OFFICE OF HEALTH PROTECTION (OHP)
Division of Infectious Diseases (DID)
HIV/AIDS Section

HIV Prevention and Support Service Grants

Request for Application (RFA) Packet
ILLINOIS GRF FISCAL YEAR 2010
FY 2010 Begins July 1, 2009 through June 30, 2010

All Applications Due:
Thursday, April 30, 2009 – 4:00pm
No Exceptions

Send/Deliver original, signed, complete application, with three (3) copies
to:
Carol Anderson, Grants Manager
Illinois Department of Public Health
HIV/AIDS Section, 1st floor
525 West Jefferson Street
Springfield IL 62706
Electronic submittal also required by 4:00pm, 4/30/2009 to:
dph.hivconf@illinois.gov
A. Timeline, Purpose, and Key Terms

Announcement of Revised Application Process ......................... January 30, 2009
Application Packets Available .................................................. February 23, 2009
Grant Seeker’s Workshops - February 24, March 3, March 10, March 11, 2009
Full Proposals Due: (final deadline) ........................................ April 30, 2009
Announcement of Final Funding Decisions .......... **Week of June 22, 2009
Grant Agreement Period Begins .................................................. July 1, 2009
Grant Agreement Period Ends ..................................................... June 30, 2010

**All submission deadlines are final.** Applications not received by the deadlines outlined above, or arriving incomplete will not be considered and returned. All expenses incurred in responding to this notice are solely the responsibility of the responder.

**Award amount and announcement date contingent upon budget approval date and amount allocated by the Illinois General Assembly.**

Purpose
The HIV/AIDS Section of the Division of Infectious Diseases/Office of Health Protection will accept applications for HIV Prevention and Support Services initiatives for FY 2010. Eligible applicants for this funding opportunity include: community-based organizations with IRS 501(c)3 tax-exempt status, state and local government agencies, which may include, but not limited to public schools, academic organizations, disciplinary and professional associations and certified local health agencies with the capacity to reach areas where the prevalence and incidence of HIV and AIDS are high, and/or where regions/communities are underserved with evidence-based HIV prevention interventions and/or support services for HIV positive persons. Successful applicants will propose and implement prevention or support programs that are grounded in best practice principles; are science-based, stigma-free, culturally competent and uniquely designed to meet the needs of the targeted populations. Successful applicants will provide evidence of their experience and capacity in performing such interventions with proposed target populations.
Key Terms Used in This RFA

**Co-factors:** Influences that indirectly put individuals and communities at risk for HIV infection or transmission. Example: Mental health – mental health conditions may impact a person’s ability to make healthy choices regarding safer sex and/or drug use.

**Core HIV risk factors:** Those behaviors that put people at risk of HIV infection or transmission. Specifically, 1) unprotected anal or vaginal sex with a person or persons of unknown or different HIV status (example: someone who knows s/he is HIV negative who is engaging in unprotected anal or vaginal sex with someone who is HIV positive or whose HIV status is unknown); and 2) sharing of injection drug equipment and other instruments that puncture the skin.

**HPP:** HIV Prevention Projects provide education and risk reduction support to decrease HIV infection or transmission.

**Intervention(s):**

- **Project:** The planning, implementation, and evaluation of one or more intervention(s) addressing the core HIV risk factors and selected co-factors and for a given target population. Example: providing Outreach Intervention and a Group Level Intervention for adult African American men who have sex with men (MSM).

**Evidence-Based Interventions:** Effective Behavioral Interventions employ behavioral science at the core of their design, with an emphasis on evaluative elements that can be tracked with participants to demonstrate effectiveness. Diffusion of Effective Behavioral Interventions (or DEBIs), are actual evidence-based HIV/STD/Viral Hepatitis prevention interventions that have been proven effective through research studies that showed positive behavioral (e.g., use of condoms; reduction in number of partners) and/or health outcomes (e.g., reduction in the number of new STD infections). Studies associated with DEBIs employed rigorous research designs, with both intervention and control groups, so that the positive outcomes could be attributed to the interventions. The Centers for Disease Control and Prevention (CDC) and IDPH strongly encourage the use of DEBIs for HIV Health Education/Risk Reduction (HE/RR) activities. Interventions carried out well by skilled, well-trained staff have been shown by researchers to be effective in preventing HIV infection or transmission.

**HIV Counseling/Testing/Referral Services:**

- **Client-centered HIV prevention counseling:** An interactive risk-reduction counseling model usually conducted with HIV testing, in which the counselor helps the client identify and acknowledge personal HIV risk behaviors and commit to a single, achievable behavior change step that could reduce the client’s HIV risk.
**HIV test:** The HIV test is a laboratory procedure that detects antibodies for HIV or actual presence of virus in the human body. Rapid testing is done with an FDA-approved point-of-care test device that can be used in clinical and non-clinical settings by licensed medical providers and trained counselors who meet additional specific criteria as determined by IDPH.

**Referral:** The process through which a client is connected with services to address prevention needs (medical, prevention, and psychosocial support).

**Target population(s):** The population(s) identified and prioritized as most at risk for HIV infection or transmission in Illinois as prioritized by the Illinois Prevention Community Planning Group (PCPG):

- **Men who have Sex with Men (MSM)**: All nationalities of men who identify as gay, bisexual, straight or other; ages 13 and over;
  - HIV-positive persons
  - Adults: MSM 20 years of age and up, of unknown HIV status, who are currently, sexually active outside the context of a mutually-monogamous relationship
  - Youth: Males, 13-19 years of age, of unknown HIV status, who identify as gay, bisexual, questioning, or engaging in MSM behavior, and may or may not be currently sexually active

- **Males and transgender pre-operative male-to-female (MTF) and post-operative female-to-male (FTM) persons:** All nationalities

- **Injection Drug Users (IDU):** All nationalities; All genders, ages 12 and over, including:
  - HIV-positive persons
  - Persons of unknown HIV status

- **High-Risk Heterosexual (HRH):** (All nationalities); Females and males age 13 or older, engaging in unprotected vaginal and/or anal sex, defined as any of the following:
  - HIV-positive persons
  - Persons with HIV+ partners of the opposite sex
  - Persons w/IDU partner(s) of the opposite sex
  - Female partners of MSM
  - Heterosexual males and females with two or more STDs in 12 months
  - Males and Females with multiple partners, including sex workers

- **Perinatal:** Pregnant women of all nationalities including:
  - HIV-positive pregnant women, HIV positive women of child-bearing age
  - HIV-positive males with female partner(s) of child-bearing age
  - Pregnant women of unknown serostatus.

**Correctional/detained, post-discharge populations:**
• Recently released males and females who have been incarcerated for a minimum of one year in any facility or any length of time in an Illinois Department of Corrections (IDOC), local jail or detention facility, and their partners.

A. HIV Prevention Projects

The Illinois Department of Health (IDPH) works to implement comprehensive HIV prevention activities for the State of Illinois. IDPH believes that the most effective HIV health education and risk reduction activities are targeted to communities and individuals most at risk for HIV and are designed and delivered by agencies and individuals from within those communities.

Anticipated projects shall:
• Identify high risk individuals from the target population who may or may not understand their risk factors and change their risky behavior.
• Increase the number of high risk individuals from the target population who test for HIV and return for their HIV test results.
• Increase the number of HIV positive individuals from the target population who are linked into HIV/AIDS care and treatment and partner services within forty-eight hours of their HIV diagnosis.
• Increase the number of primary, urgent and emergency medical care providers and communicable disease screening/treatment programs to offer Opt-Out HIV testing in their regular practice while increasing the number of people who learn their HIV status.

Applicants will identify outcome and process measures that are consistent with the overall program purpose.

B. Support Service Projects

Services for HIV Positive Individuals and Affected Loved Ones; (includes housing-related services, legal assistance, logistical support, peer leadership development, support groups/respite care, formal topical/educational initiatives with clients which promote risk reduction and healthy decision making.

**Support Services (Housing):** Supportive on-site housing services for HIV positive individuals and affected loved ones. Collaborate with regional/local Continuum(s) of Care to identify permanent housing resources for low-income and homeless persons with HIV disease. Attend at least one training session sponsored by the Department on issues relevant to persons living with HIV disease. Keep client, financial, and service records in such a way as to demonstrate compliance with the program. Provide the Department with a half-year and a final-year progress reports. Provide long term rental subsidies for scattered site apartments. Provide training sessions to shelter and transitional housing staff on HIV/AIDS housing and confidentiality issues. Establish collaborative partnerships with local agencies, organizations, and medical providers to increase accessibility to critical services for people with HIV disease.
Legal Assistance includes: analysis/advocacy for benefit eligibility, guardianship, anti-discrimination rights and disability rights in housing, employment and other arenas of service for HIV positive persons.

Logistical support includes transportation assistance, establishing or re-establishing official identification for the purpose of documenting eligibility for services.

Peer leadership development includes: Skillbuilding and support for peer-led HIV prevention/education initiatives; peer support with disclosure issues and/or treatment adherence; support and mentorship for peer participation in community planning and HIV policy advocacy.

Support groups are led by professional facilitators and/or trained peer leaders. These are safe forums to explore adjusting to living with a diagnosis of HIV/AIDS; skill-sharing for the prevention of secondary infection; talking through disclosure issues; caregiving challenges; treatment adherence; relapse prevention (for HIV positive people in recovery from addiction), and other issues of health and wellness that relate to life with HIV infection.

Respite care is a specific form of support that is organized and coordinated for caregivers, affected family members and persons living with HIV, which is usually delivered in time-limited, retreat-like settings to facilitate peer support, leadership development, rejuvenation and burnout prevention.

C. What initiatives will be supported by this Application process?

The Illinois General Assembly makes funds available to IDPH for the purpose of reducing new HIV infections, conducting strategically planned HIV testing/counseling/referral services and a variety of care and support services for persons living with HIV/AIDS. IDPH emphasis for this application process will be to:

1) Support evidenced-based interventions and counseling/testing/referral strategies to reduce HIV transmission among populations identified by current surveillance data as being most at risk, and/or identify early HIV infection with swift linkage to care. In Illinois, HIV infection occurs primarily among men of all nationalities who have unprotected sex with men; women of color who have unprotected sex with men, and people who inject drugs and share syringes and other injection equipment. While individuals from any community who engages in these behaviors are at risk for HIV, in Illinois, HIV infection rates are disproportionately high among African American and Latino
men who have sex with men; African American men, women and youth; and Latino/a women, men and youth.

2) Provide competent, culturally-specific support services for persons living with HIV/AIDS (PLWHA) and affected loved ones, which include one or more of the following: supportive housing services, support group facilitation, respite care, legal assistance, peer leadership training and HIV prevention education with PLWHAs, and/or logistical support for PLWHA returning to communities post incarceration or detainment.

IDPH priority funding will be made with community partners who demonstrate credibility, effectiveness and skills working with the targeted populations. IDPH expects agencies to honor and respect the diversity of experiences, backgrounds, beliefs, language, interpersonal styles, and behaviors of individuals and families receiving HIV prevention or support services. In addition, disparities in access to health care and social services exist among populations affected by HIV/AIDS. Each target population may have unique attributes based on race, ethnicity, national origin, language, class, religion, gender, age, sexual orientation, mental health status, HIV transmission-based activities (e.g., drug use), geography (rural or urban), or a combination of these characteristics. IDPH encourages agencies responding to this RFA to provide services in a culturally appropriate, stigma-free manner in order to propel human dignity, increase access to health care and supportive services.

D. What funds are available, for what purposes?
This competitive RFA makes available state general revenue funds for grant agreements for HIV prevention and/or support service projects in Illinois. Successful applicants will demonstrate how they will create a continuum of culturally and linguistically specific HIV prevention and/or support services for each population identified to be at high risk for HIV infection and/or living with HIV/AIDS. Funded projects will implement one or more interventions or services (which include specific activities) for selected target populations that can contribute to this continuum.

Each target population, including those who are living with HIV/AIDS, has risk factors that contribute to HIV infection or transmission risk. Agencies selected for funding will be expected to proactively address the core HIV risk factors, which are attributed to all populations, as well as the selected co-factors identified for each target population (see Appendix C for definitions of the core HIV risk factors and co-factors).

While the Illinois General Assembly will make the final determination, the anticipated funds that will be available include:
HIV Prevention: $1.2 million to continue existing projects and fund limited new initiatives.
- Health Education/Risk Reduction (HERR) (evidence/science-based methods)
- HIV Counseling/Testing with enhanced linkage to care/partner services referral
- Innovative Opt-Out HIV testing/follow up initiatives
- Correction/Detention Population HIV prevention education initiatives

Support Services for Persons Living with HIV/AIDS and caregivers: $1.3 million to continue existing projects and fund limited new initiatives.
- Supportive Housing Services for HIV positive people
- Legal Assistance for HIV positive people
- Peer Leadership Development; Support Groups; Respite care
- Services for formerly Incarcerated/Detained PWLHAs Returning to Communities
- Supportive services that link and retain HIV positive people into appropriate medical care

Funded projects will enter into a grant agreement with IDPH for a one (1) year time period of July 1, 2009 through June 30, 2010.

A. Organizations Eligible to Apply
Eligible applicants include: tax-exempt community-based organizations, non-profits, private associations, religious organizations, voluntary organizations, organizations serving youth, women, same-gender-loving persons, or specific ethnic populations; schools/school districts, and collaboratives of government and community-based organizations. Local health departments and other governmental agencies are eligible to apply. Local health departments may participate as a member of a coalition, partnership, or collaborative. Only organizations based in Illinois are eligible to compete for these funds, and all applicants must submit a letter of support from their regional HIV prevention lead agency.

B. Minimum expectations of applicants include:
1. Develop a basic needs assessment for the targeted community and population
2. Present clear, specific, time-framed, measurable goals, objectives and activities for the proposed project.
3. Demonstrate how individuals from the target populations will be recruited, identified and engaged with evidence-based HIV prevention messages, education, risk reduction training, other interventions, or support services.
4. Demonstrate how HIV prevention messages will be integrated into larger program activities, including supportive services.
5. Develop strategies that are culturally sensitive through solicitation of unique ways of contacting and exposing individuals from the target population to the HIV prevention messages in both group and individual settings.

6. Present a documentation/evaluation plan that corresponds with each of the proposed goals and objectives of the proposed project. The plan will address both process and outcome indicators to demonstrate the effectiveness of the interventions or services proposed and implemented or delivered.

7. Present a clear, detailed and reasonable budget and budget justification that is derived from the goals, objectives and evaluation/documentation plan.

It is understood that HIV prevention interventions are most effective at changing the high-risk behaviors of individuals and communities when they are provided on an ongoing basis, and when many different kinds of activities are available to meet the needs of individuals who are at different stages of behavior change. In addition to the behavior that exposes individuals to HIV, individuals and communities have influences that indirectly put them at high risk for HIV infection or transmission (co-factors). Effective HIV prevention projects address these co-factors throughout the delivery of their programming (see **Appendix C** for definitions of the core HIV risk factors and co-factors).

The HIV prevention projects are therefore intended to develop a continuum of age-appropriate, culturally and linguistically specific interventions for each population identified to be at risk for HIV infection or transmission and to address the core HIV risk factors and identified co-factors for the population targeted. Applicants are asked to apply for funds to implement one or more HIV prevention projects for a given target population that can contribute to this continuum.

The primary objectives of HIV prevention projects are to assist individuals to identify their risk for HIV infection or transmission, learn how to change the behavior(s) that place them and/or their partners at risk, learn how to access HIV testing and learn their HIV status. Strong applications will reflect the following objectives throughout the proposal:

- **Ability to serve one or more of the targeted populations as prioritized by the Illinois Prevention Community Planning Group (PCPG) see page 4:**

- Ability to effectively locate and reach those individuals within the proposed target population identified as being at risk of HIV infection or transmission.
• Ability to effectively address the core HIV risk factors identified such as: 1) unprotected anal or vaginal sex with a person or persons of unknown or different HIV status (example: someone who knows s/he is HIV negative who is engaging in unprotected anal or vaginal sex with someone who is HIV positive or whose HIV status is unknown); and 2) sharing of injection drug equipment and other instruments that puncture the skin (see Appendix C).

• Ability to effectively address the selected co-factors identified for the target population (see Form D and Appendix C).

• Ability to implement intervention(s) through activities and strategies, some of which are described in Appendix D, that facilitate and maintain behavioral changes to reduce the risk of HIV infection or transmission in the target population.

• Document evidence of the ability to develop and maintain community partnerships that will directly impact HIV prevention programming for the proposed target population(s) to be served.

• Document the organizational experience and evidence of excellence in providing services to people living with HIV and AIDS, if applying for supportive service projects or prevention interventions for HIV positive persons and their loved ones.

• Document progress made with proposed interventions and activities, if previously funded for any HIV intervention or service delivered.

• If applying for support of HIV counseling/testing/referral services for the first time, present organizational evidence of previous HIV prevention education experience; track record with selected target population(s), including skills of key personnel to be assigned to the project with a compelling rationale for the request. The proposed timeline and work plan for such applicants must include planning, assessment and training objectives for the project that will precede counseling/testing/referral objectives. PLEASE NOTE: No more than ten (10) organizations, new to HIV counseling/testing/referral, will be likely obtain awards due to limited capacity for enrollment into required IDPH training with access to supplies before such services can begin.

C. Application Style Requirements

All agencies that meet the eligibility and minimum expectations criteria outlined above are eligible to submit a proposal. Applications will be
accepted if they address one or more of the target populations outlined above and one to three risk co-factors for that target population.

Format and Style Requirements:
1. Submit one (1) signed unbound original and three (3) copies of the complete application.
2. Use 12-point font, one-inch margins, and single spaced lines on 8½ X 11-inch paper.
3. Do not exceed the section page limits set forth.
4. Include a proposal Table of Contents.
5. Number all pages including any attachments.
6. Staple or clip proposal. Do not bind in any other way.

PLEASE NOTE: All submissions are final. Full and complete applications not received by the deadline outlined above will NOT be considered and returned.

