of the existing funds, and identifies new sources of funding.

2. There is an identified gap in mobilizing the black and Hispanic communities to raise awareness of HIV and AIDS and change sexual and drug use norms. This might be done by eliciting greater involvement from faith-based organizations who could help congregants understand HIV and AIDS and engage in an accurate assessment of their own risk and seek HIV testing.
3. The barrier to expanded programs is as much political as financial. There is a gap between the existing public understanding and support of harm reduction programs, including needle exchange, and the level necessary to support expanded programs.
4. As noted by participants in the Gap Analysis, reasons for the lack of testing and avoidance of services, particularly in communities of color, are the stigmatization and homophobia that surround AIDS, and the fear of discrimination both from within the community and from providers. These are major barriers that continue to hinder those at risk from identifying themselves and, for those infected, receiving support from their families and community. General support of social programs directed toward reducing homophobia, stigmatization, and discrimination need additional support. The gap analysis noted that venues such as supermarket, hair salons, flea markets, block councils, and other public venues could be mobilized, and they are ideal candidates for these types of programs.

<u>High-Risk Populations</u>

5. There is a large gap in programs specifically designed to increase testing among high-risk populations, particularly in the black and Hispanic communities. The gap between estimated and recorded PLWH is large, while the utilization of testing among communities of color is relatively low. Programs to encourage testing and follow-up counseling for prevention are needed. Once HIV status is determined, there must be flawless interface with small group and interactive programs directed at those with high-risk behaviors.
6. There is a gap in recording the risk group of tested populations. The great increase in the number of persons for whom there is no risk group suggests that testing staff could improve the way they identify the risk factor for those testing.
7. There is a gap in the increase in seroprevalence among young MSM and the availability of funding for targeted programs. Effective programs must be expanded and new programs implemented that target young gay men of all ethnicities. As recommended in the Gap Analysis, young MSM must be approached where they congregate with condoms and HIV and STD testing. Testing should be easy with confidential and rapid results (rapid testing).
8. A gap exists in the perception that the HIV epidemic affects primarily MSM and IDU communities and the reality that Westchester County is on the cusp of becoming a heterosexual epidemic in the black community. Outreach and targeted prevention to high-risk women, including CSWs, in STD clinics, neonatal and perinatal clinics, on the street, and in drug program must be a priority. Testing must be easily available and counseling sensitive to their needs. As discussed by a physician's assistant at one of the local health

centers, routine testing as part of general health check-ups are well over due and can greatly help reduce the stigma associated with testing.

9. Although the proportion of IDUs living with HIV is decreasing, they continue to be the largest number of PLWH/A in Westchester. HIV/STD testing should be available at places where IDUs congregate. Hepatitis C is likely to have a high incidence. Treatment of STDs should include HIV prevention. Recommending and tracking referrals to treatment facilities with strong HIV prevention programs should be a priority. Expanded needle exchange and working with pharmacies have proven to be effective prevention measures.
10. While it is not known if such a problem exists in Westchester, one of the highest risk groups emerging in NYC is likely to be MSM who use "party drugs" such as poppers, GHB, ecstasy, and crystal meth. Working with party organizers to reduce tolerance for drugs, increasing enforcement activities for illegal drug use, raising awareness, and encouraging communication about prevention practices may be effective strategies.
11. There appears to be a gap in programs that bridge prevention in jails and prisons and prevention for the recently released. Recently released are among the most vulnerable populations. While programs among the incarcerated are effective in Westchester County, an effort should be made to enroll recently released into effective support groups, and working with parole and other correctional system officials.
12. There appears to be a need to promote programs at neonatal clinics for women at risk, particularly for women of color. Women at risk who have or want to have children can be reached at these clinics and birthing programs. Skill building for safer sex after birth could be incorporated into these programs. There should be literature, counseling, and support groups that complement neonatal and perinatal care.

<u>Those Who Know Their HIV Status</u>

HIV negative

13. As indicated above there is a gap between the need and the utilization of testing in communities of color. To increase identification of positive individuals, providers can offer a routine scheduling of re-testing.
14. For those who test negative with repeated STDs, clinicians can provide more intensive HIV prevention information and enroll individuals in skills building and support groups. Prevention case management can be part of HIV and STD control.

HIV positive

15. While there is prevention information available at medical providers, and many interventions are available for negative and positive persons, there are few specific programs offered for only positive persons. There are several prevention-for-positive protocols developed by other geographic areas and the CDC that could be implemented to address this gap.

Partners

16. There are very few programs that include partners and target the interaction between sexual and needle sharing partners. This is particularly important for discordant couples or those

who have multiple partners. Strategies and partner sessions can be established that have partners commit to safer behaviors. Heterosexual partners should be among the target populations. There is evidence that a request by one partner to engage in safer sexual or drug use behavior results in the much more likely practice of safer sex or drug use. There is gap between the need to focus on interactive communication strategies and the availability of programs with that objective.

Provider Training

17. Provider training available at no or low cost is available from various sources in the State and New York City, and recently, by the TA provider in Westchester. Schedules of trainings in the region could be developed and management at the CBOs and contract monitors could encourage participation.
18. Providers have an opportunity to request technical assistance and clear information can be disseminated on how to access and use TA.

Program Assessment and Evaluation

19. There is a gap between desired analysis of prevention programs and available data. A program of continuous data collection should be developed that utilizes existing databases and monitoring information, plus standard tools for needs assessments and client satisfaction.