D. Workshops and Technical Assistance Resources

IDPH will offer workshops in association with this RFA process. Though workshop attendance is not required, we strongly encourage applicants to attend. You may submit a proposal if you do not attend a workshop. Workshops are open to all applicants. Registration is strongly encouraged. Please register for workshops in advance at www.idph.state.il.us/training.htm
Grant Seeker’s Workshops
These forums will provide an opportunity to ask questions and receive clarifications about the RFA process and requirements. Each workshop will have on-site sign in beginning at 8:30 am. You may choose to attend the workshop on one of the following four dates/locations:

<table>
<thead>
<tr>
<th>DATE</th>
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<th>LOCATION</th>
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| Tuesday, February 24, 2009 | 9:00 am – 1:00 pm | Southwestern Illinois College  
Main Campus Complex, Room 1040  
2500 Carlye Avenue  
Belleville IL 62221 |
| Tuesday, March 3, 2009  | 9:00 am – 1:00 pm | Capital City Training Center  
130 West Mason  
Springfield, IL 62702 |
| Tuesday, March 10, 2009 | 9:00 am – 1:00 pm | DePaul Center  
333 South State Street Room 5D, 5th floor  
Chicago, IL 60604 |
| Wednesday March 11, 2009 | 9:00 am – 1:00 pm | Fairfield Inn Marriott  
645 West North Avenue  
Lombard IL 60148 |

Note: The content of each workshop is identical. IDPH is offering multiple dates and locations for your convenience. You do not need to attend more than one.

Technical Assistance Resources
Agencies submitting proposals may choose, but are not required, to utilize one or more of the Diffusion of Effective Behavioral Intervention (DEBI) projects. Appendix D includes descriptions of the DEBI projects, interventions included in the Compendium of HIV Prevention Interventions with Evidence of Effectiveness (Compendium), as well as other interventions that have been shown to be effective. See:  
http://www.effectiveinterventions.org,  
http://www.cdc.gov/hiv/resources/reports/hiv_compendium/index.htm, and  

Disclaimer
This RFA does not obligate the IDPH to complete the RFA process or to enter into grant agreements. Applicants responding to the RFA assume all risk and costs associated with the submission of their proposals.

IDPH reserves the right to withhold the distribution of funds in cases where proposals submitted do not meet the necessary criteria and the proposed
projects do not meet the HIV health education and risk reduction needs of the target population. These funds would then be set aside to ensure those needs are met through an alternative. All funds are dependent upon the availability of state General Revenue Funds (GRF).

**Right of Refusal**

This RFA does not obligate the state to award a grant agreement or complete the project and the state reserves the right to cancel the solicitation if it is considered to be in its best interest.

**E. Application Review Process**

Applications will first undergo a technical review for completeness and documentation of on-time arrival. If the application is received late or incomplete after 4:00pm, 4/30/09, it will be returned without further review. If the application is received on time and complete, then the content will be reviewed and scored by teams of community members and IDPH staff. This input will be one of the criteria used for developing final funding recommendations and awards. The community members will reflect the diversity of Illinois and will have familiarity with HIV. Reviewers will be required to identify any conflicts of interest and will not review an application if they have a direct relationship with the applicant.

In addition:
- Reviewers will first evaluate and score each proposal independently.
- Each proposal will be evaluated and scored individually against the criteria described in the “Criteria for Scoring Proposals” section (see page 14), not against other proposals.
- Proposal budgets and budget narratives will be reviewed to assess feasibility.
- Reviewers will not score the “Accounting System and Financial Capability Questionnaire” (Form J). IDPH staff will review this information to identify the technical assistance needs of the awarded agencies.
- Reviewers will forward their scores, funding recommendations, and comments to the IDPH for compilation.
- Reviewers will then meet to discuss all proposals assigned to their team and identify their individual and final funding recommendations. Consensus will not be sought in the proposal review process.

**Internal Review Process**

Staff from the OHP/DID HIV/AIDS Section of IDPH will develop the final funding recommendations during the Internal Review process. This process will consider the proposal review team’s scores, funding recommendations and comments, as well as, but not limited to, the following criteria. Therefore, final awards will not be based solely on the proposal review results.

- IDPH staff will strive to achieve a continuum of HIV prevention Interventions and activities for each target population.
• The internal review process will determine the number and locations of the programs selected to conduct of HIV prevention project, HIV counseling, testing and referral (CTR).
• IDPH will consider communities with the highest HIV incidence and those most impacted by the co-factors.
• Cultural competency will be measured using the average of seven (7) scores for responses to the indicators of cultural competency (see below). IDPH will consider the average score, and may also use it for determining final funding recommendations.
• Organizational competency will be measured using the budget scores, Form J, and a site visit if needed. IDPH will consider these, and may also use them for determining final funding recommendations.
• IDPH may need to contact applicant agencies to gain clarification regarding a proposal and thus reserves the right to collect additional information as needed. This may include a site visit during mid-August 2009.
• Other considerations will include, but are not be limited to:
  o the agency’s experience with the target population and its success in reaching this population;
  o the costs of the proposed intervention(s) and projects;
  o the agency’s fiscal stability and capacity;
  o the other potential sources of funding and current, non-IDPH funded HIV prevention programming for a target population;
  o geographic coverage reflecting HIV/AIDS epidemiology; and,
  o the performance of currently funded projects regarding both intervention delivery and meeting contractual requirements.
• Assessment items include:
  o Is staff time in alignment with the grant agreement?
  o Is the grantee reaching their intended target population(s)?
  o Is the grantee meeting the core elements of the intervention(s)?
  o Is the grantee addressing the co-factor(s) they selected?
  o Has the grantee developed and used a consumer advisory mechanism?
  o Has the grantee implemented an appropriate process to develop and/or revise their program?

Final funding recommendations will be forwarded to the IDPH Director for approval. All funding decisions are dependent upon the availability of state GRF prevention funds to IDPH.

Criteria for Scoring Proposals
(Note: criteria in *italics* are indicators of cultural competency)

Needs Assessment (20 points)
• Description of specific population(s) and community/region of Illinois where the intervention or service is proposed for implementation.
• Rationale and evidence of community need for the intervention(s) proposed, based upon the epidemiological and socio-economic trends of the specific target community or region and population, *including stated needs of target population representatives.*
Organizational capacity (10 points)
Compelling description of organizational ability to manage the proposed project as determined by qualifications and appropriateness of proposed staff, or requirements for “to be hired” staff and consultants. Describe the proposed staff level of effort and previous program experience of the organization. Provide evidence of target population representation in the leadership, line staff and/or membership of the applicant organization, and/or input into the design of the proposed project. Describe the organizational structure and proposed project organizational structure.

Project Narrative – Goals & Objectives of the Project (40 points)
- Methods to gather, document and use input from the target population for the development, implementation, and evaluation of the project are fully described.
- Strategies to recruit high-risk individuals are fully described.
- Methods to ensure cultural and developmental appropriateness for the target population are fully described and are workable for the target population.
- Settings and activities for each intervention are appropriate and feasible.
- If two or more interventions are proposed, how the interventions work together to create the proposed project is fully described.
- Expected outcomes (i.e., changes in knowledge, attitudes, behavioral intentions, beliefs, skills, and behaviors) relate to the proposed activities and are measurable indicators of success.
- Types and methods of client referrals within or between agencies are fully described and are feasible. Letters of agreement provided for proposals of organizational collaboration.
- Proposed intervention flows directly from epidemiological and socio-economic trends documented in the needs assessment section.
- Cultural factors that create barriers to delivering prevention messages to and implementing prevention interventions with the target population are fully described.
- Strategies to deliver programming in light of described cultural factors and barriers are fully described and are feasible.
- Strategies to address core HIV risk factors are fully described and are feasible.
- Between one (1) and four (4) co-factors are selected, the selections are realistic and consistent with the resources available, and the identified co-factors are fully described and non-duplicative with other service providers. (Note: Projects will not be evaluated based on the number of co-factors selected; rather, they will be evaluated based on how well the proposed intervention(s) will address the co-factor(s).
- Integration of STD and hepatitis (A, B, and C) prevention into programming is fully described.
• **The type and number of staff needed and the duties of each staff member are stated and appropriate.**

• **Staff qualifications/requirements (and recruitment strategies, if needed) are stated and appropriate.**

• The description of monitoring the planning, implementation, and evaluation of the proposed project is fully described and feasible.

• Appropriateness of proposed approach and specific activities for each objective; logic and sequencing of the planned approaches in relation to the objectives and program evaluation; soundness of any proposed partnerships (e.g., coalitions), if applicable; and likelihood of successful implementation of the project.

• **Skills, credibility and organizations experience fully described for providing direct services for people living with HIV/AIDS (if applicable).**

### Project Budget and Budget Justification and potential for matching funds (20 points)

- The project budget and project budget narrative are complete.
- The project budget and project budget narrative are mathematically correct.
- The information in the budget narrative is consistent with the proposed activities.
- The costs projected for the proposed activities and staffing level are reasonable.
- Demonstrates sufficient and prudent allocation of resources to successfully implement the project
- Budget justification is present for each expenditure
- All acronyms are defined
- If travel is requested, justification is included and notation indicates state rate
- Position titles and staff members’ names that are paid from the grant are present and justified.
- Administrative costs are less than 10% of overall budget.

### Documented attendance at Grantseeker's Workshop and/or submittal complete and on time: (10 points)

Note: Though not a criteria for scoring, all forms (A through J) must be completed as indicated. Failure to complete all forms may be grounds for disqualification.

### F. Applicants for this funding must agree to the requirements described below

1. During the Application Process
   a. If choosing to collaborate with another agency(s), to submit one proposal, a lead organization must be designated. All collaborating partners must meet the eligibility criteria (see page 6). The lead
organization should serve as the fiscal agent and also be the applicant agency. If selected for funding, the lead organization (fiscal agent) will:

- assure that the proposed project occurs;
- be responsible for reporting required evaluation data;
- report progress on project with data from each partnering organization;
- develop and implement a system for regular communication with other partners; and,
- maintain accurate financial records and submit invoices in a timely manner.

NOTE: The lead organization will need to have the capacity and expertise to effectively implement the proposed strategies or project activities and to effectively provide broad fiscal oversight.

b. Complete all forms as specified in Appendix A, answer all questions, provide the required signatures on all forms that request signatures, and submit proposal (original and three copies) by the due dates stated above.

2. If Awarded:
   a. Consult with IDPH grant management staff to complete grant agreement negotiations including completion of “Administrative HIV Prevention Project Form”.

   b. Consult with IDPH grant management staff on the development of annual Intervention Work Plans that set goals and objectives for each intervention each year, and annual Budget Plans.

   c. Provide documentation of consumer input regarding the effectiveness and appropriateness of the interventions for the target population being served.

   d. Consult with IDPH grant management staff on the development and content of all products used or distributed through the IDPH funded Project. This includes submitting for review and approval, prior to use, all brochures, media, curricula, educational and outreach materials, or other items used in the Project.

   e. Develop and maintain a system to collect information that will document and measure the implementation of strategies and interventions (i.e., process monitoring evaluation).

   f. Participate in the evaluation of the HIV prevention or support service project. Evaluation responsibilities:

      - provide project data to IDPH regularly using formats developed by IDPH;
      - provide a narrative report at least twice each year on the project’s progress; and,
      - respond to technical assistance and recommendations (regarding project planning staffing, implementation, and evaluation) from IDPH staff.
g. Send IDPH an Expenditure Reimbursement Form monthly for incurred expenses as approved. IDPH reimburses actual costs incurred during an invoiced period. The agency must notify the grant manager of any new developments in project before they occur during the grant agreement period. Proposed budget revisions, if any, must be approved before implementation.

h. Provide the grant manager with the names and positions of all paid project staff and any subcontractors. The agency shall provide the grant manager with written notice of any staff changes during the grant agreement period. Please note that administrative costs greater than ten (10) percent of the overall budget will not be funded.

i. Agencies must ensure the confidentiality of all client records including any records of HIV/AIDS status. Pursuant to the Illinois and federal HIPAA requirements, the agency must agree to maintain the data on individuals received or to which the agency has access according to the statutory provisions applicable to the data.

j. Operate the funded project according to the HIV, AIDS, and STD policies and recommendations of IDPH and the CDC.

k. Acknowledge IDPH in product development or activities supported with these funds.

l. Incorporate other Sexually Transmitted Disease (STD), hepatitis A, B, and C health education and risk reduction activities and information into the funded project as appropriate and feasible.

m. Be prepared to modify the funded project to respond to emerging priorities established by the IDPH; meet all other terms and requirements in the IDPH grant agreement.

n. Use science-based research methods on behavior change interventions in planning, implementing, and evaluating interventions that are supported with these funds.

G. Available IDPH Assistance

1. During the RFA Process, IDPH will:
   a. Respond to applicant e-mail and telephone inquiries about the RFA document, its requirements, and this process.
   
   b. Provide pre-application workshop(s) to address questions and facilitate clarifications about the RFA document, its requirements, and this process (see page 10).
   
   c. Communicate a summary of the questions and answers from the pre-proposal workshops.
2. During the grant agreement period IDPH will:
   a. Provide, or make referrals to, technical assistance and training for grantees that will address such topics as skill building for intervention planning/delivery and evaluation.
   
   b. Provide assistance in developing evaluation plans and data collection tools for all grantee projects to measure project implementation (process evaluation) and as appropriate, effectiveness (outcome monitoring evaluation).
   
   c. Provide technical assistance through administrative and programmatic site visits to improve the quality of delivered interventions.
   
   d. As required by the CDC, any product used within an HIV prevention project needs to be submitted for review prior to use. Thus IDPH provides for the review and approval of all HIV prevention materials submitted in a timely manner. Material review includes but is not limited to technical accuracy, compliance with federal guidelines, and appropriateness for the target audience.
   
   e. Work in partnership with community based organizations, the PCPG, and other health care/education systems to develop an overall coordinated and comprehensive plan to reduce health disparities in HIV infection rates.
   
   f. Provide data and information about HIV, STDs, hepatitis, and recommendations for effective interventions and promising project strategies.
   
   g. Coordinate the activities of the HIV Prevention Projects with other efforts at the local, state, and national levels to avoid duplication of effort and to promote consistency.
   
   h. Assist grantees in working with state and local health departments, community planning groups, foundations, funding institutions, and other potential partners.
   
   i. Share information regarding educational opportunities and available funding from foundations and other public and private groups.
Application instructions

Forms required for all Applications

All forms specified herein are located in Appendix A. Applicants are required to complete Form B “Forms Checklist and Certification” as part of the application. This will help to assure that the application is complete. Please review Form B before beginning.

The application must be complete and signed where noted. All of the required forms, located in Appendix A, must be completed and included in the application. The entire application can also be accessed on the IDPH website at: http://www.idph.state.il.us/fundop.htm

If Form B “Forms Checklist and Certification” and all other forms (A through J) are not completed and submitted by the deadline, the proposal may be disqualified.

Writing an application involves completing all forms and in some cases attaching additional required documents. The instructions in the section “Developing the Application” are stated in seven (7) steps. First, take time to read and consider the following.

1. What to Consider Before Beginning

   a. First, determine which target population you or your agency has the capacity to serve. The eligibility requirements and minimum expectations described in Part Two: Process section (pages 9-11) of this RFA will serve as your guide. Remember that you must include targeting persons at highest risk in these populations, in particular people who engage in: 1) unprotected anal or vaginal sex with a person or persons of unknown or different HIV status, and/or 2) share injection drug equipment and other instruments that puncture the skin.

   b. After reviewing this RFA packet in its entirety, determine which intervention(s) will be proposed for the target population the agency intends to serve. Consider how the interventions will address the core HIV risk factors and the identified co-factor(s) for the selected target population.

   c. Consider the agency’s capacity to feasibly implement a successful HIV prevention projects. Quality is more important than quantity.

   d. While planning a project, be sure to consider all costs of the project, including competitive salaries, inflation costs, and cost of living adjustments over the four (4) year grant agreement period.

   e. Plan on attending a pre-proposal workshop (see page 11) and bring any ideas or questions. If unable to attend a workshop and have questions, please send an email to: dph.hivconf@illinois.gov.

   f. Lastly, consider what the agency already does well. It may be better to propose one or a few things the agency does well, perhaps with modifications, instead of proposing many new things that may challenge the success of the project.
A. Developing the Application – Steps 1 to 7

All forms can be found with instructions in Appendix A. Please number all pages consecutively in the application.

Step 1
Complete Form A: Application Information Sheet 1
This form is required to be able to submit a proposal. It allows IDPH to plan the review process.

Step 2
Complete Form B: Forms Checklist and Certification
This form is self-explanatory. Applicants are required to use and complete this form and submit the completed form as part of the application. Check each item on this form as it is completed. The signature of the director of the applicant agency is required on the certification section of Form B.

Step 3
Complete Forms C and D
Form C: Applicant Information Sheet
Form D: Project Information Sheet
Form C provides IDPH contact information and other information required by the CDC. Form D provides IDPH and reviewers easy reference to key information about the proposed project.

Step 4
Complete Form E
Form E: Needs Assessment Narrative (Note: Limit 4 pages)
The questions that require a response are provided on Form E.

Complete Forms F, G, and H
Please read and understand all appendices before completing Form F. Appendix B provides explanations for acronyms and terms used in this form, Appendix C lists cofactors and their definitions. Please take into account that some interventions are more time intensive and expensive than others when designing and proposing the project. Agencies intending to replicate or adapt a DEBI project, must define the interventions that make up the DEBI project (example: Many Men, Many Voices is a group level intervention).

Be sure to understand and be able to provide the required core elements for each type of intervention being proposed (see Appendices B and E).

(Hint: It may be easiest to work on these forms at the same time)

Form F: Organizational Capacity Narrative (Note: Limit 4 pages.)
Form G: Project Goals and Objectives Narrative (Note: Limit 10 pages.)
Form H: Project Budget and Budget Justification Narrative
Be sure to follow all of the instructions for the completion of all forms.
Be sure to answer all of the questions listed for each of the narrative sections.
Be sure to prepare a table of contents and a cover letter signed by the Executive Director and Board President or Chairperson on your organizational letterhead.

**NOTE:** If the project description includes two (2) or more interventions:
HIV prevention projects that include a number of interventions usually move people through different stages of health education and risk reduction. Such programming includes a combination of interventions that support one another and create a “whole” effect that is greater than the sum of the “parts.” Agencies that are considering proposing two (2) or more interventions for one population, should be sure that the interventions fit together well and that staff skills and time are adequate to ensure project success.

**NOTE:** If you plan to offer Counseling Testing and Referral (CTR):
Agencies implementing CTR must comply with CTR project requirements and must also provide Individual Level Interventions (ILI), see Appendix B.

See Appendix B “Definitions and HIV Prevention Intervention Comparison Guide”, Appendix C “Co-factor List and Definitions”, and “Counseling Testing and Referral Definition and Guidelines” at the CDC website, [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm) when completing step 5. See also: [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm)

**Step 6**

**Complete Forms I, and J**

**Form I: Partners Chart**

**Form J: Accounting System and Financial Capability Questionnaire**

Each of these forms includes instructions for their completion.

**Step 7**

Once again, please check to be sure that all forms have been completed (A through J) and all completed forms are included in the application.
**Illinois Department of Public Health**  
HIV Prevention and Support Service Grants - Year FY 2010  
(Please type or print)

### 1. Agency Name and Contact Information

<table>
<thead>
<tr>
<th>Applicant Agency</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Person:</td>
</tr>
<tr>
<td>Address:</td>
<td>Telephone:</td>
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<td></td>
<td>Fax:</td>
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<td></td>
<td>E-mail:</td>
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</tbody>
</table>

**Funding Requested**

### 2. Proposed Target Population(s)

**Instructions:**  
Check the target population(s) the agency proposes to reach.  
Keep in mind EACH of the eligibility criteria checked below pertains to EACH target population the agency proposes to reach.

1. **HIV Positive Persons**  
   - HIV + Persons All Races, All Ages, and All Gender

2. **Men Who Have Sex with Men (MSM)**  
   - MSM of All Races (ages 25+); MSM+IDU  
   - Young High Risk MSM of All Races (ages 13-24)

3. **Correctional/Detained males and females (all races), and formerly incarcerated/detained males and females returning to Illinois communities.**

4. **High Risk Heterosexual (HRH) Men and Women – all races**  
   - Young HRH male/females (ages 13-24)  
   - African HRH (ages 25+)  
   - African American HRH (ages 25+)  
   - Latino/a HRH (ages 25+)  
   - Native American HRH (ages 25+)

5. **Injection Drug Users (IDU)**  
   - MSM/IDU All Races and All Ages  
   - IDUs All Races, Ages, Genders;

### 3. Geographical Area Served Agency

- [ ]
- [ ]
- [ ]

### 4. Eligibility

- [ ]
- [ ]
- [ ]
Illinois Department of Public Health
HIV Prevention Grant

**Forms Checklist and Certification**

Please check each form as it is completed and include it with the application packet.

[ ] FORM A: Applicant Information Sheet 1
[ ] FORM B: Forms Checklist and Certification
[ ] FORM C: Applicant Information Form 2
[ ] FORM D: Project Information Sheet
[ ] FORM E: Needs Assessment Narrative (4 pgs)
[ ] FORM F: Organizational Capacity Narrative (4 pgs)
[ ] FORM G: Goals and Objectives Narrative (with responses to questions; 10 pgs)
[ ] FORM H: Project Budget with Budget Justification Narrative (Use Excel Spreadsheet Template)
[ ] FORM I: Partners Chart (if applicable)
[ ] FORM J: Accounting System and Financial Capability Questionnaire (if applicable)

**Reminder:**

1. Submit one (1) signed unbound original and three (3) copies of the complete application.
2. Use 12-point font, 1-inch margins, and single spaced lines on 8½ X 11-inch paper.
3. Do not exceed the section page limits.
4. Include a proposal Table of Contents.
5. Number all pages including any attachments.
6. Staple or clip proposal. Do not bind in any other way.
7. Cover letter signed by Executive Director and Board President or Chairperson on organization letterhead.

If **ALL** forms are not completed and submitted by the deadline, proposals may be **disqualified from this process**.

**Certification:**

*I hereby certify that all required forms have been completed as instructed. I also certify that all information describing my agency's eligibility is correct. I understand that if any of the required information is missing, this application may be disqualified from this process. I further certify that I have reviewed Appendix G – Sample Grant Agreement and understand the contractual obligations described. I understand that all awards are final and that a grievance can only be filed with regard to a faulty process and not with regard to an unfavorable decision.*

Signature of Director of Applicant Agency  Title  Date

Remember to also attach if applicable:

[ ] Evidence of tax-exempt 501(c)3 status
[ ] Job description and current resume for each person assigned for any % time on the proposed project
[ ] Documentation of DEBI, Red Cross, MATEC and/or HIV Testing/Counseling training from IDPH or CDPH (Chicago Dept of Public Health).
[ ] Current/recent funded organizations: submit narrative of progress made on most recent goals/objectives (minimum 2 pages).
**FORM C Applicant Information Form 2**

**Applicant Agency with which grant agreement would be executed:**

<table>
<thead>
<tr>
<th>Agency Legal Name:</th>
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<tbody>
<tr>
<td>Agency Address:</td>
<td></td>
</tr>
<tr>
<td>Website Address:</td>
<td></td>
</tr>
<tr>
<td>Illinois Tax I.D. Number:</td>
<td></td>
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<tr>
<td>Federal Tax I.D. (EIN) Number:</td>
<td></td>
</tr>
<tr>
<td>Agency Fiscal Manager Name, Title/ telephone phone#:</td>
<td></td>
</tr>
</tbody>
</table>

**Non-profit Status – 501(c) 3**

- [ ] Yes  
- [ ] Not Applicable  
  If “Yes” attach the agency’s documentation of 501 (c) 3 status.

**Agency Type:**

- [ ] Local Health Department  
- [ ] Academic Institution  
- [ ] Other Public Agency  
  (specify):  
- [ ] Community Based Organization (CBO)

**Director of Applicant Agency**

<table>
<thead>
<tr>
<th>Name:</th>
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<tr>
<td>Title:</td>
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<tr>
<td>Address:</td>
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<tr>
<td>E-mail Address:</td>
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<td>Telephone Number:</td>
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<td>Fax Number:</td>
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</table>

**Contact Person for Further Information on Application (if different from above)**

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<tr>
<th>Name:</th>
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<tbody>
<tr>
<td>Title:</td>
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<td>Address:</td>
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<td>E-mail Address:</td>
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<td>Telephone Number:</td>
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<td>Fax Number:</td>
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**Certification:**

I certify that the information contained herein is true and accurate to the best of my knowledge and that I have authority to submit this application on behalf of the applicant agency.

Signature: Director of Applicant Agency  
Title:  
Date:
Illinois Department of Public Health
HIV Prevention or Support Services Grant Application
Instructions: Applicant Information Sheet

Please type or print all items on the Applicant Information Sheet.

If there are questions, or assistance is needed in completing this form, please contact the HIV/AIDS Section by e-mail at: dph.hivconf@illinois.gov.

Applicant Agency/Address/Website
Legal name of the agency authorized to enter into a grant agreement with the Illinois Department of Health (e.g., ABCD County Community Health Service, I.M. Healthy Community Clinic, or OutReachers Community-based Organization).
Mailing address for the applicant agency: If the agency has a website, list the website address.

Tax ID numbers
Illinois Tax ID number is issued by the Illinois Department of Revenue; the EIN (Employer Identification Number) is the federal tax identification number.

Non-profit Status – 501 (c) 3 Copy Attachment
Check appropriate answer. Agencies other than governmental units are required to attach their 501 (c) 3 documentation with the application as evidence the agency is a non-profit institution, corporation, or organization.

Agency Type
Check appropriate answer.
Local Health Department - county or city health department
Other Public Agency: correctional institutions, mental health facilities, etc.
Community Based Organization (CBO) - 501 (c) 3 tax exempt non-profit organization
Academic/Research Institution: university, research center, etc.
If none of the options fit, then fill in “other” and specify.

Director of the Applicant Agency
Person responsible for directing the applicant agency;

Contact Person for Further Information
Person who may be contacted for detailed information concerning the application, or proposed project(s), if different from number 6 above.

Certification and Signature of Director of Applicant Agency
By signing the Director of the applicant agency certifies that they are in agreement with the application content and commitment to grant management standards as previously described in these instructions. Provide original signature and date.
Illinois Department of Public Health
HIV Prevention Grant FORM D
Project Information Sheet

<table>
<thead>
<tr>
<th>Agency Name:</th>
<th>Project Name (if appropriate):</th>
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<tr>
<th>Target Population:</th>
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<table>
<thead>
<tr>
<th>Selected Intervention(s):</th>
<th>Selected Co-factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Counseling Testing and Referral (CTR)</td>
<td>(Refer to Appendix C then list your selected co-factors)</td>
</tr>
<tr>
<td>(Note: Please read and understand Appendix E)</td>
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<tr>
<td>[ ] Community Level Intervention</td>
<td></td>
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<tr>
<td>[ ] Health Communication/Public Information</td>
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<tr>
<td>[ ] Outreach Intervention</td>
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<tr>
<td>[ ] Group Level Intervention</td>
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<tr>
<td>[ ] Individual Level Intervention</td>
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<tr>
<td>[ ] Comprehensive Risk Counseling and Services (CRCS)</td>
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<tr>
<td>Supportive Services (HIV positive populations)</td>
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</tbody>
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<tr>
<th>Total Requested Funding (1 year):</th>
<th>12-month Project Budget Estimate:</th>
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<tr>
<th>Service Area (community, city, county, or region):</th>
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</table>
**Instructions:**
Please type or print all items on the Project Information Sheet.

**Agency Name**
Legal name of the agency authorized to enter into a grant agreement with the Illinois Department of Public Health, (e.g., ABC County Community Health Service; ABCD Healthy Community Clinic or, ABCD OUT Reach Community-based Organization).

**Project Name**
List if appropriate (or if you have one) the name of the proposed HIV prevention projects (e.g., Healthy Mama Project).

**Target Population**
List the selected target population (one of the eleven) that this proposed project intends to serve (see page 9 of the Application and Proposal Packet).

**Selected Intervention(s)**
Check the box corresponding to the intervention(s) being proposed for this project. See “HIV Prevention Intervention Comparison Guide” within Appendix D for definitions of all interventions and required core elements for each of these interventions. Check Appendix B for additional definitions. If a DEBI project is going to be replicated or adapted, then check off the box(es) for the interventions that make up the DEBI project (example: Many Men, Many Voices is a group level intervention).

**Selected Co-factors**
After reviewing Appendix C and selecting the co-factors that best fit the capacity of the agency and the proposed project; list these co-factors in the space provided.

**Total Requested funding (1 year)**
The total requested funding amount for the project proposed for the year grant period (07/1/2009 – 06/30/2010). Consider planning for competitive salaries, cost of living increases, fringe rate increases, and inflation. Agencies may need to complete Forms G and H prior to providing this information.

**12-month Project Budget Estimate**
The total 12-month project budget estimate as described in Forms G and H. **Proposed projects for current grantees must be at or below the current dollar amount. New applicants should apply for no more than $75,000; four to six new awards will be made. No new project over $75,000 will be considered.**

**Service Area (community, city, county or region of Illinois)**
List the geographic area where the proposed project will be delivered. If the project will have multiple delivery sites list all sites. If the proposed project is considered state wide, please indicate as such.
Applicants must write their proposal in a 12-point font with one-inch margins and single-spaced lines on 8½ X 11-inch paper. Criteria in italics are indicators of cultural competency.

**Needs Assessment Narrative Form E** (20 point value)

Describe the specific population(s) and community/region where the intervention or service is proposed for implementation.

Provide a rationale and present evidence of community need for the intervention(s) proposed, based upon the epidemiological and socio-economic trends of the specific target community or region and population, *including stated needs of target population representatives.*

**LIMIT:** Four (4) pages

<table>
<thead>
<tr>
<th>Criteria for Scoring Proposals: The Needs Assessment section of the application will be reviewed and scored according to the following criteria (20 Points):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The applicant provided a thorough description of specific population(s) and community/region where the intervention or service is proposed for implementation.</td>
</tr>
<tr>
<td>• The applicant provided a compelling rationale and evidence of community need for the intervention(s) proposed, documenting epidemiological and socio-economic trends of the specific target community or region and population, <em>including stated needs of target population representatives.</em></td>
</tr>
<tr>
<td>• <em>The applicant demonstrates knowledge of the community area, county or region and target population it intends to serve.</em></td>
</tr>
</tbody>
</table>
Organizational capacity – Form F
LIMIT: Four (4) pages or less

Please provide a description of your agency, including:

Agency Name: __________________________

1. A brief description your agency history and its mission.

2. A description of your current or history within the past five (5) years of providing HIV prevention or support service activities that reaches the target population you are proposing to serve. If you do not currently provide HIV prevention activities to the target population, then describe the current or historical health programming or services for people living with HIV/AIDS that you do provide. Please include the following information: a description of who you reach (i.e., within the broader target population, the audience for your targeted intervention(s)), a brief description of the intervention(s) and the setting in which it is provided, and how long you have been providing the intervention(s).

3. A brief description of sexual health education and health promotion provided in current programming.

4. Describe organizational ability to manage the proposed project as determined by qualifications and appropriateness of proposed staff, or requirements for “to be hired” staff and consultants.

5. Describe and provide evidence of meaningful target population representation in the leadership, line staff and/or membership of the applicant organization, and/or advisory role into the work of the organization.

6. What makes your agency well suited to provide HIV prevention or supportive services activities for the target population and/or geographic areas you are proposing to serve?

Criteria for Scoring Proposals: The Agency Overview Narrative section of the application will be reviewed and scored according to the following criteria (10 Points):

- The applicant agency history and mission are compatible with providing HIV Prevention Activities or Delivering Supportive Services.
- The applicant agency has current or historical (within the past five (5) years) experience providing HIV prevention education, counseling/testing/referral services for at-risk populations, or other programming or services for people living with HIV/AIDS to the intended target population.
- The applicant agency currently provides sexual health education and health promotion programming.
- The applicant agency is well suited to provide the selected intervention or service proposed for the intended target population.
Illinois Department of Public Health
HIV Prevention or Support Service Grant FORM G

Project Goals & Objectives Narrative (40 point value)

Instructions: LIMIT: Ten (10) pages may be less depending on the number of proposed interventions.

REMEMBER: Applicants must write their proposal in a 12-point font with one-inch margins and single-spaced lines on 8½ X 11-inch paper.

Criteria in italics are indicators of cultural competency.

Agency name: ________________________________

Project name: ________________________________

Target population: ________________________________

Intervention(s):

Check the box corresponding to the intervention(s) you are proposing for this project.

Note: Interventions are NOT listed in any ranked order.

[ ] A. Counseling Testing and Referral (CTR)
   (Note: Please read and understand Appendix B)
   (Also: If you propose CTR you MUST also propose Individual Level Intervention (ILI) and describe how CTR will be conducted in the context of ILI.)

[ ] B. Community Level Intervention (CLI)

[ ] C. Health Communication/Public Information (HC/PI)

[ ] D. Outreach Intervention

[ ] E. Group Level Intervention (GLI)

[ ] F. Individual Level Intervention (ILI)

[ ] G. Comprehensive Risk Counseling and Services (CRCS)

[ ] H. Supportive Services (with specific service description/population):
1. Check the box(es) indicating the rationale(s) that serves as the foundation in the development for each of the checked intervention(s) that make up your proposed project and provide the information requested. Note: These are NOT listed in any ranked order.

[ ] A. Scientific, theoretical, or operational basis (e.g. social learning theory, evaluation of agency project, journal article); for interventions based on a scientific theory or published journal article, describe how the theory or findings from the journal article will be reflected in intervention activities

[ ] B. Replication\(^1\) of evidence-based project from Appendix D with documented evidence of effectiveness; If the intention is to replicate a DEBI project, then the interventions that make up the DEBI project must be defined. (Example: Many Men, Many Voices is a group level intervention)

Name of project/intervention to be replicated: _______________________________________

[ ] C. Adaptation\(^2\) of evidence-based project from Appendix D with documented evidence of effectiveness; If you intend to adapt a DEBI project, then you must define the interventions that make up the DEBI project. (Example: Many Men, Many Voices is a group level intervention) Name of project/intervention to be adapted:

Describe the adaptations that will be made for use with your target population:

[ ] D. CDC Guidelines (e.g. CTR, PRCS) Describe how CDC Guidelines have or will be put into place:

[ ] E. Program Outcome Monitoring If your agency has conducted Outcome Monitoring in the past, describe the project, its findings, and how the findings support the proposed continuance of the project. Add if applicable, how findings informed any project improvements:

[ ] F. Other rationale or experience

---

\(^1\) Replication means that you will implement the intervention EXACTLY as it was designed.

\(^2\) Adaptation means that you will tailor the intervention for your target population but you will meet ALL core elements of the intervention. If you are adapting a DEBI but are not meeting ALL of its core elements, then it is not considered an adaptation and you must select another evidence basis option.
1. Describe how ongoing input from the target population will be gathered, documented, and used for the development, implementation, and evaluation of this project.

2. Describe how high-risk individuals will be recruited and reached to participate in the project.

3. Describe how you will ensure that the project is culturally and developmentally appropriate to the target population. Explain why the activities proposed will work for that target population.

4. a. For EACH intervention, use a table like the one below to describe where it will take place (the location/setting), the activities that will be conducted, and the estimated number of people from the target population who will be served by the intervention(s).

(Note: If you propose CTR you MUST also propose ILI and describe how CTR will be conducted in the context of ILI.)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Location/setting (be specific)</th>
<th>Intervention activities</th>
<th>Estimated number of people reached for a 12-month period</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

b. If two or more interventions are proposed, describe how the interventions knit together to create a whole.

5. Describe the specific and measurable changes that are expected in the target population as a result of the intervention activities and explain how these changes would be measured (e.g. changes in participant knowledge, attitudes, behavioral intentions, beliefs, and skills). Be S.M.A.R.T. – specific, measurable, achievable, relevant/realistic, and time-bound.
6. Describe the types and methods of referrals that will be made during the intervention(s) (both internally and externally).

7. Describe the cultural factors that create barriers to delivering prevention messages to and implementing prevention interventions with the target population.

8. Given the barriers described in your answer to #8 above, describe your plan to deliver your programming in light of the described barriers.

9. Describe how this project will address the core HIV risk factors and the co-factor(s) you selected for this target population (selected from listings in Appendix C). Note: you must refer to Appendix C prior to completing 10. b. and c. below.
   a. How will the core HIV risk factors (see Appendix B) be addressed through the delivery of the intervention(s)?
   b. How will the risk co-factor(s) selected for this target population be addressed (see Appendix C) through the delivery of the intervention(s)?
   c. Briefly describe other resources that address the co-factor(s) selected for this target population and how partnerships will be established with these resources to prevent the duplication of services.

10. Describe how the proposed project will integrate health education and risk reduction regarding STDs and hepatitis A, B, and C into intervention delivery.