SUMMARY AND CONCLUSIONS

This Prevention Needs Assessment starts with a new conceptual framework, the Continuum of Prevention Services (CPS), that suggests a framework for planning and implementing prevention activities. Although behavioral risk groups are a key component of the CPS, it is outcome-based and organized by the six populations receiving different sets of services: 1) the general public, 2) high-risk populations, 3) individuals who know they are HIV negative, 4) individuals who know they are HIV positive, 5) sexual partners – both same HIV status and different HIV status, and 6) service providers, grantees and administrators of HIV services. Throughout the report the CPS is used as a referent for assessing and recommending prevention services.

To date there is no agreed upon and reliable estimate of PLWH for Westchester County. While there are probably about 4,500 PLWH/A, it would be useful for policy makers to agree upon a methodology and estimate that can be used for public information. Westchester County Department of Health should continue working with the New York State Department of Health to obtain routine HIV/AIDS case reports.

Epidemiology

While details of the epidemiology trends are presented in the body of needs assessment, overall, the findings below summarize critical findings:

1. As is the case across many other counties in New York State, Westchester's epidemic continues to disproportionately affect communities of color. While non-Hispanic blacks comprise 13.6% of the County's population,[7] they account for 49.4% of cumulative AIDS cases and 52.4% of those presumed to be living with AIDS.
2. Hispanics are probably the most undercounted HIV population, but still disproportionately represented in the epidemic compared to their proportion in the population. Hispanics represent 15.6% of the County's residents and 20.2% of persons presumed living with AIDS.
3. The HIV and AIDS epidemic in Westchester County is majority IDU, but moving consistently toward becoming a heterosexual epidemic, particularly in the black population.
4. While women account for 26.6% of all reported county AIDS cases, the rate of newly diagnosed AIDS cases among women has been on the rise. In 1985 the percent of new cases among women was 16.9%; in 1990 it increased to 21.1%; and in 1995 it further grew to 26.5%. Women represent 32% of those presumed to be living with AIDS in Westchester.
5. Young gay men are at an increased risk of becoming HIV positive.
6. STD rates, particularly in the black community, are increasing, and these STD patterns send a clear warning that HIV rates are very likely to increase among blacks.

[7] The 2000 U.S. Census is the source for all population figures cited.

A Resource of Prevention Activities

With a response rate of 61% among all providers sent a provider information form, and 85% among those most likely to be providing prevention services, the provider information form did not present a full picture of HIV prevention services in Westchester County. In addition the information form did not attempt to quantify the units of services delivered or estimate the costs of services.

Still, the provider information forms do present a beginning to the collection of provider information that corresponds to the Continuum of Prevention Services. This report develops templates for prevention activities that can be updated regularly as information becomes more complete.

In efforts to obtain reliable information on the provider forms, the process demonstrated that prevention providers have no agreed upon or comprehensive view of the goals. If the CPS could become a more general referent it would be helpful in creating a common view of prevention. Further, providers have difficulty reporting specific prevention activities and don't have numbers served by risk group, gender, or race/ethnicity. Clearly their ability to measure and report utilization is limited and, by inference, their ability to measure effectiveness is limited. This suggests that a client tracking system has to be adopted that tracks prevention as well as care activities.

The responses from the 34 providers is the beginning of cataloging the prevention activities in Westchester County. It demonstrates that most major areas of prevention have some programs, and suggests that they are most available in areas of highest HIV incidence.

From the perspective of monitoring programs, the success or failure of specific preventions based on the data collected is unknown. Until assessment of the effectiveness of the programs is done and they are linked to outcomes (and there is unlikely to be the kind of resources available for those kinds of studies), the best that can be expected is more systematic monitoring of programs and an agreed upon approach, based on evidence-based program evaluation, that is executed.

Evidence Based Programs

The evidence-based review was comprehensive and suggestions are made for programs that can be adopted for residents of Westchester County. Many are individual, group and community-based and are based on behavioral theories. Because those programs identified as evidence-based require empirical evidence that programs are effective, it is limited. Many effective programs have not been assessed. There is a dearth of assessment of programs targeting structural and organizational change, and these should be considered outside of the evidence-based review.

Recommendations from the review suggest:

- Adoption of a public campaign that emphasizes the growing number of PLWH/A. "AIDS: It Ain't Over Yet".
- For the growing number of heterosexuals at risk for and living with HIV and AIDS, small group activities combined with individual level intervention have proved effective. Key to their success is the distribution of condoms and bleach kits necessary to adopt recommended prevention behaviors.
- For young gay men, empowerment programs have proved effective where opinion leaders are identified to diffuse prevention strategies.
- For drug users, effective programs are built upon having drug users prepared to accept and adopt behaviors. For active drug users this is likely to involve risk reduction and increasing the importance of HIV prevention in their lives. Prevention information that is relevant to individuals in treatment and counseling are likely to be more effective than general AIDS 101 information.
- Needle exchange has been shown to be effective.
- Women living with HIV and AIDS tend to be more isolated than men living with HIV and AIDS. Activities that bring them together and provide social support are likely to be effective.
- Youth are particularly effected by peer norms and peer pressure. Efforts to make HIV prevention the accepted norm may help in its adoption.
- The magnitude of the epidemic in the black Community must be brought to the attention of community and church leader and diffused throughout the population. Increasing the involvement of Blacks living with HIV and AIDS and increasing the visibility of the epidemic in the community may have a positive impact.
- When partners can be brought together to discuss and commit to prevention behavior, there is an excellent change that they will be adopted.