11. Describe staffing needs and staff recruitment.
   a. Describe the types of staff needed, the number of staff needed, and the duties of each staff person involved in project administration and delivery (e.g. who will be responsible for delivering intervention services, who will attend required training, who will collect and report project data, etc.).
   b. Be sure to include the desired qualifications/requirements of staff hired to deliver these interventions. If you currently have an HIV prevention project that is the same or similar to the proposed project, describe the qualifications and skills of current staff. (Attach job descriptions, resumes/CVs for every name/position listed for any percent of time on the proposed project.)
   c. If not currently in place, how will staff be recruited?
12. Describe how the agency will monitor the planning, implementation and evaluation of the proposed project.

<table>
<thead>
<tr>
<th>Criteria for Scoring Proposals: The Project Goals/Objectives and Evaluation Narrative section of the application will be reviewed and scored according to the following criteria (40 Points):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Strong rationale(s) and support for the intervention(s) that make up the project are provided.</td>
</tr>
<tr>
<td>• Methods to gather, document, and use input from the target population for the development, implementation, and evaluation of the project are fully described.</td>
</tr>
<tr>
<td>• Strategies to recruit high-risk individuals are fully described.</td>
</tr>
<tr>
<td>• Methods to ensure cultural and developmental appropriateness for the target population are fully described and are workable for the target population.</td>
</tr>
<tr>
<td>• Settings and activities for each intervention are appropriate and feasible.</td>
</tr>
<tr>
<td>• If two or more interventions are proposed, how the interventions work together to create the proposed project is fully described.</td>
</tr>
<tr>
<td>• Expected outcomes for HIV prevention projects or supportive services are clearly stated, (i.e., changes in knowledge, attitudes, behavioral intentions, beliefs, skills,) and relate to the proposed activities and are measurable indicators of progress or effectiveness.</td>
</tr>
<tr>
<td>• Types and methods of client supportive services and/or referrals within or between agencies are fully described and are feasible.</td>
</tr>
<tr>
<td>• Cultural factors that create barriers to delivering prevention messages to and implementing prevention interventions with the target population are fully described.</td>
</tr>
<tr>
<td>• Strategies to deliver programming in light of described cultural factors and barriers are fully described and are feasible.</td>
</tr>
<tr>
<td>• Strategies to address core HIV risk factors are fully described and are feasible.</td>
</tr>
<tr>
<td>• Between one (1) and four (4) co-factors are selected, the selections are realistic and consistent with the resources available, and the identified co-factors are fully described and non-duplicative with other service providers. (Note: Projects will not be evaluated based on the number of co-factors selected; rather, they will be evaluated based on how well the proposed intervention(s) will address the co-factor(s).)</td>
</tr>
<tr>
<td>• Integration of STD and hepatitis (A, B, and C) prevention into programming is fully described.</td>
</tr>
<tr>
<td>• The type and number of staff needed and the duties of each staff member are stated and appropriate.</td>
</tr>
<tr>
<td>• Staff qualifications/requirements (and recruitment strategies, if needed) are stated and appropriate.</td>
</tr>
<tr>
<td>• The description of monitoring the planning, implementation and evaluation of each objective for the proposed project is fully described and feasible.</td>
</tr>
<tr>
<td>• A timeline of activities, with designated persons responsible for each is identified.</td>
</tr>
</tbody>
</table>
Project Budget: (20 point value combined Project Budget and Project Budget Narrative)


| Total: | $ |

Please note: Please complete the Excel Spreadsheet template for this portion of your grant application. Completion of the Excel Spreadsheet form is considered to be FORM H. The Excel Spreadsheet can be located and downloaded at: http://www.idph.state.il.us/fundop.htm

Criteria for Scoring Proposals: The Project Budget and Project Budget Narrative section of the application will be reviewed together and scored according to the following criteria (10 Points):

- The project budget and project budget narrative are complete.
- The project budget and project budget narrative are correct.
- The information in the budget narrative is consistent with the proposed activities.
- The costs projected for the proposed activities and staffing level are reasonable.
Illinois Department of Public Health
HIV Prevention or Support Services Grant Application

Project Budget Justification Narrative
(10 point value combined Project Budget and Budget Justification Narrative)

A. Please present a brief justification for the budget items requested. Include an explanation of how costs were determined. If more space is required, attach another sheet. Each line item from the budget must clearly relate to the project objectives described. Keep in mind that this is a 12-month budget.

List Project Name and Target Population:

1. **Salaries:** Indicate for each position the name and title, the full time equivalent on this project, the expected rate of pay, and the total amount for a 12-month period. State each staff person’s salary per year. Funds can be used for salary of staff members directly involved in the proposed project (planning, developing, delivering, or evaluating). Salaries should be based on qualifications and experience.

   “Full time equivalent” (or FTE) is defined as the percentage of time a person will work on the proposed project. To calculate the FTE, divide the hours the person will work by the standard number of work hours, which is 40 hours per week, 174 hours per month, or 2,088 hours per year. For example, a person who works 20 hours per week on this project is a 0.5 FTE (20/40 = 0.5).

   Example: .75 FTE Health Educator, $35,000 per year x 12-months = $ 26,250

2. **Fringe:** All other costs, except for compensation, for full- or part-time employees of the applicant agency with project responsibilities, except those funded from administrative costs. These may, but do not have to, include: employer portion of FICA and Medicare, medical and dental insurance, long-term disability insurance, life and accidental death and dismemberment insurance, workers compensation insurance, and unemployment insurance. State each staff person’s fringe per year.

3. **Travel and Subsistence:** All costs related to the transportation of project employees for approved project activities. Client travel is reported under “Other” expenses. Mileage should be calculated at a maximum of the current IRS allowable amount (.055). Only in-state travel should be calculated here.

4. **Supplies:** All project costs related to the purchase of items with a cost of less than $5,000. Examples: office supplies (paper products, clips, pencils), condoms & lube, copying costs, brochures and educational material, computer software, client incentives, etc.

5. **Contractual Services:** If you plan to hire independent contractors for specific services on a fee basis, please indicate: (1) the name(s) of the contractor(s) or consultant(s) and their credentials relevant for the proposed project; (2) the dollar amount(s) proposed for payment for each contractor or consultant; (3) the specific expense line items; and, (4) the service(s) being provided. Please use additional pages if necessary. Note: Sub-contracts require prior written approval by IDPH.
6. **Equipment:** Itemize and justify all costs of equipment that is tangible, and has a useful life of more than one year.

7. **Other:** All project cost items, not included in the previous definitions must be specified here. Examples: office phone, cell phone, internet access, postage, refreshments, advertising, translation/interpretation costs, costs associated with staff training and in-state travel. Note: Do not include HIV testing kits nor laboratory processing costs (see Appendix E).

8. **Subtotal:** (no narrative required for this line)

9. **Administrative Costs:**
   This line is not to exceed 10% of the total of the proposed expenses.
   Administrative Costs are defined as costs that represent the expenses of doing business that are not easily identified with a particular grant, contract, project, function, or activity but are necessary for the general operation of the organization and the conduct of activities it performs. Examples: accounting, human resources, general agency administration, and costs to operate and maintain facilities (including occupancy). Describe what kinds of administrative costs are expected.

10. **Total:** (no narrative required for this line)

B. If funding from other sources has been secured, or will be requested to support this project, please indicate: (1) the dollar amount; (2) the source of these funds; and, (3) when a final decision regarding the funding requests is expected.

<table>
<thead>
<tr>
<th>Amount Requested</th>
<th>Source</th>
<th>Status</th>
<th>Date of Expected Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

C. Please estimate the total project budget necessary to maintain this project from July 1, 2009 through June 30, 2010 (One year budget).

D. Describe if applicable, any “in-kind” contribution your agency will provide to support this project.
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ALLOWABLE COSTS FOR REIMBURSEMENT

To be reimbursable under IDPH/OHP Grant Agreement, expenditures must meet the following general criteria:

a. Be necessary and reasonable for proper and efficient administration of the program and not be a general expense required to carry out the overall responsibilities of the agency.
b. Be authorized or not prohibited under federal, state or local laws or regulations. Federal regulations can be found at www.whitehouse.gov/omb/circulars/a087.
c. Conform to any limitations or exclusions set forth in the applicable rules, program description or grant agreement.
d. Be accorded consistent treatment through application of generally accepted accounting principles appropriate to the circumstances.
e. Not be allocable to or included as a cost of any other state or federally financed program in either the current or a prior period.
f. Be net of all applicable credits.
g. Be specifically identified with the provision of a direct service or program activity.
h. Be an actual expenditure of funds in support of program activities, documented by check number and/or internal ledger transfer of funds.

Unallowable costs include, but are not limited to:

• Bad debts
• Building Alarm or security systems
• Costs for rental, lease or purchase of office space or buildings
• Capital Improvements to Buildings
• Contingencies or provision for unforeseen events
• Contributions and donations
• Major Equipment (unless prior approval is obtained from the Department)
• Depreciation and use allowance
• Entertainment, food, alcoholic beverages, gratuities, other than simple refreshments such as coffee, non-alcoholic beverages and snacks for use in events specifically for clients served.
• Fines and penalties
• Interest and financial costs related to accounting or auditing activities
• Legal, Legislative and lobbying expenses
• Out-of-state travel

THESE COSTS MAY NOT BE INCLUDED IN THE GRANT BUDGET.
Illinois Department of Public Health  
HIV Prevention or Support Services Grant Application  
Partners Chart – Form I  
(Required use if application seeks support for collaboratively proposed projects)

Applicant Agency: ______________________________________ Project Name: ______________________________________

Target Population (s): ______________________________________

IDPH emphasizes the importance of people working together in communities. IDPH wants to know what partnerships are proposed, what experience exists in working together, what role those partners have in the project, and who was contacted about this proposed project. Use the table below to provide information on the partnerships proposed in this project. (Hint: Partners may appear on each other’s Partners Charts.) Complete this chart only if partnerships make sense in the planning, development, and/or implementation of the proposed project. Examples of partnerships may include collaborations, mentoring, and clinical referral. This chart is not limited to one page; you may add rows as needed, however please do not exceed two pages.

<table>
<thead>
<tr>
<th>Name of Partner Agency, Organization, Group, or Individual</th>
<th>Describe existing partnership experiences</th>
<th>Describe the partner’s role in the proposed project</th>
<th>Key Partner Contact Person</th>
</tr>
</thead>
<tbody>
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Note: Please DO submit letters of agreement or agency collaboration attached as appropriate.

Note: If the COLLABORATIVE is more elaborate than this form captures, please attach a 1-2 page description.

Criteria for Scoring Proposals: If applicable, the completed Partners Chart section of the application will be required. Collaborative proposals submitted without this document will be considered incomplete and returned without review.

- Reviewers will note if cooperative relationships with other community organizations appear to be in place and are appropriate.
ACCOUNTING SYSTEM AND FINANCIAL CAPABILITY QUESTIONNAIRE – FORM J

This standard form is used to determine the financial capacity of grant applicants. This form should be used for applicant agencies that: are requesting, or will receive, more than $50,000; are new to state granting; are recently incorporated (five years or less); had previous unfavorable financial performance with federal and/or state funds; had significant audit findings; or for any applicant whose financial capacity is unknown or questionable. All applicants for this RFA are required to complete this form.

No applicants will be excluded from receiving funding based solely on the answers to these questions.

<table>
<thead>
<tr>
<th>SECTION A: APPLICANT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Organization Name and Address</td>
</tr>
<tr>
<td>2. Employer Identification Number</td>
</tr>
<tr>
<td>3. Number of Employees</td>
</tr>
<tr>
<td>Full Time:</td>
</tr>
<tr>
<td>Part Time:</td>
</tr>
<tr>
<td>4. When did the applicant receive its 501(c)3 status? (MM/DD/YYYY)?</td>
</tr>
<tr>
<td>5. Is the applicant affiliated with or managed by any other organizations (Ex. regional or national offices)? [ ] YES [ ] NO If “Yes,” provide details:</td>
</tr>
<tr>
<td>5b. Does the applicant receive management or financial assistance from any other organizations? [ ] YES [ ] NO If “Yes,” provide details:</td>
</tr>
<tr>
<td>6a. Total revenue in most recent accounting period (12 months).</td>
</tr>
<tr>
<td>6b. How many different funding sources does the total revenue come from?</td>
</tr>
<tr>
<td>7. Does the applicant have written policies and procedures for the following business processes?</td>
</tr>
<tr>
<td>a. Accounting [ ] Yes [ ] No [ ] Not Sure If yes please attach a copy of the table of contents</td>
</tr>
<tr>
<td>b. Purchasing [ ] Yes [ ] No [ ] Not Sure If yes please attach a copy of the table of contents</td>
</tr>
<tr>
<td>c. Payroll [ ] Yes [ ] No [ ] Not Sure If yes please attach a copy of the table of contents</td>
</tr>
</tbody>
</table>

SECTION B: ACCOUNTING SYSTEM

| 1. Has a Federal or State Agency issued an official opinion regarding the adequacy of the applicants accounting system for the collection, identification and allocation of costs for grants [ ] Yes [ ] No |
|   Note: If a financial review occurred within the past three years, omit Questions 2 – 6 of this Section and 1-3 of Section C. |
| a. If yes, provide the name and address of the reviewing agency: |
| b. Attach a copy of the latest review and any subsequent documents. |

No applicants will be excluded from receiving funding based solely on the answers to these questions.
2. Which of the following best describes the accounting system?  
   [ ] Manual  [ ] Automated  [ ] Combination

3. Does the accounting system identify the deposits and expenditures of program funds for each and every grant separately?  
   [ ] Yes  [ ] No  [ ] Not Sure

4. If the applicant has multiple programs within a grant, does the accounting system record the expenditures for each and every program separately by budget line items?  
   [ ] Yes  [ ] No  [ ] Not Sure  [ ] Not Applicable

5. Are time studies conducted for an employee(s) who receives funding from multiple sources?  
   [ ] Yes  [ ] No  [ ] Not Sure  [ ] No Multiple Sources

6. Does the accounting system have a way to identify over spending of grant funds?  
   [ ] Yes  [ ] No  [ ] Not Sure

<table>
<thead>
<tr>
<th>SECTION C: FUND CONTROL</th>
</tr>
</thead>
</table>
| 1. Is a separate bank account maintained for grant funds?  
   [ ] Yes  [ ] No  [ ] Not Sure |
| 2. If grant funds are mixed with other funds, can the grants expenses be easily identified?  
   [ ] Yes  [ ] No  [ ] Not Sure |
| 3. Are the officials of the organization bonded?  
   [ ] Yes  [ ] No  [ ] Not Sure |

<table>
<thead>
<tr>
<th>SECTION D: FINANCIAL STATEMENTS</th>
</tr>
</thead>
</table>
| 1. Did an independent certified public accountant (CPA) ever examine the organization’s financial statements?  
   [ ] Yes  [ ] No  [ ] Not Sure |

<table>
<thead>
<tr>
<th>SECTION E: CERTIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>I certify that the above information is complete and correct to the best of my knowledge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. Signature</th>
<th>2. Date</th>
<th>3. Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B
Definitions
And
HIV Prevention
Intervention
Comparison Guide
(Reference Materials)
General Definitions

**Project:** The planning, implementing, and evaluation of one or more intervention(s) addressing the core HIV risk factors and selected co-factors and for a given (one of the eleven) target population. Example: providing Outreach Intervention and a Group Level Intervention for adult high risk heterosexual African Americans.

**Application or Proposal** includes: Completing Forms A through J, attaching other documents as applicable, making the required three (3) copies and electronic submittal on time.

**Core HIV risk factors:** Those behaviors that put people at risk of HIV infection or transmission. Specifically, 1) Unprotected anal or vaginal sex with a person or persons of unknown or different HIV status (Example: Someone who knows s/he is HIV negative who is engaging in unprotected anal or vaginal sex with someone who is HIV positive or whose HIV status is unknown); and 2) Sharing of injection drug equipment and other instruments that puncture the skin.

**Co-factors:** Influences that indirectly put individuals and communities at risk for HIV infection or transmission. Example: Mental health – mental health conditions may impact a person’s ability to make healthy choices regarding safer sex and/or drug use.

**HPP:** HIV Prevention Project provides education and risk reduction support to decrease HIV infection or transmission.

**Intervention(s):** Interventions are how the CDC and the IDPH categorize all HPP activities. Interventions carried out well by skilled staff have been shown by researchers to be effective in preventing HIV infection or transmission.

**Target population(s):** The population(s) identified and prioritized as most at risk for HIV infection or transmission in Illinois. Priority populations and risk factors are described in the HIV EPI Profile (available from the Illinois Department of Health upon request).
**Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>African American</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CLI</td>
<td>Community Level Intervention (see HIV Prevention Intervention Comparison Guide below)</td>
</tr>
<tr>
<td>CRCS</td>
<td>Comprehensive Risk Counseling &amp; Services (see HIV Prevention Intervention Comparison Guide)</td>
</tr>
<tr>
<td>CTR</td>
<td>HIV Counseling Testing and Referral</td>
</tr>
<tr>
<td>DEBI</td>
<td>Diffusion of Effective Behavioral Interventions (see Appendix D Effective Interventions)</td>
</tr>
<tr>
<td>FTE</td>
<td>Full time equivalent, used to describe number of staff, in terms of a 40 hour work week</td>
</tr>
<tr>
<td>GLI</td>
<td>Group Level Intervention (see HIV Prevention Intervention Comparison Guide)</td>
</tr>
<tr>
<td>HPP</td>
<td>HIV Prevention Project</td>
</tr>
<tr>
<td>Hetero</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>HC/PI</td>
<td>Health Communication/Public Information (see HIV Prevention Intervention Comparison Guide)</td>
</tr>
<tr>
<td>HRH</td>
<td>High Risk Heterosexual</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
</tr>
<tr>
<td>ILI</td>
<td>Individual Level Intervention (see HIV Prevention Intervention Comparison Guide)</td>
</tr>
<tr>
<td>IDPH</td>
<td>Illinois Department of Health</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>RFA</td>
<td>Request for Applications</td>
</tr>
<tr>
<td>STD/STI</td>
<td>Sexually Transmitted Disease/Sexually Transmitted Infection</td>
</tr>
</tbody>
</table>

**Intervention Definitions**

*Interventions are how the CDC and the IDPH categorize all HIV HE/RR activities. The IDPH has developed core elements required to be met for each intervention. Interventions carried out well by skilled staff have been shown by researchers to be effective in preventing HIV infection or transmission. You should review the HIV Prevention Intervention Comparison Guide in detail. If selected for funding, your project will be required to meet the required core elements for the funded intervention. You may select one or more of these interventions to include in your project description.*

Note: In accordance with Principle #7 of the Allocation and Funding Principles (Appendix F), applicants proposing to use a combination of IDPH and non-IDPH funding to replicate a DEBI, or adapt a DEBI on a large scale, will be required to discuss their proposal with Mildred Williamson by e-mail at dph.hivconf@illinois.gov or if you do not have e-mail access telephone her at 312-814-4846.

Note: *If you intend to replicate or adapt a DEBI project, then you must define the interventions that make up the DEBI project (Example: Many Men, Many Voices is a group level intervention).*

Note: *If you have questions regarding interventions or activities and strategies that make up an intervention, please contact Mildred Williamson by e-mail at dph.hivconf@illinois.gov or if you do not have e-mail access telephone her at 312-814-4846.*
<table>
<thead>
<tr>
<th>Intervention Type</th>
<th>CDC Intervention Description</th>
<th>Required Core Elements¹</th>
<th>Secondary Elements²</th>
<th>Data Collection and Reporting</th>
</tr>
</thead>
</table>
| Outreach          | HIV/AIDS educational interventions conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the neighborhoods or other areas where clients typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Included are peer opinion leader models. | • Face-to-face communication with high-risk individuals  
• Intervention conducted where high-risk individuals typically congregate outside more traditional, institutional settings and times  
• Discussion of risk and provision of basic HIV/STD health education and risk reduction messages  
• Referral and linkages to counseling, vaccination and testing (HIV, STD, hepatitis) | • Distribution of risk reduction materials, including materials to reduce sexual and injection drug use risk  
• Appropriate referrals for other needs such as medical, social services, chemical dependency, behavioral interventions, care and treatment, etc.  
• Informal assessment of individual’s risk behavior | Collection: Outreach form  
Reporting: Program. Monitoring Report |
| Health Communication / Public Information (HC/PI) | The delivery of HIV/STD/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. | • Provision of brief basic HIV/STD education and/or materials (for example, through community events, presentations/lectures, hotline or media)  
• Builds general support for behavior that prevents HIV, STDs and hepatitis  
• Provision of information about counseling, vaccination and testing services (HIV, STD, hepatitis) | • Inclusion of messages that reduce the stigma against people living with HIV and populations at risk  
• Distribution of HIV/STD risk reduction materials, including materials to reduce sexual and injection drug use risk (often through community events and fairs)  
• Appropriate referrals for medical services, social and emotional support, behavior change interventions, and partner counseling and referral | Collection: HC/PI form (Form used only for community events and presentations/lectures)  
Reporting: Program Monitoring. Report |

¹ Required Core Elements are essential to the effective delivery of the intervention. They are monitored by agency management and IDPH for quality assurance.
² Secondary Elements are not required, though inclusion of them in the delivery of the intervention will have a beneficial effect on outcome.
| Community Level Intervention | Community level interventions combine community organizing and social marketing, and are directed at specific populations, rather than at individuals. The fundamental program goal of these interventions is to change attitudes, norms, and practices by using social networks to consistently promote healthy behaviors. It is also a program goal to change those factors that negatively affect the health of a community's residents. Community level intervention strategies offer opportunities for peers to acquire skills in HIV risk reduction and, in turn, reinforce these abilities when they become the teachers of these same skills to others. | • Define and describe the social networks of the target population  
• Sustain a consistent intervention throughout the entire social network of the target population  
• Utilize behavior change theory to predict and document changes in group norms  
• Get by in and participation of gate keepers and community opinion leaders  
• Referral and linkages to counseling, vaccination and testing (HIV, STD, hepatitis) | • Use of peers to deliver intervention  
• Long-term ownership and implementation of the intervention by the community  
• General community mobilization | Collection: Group sign-in form and other forms developed by the project  
Reporting: Program Monitoring Report |
| Group Level Intervention (GLI) | Health Education/Risk Reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. GLI uses peer and non-peer models involving a wide range of skills, information, education, and support. | • Interactions with more than one client at a time  
• Group members with similar risk behaviors or life circumstances  
• Sufficient intensity to make behavior change likely, generally this means two or more sessions and/or total session time of 3 or more hours  
• Inclusion of skills-building activities designed to help group members initiate and maintain HIV behavior change  
• Provision of information about counseling, vaccination and testing (HIV, STD, hepatitis) | • Exploration of issues facing group members, including HIV risk behaviors and concerns  
• Use of group interaction to normalize and reinforce behavior change  
• Appropriate referrals for other needs such as medical, social services, chemical dependency, behavioral interventions, care and treatment, etc.  
• Distribution of risk reduction materials, including materials to reduce sexual and injection drug use risk | Collection: Group sign-in form and other forms developed by the project  
Reporting: Program Monitoring Report |
| Individual Level Intervention (ILI) | Health Education/Risk Reduction counseling with skills practice provided to one person at a time. ILI assists clients in making plans for individual behavior change and ongoing | • One-on-one interactions, between the client and the provider (telephone may be allowable after an initial face-to-face contact) | • Appropriate referrals for other needs such as medical, social services, chemical dependency, behavioral interventions, care and  | Collection: Client intake form or other form developed |
| **Appraisals of their own behavior and includes skill-building activities. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services.** | **Sufficient intensity and time to make behavior change likely, generally this means two or more sessions**  
- Assessment of the client’s HIV/STD risk behaviors and concerns  
- Provision of appropriate HIV/STD health education and risk reduction messages using a client-centered approach based on client’s particular risk behavior  
- Inclusion of skill-building activities designed to motivate the client to initiate and maintain HIV risk behavior change independently  
- Referral and linkages to counseling, vaccination and testing (HIV, STD, hepatitis) | **Distribution of risk reduction materials, including materials to reduce sexual and injection drug use risk**  
- Incorporation of harm reduction principles | **Reporting:** Program Monitoring Report |
<table>
<thead>
<tr>
<th><strong>Counseling Testing and Referral Intervention (CTR)</strong></th>
<th><strong>Client-centered HIV prevention counseling:</strong> An interactive risk-reduction counseling model usually conducted with HIV testing, in which the counselor helps the client identify and acknowledge personal HIV risk behaviors and commit to a single, achievable behavior change step that could reduce the client’s HIV risk. <strong>HIV test:</strong> The HIV test is a laboratory procedure that detects antibodies for HIV or actual presence of virus in the human body. <strong>Referral:</strong> The process through which a client is connected with services to address prevention needs (medical, prevention, and psychosocial support).</th>
<th>**Prior to conducting CTR project staff must successfully complete the following Department of Health training sessions: “Fundamentals of HIV Prevention Counseling”, “HIV Test Results”, and “HIV Testing Data”; and complete the CDC training: “Fundamentals of Waived Rapid Testing” (either taught by the CDC or person who is CDC TOT certified). An orientation to the rapid test technology will be provided by IDPH or the manufacture’s representative.</th>
<th><strong>Provide HIV risk reduction education</strong>&lt;br&gt;<strong>Provide STD and hepatitis A, B, and C risks reduction education</strong>&lt;br&gt;<strong>Provide referrals for social services as need is identified.</strong></th>
<th><strong>Form to Use:</strong> IDPH HIV Test Site (HTS) bubble form (one per test)&lt;br&gt;<strong>Completed by:</strong> Agency staff conducting the CTR session&lt;br&gt;<strong>Recommendation:</strong> To ensure reporting accuracy, test sites develop method of documenting information required for completing Department of Health required reports throughout grant cycle.</th>
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<tr>
<td><strong>Note:</strong> Implementation of this intervention requires specialized training.</td>
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</table>
• Ensure high-quality services (delivered according to recommended protocols for counseling, referral, and evaluation or regulatory standards for testing). This includes maintaining staff proficiency by adhering to the requirement of each testing staff conducting at least 50 tests per year.
**Comprehensive Risk Counseling Services (CRCS)**

**Note:** Implementation of this intervention requires specialized training.

CRCS is intensive, individualized, client-centered counseling for adopting and maintaining HIV risk reduction behaviors. CRCS is designed for HIV+ and HIV- or those of unknown serostatus who are at high risk for acquiring or transmitting HIV and STDs and struggle with issues such as substance use and abuse, physical and mental health, and cultural factors that affect HIV risk. The ultimate goal of a CRCS program is to enact behavior changes or modifications that will reduce the risk of HIV transmission or acquisition.


- One-on-one, multi-session interactions with the client
- Provision, identification, and brokerage of client-centered services that use harm reduction principles
- Assessment of HIV/STD risk behavior at designated intervals
- Assessment of risk cofactors (mental health, substance use, etc.) and referral to appropriate resources
- Development of a written prevention plan with measurable behavioral outcomes
- Supportive services and skill-building activities to implement the plan, and careful monitoring follow-up and referral through case notes
- Ongoing HIV/STD harm reduction and/or risk reduction counseling (3-18 months)
- Advocacy for client services

**Collection:** CRCS client intake form, assessment form and case notes

**Reporting:** Program Monitoring Report and possibly direct online data reporting

*(Note: Please contact IDPH if you plan to conduct CRCS to determine electronic capacity)*
Appendix C
Co-Factor Lists and Definitions
IDPH has identified co-factors that contribute to HIV risks for each target population. Projects selected for funding are expected to address the co-factors selected throughout their programming. This includes but is not limited to: tailoring where you carry out your activities/interventions; what is included in curricula, risk assessments, and educational material; the skills and background of staff; and who your partner’s are (Form I). Consider co-factors when planning and implementing interventions.

Note: Projects will NOT be funded to address co-factors without addressing their impact on HIV risks. Projects will NOT be funded for activities that duplicate what is already being provided through other resources. Example: If substance use is the selected co-factor, the applicant should not describe fully funding a chemical dependency counselor position, but rather how substance use and its impact on HIV risk will be addressed through the HIV prevention projects being proposed.

IDPH has identified the following two Core HIV Risk Factors: 1) unprotected anal or vaginal sex with a person or persons of unknown or different HIV status (example: someone who knows s/he is HIV negative who is engaging in unprotected anal or vaginal sex with someone who is HIV positive or whose HIV status is unknown); and 2) sharing of injection drug equipment and other instruments that puncture the skin. Agencies funded through this RFP are expected to address these two Core HIV Risk Factors throughout their programming regardless of the number of co-factors they intend to address.

This appendix provides a list of each target population and the co-factors IDPH identified as affecting the population. After the lists, descriptions of each co-factor and how it relates to HIV risk can be found. Some co-factors are more complex to address than others, take this into account when designing and proposing programming. Keep in mind the feasibility of adequately addressing the co-factor(s) you select. Proposals will be evaluated based on how effectively co-factor(s) are addressed, not on the number of co-factors proposed to be addressed. Agencies funded through this RFP are expected to select and address through the delivery of interventions between 1-4 co-factors.

**Instructions:**

**Step 1:** Find the list for your selected target population.

**Step 2:** While keeping in mind the capacity of your agency and proposed project, select at least one but no more than four (4) co-factors that will be addressed through the proposed intervention delivery.

**Step 3:** Review the listing for your selected co-factors in the table of definitions of each of the co-factor and a description of their impact on HIV risk. Ensure that you fully understand the definition and impact on HIV risk.

**Step 4:** List your selected co-factor(s) on Form D “Project Information Sheet” and answer questions 10.b. and c. on Form F using your selected co-factors.

**REMEMBER:** Select at least one but NO MORE than four (4) co-factors.

If you have questions about addressing co-factors contact Mildred Williamson by e-mail at Mildred.Williamson@illinois.gov or if you do not have e-mail access, telephone her at 312-814-4846.
Note: Co-factors are listed alphabetically and are NOT prioritized.

Co-Factors for HIV Positive Persons (HIV+)

HIV + Persons All Races, All Ages and All Genders:
- Access to Health Care
- Disclosure
- Economic Dependence
- Gender Power Imbalance
- Health Literacy
- Health Physical Appearance
- Homelessness
- Immigration
- Mental Health
- Perception of Risk
- Self Esteem (Low)
- Sexual Networks
- Stigma /Disclosure
- Substance Use

Example: If the third box in the African HRH population is selected, then BOTH Gender Power Imbalance and Survival Sex must be addressed.

Co-Factors for Men Who Have Sex with Men (MSM)

MSM of All Races (ages 25+):
- Access to Health Care
- Active/Untreated STDs
- Cultural Barriers
- Disclosure
- Domestic Violence
- Hate Crime Violence
- Health Literacy
- Lack of Healthy Community Norms
- Language Barriers (Latino and other non-English speaking MSM)
- Mental Health
- Non-gay/Bisexual-identified MSM
- Religious/Spiritual beliefs
- Sexual networks
- Sexual Role Power Dynamics
- Sexual victimization
- Short-term emotional fulfillment
- Stigma
- Substance use
- Survival sex

Young High Risk MSM All Races (ages 13-24):
- Access to Health Care (access to HIV (CTR) testing and results)
- Access to Syringes
- Active/Untreated STDs
- Developmental Issues
- Economic Dependence
- Education System Barriers to Discussing Safer Sex and Sexuality
- Health Literacy
- Homelessness
Young High Risk MSM All Races (continued):
- Internet (and other technology)
- Mental Health
- Perception of Risk
- Population Mobility
- Sexual Networks
- Sexual Role Power Dynamics
- Social Norms of Risky Behavior
- Stigma
- Substance Use
- Survival Sex

Co-Factors for High Risk Heterosexuals (HRH)

Young High Risk Heterosexuals All Races (ages 13-24):
- Access to Health Care (testing, privacy/confidentiality)
- Active/Untreated STDs
- Cultural Barriers
- Developmental/Learning Disabilities
- Domestic Violence
- Education System Barriers to Discussing Safer Sex and Sexuality
- Foster Care
- Having Sex Before Age 13
- Health Literacy
- Health/Medical Insurance (paperwork barriers)
- Homelessness
- Internet (My Space & Facebook, and other technology)
- Lack of Family/Supportive adult
- Lack of Family Cohesion
- Mental Health
- Peer Pressure
- Perception of Risk
- Sexual Experimentation
- Sexual Networks
- Sexual Victimization
- Substance Use
- Survival Sex
- Unequal Partners
- Unsupervised Youth

African High Risk Heterosexuals (ages 25+):
- Access to Health Care
- Active/Untreated STDs
- Chemical Abuse (i.e.: alcohol, drugs)
- Cultural Barriers
- Disclosure
- Economic Dependence
- Gender Power Imbalance
- Health Literacy
- Homelessness
- Immigration
- Incarceration
African/Caribbean Immigrant High Risk Heterosexuals (Continued):
- Language Barriers
- Mental Health
- Perception of Risk
- Refusal to Use Condoms
- Religious/Spiritual Beliefs
- Sexual networks
- Stigma
- Survival Sex

African American High Risk Heterosexuals (ages 25+):
- Access to Health Care
- Domestic Violence
- Gender Power Imbalance
- Homelessness
- Lack of Cultural Competent HIV Services
- Late Stage Diagnosis Due to Barriers
- Medication Adherence
- Mental Health
- Mistrust of Healthcare System
- Perception of Risk
- Religious/Spiritual Beliefs
- Sexual Victimization
- Stigma
- Substance Use
- Survival Sex

Latino/a High Risk Heterosexuals (ages 25+):
- Access to Health Care
- Active/Untreated STDs
- Cultural Barriers
- Domestic Violence
- Economic Dependence
- Fear of Deportation
- Gender Power Imbalance
- Health Literacy
- Homelessness
- Language Barriers
- Population Mobility
- Religious/Spiritual Beliefs
- Sexual Networks
- Sexual Victimization
- Stigma
- Survival Sex

Native American High Risk Heterosexuals (ages 25+):
- Access to Health Care
- Active/Untreated STDs
- Cultural Barriers
- Domestic Violence
- Economic Dependence
- Homelessness
- Incarceration
Native American High Risk Heterosexuals (Continued):
- Mental Health
- Population Mobility
- Religious/Spiritual beliefs
- Sexual Networks
- Sexual role power imbalance
- Social Norms of Risky Behaviors
- Stigma
- Substance Abuse
- Survival Sex

Asian Pacific Islander High Risk Heterosexuals (ages 25+):
- Access to Health Care
- Cultural Barriers
- Domestic Violence
- Economic Dependence
- Education/Low High School Graduation Rates
- Education System Barrier to Discussion Safer Sex and Sexuality
- Gender Power Imbalance
- Health Literacy
- Health/Medical Insurance
- Language Barriers
- Late Stage Diagnosis Due to Barriers
- Low HIV Testing Rates
- Multiple Languages and Cultures
- Non-gay/Bisexual Identified MSM
- Perception of Risk
- Poverty
- Refusal To Use Condoms
- Sexual Role Power Dynamic
- Sexual Victimization
- Stigma
- Transgender Women (primarily M to F)
- Unemployment

Co-Factors for Injection Drug Users (IDUs)

MSM/Injection Drug Users All Races and All Ages:
- Access to Health Care (insurance loss and self-care activities diminished due to use)
- Access to Syringes
- Active/Untreated STDs
- Cultural Barriers
- Health Literacy
- Homelessness
- Hormonal Injections
- Mental Health
- Relapse Probability
- Sexual Networks (especially through internet use)
- Social Norms of Risky Behavior
- Stigma (shame at being IDU if MSM identified and vise versa)
- Substance Use
- Survival Sex
- Unemployment
IDU (except MSM/IDUs), All Races, All Ages and All Genders:
- Access to Health Care
- Access to Syringes
- Active/Untreated STDs
- Fear of Criminal Prosecution/Incarceration
- Health Literacy
- Injection Drug Use Secrecy
- Isolation
- Mental Health
- Secrecy
- Social Norms of Risky Behavior
- Stigma
- Substance Use
- Survival Sex
Co-Factor Definitions

The following table includes definitions of each of the co-factors and a description of their impact on HIV risk. Besides addressing selected co-factors, all funded prevention projects, regardless of the target population they are reaching, will be required to address both of the following core HIV risk factors:

- Unprotected anal and/or vaginal sex with a person or persons of unknown or different HIV status.
- Sharing of injection drug equipment and other instruments that puncture the skin.

Note: Co-factors are listed alphabetically and are NOT prioritized.