Some common themes include:

- Knowledge is not the final objective. Because you know about safer behaviors doesn't mean you adopt them.
- Peer models and role models are effective tools.

- Addressing the needs of the populations and designing programs to meet them is more effective than developing program objectives in isolation.
- Participant involvement is better than lectures.
- Programs must be culturally appropriate.
- Target interventions to specific populations with common interests.
- Sustained involvement is more effective than single sessions.
- Interactive small group can be as effective or more effective than 1-1.
- Skills building and role playing are effective tools.
- The effectiveness of expert or peer led programs depend on the audience and subject. Peers often need extensive training.

Gap Analysis

The gap analysis uses all the available information to identify and recommend programs to fill gaps. It integrates information from the recent Lower Hudson Valley Gap Analysis and information collected in this needs assessment. It demonstrates how the CPS can be used to guide discussions. Like the best practices review, this gap analysis is part of an ongoing process where community participation can garner consensus about important gaps, and programs to fill those gaps can be prioritized. Below are some observations with recommended actions.

General population

Gap	**Action**
A gap exists between needed funds and existing funds.	Targeted education and advocacy to politicians, policy makers, private businesses, and community leaders are needed to assure continued funding for HIV prevention.
A gap exists in mobilizing the Black and Hispanic communities.	Greater involvement from faith-based organizations who could help congregants understand HIV and AIDS and engage in an accurate assessment of their own risk and seek HIV testing is needed.
A gap exists between the existing public understanding and support of harm reduction programs, including needle exchange.	There should be greater public information about the efficacy of needle exchange and risk reduction.
Stigmatization and homophobia that surrounds AIDS continues to be a significant barrier.	Additional support for programs directed toward reducing homophobia, stigmatization, and discrimination is needed.

High Risk Populations

Gap	Action
The gap between estimated and recorded PLWH is large yet utilization of testing among communities of color is relatively low.	Programs specifically designed to increase testing among high-risk populations, particularly in the Black and Hispanic communities are needed.
There is a gap in the increase in seroprevalence among young MSM and the availability of funding for targeted programs.	Effective programs must be expanded and new programs implemented that target young gay men of all ethnicities.
A gap exists in the perception that the HIV epidemic affects primarily MSM and IDU communities. Yet, Westchester County is on the cusp of becoming a heterosexual epidemic in the Black Community.	Outreach and targeted prevention to high-risk women must be a priority.
Although the proportion of IDUs living with HIV is decreasing, they continue to be the largest number of PLWH/A in Westchester.	HIV/STD testing should be available at places where IDUs congregate and linked to Hepatitis C treatment. Referral to treatment facilities with strong HIV prevention programs should be a priority. Expanded needle exchange and working with pharmacies have proven to be effective prevention measures in other communities.
One of the highest risk groups is likely to be MSM who use “party drugs” such as poppers, GHB, ecstasy, and crystal meth.	Working with party organizers to reduce tolerance for drugs, increasing enforcement activities for illegal drug use, raising awareness, and encouraging communication about prevention practices may be effective strategies.
There appears to be a gap in programs that bridge prevention in jails and prisons and prevention for the recently released. Recently released are among the most vulnerable populations.	While programs among the incarcerated are effective in Westchester County, an effort should be made to enroll recently released into effective support groups, and working with parole and other correctional system officials.
While heterosexual programs are funded in disproportionate amounts relative to the seroprevalence among heterosexuals, there appears to be a need to promote programs at neonatal clinics for women at risk, particularly for women of color.	Enhanced programs for women at risk who have or want to have children including skills building for safer sex after birth. There should be literature, counseling, and support groups that complement neonatal and perinatal care.

HIV Negative

Gap	Action
For HIV negative, there is a gap between the need and the utilization of re-testing in communities of color.	To increase identification of positive individuals, providers can offer a routine scheduling of re-testing.
	For those who test negative with repeated STDs, clinicians can provide more intensive HIV prevention information and enroll individuals in skills building and support groups.
	Prevention case management can be part of HIV and STD control.

HIV Positive

Gap	Action
While PLWH/A receive prevention information, there is a gap in the existence and adoption of specific protocols for prevention-for-positives.	Evaluate and adopt specific programs for prevention-for-positives.

Partners

Gap	Action
A gap exists between the need to focus on interactive communication strategies and availability of programs with that objective. There is evidence that a request by one partner to engage in safer sexual or drug use behavior results in the much more likely practice of safer sex.	Initiate programs that include partners and target the interaction between sexual and needle sharing partners. This is particularly important for discordant couples or those who have multiple partners.
	Strategies and partner sessions can be established that have partners commit to safer behaviors.
	Heterosexual partners should be among the target populations.

Providers

Gap	Action
A gap exists between the availability of TA and utilization. Provider training available at no or low cost are available from various sources in the State and New York City, and recently, by the TA provider in Westchester.	Schedules of trainings in the region could be developed and management at the CBOs and contract monitors could encourage participation.
	Providers have an opportunity to request technical assistance and clear information can be disseminated on how to access and use TA.

This Needs Assessment fills a significant gap in information about prevention needs, gaps, and resources in Westchester County. However, this project has identified a lack of systematic data collection and consensus about prevention in Westchester County as a substantial barrier to planning prevention. If successful, this report will establish an overall conceptual framework on prevention and identify key prevention needs and gaps within that framework. If the report ferments discussion and contributes to a consensus about the County approach to HIV prevention, then it has played an important role.

RECOMMENDATIONS

Based on our research, the following five recommendations are offered. We have divided the recommendations into three for our community to address and two as the responsibility of the health department.

1. The community, with leadership from the Westchester County AIDS Council, should continue to encourage and support the initiation and expansion of prevention programs that target sex- and needle-sharing partners of HIV positive individuals.

2. The community, with leadership from the Westchester County AIDS Council, should create a forum where funding opportunities for HIV prevention may be discussed and, as appropriate, coordinated.

3. The community, with leadership from the Westchester County AIDS Council and support from the Westchester County Department of Health, should consider key gaps in programs and in services to targeted populations, to identify providers who could offer more tailored programs to specific populations or communities and to identify interventions that address those gaps.

4. The Westchester County Department of Health will work with funded training centers and the AIDS Institute to help providers to enhance their communication skills when discussing sensitive issues with clients, in order to more effectively assess risk and to provide more appropriate support.

5. The Westchester County Department of Health will develop a more detailed inventory of HIV prevention outreach programs in the county that will include a listing of actual locations and days/times of service to identify specific gaps in services and to help to guide future planning.

ATTACHMENTS

WESTCHESTER HIV PROVIDER INFORMATION FORM AGENCY INFORMATION

Attachment 1 Provider Information Form

This Provider Information Form will be used to help plan for HIV/AIDS prevention services. Information provided will be used as input to a service guide, and it will assist in the completion of funding applications.

SECTION I AGENCY INFORMATION

SECTION I: AGENCY INFORMATION

1. INITIALS OF PERSON COMPLETING FORM __ __ __		**2. POSITION**
3. AGENCY NAME		**4. ALSO KNOWN AS**
5. STREET ADDRESS		Suite #
P.O. or other address information		Website
City	State	Zip

6. HEAD OF AGENCY		
Mr./Ms./Dr. First		Last
Title		
Telephone	Fax	Email

7. PERSON TO CONTACT ABOUT AGENCY		
Mr./Ms./Dr. First		Last
Title		
Telephone	Fax	Email

8. TYPE OF AGENCY (circle all that apply)

All volunteer	☐	Governmental	☐
For-profit	☐	Non-profit –501c (3) or 501 (c) (4)	☐

9. We will use this questionnaire to identify services available to people living with or at risk of becoming infected with HIV/AIDS. A resource guide will be made available to both clients and providers. Please select one of the choices below to indicate whether you want your agency to be listed in the guide using information from this questionnaire.

Yes, please list our agency in the resource guide	☐
No, do not include information regarding our agency in the resource guide	☐
Maybe, but please contact us again before using our information	☐

In the next section please check off services you offer and provide a description of them. They are divided into seven broad categories: 1) Public advocacy, 2) Outreach to high-risk populations, 3) Prevention to HIV negative individuals, 4) Prevention to HIV positive individuals, 5) Prevention to partners, 6) Other services such as training and assessment.

SECTION II WESTCHESTER HIV PROVIDER INFORMATION FORM SERVICES

1a PUBLIC ADVOCACY

Please check the box on the left column if this agency offers the service. In the space provided below, please add detail about the service.

- ☐ Place Advertisements / PSAs in mass and small media, bill boards, brochures, and leaflets.
- ☐ Write articles & editorials advocating HIV/AID prevention.
- ☐ Circulate a newsletters
- ☐ Conduct group educational intervention such as HIV/AIDS prevention curriculum, drama or theater presentation, World AIDS day presentation.
- ☐ Have a hotline or other type of information exchange, etc.
- ☐ Organize rallies, public meetings, write-in campaigns
- ☐ Have advocacy / educational volunteers or interns.
- ☐ Provide advocacy / educational training
- ☐ Solicit financial support for HIV/AIDS prevention advocacy

SERVICE DESCRIPTION: For each service checked above note: 1) Target population, 2) a sampling of specific activities or publications noted, 3) number of persons reached or using the service in 2002, 4) please be as specific as possible in your description of activities completed in 2002 and planned for 2003.

SECTION II SERVICE INFORMATION

SECTION II WESTCHESTER HIV PROVIDER INFORMATION FORM SERVICES

1b. OUTREACH TO HIGH RISK POPULATIONS
Please check the box on the left column if this agency offers the service. In the space provided below, please add detail about the service including..

- ☐ Health education and risk reduction through targeted group and community level interventions including schools, street outreach, house parties, health fairs, public sex venues such as parks or bathhouses, bars, STD and health care clinics, etc.
- ☐ Conduct 1-1 contact with high –risk individual
- ☐ Operate a mobile Van
- ☐ Exchange dirty needles
- ☐ Distribute bleach kits
- ☐ Distribute condom
- ☐ Offer HIV Testing and Counseling
- ☐ Offer STD testing
- ☐ Offer TB testing
- ☐ Offer Substance Abuse treatment, detox, and methadone maintenance.
- ☐ Offer 12 step and other abstinence
- ☐ Offer care at neonatal clinics
- ☐ Offer family planning to populations at high risk for HIV infection.

SERVICE DESCRIPTION: For each service checked above note: 1) Target population by Race/Ethnicity, risk group, and sex, 2) number of persons reached or using the service in 2002 including whether it as face-to-face, phone, or in group or individual setting, 3) as complete a description of activities completed in 2002 and planned for 2003 as possible.

SECTION II WESTCHESTER HIV PROVIDER INFORMATION FORM SERVICES

1c. PREVENTION TARGETED TO HIV NEGATIVE INDIVIDUALS
Please check the box on the left column if this agency offers the service. In the space provided below, please add detail about the service.