<table>
<thead>
<tr>
<th>CO-FACTOR</th>
<th>DEFINITION</th>
<th>RELATION TO HIV RISK</th>
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<tbody>
<tr>
<td>Access to Health Care</td>
<td>Health care that is available, acceptable, affordable, accountable and utilized (includes access to health insurance and culturally and linguistically competent care).</td>
<td>HIV+ persons who do not have access to health care and/or treatment have an increased chance of viral load being high, which increases transmissibility of HIV and drug resistance. Also, if they have an active/untreated STD, there may be a higher likelihood of HIV transmission. HIV- persons who do not have access to health care are less likely to test for HIV/STDs, less likely to get treatment for STDs, and will not get HIV messages from health care professionals (in some cultures, messages from health care professionals are deemed to be more important/are valued more than messages from other sources).</td>
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<tr>
<td>Access To Syringes</td>
<td>Ability to access clean syringes. This may include needles exchange programs and syringes available at pharmacies through the Syringe Access Initiative. Accessibility is related to things such as affordability, location, non-judgmental attitude of person providing syringes.</td>
<td>Sharing needles, syringes or “works” contaminated with blood increases risk of HIV transmission. Access to syringes can be difficult for some populations of young MSM due to social isolation, drug use stigma and can lead to unsafe needle use.</td>
</tr>
<tr>
<td>Active/Untreated STDs</td>
<td>STDs (e.g., gonorrhea, herpes, chlamydia, syphilis) that have not been treated or are active. Many STDs are asymptomatic.</td>
<td>Active/untreated STDs make it easier for HIV to be acquired or transmitted. Active/untreated STDs in an HIV positive person results in a jump in HIV viral load.</td>
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<tr>
<td>Chemical Abuse</td>
<td>Drug or chemical abuse has a wide range of definitions related to</td>
<td>See substance use co-factor.</td>
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<tr>
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<tr>
<td>Taking a psychoactive drug or performance enhancing drug for a non-therapeutic or non-medical effect. Some of the most commonly abused drugs include alcohol, marijuana, amphetamines, barbiturates, benzodiazepines, cocaine, heroin, morphine, and other opiates (codeine, hydrocodone, etc). Use of these drugs may lead to criminal penalty in addition to possible physical, social, and psychological harm, both strongly depending on local jurisdiction.</td>
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<tr>
<td>Cultural Barriers</td>
<td>Cultural attitudes, beliefs and social norms within a specific cultural group that are barriers to HIV prevention messages and interventions (e.g., myths about HIV transmission and cures for HIV, female genital mutilation, bride price, machismo, fatalism, focus on youth culture, belief that most other youth are having sex).</td>
<td>Cultural beliefs and social norms are very deeply engrained within individuals and communities. Individuals/communities may not realize their beliefs/social norms impact risky behavior and/or may not be willing or able to change risky behavior because it would go against their cultural beliefs/norms.</td>
</tr>
<tr>
<td>Denial of Partners Infection</td>
<td>Denial is a defense mechanism in which a person is faced with a fact that is too painful to accept and rejects it instead, insisting that it is not true despite what may be overwhelming evidence. The subject may deny the reality of the unpleasant fact altogether (simple denial), admit the fact but deny its seriousness (minimization) or admit both the fact and seriousness but deny responsibility (transference).</td>
<td>A person in denial that their partner is HIV positive or one who minimizes the infectiousness of HIV may not take adequate precautionary measures.</td>
</tr>
<tr>
<td>Developmental Issues</td>
<td>Age related behavioral changes that occur as a child grows up including: motor skills, problem solving abilities, conceptual understanding, acquisition of language, understanding of consequences of actions, perceptions of vulnerability, moral understanding, and identity formation.</td>
<td>A person’s understanding of and ability to make decisions related to HIV risk may be influenced by their psychological development or their age (e.g., a normal stage of adolescent behavior includes risk taking and rebellion which could lead to unprotected sex or unsafe drug use. Adolescents also have feelings of invincibility and often lack of forward thinking about the future).</td>
</tr>
<tr>
<td>Developmental/</td>
<td>A disability is a condition or</td>
<td>A person with developmental</td>
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<tr>
<td>CO-FACTOR</td>
<td>DEFINITION</td>
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<td>Learning Disabilities</td>
<td>function judged to be significantly impaired relative to the usual standard of an individual of their group. The term is often used to refer to individual functioning, including physical impairment, sensory impairment, cognitive impairment, intellectual impairment, mental illness, and various types of chronic disease. This usage is associated with a medical model of disability. Disabilities may come to people during their life or people may be born disabled.</td>
<td>disabilities may not be able to cognitively assess they are at risk. General HIV prevention education is not effective. A person with learning disabilities may not be able to effectively take in and process information provided in a written format. A person with a disability may be viewed as vulnerable and be pressured, tricked or forced into risky behaviors.</td>
</tr>
<tr>
<td>Disclosure</td>
<td>Disclosure involves issues and concerns around revealing something about one’s self (e.g., sexual orientation, HIV status, drug use history, bisexual behavior, etc.).</td>
<td>For HIV positive persons, fear of disclosing status to sexual partners and/or family/friends, may lead them to engage in risky behavior or not seek care or support services. HIV negative persons may not seek testing, talk about risk behaviors, HIV or condom use with partners.</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Violence and abuse (including emotional, physical and sexual) perpetrated by family members, acquaintances, strangers, or intimate partners (e.g., spouse, former spouse, boyfriend or girlfriend, ex-boyfriend or ex-girlfriend, or date). This includes marital rape.</td>
<td>Lack of sexual choice or consent may place persons experiencing abuse at risk for HIV. Persons in an abusive relationship may feel unable to remove themselves from an activity that places them at risk for HIV. A history of childhood sexual abuse has been shown to be associated with risky behavior in youth and adults. Disclosure of domestic violence is taboo in some cultures and frowned upon.</td>
</tr>
<tr>
<td>Economic Dependence</td>
<td>Depending or relying on others for money or basic needs</td>
<td>A person who has to rely on others for meeting basic needs may engage in HIV risk behaviors such as survival sex or staying in a relationship that puts them at risk.</td>
</tr>
<tr>
<td>Education System Barriers to Discussing Safer Sex and Sexuality</td>
<td>Barriers such as reluctance to discuss condom use or sexual orientation within the educational system (schools).</td>
<td>Educational policies such as abstinence until marriage based curriculums and homophobia within schools may lead to misinformation, lack of access to safer sex materials, and social isolation for some students.</td>
</tr>
<tr>
<td>Education/Low High School</td>
<td>Low high school graduation rates refers to populations who have a</td>
<td>Individuals who have not graduated from high school are less likely to be</td>
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<td>CO-FACTOR</td>
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<tr>
<td>Graduation Rates</td>
<td>low rate of students who graduate from high school. Some may go on to pass a General Educational Development (GED) test that certifies that the taker has American or Canadian high school-level academic skills.</td>
<td>employed and insured which in themselves are barriers to HIV prevention information and health care access. See economic dependence co-factor.</td>
</tr>
<tr>
<td>Fear of Criminal Prosecution/Incarceration</td>
<td>Fear of legal proceedings for engaging in criminal behavior and/or being imprisoned in jail or prison.</td>
<td>Fear of criminal prosecution/incarceration can lead some to be less likely to access clean syringes. This fear may also be a barrier to seeking drug treatment.</td>
</tr>
<tr>
<td>Fear of Deportation</td>
<td>Deportation - The act of banishing a foreigner from a country, usually to the country of origin. Thus fear of deportation is being afraid of banishment and removal (in this case) from the United States.</td>
<td>The fear of deportation may lead people who are in Illinois without immigration documentation to engage in survival sex, remain in relationships with gender power imbalance or domestic violence. This fear may also stop HIV- people from getting tested for HIV, or HIV+ people from seeking medical care or other services.</td>
</tr>
<tr>
<td>Foster Care</td>
<td>Is a system by which a certified, stand-in &quot;parent(s)&quot; cares for minor children or young people who have been removed from their birth parents or other custodial adults by state authority.</td>
<td>Research shows that adolescents in foster care present with multiple psychosocial and mental health problems that individually are associated with increased risk for HIV infection. They may also be exposed to HIV due to sexual abuse.</td>
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<tr>
<td>Gender Power Imbalance</td>
<td>Gender is the perceived masculinity or femininity of a person or characteristic. A person's aggregate gender is complex, encompassing countless characteristics of appearance, speech, movement and more. Power Imbalance is an unequal distribution of control and/or decision making ability within a relationship.</td>
<td>A person's vulnerability and lack of sexual choice or consent may place them at risk for HIV. An imbalance of power may place one individual at higher risk than another. In some cultures, gender power imbalance favors men over women, making it difficult for women to self determine when, where or how they engage in sex.</td>
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<tr>
<td>Hate Crime Violence</td>
<td>Occur when a perpetrator targets a victim because of his or her membership in a certain social group, usually defined by race, religion, sexual orientation, disability, ethnicity, nationality, age, gender, gender identity, or</td>
<td>A victim of hate crime violence may be more likely to isolate themselves from their community and experience distress, depression, and other behavioral co-factors that increase the chance of risk taking behaviors. The hate crime itself may place a person</td>
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<td>political affiliation. Hate crimes differ from conventional crime because they are not directed simply at an individual, but are meant to cause fear and intimidation in an entire group or class of people. Hate crime can take many forms. Incidents may involve physical assault, damage to property, bullying, harassment, verbal abuse or insults, or offensive graffiti or letters.</td>
<td>at risk such as in rape or other forms of sexual victimization.</td>
</tr>
<tr>
<td>Health Literacy</td>
<td>Ability to read and comprehend health education material (also, ability to understand Western medical interpretation of health and how the body works).</td>
<td>HIV health education (spoken, visual or written) provided in a manner that does not take into account the client’s health literacy will be ineffective. It will also be ineffective if the health education is inaccessible to the target audience (e.g., provider has the information but no mechanism to disseminate it to the target; a radio show may only reach one area of the city).</td>
</tr>
<tr>
<td>Health/Medical Insurance</td>
<td>The term is generally used to describe a form of insurance that pays for medical expenses.</td>
<td>Individuals without insurance or underinsured are less likely to access healthcare. This means that they may not get tested for HIV. They may only come in contact with the health system when it is critical (e.g., advanced AIDS and related complications.) Also, for some populations the paperwork involved in acquiring insurance serves as a barrier. See access to healthcare co-factor.</td>
</tr>
<tr>
<td>Healthy Physical Appearance (Health POZ)</td>
<td>Refers to HIV positive individuals looking healthy due to medications, nutrition etc. Early in the epidemic HIV was associated to wasting and loss of weight.</td>
<td>A person may assume that their sexual or injecting drug use partner is not infected and may not take protective measures. Additionally, a population may not perceive that HIV is a risk to their community if they only associate HIV with a sickly demeanor.</td>
</tr>
<tr>
<td>Homelessness</td>
<td>Homelessness is a situation in which a person does not have a permanent place of residence. The federal McKinney Assistance Act of 1987 defines homelessness as &quot;Lacking a fixed, regular, stable, adequate nighttime residence.&quot;</td>
<td>Being homeless may place a person at risk for HIV through engaging in survival sex, being economically dependent, or not protecting oneself from HIV due to gender power dynamics. There is also a correlation between substance abuse, mental illness and homelessness.</td>
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<tr>
<td>CO-FACTOR</td>
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<tr>
<td>Hormonal Injections</td>
<td>Hormone replacement therapy (HRT) for transgender and transsexual people replaces the hormones naturally occurring in their bodies with those of the other sex. Its purpose is to cause the development of the secondary sex characteristics of the desired gender.</td>
<td>Hormone replacement therapy is used in the transgender and transsexual community. Those identifying as transgender often experiment with their own sexual orientations and attractions. In addition, many are involved in money for sex in an effort to support substance addictions or to make money for the purchase of necessary hormonal therapy. Some reuse or share needles to inject their hormones because of the insurance industry’s unwillingness to cover hormonal therapy. Finding safe ways to get the hormones they need and the clean needles they need to inject the hormones is a daunting task that can lead to sex for money, sharing needles and substance use. Like any population, these sexual behaviors and sharing of needles increase HIV transmission risk.</td>
</tr>
<tr>
<td>Immigration</td>
<td>Refers to the movement of people between countries. Immigration across national borders in a way that violates the immigration laws of the destination country is termed illegal immigration.</td>
<td>Health care providers ask for documents such as IDs, SSN, etc. that a person may not have. Immigrants may be less likely to get HIV testing for fear of deportation and what will happen to their immigration status. This may lead to delayed diagnosis and unknowingly continued HIV transmission. Additionally, immigrants may delay HIV testing due to not knowing if they would qualify for medical help if diagnosed with HIV.</td>
</tr>
<tr>
<td>Incarceration</td>
<td>Incarceration is the detention of a person in jail or prison. People are most commonly incarcerated upon suspicion or conviction of committing a crime.</td>
<td>Sexual activity and injection drug use occur in prisons and jails. Condoms and clean needles (HIV prevention tools) are not available to this population.</td>
</tr>
<tr>
<td>Injecting Drug Use Secrecy</td>
<td>Secrecy is the practice of sharing information among a group of people, which can be as small as one person, while hiding it from others. That which is kept hidden is known as the secret.</td>
<td>Drug use and particularly injecting drug use, is a frowned upon behavior and therefore often done in secrecy. The injecting drug use community is a close knit group of people that are hard to access. Therefore getting information to them regarding prevention and transmission of HIV is difficult.</td>
</tr>
<tr>
<td>Internet (and other)</td>
<td>The Internet, sometimes called the &quot;Information Superhighway,&quot;</td>
<td>The internet is becoming a popular avenue for “hook ups”. Studies show</td>
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<tr>
<td>technology)</td>
<td>is a &quot;network of networks&quot; that consists of millions of smaller domestic, academic, business, and government networks, which together carry various information and services, such as electronic mail, online chat, file transfer, and the interlinked web pages and other resources of the World Wide Web (WWW). Youth use internet, text messaging and other technology at higher rates than adult populations.</td>
<td>that people (including MSM) that meet partners online are more likely to have unprotected sex, multiple sex partners and HIV positive sexual partners. Youth use electronic technology, including the internet as a means to build and maintain social networks (which may or may not coincide with sexual networks). Text messaging is a highly used means of communication.</td>
</tr>
<tr>
<td>Isolation</td>
<td>An act or instance of isolating. The state of being isolated (i.e. lack of contact or meaningful relationships with other people).</td>
<td>See mental health and stigma cofactors.</td>
</tr>
<tr>
<td>Lack of Culturally Competent HIV Services</td>
<td>Is the absence of services that can effectively address varying cultural practices and world views. Lack of cultural competence results in inability to understand, communicate with, and effectively interact with people across cultures.</td>
<td>Lack of culturally competent HIV services can create an environment where people do not feel understood and may lead to them not access services.</td>
</tr>
<tr>
<td>Lack of Family Cohesion</td>
<td>The lack of a healthy and supportive family environment.</td>
<td>This mainly affects youth that end up soliciting affection from unhealthy relationships. The lack of family cohesion may put teens in relationships with people that take advantage of them. (See sexual role power dynamics and gender power imbalance co-factors).</td>
</tr>
<tr>
<td>Lack of Family /Supportive Adult</td>
<td>Lack of a family or supportive adults in a youth’s life.</td>
<td>Youth who have no or few supportive adults or family members in their life may end up soliciting affection from unhealthy relationships. They may also suffer from few positive role models and voices of reason based on life experience. (See also Lack of Family Cohesion and Lack of Healthy Community Norms).</td>
</tr>
<tr>
<td>Lack of Healthy Community Norms</td>
<td>In sociology, a norm, or social norm, is a rule that is socially enforced. <strong>Social sanctioning</strong> is what distinguishes norms from other cultural products. Social norms can also be viewed as statements that regulate behavior and act as informal social</td>
<td>See social norms for risky behavior.</td>
</tr>
<tr>
<td><strong>CO-FACTOR</strong></td>
<td><strong>DEFINITION</strong></td>
<td><strong>RELATION TO HIV RISK</strong></td>
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<tr>
<td>Lack of Resource Programs</td>
<td>Refers to the lack of a set of services to address social needs.</td>
<td>Lack of resource programs in a community is a missed opportunity for referrals to testing, counseling and care. High risk individuals in such communities therefore miss prevention educational messages and access to condoms when needed.</td>
</tr>
<tr>
<td>Language Barriers</td>
<td>Difficulties in communication due to not understanding or misunderstanding the dominant language (spoken, read or written)</td>
<td>Lack of educational material and trained professionals able to communicate in the client’s preferred language may lead to low understanding of HIV and increased risk behavior.</td>
</tr>
<tr>
<td>Late Stage Diagnosis Due to Barriers</td>
<td>Refers to barriers like lack of self-identified risks, transportation, childcare and non-insurance that hinder access to testing. This also refers to low test rates and individuals discovering their HIV status only after seeking care for HIV/AIDS related infections/health issues.</td>
<td>Untested individuals that engage in risky behaviors due to barriers, if HIV positive, are likely to continue transmitting the virus and only access healthcare when faced with complications arising from becoming ill. Additionally, if there are many barriers within a community, there may be an overall low testing rate.</td>
</tr>
<tr>
<td>Low HIV Testing Rates</td>
<td>Refers to a small number of people in a community testing for HIV due to a perception of no or low risk.</td>
<td>A study shows that Asian Pacific Islanders have a low perception of risk. This has led to low numbers of testing and likelihood of engaging in risky behaviors. Additionally, illness in some API cultures is not openly addressed. Health care and HIV prevention is secondary for individuals with more fundamental human needs.</td>
</tr>
<tr>
<td>Medication Adherence</td>
<td>Agreeing to a regimen and schedule of medication prescribed by a medical doctor.</td>
<td>Adherence to medication is important to manage HIV infection and to suppress viral load. Someone with a high viral load is more likely to transmit the virus. Non adherence also increases the likelihood of developing drug resistance.</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Mental health conditions such as depression, anxiety, sexual impulsivity, etc.</td>
<td>Mental health conditions may impact a person’s ability to make healthy choices regarding safer sex and/or drug use.</td>
</tr>
<tr>
<td>Mistrust of Healthcare</td>
<td>The belief that the healthcare system has a hidden agenda and</td>
<td>People that do not have trust in the healthcare system are less likely to</td>
</tr>
<tr>
<td>CO-FACTOR</td>
<td>DEFINITION</td>
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<tr>
<td>System</td>
<td>does not have your best interest at heart.</td>
<td>test for HIV. They are also less likely to access care when positive. There may be mistrust regarding confidentiality. Trust regarding accuracy of information may be low therefore medication adherence may be compromised.</td>
</tr>
<tr>
<td>Multiple Languages and Cultures</td>
<td>Refers to the diversity of languages and cultures within immigrant communities, and thus within immigrant communities. More than 30 languages are spoken by the Asian Pacific Islander communities in Illinois. It is estimated that more than 800 languages are spoken in Africa; however, they belong to comparatively few language families. Some 50 African languages have more than half a million speakers each, but many others are spoken by relatively few people.</td>
<td>Immigrants from different countries on the same continent or geographic region are often lumped together. The diversity in language and culture are lost and are often one of the main barriers to prevention and access to HIV/AIDS information.</td>
</tr>
<tr>
<td>Non-gay/Bisexual Identified MSM</td>
<td>Men who engage in sex with men but don’t identify as gay or bisexual.</td>
<td>Because of stigma and internalized homophobia non-gay/bisexual identified MSM may not take precaution to protect themselves or their partners. They may also perceive themselves as low risk because they associate HIV with a community they do not identify with.</td>
</tr>
<tr>
<td>Peer Pressure</td>
<td>Peer pressure is a term describing the pressure exerted by a peer group in encouraging a person to change their attitude, behavior and/or morals, to conform to, for example, the group's actions, fashion sense, taste in music and television, or outlook on life.</td>
<td>Peer pressure can lead to risky behaviors. For example it can be used to pressure someone into having sex without a condom. For popularity, drugs, money, etc. a person may engage in behavior that places them at risk for HIV.</td>
</tr>
<tr>
<td>Perception of Risk</td>
<td>A person’s understanding of whether s/he is at risk of HIV infection or transmission. A person may believe s/he has no, low, moderate or high risk based on their risk behaviors, their understanding of HIV, their knowledge of their partner’s risk, their religious beliefs, etc.</td>
<td>A person's perceived vulnerability to HIV may influence their risk taking behavior (e.g., if a person thinks the people they have sex with are unlikely to have HIV, they may choose not to have safer sex).</td>
</tr>
<tr>
<td>Population Mobility</td>
<td>Population mobility is a phrase coined to encompass the entire</td>
<td>Evidence of the relationship between mobile populations and HIV/AIDS is</td>
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<tr>
<td><strong>Poverty</strong></td>
<td>Is the condition of lacking full economic access to fundamental human needs such as food, shelter and safe drinking water.</td>
<td>Health care and HIV prevention is secondary for individuals with more fundamental human needs.</td>
</tr>
<tr>
<td><strong>Recognition of Risk of HRH by Medical Providers</strong></td>
<td>The ability of a healthcare provider to recognize and identify risky needle use and/or sexual behaviors in a heterosexually identified person.</td>
<td>Healthcare providers that don’t recognize risk or use a behavioral risk assessment may miss the opportunity to offer testing and prevention education. Furthermore the healthcare provider may not recognize a person in the acute phase of sero-converting that is characterized by a high viral load and a high likelihood of transmitting the virus if engaging in risky behaviors.</td>
</tr>
<tr>
<td><strong>Re-entry to Community from Correctional Facility</strong></td>
<td>Refers to individuals re-entering the general community after being incarcerated.</td>
<td>Individuals re-entering the community from a correctional facility maybe eager for sexual and/or injection drug use. They may or may not take precautions and may have engaged in risky behaviors while incarcerated (e.g. tattoos, injection drug use, unprotected sex etc.)</td>
</tr>
<tr>
<td><strong>Refusal to Use Condoms</strong></td>
<td>A partner refusing the suggestion to use condoms.</td>
<td>See gender power imbalance and sexual role power dynamics co-factors.</td>
</tr>
<tr>
<td><strong>Relapse Probability</strong></td>
<td>A relapse occurs when a person is affected again by a condition that affected them in the past.</td>
<td>Lack of adequate after-care programs specifically designed for the needs of a population or inadequate community</td>
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<td>This could be a medical or psychological condition such as depression, bipolar disorder, multiple sclerosis, cancer or an addiction to a drug. It is different from a slip or lapse in that it implies a return to previous behavior patterns, as opposed to a one-time occurrence.</td>
<td>support may lead to isolation and a high probability of relapse. This can include returning to previous behavior patterns that are high risk for HIV exposure.</td>
</tr>
<tr>
<td>Religious/Spiritual Beliefs</td>
<td>An individual or community’s beliefs concerning the supernatural, sacred, or divine, and the practices and institutions associated with such beliefs.</td>
<td>A person or community’s religious or spiritual beliefs may conflict with HIV risk reduction measures (condom use, accepting their sexual orientation). Some religious institutions or dogma may contribute to stigma.</td>
</tr>
<tr>
<td>Self Esteem (Low)</td>
<td>In psychology, self-esteem reflects a person’s overall self-appraisal of their own worth. Psychologists usually regard self-esteem as an enduring personality characteristic, though normal, short-term variations occur.</td>
<td>For many men who have sex with men (MSM), low self-esteem and internalized homophobia can impact HIV risk-taking. Internalized homophobia is a sense of unhappiness, lack of self-acceptance or self-condemnation of being gay. In one study, men who experienced internalized homophobia were more likely to be HIV+, had less relationship satisfaction and spent less social time with gay people. Male-to-female transgender persons (MTFs) identify low self-esteem, depression, feelings of isolation, rejection and powerlessness as barriers to HIV risk reduction. For example, many MTFs state that they engage in unprotected sex because it validates their female gender identity and boosts their self-esteem.</td>
</tr>
<tr>
<td>Senior Population</td>
<td>Often defined as &gt; 55 years of age, it refers to men and women, gay/bi/straight, of all races and sero-status.</td>
<td>The false assumption that elders do not have sex reduces the amount of education and screening offered this population. For those who become single after many years in a relationship, they may not have the skills to navigate safer sex standards of today. As individuals with HIV age into the senior population, and new infections occur after age 55, the prevalence of people living with HIV</td>
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<tr>
<td>Sexual Experimentation</td>
<td>Although there is variation between individuals, children and teens generally are curious about their own bodies and those of others and engage in <strong>explorative sex play</strong>.</td>
<td>If not using safer sex practices and engaging in risky behavior, a person could inadvertently put themselves at risk for HIV transmission while engaging in sexual experimentation. It is not uncommon for sexual experimentation to include same gender exploration.</td>
</tr>
<tr>
<td>Sexual Networks</td>
<td>Sexual networks refer to a combination of patterns of sexual relationships and where people meet their sexual partners. Patterns of sexual relationships include polyamory, serial monogamy, and monogamy, dating within or outside of racial/ethnic group. Also within or between sero-status (e.g. pos/pos; neg/neg; mix status). Places people meet sexual partners include Internet, parks, sex parties, bars, street, traveling, etc. Examples: MSM – Internet, circuit parties Young HRH – friends with privileges, concurrent relationships HIV positive – practicing ser-sorting i.e. staying within all positive circle of sexual partners as a harm reduction behavior.</td>
<td>HIV prevalence is higher among some populations than others, and HIV risk is higher within a sexual network that has a high prevalence of HIV. Some of the places people meet partners facilitate unprotected sex and/or multiple partners.</td>
</tr>
<tr>
<td>Sexual Role Power Dynamics</td>
<td>An inequality based on economics, age, outness, relationship status, and gender roles, i.e. roles that partners in relationships may take on related to active and passive sexual roles and/or traditional male and female gender roles. Power dynamics are related to an individual’s ability to make choices about their behavior.</td>
<td>A person’s vulnerability and lack of sexual choice or consent may place them at risk for HIV. An imbalance of power may place one individual at higher risk than another.</td>
</tr>
<tr>
<td>Sexual Victimization</td>
<td>Is an umbrella term that is inclusive of but not limited to rape, sexual assault, non-consensual sex with spouse/partner, etc.</td>
<td>Those experiencing sexual victimization have no opportunity to protect themselves during the act. Lack of sexual choice or consent may</td>
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<tr>
<td><strong>Short-term Emotional Fulfillment</strong></td>
<td>Is a state of being content with who you perceive yourself to be for a short duration of time.</td>
<td>Individuals that seek short term emotional fulfillment are more likely to engage in risky sexual behaviors without considering the longer term consequences. See self esteem co-factor.</td>
</tr>
<tr>
<td><strong>Social Norms for Risky Behavior</strong></td>
<td>A norm, or social norm, is a pattern of behavior expected within a particular society (or group of people) in a given situation. The shared belief of what is normal and acceptable shapes and enforces the actions of people in a society. Those who do not follow their social norms are considered eccentric or even deviant and are typically stigmatized. The very fact that others in one's society follow the norm may give them a reason to follow it. Thus, social norms for risky behavior are the shared belief that a risky behavior is normal and acceptable.</td>
<td>Believing that a risk behavior for HIV is normal and acceptable among your peers may lead one to engage in the risk behavior (e.g., adolescents who believe their peers are engaging in unprotected sex are more likely to do so themselves; IDUs whose peers share needles without cleaning them are more likely to do so themselves; a person whose sexual network uses drugs is likely to also use drugs). People who are single are often perceived to be at higher risk than those who are married, however this false assumption can lead to social norms that place people at risk.</td>
</tr>
<tr>
<td><strong>Stigma</strong></td>
<td>Stigma is a characteristic that an individual or group possesses that is seen as deviant and violates a set of shared values, attitudes and beliefs. Stigmatization can lead to Stigma experienced at the individual level may result in denial of risk, fear of getting tested or seeking prevention or care services, fear of talking about HIV and safer behaviors with</td>
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<tr>
<td>Prejudice</td>
<td>Prejudicial thoughts, behaviors and/or actions manifested at the individual or societal level. Examples of stigma at the individual level include rejection of an HIV positive person by family/friends, gay bashing, being passed over for promotion due to race. At the societal level, stigma is experienced through laws, policies, public opinion and social conditions (e.g., laws prohibiting gay marriage, laws prohibiting possession of syringes). Stigma can be internalized or externalized. Stigma can be related to: - HIV - Sexuality - Race/ethnicity - Other (poverty, drug use, sex work, gender, age, immigration status, education level, etc.).</td>
<td>Sexual/needle sharing partners, or being unable to access services that are culturally and linguistically appropriate. Stigma experienced at the societal level may result in prevention messages not being effective with specific populations, or specific populations being unable to access prevention and care services and tools. Internalized stigma occurs when people believe the attitudes that others have about them. This can lead to loss of self-esteem and a sense that they will inevitably become infected with HIV, or that they deserved to have become infected.</td>
</tr>
<tr>
<td>Substance Use</td>
<td>Use of alcohol and/or drugs (e.g., crystal meth, Khat, marijuana, cocaine, GHB, ecstasy, heroin, etc.).</td>
<td>Substance use may impact a person’s ability to make healthy choices regarding safer sex and/or drug use. Substance use may impair a person’s judgment or reduce inhibitions. Some drugs also make people hypersexual.</td>
</tr>
<tr>
<td>Survival Sex</td>
<td>Trading sex to get something a person needs (shelter, money, drugs, food, etc.). Includes prostitution and other sex work.</td>
<td>A person who is trading sex is often not in a position of power to negotiate for condom use.</td>
</tr>
<tr>
<td>Transgender Women (primarily M to F)</td>
<td>Transgender is a general term applied to a variety of individuals, behaviors, and groups involving tendencies that diverge from the normative gender role (woman or man) commonly, but not always, assigned at birth, as well as the role traditionally held by society. &quot;Transgender&quot; does not imply any specific form of sexual orientation; transgender people may identify as heterosexual, homosexual, bisexual, pansexual, polysexual or asexual.</td>
<td>Studies have shown that transgender women, particularly transgender women of color, are more likely to have experienced unprotected sex due to a multiple of risk factors. Also, transgender women commonly experience a combination of many of the co-factors including but not limited to sexual victimization, survival sex, isolation, violence, and stigma. See also hormonal injection co-factor.</td>
</tr>
<tr>
<td>Unemployment</td>
<td>Is the state in which a person is</td>
<td>A person that is out of work may be</td>
</tr>
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<td>without paid work or employment.</td>
<td>economically dependent on others. See economic dependence co-factor.</td>
</tr>
<tr>
<td>Unequal Partners</td>
<td>Refers to youth being in a relationship with an older person.</td>
<td>See gender power imbalance and sexual role power dynamics co-factors.</td>
</tr>
<tr>
<td>Unsupervised Youth (Out of School/Work)</td>
<td>This refers to the lack of engagement for youth after school when their parents are at work. Also includes youth who drop out of school before graduation and cannot find a job.</td>
<td>Youth are more apt to engage in risky behaviors when they are not occupied or supervised by adults and have extensive unstructured time. Likewise, youth who drop out of school may be affected by other co-factors such as economic dependence, poverty, etc.</td>
</tr>
<tr>
<td>Viral Load</td>
<td>Amount of HIV in the body, commonly expressed as “copies (of virus) per milliliter (mL) of plasma.” Plasma is a component of blood. Viral load values range from fewer than 100 copies/mL to 500,000 or more copies/mL.</td>
<td>Viral load is associated with HIV transmission; the higher the viral load the higher the risk of transmission. This is true for all modes of transmission. Maintaining a low or undetectable viral load is also associated with slower disease progression.</td>
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</table>
Appendix D
Effective, Evidence-Based Interventions
Effective Interventions

Research on Effective Interventions

There is now a body of evidence demonstrating that behavioral interventions can be effective in reducing sexual and drug related risk behaviors among populations that are at increased risk for contracting and transmitting HIV infection. However, the next major challenge lies in the translation of what has been learned through behavioral research into the realities of implementation in the community (Sweat et al., 2001).

HOW TO USE THIS INFORMATION

The material in this section summarizes research results related to HIV prevention interventions that have been shown to be effective in reaching the target populations. Any organization with an interest in implementing prevention interventions, including organizations that receive funding from IDPH and those that do not, can use the information in this chapter to help in designing effective interventions for each of the priority target populations. If you wish to read the complete reference related to a specific intervention, citations are provided in the References section of this plan. Please note that the amount of research available varies significantly by target population.

INTERVENTION CATEGORIES

In general, within each target population, the interventions and strategies are discussed under seven intervention categories: Counseling, Testing and Referral; Outreach; Individual Level Intervention; Group Level Intervention; Comprehensive Risk Counseling and Services; Community Level Intervention; and Health Communication/Public Information.

Counseling, Testing and Referral (CTR): HIV testing includes counseling before and after the test is given. High risk individuals who test negative are referred to prevention programs and other support services, and individuals who test positive are referred to medical care and other support services, as well as to prevention programs.

Outreach: Interventions that are designed to identify individuals who are at high risk for being infected with HIV in their neighborhoods or places they normally congregate; give them condoms, bleach, sexual responsibility kits, and educational materials; and refer them to services that can help them reduce or change their risk behaviors. Outreach activities can also include field based testing.

Individual Level Interventions (ILI): Health education and risk reduction counseling provided to one individual at a time. ILI assists clients in assessing their HIV risk and making plans for individual behavior change and ongoing assessment of their behavior. ILI includes skills building components. These services can also facilitate linkages to other services that support the reduction of risk, such as substance use treatment.

Group Level Interventions (GLI): Health education and risk reduction counseling with groups of different sizes. GLI models can either be led by peers or by professionals. As with ILI, group interventions contain a skills building component, and assist clients in assessing their risk, making plans for behavior change and assessing their progress.

Comprehensive Risk Counseling and Services (CRCS): Previously known as prevention case management (PCM), CRCS is a client-centered prevention activity focused on assisting clients with multiple, complex issues to adopt and maintain HIV risk reduction behaviors. CRCS provides intensive, ongoing, and individualized prevention
counseling, including the development and monitoring of an individual prevention plan with goals and measurable objectives. CRCS also provides coordination with other case management services (e.g., Ryan White or Medicaid), when available, or provides case management services to clients who do not have access to other case management services.

**Community Level Interventions (CLI):** Community level interventions combine community organization and social marketing, and are directed at specific populations, rather than at individuals. The primary goal of these interventions is to improve health status by promoting healthy behaviors and changing those factors that negatively affect the health of a community's residents by changing group norms to improve or enhance the quality of health. Community level intervention strategies offer opportunities for peers to acquire skills in HIV risk reduction and, in turn, to reinforce these abilities when they become the teachers of these same skills to others.

**Health Communication/Public Information (HCPI):** The delivery of planned HIV prevention messages through one or more mediums to target audiences. The focus of the messages are to build general support for safe behavior, support for personal risk reduction efforts, and/or inform persons at risk how to obtain specific services. HCPI interventions may be delivered through: electronic media, print media, telephone hotline, information clearinghouse, presentations or lectures, community events, and web sites and chat rooms.

**DEBI PROJECT**

The CDC is currently coordinating the Diffusion of Effective Behavioral Interventions (DEBI) Project, which is a national level strategy to provide high quality training and ongoing technical assistance on selected evidence based HIV/STD prevention interventions to state and community HIV/STD program staff.

The evidence based interventions included as a part of this project have been proven effective through research studies that showed positive behavioral (i.e., use of condoms; reduction in number of partners) and/or health outcomes (i.e., reduction in the number of new STD infections). Studies employed rigorous research designs, with both intervention and control groups, so that the positive outcomes could be attributed to the interventions. Interventions included in this chapter that are part of the DEBI Project are denoted by a “DEBI” in parentheses. (Note: IDPH-funded organizations providing prevention services in Illinois are not required to use interventions included in the DEBI Project.)

The DEBI Project emphasizes community and group level interventions over individual level interventions because CDC feels they have the potential to reach large numbers of the population and to reach individuals at high risk who might not voluntarily seek prevention information or services. They are also more cost effective. More information on all DEBI interventions can be found at [http://www.effectiveinterventions.org](http://www.effectiveinterventions.org)

**Compendium of HIV Prevention Interventions with Evidence of Effectiveness**

The CDC also encourages the use of interventions included in the Compendium of HIV Prevention Interventions with Evidence of Effectiveness (CDC, 2001). Many of the DEBI interventions are based on those highlighted in the Compendium, although the Compendium also includes additional...
interventions. Interventions from the Compendium that are included in this chapter are so noted. IDPH does not require funded organizations to use interventions included in the Compendium. A copy of the Compendium can be found at http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm

HIV Positive Persons...