☐	Provide skill building workshops	☐	Offer 1-1 counseling
☐	Provide peer education / support	☐	Offer support groups
☐	Conduct behavioral modification programs	☐	Offer HIV/AIDS re-test
☐	Offer prevention case management	☐	Include partner negotiation

SERVICE DESCRIPTION: For each service checked above note: 1) Target population by Race/Ethnicity, risk group, and sex, 2) number of persons reached or using the service in 2002 including whether it as face-to-face, phone, or in group or individual setting, 3) as complete a description of activities completed in 2002 and planned for 2003.

Continue on back if not enough room

SECTION II SERVICE INFORMATION

SECTION II WESTCHESTER HIV PROVIDER INFORMATION FORM SERVICES

1d. PREVENTION TARGETED TO HIV POSITIVE INDIVIDUALS
Please check the box on the left column if this agency offers the service. In the space provided below, please add detail about the service.

☐ Provide adherence programs	☐ Circulate newsletters
☐ Offer support groups	☐ Provide partner notification
☐ Behavioral modification	☐ Monitor HIV status
☐ Counseling	☐ Provide safer behavior workshops

SERVICE DESCRIPTION: For each service checked above note: 1) Target population by Race/Ethnicity, risk group, and sex, 2) number of persons reached or using the service in 2002 including whether it as face-to-face, phone, or in group or individual setting, 3) as complete a description of activities completed in 2002 and planned for 2003.

Continue on back if not enough room

SECTION II WESTCHESTER HIV PROVIDER INFORMATION FORM SERVICES

1e. PREVENTION TO PARTNERS
Please check the box on the left column if this agency offers the service. In the space provided below, please add detail about the service.

- ☐ Provide partner negotiation workshops
- ☐ Partner negotiation campaign
- ☐ Develop partner agreements
- ☐ Other program for partners of PWLH/A

SERVICE DESCRIPTION: For each service checked above note: 1) Target population by Race/Ethnicity, risk group, and sex, 2) number of persons reached or using the service in 2002 including whether it as face-to-face, phone, or in group or individual setting, 3) as complete a description of activities completed in 2002 and planned for 2003.

Continue on back if not enough room

SECTION II WESTCHESTER HIV PROVIDER INFORMATION FORM SERVICES

1f. OTHER SERVICES
Please check the box on the left column if this agency offers the service. In the space provided below, please add detail about the service.

	SERVICES TO PROVIDERS AND HEALTHCARE WORKERS		PROGRAM ASSESSMENT AND EVALUATION
☐	Training	☐	Program monitoring
☐	Infrastructure support	☐	Needs assessment
☐	Program development	☐	Consumer satisfaction
☐	Newsletters		

SERVICE DESCRIPTION: For each service checked above note: 1) Target population by Race/Ethnicity, risk group, and sex, 2) number of persons reached or using the service in 2002 including whether it as face-to-face, phone, or in group or individual setting, 3) as complete a description of activities completed in 2002 and planned for 2003.

Continue on back if not enough room

SECTION II WESTCHESTER HIV PROVIDER INFORMATION FORM SERVICES

2. Please indicate which of the PREVENTION SERVICE CATEGORIES are offered in <u>each</u> area/region (check all that apply)

REGION/ MUNICIPALITY	PUBLIC ADVOCACY	OUTREACH TO HIGH-RISK POPS	PREVEN-TION FOR HIV	PREVEN-TION FOR HIV+	PREVEN-TION FOR PARTNERS	OTHER SERVICES
Ardsley	☐	☐	☐	☐	☐	☐
Bedford	☐	☐	☐	☐	☐	☐
Briarcliff Manor	☐	☐	☐	☐	☐	☐
Bronxville	☐	☐	☐	☐	☐	☐
Buchanan	☐	☐	☐	☐	☐	☐
Cortlandt	☐	☐	☐	☐	☐	☐
Croton-on-Hudson	☐	☐	☐	☐	☐	☐
Dobbs Ferry	☐	☐	☐	☐	☐	☐
Eastchester	☐	☐	☐	☐	☐	☐
Elmsford	☐	☐	☐	☐	☐	☐
Greenburgh	☐	☐	☐	☐	☐	☐
Harrison	☐	☐	☐	☐	☐	☐
Hastings-on-Hudson	☐	☐	☐	☐	☐	☐
Irvington	☐	☐	☐	☐	☐	☐
Larchmont	☐	☐	☐	☐	☐	☐
Lewisboro	☐	☐	☐	☐	☐	☐
Mamaroneck	☐	☐	☐	☐	☐	☐
Mount Kisco	☐	☐	☐	☐	☐	☐
Mount Pleasant	☐	☐	☐	☐	☐	☐
Mount Vernon	☐	☐	☐	☐	☐	☐
New Castle	☐	☐	☐	☐	☐	☐
New Rochelle	☐	☐	☐	☐	☐	☐
North Castle	☐	☐	☐	☐	☐	☐
North Salem	☐	☐	☐	☐	☐	☐
Ossining	☐	☐	☐	☐	☐	☐
Peekskill	☐	☐	☐	☐	☐	☐
Pelham Manor	☐	☐	☐	☐	☐	☐
Pleasantville	☐	☐	☐	☐	☐	☐
Port Chester	☐	☐	☐	☐	☐	☐
Pound Ridge	☐	☐	☐	☐	☐	☐
Rye	☐	☐	☐	☐	☐	☐
Rye Brook	☐	☐	☐	☐	☐	☐
Scarsdale	☐	☐	☐	☐	☐	☐
Sleepy Hollow	☐	☐	☐	☐	☐	☐
Somers	☐	☐	☐	☐	☐	☐
Tarrytown	☐	☐	☐	☐	☐	☐
Tuckahoe	☐	☐	☐	☐	☐	☐
White Plains	☐	☐	☐	☐	☐	☐
Yonkers	☐	☐	☐	☐	☐	☐
Yorktown	☐	☐	☐	☐	☐	☐

SECTION II WESTCHESTER HIV PROVIDER INFORMATION FORM SERVICES

3. Below are barriers to services that can prevent <u>you</u> as a provider from delivering your main prevention service. For each item below, for your main prevention service, circle the number relative to the level of the barrier you think it represents for <u>your</u> agency to provide this service. Is it a big barrier (4), a moderate barrier (3), a small barrier (2), or no barrier at all (1)? A "big barrier" prevents clients from obtaining program services. A "moderate barrier" is one that causes concern and delays providing program services. A "small barrier" causes minor concern and delay. *If you offer more than one category of prevention services, please indicate the main service category offered by your agency and complete the barriers section for that one category.*

Main Prevention Service (*check*): ☐ ***advocacy*** ☐ ***outreach*** ☐ ***HIV-*** ☐ ***HIV+*** ☐ ***Partners*** ☐ ***Other***	**Big Barrier**	**Moderate Barrier**	**Small Barrier**	**No Barrier at all**	**Not Applicable**
a. Lack of funding for the service.	4	3	2	1	0
b. Difficulty finding/training qualified staff, volunteers, subcontractors	4	3	2	1	0
c. Difficulty retaining qualified staff, volunteers, subcontractors	4	3	2	1	0
d. Location or physical limitations of the building or office space ***(please specify in***	4	3	2	1	0
e. Cultural diversity issues ***(please specify in Q.3a)***	4	3	2	1	0
f. Organizational issues or infrastructure development ***(please specify in Q.3a)***	4	3	2	1	0
g. Rules and regulations regarding HIV reporting.	4	3	2	1	0
h. Not knowing where to refer a client for another service.	4	3	2	1	0
i. Lack of transportation to service sites	4	3	2	1	0
j.. The consumer thinking they are not being affected by HIV (denial).	4	3	2	1	0
k. The amount of red tape and paperwork needed to be filled out to get the	4	3	2	1	0
l. No childcare available for the service.	4	3	2	1	0
m. Poor coordination among the organizations and programs providing	4	3	2	1	0
n. Consumers do not know what services are available	4	3	2	1	0
o. Consumers ability to follow instructions	4	3	2	1	0
p. Loss of contact with client (e.g. no phone, no return visit)	4	3	2	1	0
q. High no-show rate (consumer fails to keep appointments)	4	3	2	1	0
r. Hours of Operation	4	3	2	1	0
s. The cost of the service to the consumer (i.e. insufficient insurance	4	3	2	1	0
t. Long waiting list for services (i.e. high demand)	4	3	2	1	0
u. Not being able to communicate in the consumer's language	4	3	2	1	0
v. Clients' concern that other people would see them when they went to the program (fear of loss of confidentiality)	4	3	2	1	0
w. Clients' health	4	3	2	1	0
w. Other **(Specify)** _____	4	3	2	1	0

3a. For those barriers you have identified, what are you doing at the present time to overcome them? (***Please use an additional page of paper if necessary***)

*

Attachment 2 Provider Distribution List

CaseID	AGENCY/PROGRAM	COMPLETED
1	AIDS Counseling and Education (ACE) Bedford Hills Corr. Facility	
34	American Red Cross	x
2	ARCS, Westchester Co.	x
3	BOCES	
4	Center for Preventive Psychiatry – Yonkers	
6	Children's Village/Westchester Youth Services	
7	CLUSTER	x
8	Community Based Pregnancy Prevention – (WCDOH)	x
9	Correctional - Westchester County Jail	
14	Dominican Sisters Family Health Service	
15	Family Information and Referral Service	
16	Family Service of Westchester	x
17	Friars at The Atonement at Graymoor	
18	Generations	x
19	Grace Church Community Center	x
20	Greenburgh Neighborhood Health Center	x
21	Greyston Foundation	x
5	Guidance Center - Methadone Maintenance Treatment Program	
22	Hudson River Community Health	x
23	Hudson Valley Hospital Center	x
24	Living Together	x
26	Mount Vernon Hosp., Methadone Maintenance Treatment Program	
27	Mount Vernon HOPWA (Housing Opportunities for People with AIDS)	x
28	Mount Vernon Hospital	x
29	Mount Vernon Neighborhood Health Center	x
32	Open Door Family Medical Center	x
33	Planned Parenthood – Hudson Peconic	x
36	Sharing Community, Inc.	x
37	Sound Shore Medical Center	x
38	Spanish Community Progress Foundation	
39	St. John's Riverside Hospital	x
40	St. Johns Riverside Methadone Maintenance Program	
41	St. Joseph's Medical Center - Methadone Treatment	
35	St. Joseph's Medical Center - St. Joseph's Family Health Center	
25	St. Vincent's Hosp., Methadone Maintenance Treatment Program	
42	The LOFT: Lesbian & Gay Community Service Center	x
43	Urban League of Westchester, Inc.	x
44	Veterans Administration Hudson Valley Health Care Medical Center	x
45	Volunteers of America	x
46	Westchester and Putnam School Board Assoc.	x
10	Westchester County Dept. of Corrections	x
11	Westchester County Dept. of Community Mental Health	x
49	Westchester County Department of Health	x
12	Westchester County Dept. of Probation	
13	Westchester County Dept. of Social Services	

CaseID	AGENCY/PROGRAM	COMPLETED
47	Westchester County. Liaison to Gay and Lesbian Community[1]	
50	Westchester County Medical Center	x
30	Westchester County Office of Disabled	
31	Westchester County Office of Women	x
51	Westchester Hispanic Coalition[1]	
52	WestCop	
53	Westhab, Inc. (includes HARP Program)	x
54	White Plains Hospital Center Methadone Maintenance	x
55	Youth Bureau	x
56	Youth Theater Interactions	

[1] Indicated no direct prevention service provided.

Attachment 3 Prevention Services by Agency

Agency	Public Advocacy	Outreach to High-Risk Pops	Prevention to HIV Negatives	Prevention to HIV Positives	Prevention to Partners	Other Prevention Services
ARCS (AIDS Related Community Services)	4	5	3	2	0	5
Hudson Valley Student Support Service Center	3	1	1	1	0	1
CLUSTER	0	1	0	0	0	0
Community Based Pregnancy Prevention	3	2	3	0	0	1
Family Service of Westchester	5	3	6	4	0	3
Generation	0	3	1	3	0	0
Grace Church Community Center	0	1	2	2	0	2
Greenburgh Neighborhood Health Center	4	7	1	3	1	5
Greyston Foundation	7	10	2	7	2	7
Hudson River Community Health	7	11	7	8	1	11
Living Together	5	0	3	4	1	5
LOFT: Gay & Lesbian Community Services	3	3	0	0	0	0
Mount Vernon (HOPWA)	2	3	6	3	0	10
Mount Vernon Hospital	2	7	0	1	0	1
Mount Vernon Neighborhood Health Center	2	9	5	7	3	6
Open Door Family Medical Center	7	6	4	7	0	0
Planned Parenthood Hudson Peconic	2	3	1	0	0	1
American Red Cross	1	1	1	0	0	5
Sharing Community	7	6	5	4	0	11
Urban League of Westchester	7	7	3	2	0	1
V.A. Hudson Valley Health Care Med.	1	7	1	4	0	2
Volunteers of America	0	0	0	1	0	0
Westchester County Dept of Health	3	7	2	2	1	7
Westchester Medical Center. (AIDS Care Center)	1	6	4	6	1	6
Westchester and Putnam School Board	0	1	0	0	0	0
Westhab	3	0	0	2	0	0
Dept. of Community Mental Health	1	0	0	0	0	1
Westchester Department of Corrections	2	7	5	3	1	5
Westchester County Office of Women	2	1	0	0	0	0
Westchester County Youth Bureau	1	1	1	0	0	0
Guidance Center - MMTP	0	3	0	0	0	4
White Plains Hospital Center - MMTP	0	4	1	0	0	0
St. John's Riverside Hospital	3	6	4	7	1	6
Sound Shore Medical Center	0	4	3	4	0	0

Attachment 4 Best Practices References

1) Centers for Disease Control and Prevention HIV Prevention Strategic Plan Through 2005.

2) Centers for Disease Control and Prevention, HIV/AIDS Prevention Research Synthesis Project Compendium of HIV Prevention Interventions with Evidence of Effectiveness.

3) The CDC AIDS Community Demonstration Projects Research Group. Community Level HIV Intervention in 5 Cities: Final Outcome Data From the CDC AIDS Community Demonstration Projects.. "American Journal of Public Health. " 89: 336 - 345.

4) Kegeles, S., Hayes, R., Coates, T. Mpowerment - A community-level HIV prevention intervention for young gay men.. "American Journal of Public Health. " 86 (: 1129.

5) Lauby, J., Smith, P., Stark, M., Person, B. 2000. RAPP: A community-level prevention intervention for inner city women: Results of the Women and Infants Demonstration Projects.. "American Journal of Public Health. " 90(2): 216-222.

6) O'Brien, J. The Office States Conference of Mayors - Best Practices Center HIV Prevention and Outreach Strategies.

7) O'Donnell, L., San Doval, A., Duran, R., O'Donnell, C., 6 1995. VOICES/VOCES: Video-based sexually transmitted disease patient education: Its impact on condom acquisition.. "American Journal of Public Health. " 85(6): 817-822.

8) Rotheram-Borus, M., Koopman, C., Haignere, C., Davies, M. 1991. Street Smart - Reducing HIV Sexual Risk Behaviors among Runaway Adolescents. "Journal of the American Medical Association. " 266: 1237-41.

9) Santana, A. Bright Ideas – Innovative or Promising Practices in HIV Prevention and HIV Prevention Community Planning.

10) Velicer, W., Prochaska, J., Fava, J., Norman, G. Detailed Overview of the Transtheoretical Model - Material adapted and updated for Website from Smoking cessation and stress management: Applications of the Transtheoretical Model of Behavior Change.

Attachment 5 Theory Briefs

Social Learning Theory

The social learning theory of Bandura emphasizes the importance of observing and modeling the behaviors, attitudes, and emotional reactions of others. Bandura (1977) states: "Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behavior is learned observationally through modeling: from observing others one forms an idea of how new behaviors are performed, and on later occasions this coded information serves as a guide for action." (p22).

Social learning theory explains human behavior in terms of continuous reciprocal interaction between cognitive, behavioral, an environmental influences. The component processes underlying observational learning are: (1) Attention, including modeled events (distinctiveness, affective valence, complexity, prevalence, functional value) and observer characteristics (sensory capacities, arousal level, perceptual set, past reinforcement), (2) Retention, including symbolic coding, cognitive organization, symbolic rehearsal, motor rehearsal), (3) Motor Reproduction, including physical capabilities, self-observation of reproduction, accuracy of feedback, and (4) Motivation, including external, vicarious and self reinforcement.

Other descriptions of Bandura's work can be found at:
http://fates.cns.muskingum.edu/~psych/psycweb/history/bandura.htm
http://www.ship.edu/~cgboeree/bandura.html
http://www.valdosta.edu/~whuitt/psy702/behsys/social.html

Social Cognitive Theory

The Social Cognitive Theory (SCT) stemmed from the Social Learning Theory (SLT), which has a rich historical background dating back to the late 1800's. Albert Bandura first began publishing his work on SLT in the early 1960's. In 1986, Bandura officially launched the SCT with his book *Social Foundations of Thought and Action: A Social Cognitive Theory*

The SCT defines human behavior as a triadic, dynamic, and reciprocal interaction of personal factors, behavior, and the environment (Bandura, 1977a;1986;1989). According to this theory, an individual's behavior is uniquely determined by each of these three factors. While the SCT upholds the behaviorist notion that response consequences mediate behavior, it contends that behavior is largely regulated antecedently through cognitive processes. Therefore, response consequences of a behavior are used to form expectations of behavioral outcomes. It is the ability to form these expectations that give humans the capability to predict the outcomes of their behavior, *before* the behavior is performed. In addition, the SCT posits that most behavior is learned vicariously.

The SCT 's strong emphasis on one's cognitions suggests that the mind is an active force that constructs one's reality, selectively encodes information, performs behavior on the basis of values and expectations, and imposes structure on its own actions (Jones, 1989). Through feedback and reciprocity, a person's own reality is formed by the interaction of the environment and one's cognitions. In addition, cognitions change over time as a function of maturation and experience (i.e. attention span, memory, ability to form symbols, reasoning skills). It is through

an understanding of the processes involved in one's construction of reality that enables human behavior to be understood, predicted, and changed.

There are three tenants of SCT:

Tenet 1: Response consequences (such as rewards or punishments) influence the likelihood that a person will perform a particular behavior again in a given situation. Note that this principle is also shared by classical behaviorists.

Tenet 2: Humans can learn by observing others, in addition to learning by participating in an act personally. Learning by observing others is called vicarious learning. The concept of vicarious learning is not one that would be subscribed to by classical behaviorists.

Tenet 3: Individuals are most likely to model behavior observed by others they identify with. Identification with others is a function of the degree to which a person is perceived to be similar to one's self, in addition to the degree of emotional attachment that is felt toward an individual.

Theory of Reasoned Action

This theory provides a framework to study attitudes toward behaviors. According to the theory, the most important determinant of a person's behavior is **behavior intent**. The individual's **intention** to perform a behavior is a combination of **attitude** toward performing the behavior and **subjective norm**. The individual's **attitude** toward the behavior includes; **Behavioral belief**, **evaluations of behavioral outcome**, **subjective norm**, **normative beliefs**, and the **motivation to comply**.

If a person perceives that the outcome from performing a behavior is positive, she/he will have a positive attitude forward performing that behavior. The opposite can also be stated if the behavior is thought to be negative. If relevant others see performing the behavior as positive and the individual is motivated to meet the exceptions of relevant others, then a positive **subjective norm** is expected. If relevant others see the behavior as negative, and the individual wants to meet the expectations of these "others", then the experience is likely to be a negative subjective norm for the individual. **Attitudes** and **subjective norm** are measured on scales (as an example the Likert Scale) using phrases or terms such as like/unlike, good/bad, and agree/disagree. The intent to perform a behavior depends upon the product of the measures of attitude and **subjective norm**. A positive product indicates behavioral intent (Glanz, & Lewis, & Rimer, Eds, 1997).

Transtheoretical Model – Stages of Change

The stages of change theory suggests that people make behavioral changes in stages and that different interventions are appropriate at each stage. The stages have been labeled:

- precontemplation,
- contemplation,
- preparation,
- action,
- maintenance, and
- termination.

In the pre-contemplation stage, individuals do not intend to change their high-risk behaviors in the foreseeable future – usually within the next 6 months, as that period is about as far in the future as people anticipate making behavior changes.

Contemplation is the stage in which people seriously intend to change in the next 6 months. Despite their intentions, it is estimated that, on the average, individuals stay in this relatively stable stage for at least 2 years.

Preparation is the stage in which individuals intend to take action in the near future, usually the next month. They typically have a plan of action and have taken action in the past year or made some behavior changes.

Action is the stage in which overt behavioral changes have occurred within the past 6 months. It is the least stable stage and tends to correspond with the highest risk for relapse.

Maintenance is the period from 6 months after the criterion has been reached until such time as the risk of returning to the old behavior has terminated.
Termination is the stage in which there is no temptation to engage in the old behavior and 100% self-efficacy in all previously tempting situations.

Further Reading:

Marcus, B. H., & Simkin, L. R. (1993). The stages of exercise behavior. *Journal of Sports Medicine and Physical Fitness*, **33**, 83-88.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change. *American Psychologist*, **47**, 1102-1114
.
Prochaska, J. O., & Marcus, B. H. (1994). The transtheoretical model: Applications to exercise. In R. K. Dishman (Ed.), *Advances in Exercise Adherence* (pp.161-180). Champaign, IL: Human Kinetics.