Overview of Interventions Targeting HIV Positive Persons

We all have the collective responsibility to create the conditions in which both seropositive and seronegative people can make healthy choices (Marks et al., 1999). This means that it is essential to engage HIV positive persons, as well as those who are HIV negative, in prevention interventions. However, until recently, prevention efforts in this country have been mostly focused on people who are at risk for becoming infected. The prevention needs of HIV positive individuals have often been overlooked, as have the significant efforts on the part of many to avoid infecting others. Although one HIV positive person is involved in each case of transmission, the world of prevention has shied away from focusing on prevention with positives because of the justifiable fear of stigmatizing people who are living with HIV/AIDS and a concern about creating a divide between HIV positive and negative individuals. In addition, the federal funding streams created two separate systems; one to provide prevention to at risk individuals and the other to provide care and support to those who are positive (Collins et al., 2000).

As HIV positive persons are living longer, they are healthier and are enjoying sexual lives. Recent evidence indicates that risk behaviors among both HIV positive and negative persons are increasing. There is more discussion about issues of intimacy and sex. In addition, many people living with HIV and AIDS face problems that may contribute to risk behavior, such as poverty, racism, homophobia, threat of violence, substance use, and mental health issues (Collins et al., 2000).

Behavioral interventions can make a significant contribution to the lasting behavior change among people living with HIV and may be enhanced with the integration of messages of personal responsibility. While the great majority of HIV positive persons take steps to protect both their partners and themselves, a recent study found that approximately 13% of HIV positive individuals do not disclose their status to sexual partners before engaging in risky behavior that could transmit the virus (Ciccarone et al., 2003).

ADVANCING HIV PREVENTION

In 2003, CDC released its Advancing HIV Prevention (AHP) strategies (CDC, 2003a). One of the key strategies of AHP is to prevent new infections by working with persons diagnosed with HIV and their partners. According to AHP, CDC will work with professional associations to disseminate guidelines regarding the incorporation of HIV prevention into the medical care of persons with HIV to primary care providers and infectious disease specialists. CDC will work closely with the Health Resources and Services Administration (HRSA) to reach persons...
who are HIV positive but are not in ongoing medical care or prevention services. CDC has also funded some demonstration projects to provide prevention case management to HIV positive persons. Finally, CDC will support new models of partner counseling and referral services (PCRS), including offering rapid testing and using peers to conduct PCRS.

**RECOMMENDATIONS REGARDING PREVENTION WITH POSITIVES PROGRAMS**

The AIDS Policy and Research Center and Center for AIDS Prevention Studies at the AIDS Research Institute, University of California San Francisco, recommends that people living with HIV, and the groups that represent their interests, must provide the leadership in designing effective prevention with positive programs. They note that not enough attention has been paid to the many efforts of HIV positive persons to change behavior and avoid infecting others. The challenge is to design prevention programs targeting HIV positive individuals that talk about accountability and responsibility without causing feelings of shame or encouraging stigma (CDC, 2003).

**NAPWA’S PRINCIPLES OF HIV PREVENTION WITH POSITIVES**

The National Association of People with AIDS (NAPWA) developed 14 principles of HIV prevention with positives to help shape these efforts. The principles were developed through a series of meeting with diverse groups of HIV positive persons across the country, and represent the perspective of those who will be most directly impacted by prevention with positives interventions.

1. **Prevention must be a shared responsibility.**
   Developing prevention programs for positive people must not become an excuse for shifting all responsibility for prevention (or blame for new infections) onto the shoulders of people living with HIV/AIDS. A culture of shared responsibility that encourages communication and equality in relationships should be a goal of our prevention programming.

2. **Don’t assume serostatus.**
   HIV prevention programs should deliver messages that are inclusive,

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**Prevention with Positives**

Because there is so much diversity among people living with HIV, different kinds of interventions must be developed in order to effectively reach various populations. There are a number of factors that can affect risk behavior and should be taken into account in the development of programs:

- **Personal** – current health status, length of time living with disease, success of HIV treatments
- **Partner** – attractiveness, power dynamics within the couple, desire to please
- **Race** – power dynamics, assumptions about roles and HIV status
- **Community** – urban or rural setting, presence or absence of HIV positive peers, communal beliefs about the origins of HIV, the degree to which HIV infection stigmatized a person, ability to feel accepted in the community and discuss challenges with practicing safer sex
- **Substances** – physical or emotional dependence on alcohol and/or drugs
- **Economic situations** – homelessness, economic crisis, dependence on sex for money
- **History** – memory of the Tuskegee syphilis study where treatment was withheld from African American men
- **Availability of health care and prevention** – supportive education campaigns, condom

understanding that HIV positive people will also hear these messages. It needs to be assumed that any HIV prevention effort will reach some people living with HIV/AIDS. Messages that are meant to apply only to uninfected people (“Stay negative,” “Don’t have sex with a person with AIDS,” etc.) will be heard and understood differently by different people. Think about how these messages shape the way people living with HIV/AIDS think about prevention, and the way others think about us.

3. **HIV positive people have unique needs and concerns that require targeted approaches to reach us.**
   It isn’t the same for positive and people of unknown or negative status.

4. **People living with HIV/AIDS are extremely heterogeneous and programs need to address the different needs of such a diverse group.**
   It simply isn’t the same for everyone, and we need culturally competent interventions for diverse populations: race, gender, sexual orientation, age, language, geography, addiction, etc. all impact the type of programming needed. One size does not fit all.

5. **Effective programs must fully accept the right of people living with HIV/AIDS to intimacy and sexual health.**
   Few issues are as emotionally charged as sexual activity by people living with HIV/AIDS. Providers must learn to be truly non-judgmental and support the human right to a fulfilling sexual life, while working with people to decrease potential risk to others and themselves.

6. **Behavior change is tough for everyone…including people living with HIV/AIDS.**
   Expecting 100% perfection from people who are HIV positive is as unrealistic as expecting it from the uninfected. Creating and sustaining behavior change is rarely instantaneous.

7. **Knowledge of serostatus is important, but isn’t enough.**
   Knowing is the first step, but it still requires support and skills. Most people who know they are HIV positive will take steps to avoid infecting others – but it is unrealistic to expect people to make and maintain change solely based on knowledge of status.

8. **There is no magic bullet, no single type of intervention that will work for everyone.**
   Just like every other population, people living with HIV/AIDS need a variety of interventions delivered in a variety of settings and sustained over time. While medical settings offer one important venue for interventions, there are many drawbacks to relying on them for positive prevention. A diverse range of interventions, delivered in diverse settings, is required.

9. **Disclosure isn’t always the answer.**
   Disclosure doesn’t guarantee safe behavior. Disclosure may produce severe and negative consequences. Helping people assess their readiness to
disclose and developing the skills to do so is different than telling people they must disclose.

10. **Stigma, discrimination, shame and fear drive people underground and make prevention harder for everyone, especially HIV positive people.**

   Programs must function with an acute understanding of the centrality of these issues in the experience of people living with HIV/AIDS, must help people cope with their impact, and should challenge these harmful attitudes in communities.

11. **Coercion/criminalization is not the answer – and certainly shouldn’t be the first answer.**

   It is impossible to retain the trust and honest engagement of people if our prevention strategies are predicated on the threat of criminal prosecution for engaging in consensual activities.

12. **Programs must be anchored in the real needs and concerns of people living with HIV/AIDS.**

   If it is driven solely by a prevention agenda without considering the priorities of people living with HIV/AIDS, it will fail. Listen to what is important to your population. Addressing relationships, housing, economic security, personal safety, etc. are all important in engaging people in prevention.

13. **People living with HIV/AIDS need to be involved in the planning, design, delivery and evaluation of these programs.**

   Things that are “done to us” won’t work as well as things that are “done with us.”

14. **Resources and capacity building efforts must support the development of HIV positive-run programs to respond to this need.**

   There is an important role for PWA coalitions and other organizations run by and for positive people in these programs. We must invest in the capacity of organizations to do this work, creating sustainable PLWHA-led prevention efforts.

**COUNSELING, TESTING AND REFERRAL**

A meta-analysis of 27 published studies involving 19,957 participants was conducted to see whether HIV counseling and testing leads to a reduction in sexual risk behavior (Weinhardt et al., 1999). This analysis found that after counseling and testing, HIV positive individuals and persons in serodiscordant couples reduced unprotected intercourse and increased condom use more than people who received HIV negative results or those who did not test.

Weinhardt et al. (1999) also note that specific outcomes of HIV counseling and testing should include identifying those HIV positive individuals who are most at risk for transmitting the disease to others and referring them to specialized behavioral interventions and support. Asking a client at the time of testing about the number of persons he or she may have infected might identify those clients at greatest risk of transmitting HIV to others. The number of persons infected
between time of infection and diagnosis significantly predicts the number of persons infected post-diagnosis.

**PARTNER COUNSELING AND REFERRAL SERVICES**

Partner Counseling and Referral Services (PCRS) are targeted at both HIV positive persons and their sexual and needle sharing partners. Disease Intervention Specialists (DIS) contact persons who test positive and offer to provide them with risk reduction and referral information. For those who accept PCRS services, the DIS provide information on HIV disease, risk reduction counseling, and referrals to medical care and support services. The DIS also discuss the importance of contacting sexual and needle sharing partners to let them know that they have been exposed to HIV. HIV positive persons can choose to contact their partners themselves, in which case the DIS will provide coaching on how to tell their partners that they are at risk of infection and how to refer them to counseling and testing services. The DIS also offers to contact partners on their behalf. In this case, the DIS locates partners using names, descriptions, and addresses provided by the HIV positive person. The anonymity of the index patient is always maintained. Once partners are located, the DIS provide an initial 45–60 minute session about HIV and risk reduction to those who accept PCRS, and offer them an OraSure test. If partners do not want to be tested by the DIS, they are referred to counseling and testing site. The DIS also provide post-test counseling for those to whom they provide an OraSure test. Several studies have shown that PCRS strategies are cost effective (Rahman et al., 1998; Varghese et al., 1998).

**GROUP LEVEL INTERVENTION**

*Healthy Relationships (DEBI)*

This DEBI Project group session intervention is based on a study involving HIV positive gay, heterosexual and bisexual men and women. Participants in the study reported greater self-efficacy for suggesting condom use with new partners, as well as reporting less unprotected sex, more protected sex, and fewer sexual contacts at the 6-month follow-up. Participants were also significantly more likely to refuse to engage in unsafe sex at the 6-month follow-up (Kalichman et al., 2001).

[Core Elements of Healthy Relationships]

Healthy Relationships is a five-session, small group intervention for HIV positive men and women. Core elements of the intervention include:

- Defining stress and coping skills in relation to disclosing to family and friends, disclosing to sexual partners, and building healthier and safer relationships
- Using modeling, role play, and feedback to teach and practice skills related to coping with stress
- Teaching decision making skills about disclosure of HIV status
- Providing personal feedback reports to motivate change of risk behaviors and maintenance of protective behaviors
- Using movie clips to set up scenarios about disclosure and risk reduction to stimulate discussions and role plays

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COMPREHENSIVE RISK COUNSELING AND SERVICES

CDC promotes comprehensive risk counseling and services (CRCS), previously known as prevention case management, as a priority for HIV positive persons. CDC defines CRCS as being "intensive, individualized client-centered counseling for adopting and maintaining HIV risk reduction behaviors."

Upon looking at prevention case management (PCM) programs across the nation, CDC found that they were being implemented very differently. They also identified some barriers to successful PCM programs, which include a lack of interest by clients, lack of clear definition of PCM, lack of referral resources in the community, and difficulty evaluating the outcome of the program (Collins et al., 2000). In response to some the lack of clarity in the definition of PCM, CDC changed the name of the service to CRCS and released new guidance for implementing CRCS programs in 2006. The guidance clarifies that the focus of CRCS is to provide risk reduction counseling. Case management services may be provided only if these services are not otherwise available to the client.

The CDC guidance also defines the primary goal and essential components of CRCS. The primary goal is to help HIV positive (and HIV negative) persons who are at high risk for HIV transmission (or acquisition) to reduce risk behaviors and address the psychosocial and medical needs that contribute to risk behavior or poor health outcomes. The seven essential components of CRCS are: client recruitment, screening, development of personal prevention plan, risk reduction counseling, coordination of client support with other case management programs and provision of referrals as needed, ongoing monitoring and reassessment of client progress and needs, and discharge.

A study of prevention case management with HIV positive clients conducted in Wisconsin found that the percentage of clients reporting risk behaviors (unprotected insertive anal or vaginal sex, or needle sharing, with partners whose HIV status was negative or unknown) decreased from 41% at baseline to 29% at first follow-up (average of 4.6 months later). However, among clients who participated in a second follow-up (approximately 3 months later), self-reported behavior indicated increases in unprotected sex with both HIV negative and HIV positive partners, as well as increases in the average number of total partners (Gasiorowicz et al., 2005).

HIV PREVENTION IN MEDICAL CARE SETTINGS

In July 2003, CDC, the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the HIV Medicine Association of the Infectious Disease Society of America released recommendations regarding the incorporation of HIV prevention into the medical care of persons living with HIV and AIDS (CDC, 2003b). The recommendations are general and apply to all HIV positive adolescents and adults, regardless of age, sex or race/ethnicity. They are intended for all professionals that provide medical care, such as physicians, nurse
practitioners, nurses, and physician assistants. They might also be useful to other providers such as case managers, social workers and health educators.

The recommendations state that clinicians can greatly affect their patients’ risk for HIV transmission by doing the following:

- Performing a brief screening for HIV transmission risk behaviors
- Communicating prevention messages, both verbally and with literature/posters
- Providing condoms
- Discussing sexual and drug use behavior
- Positively reinforcing changes to safer behavior
- Referring patients to services such as substance abuse treatment
- Facilitating partner notification
- Counseling and testing
- Identifying and treating other STDs

**HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART)**

The use of highly active antiretroviral therapy (HAART) can significantly reduce the levels of virus in the blood, often to the point of being undetectable by current tests. Lower viral load in the blood tends to correlate with lower levels of the virus in genital fluids, but it is not an exact correlation (Barroso et al., 2003).

One study in Uganda found that low blood viral load resulted in decreased transmission of HIV. No transmission was observed among the 51 serodiscordant couples whose infected partner’s blood viral load was under 1500 copies per ml (Quinn et al., 2000). Another study in Taiwan found that after implementing a policy of providing free access to HAART in 1997, the estimated rate of HIV transmission was reduced by 53% by the end of 2002 (Fang et al., 2004).

It must be noted, however, that even for HIV positive persons on HAART, virus remains in many tissues of the body, inside cells, and in the blood despite being undetectable to tests. Viral loads can also fluctuate over time due to changes in adherence to treatment, the development of drug resistance, or the natural history of disease progression (Center for AIDS Prevention Studies, 2003). Also, as previously noted in the Needs Assessment chapter of this plan, optimism about treatment has been associated in some studies to an increase in risky behavior.

**COMPREHENSIVE PROGRAMMING**

*Safety Counts (DEBI)*

Safety Counts is a client-centered, comprehensive intervention targeting HIV positive and HIV negative individuals who are currently using injection or non-injection drugs. The intervention is not specific to gender, race/ethnicity, or sexual orientation. The goal of the program is to reduce risk of becoming infected with or transmitting HIV and hepatitis viruses, and involves individual and group
level activities over a period of 4 to 6 months. Staff discusses the importance of knowing HIV status upon program enrollment and offer CTR services at each session for HIV negative clients.

Compared to persons enrolled in the comparison condition, clients who participated in Safety Counts were about 1.5 times more likely to reduce their drug and sex-related risks, were more than 2.5 times more likely to report an increase in condom use, were significantly more likely to report a reduction in the number of times they inject, and more likely to test negative for opiates through urinalysis (Rhodes and Humfleet, 1993; Rhodes and Wood, 1999).

<table>
<thead>
<tr>
<th>Core Elements of Safety Counts</th>
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<tr>
<td>The five core elements of Safety Counts are:</td>
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<tr>
<td>• Group Sessions One and Two involve hearing clients’ HIV risks and current stage of change, hearing risk reduction success stories, setting personal goals, identifying first steps to reduce HIV risk, and making referrals to CTR and medical/social services</td>
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<tr>
<td>• One (or more) Individual Counseling Session involves discussing/refining risk reduction goals, assessing client’s needs, and providing referrals</td>
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<tr>
<td>• Two (or more) Social Events are designed for socializing, participating in risk reduction activities, and receiving reinforcement for personal risk reduction</td>
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<tr>
<td>• Two (or more) Follow-up Contacts involve reviewing client’s progress, discussing barriers encountered, identifying concrete next steps and possible barriers/solutions, and referrals</td>
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<tr>
<td>• HIV/HCV Counseling and Testing is offered through the service or referral to another agency</td>
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HIV Positive Men Who Have Sex with Men

INDIVIDUAL LEVEL INTERVENTION
Richardson et al. (2004) evaluated brief provider-delivered messages in HIV primary care clinics among a sample primarily made up of MSM. The six clinics were randomly assigned to deliver risk reduction messages that emphasized the benefits of adopting safer behavior, messages that emphasized the consequences of not reducing sexual risk behaviors, or HIV treatment adherence messages (control condition). Among participants with two or more partners at baseline who received messages regarding consequences of not reducing risk, there was a 38% reduction in unprotected intercourse. The study did not find any effect among participants with one partner at baseline who received consequences messages or among participants who received messages about the benefits of adopting safer behaviors, regardless of the number of partners. The findings demonstrate that this is not a “one size fits all” intervention.

GROUP LEVEL INTERVENTION
In a study of brief (60–90 minute) risk reduction interventions, participants were randomly assigned to one of four conditions: 1) a single, targeted counseling session that focused on condom use, negotiation, or disclosure; 2) a single-session comprehensive intervention that covered all three topic areas; 3) the same comprehensive intervention with two monthly booster sessions; or, 4) an attention control exercise comparison condition. All four of the conditions, including the comparison condition, resulted in a significant decrease in total occasions of unprotected sex over 12 months. The findings suggest that a brief intervention can reduce HIV transmission risks among HIV positive MSM, but the effectiveness of one intervention over another remains unclear (Patterson et al., 2003).

HIV Positive Injection Drug Users

GROUP LEVEL INTERVENTION
Holistic Health Recovery Program (DEBI)
The Holistic Health Recovery Program (HHRP) is based on an intervention study conducted by Margolin et al. (2003). Participants were inner city HIV positive IDUs with mild to moderate cognitive impairment who were dually addicted to heroin and cocaine and had a history of unsuccessful drug treatment. HHRP has since been adapted so that it can be used with HIV positive and HIV negative IDUs.

Core Elements of HHRP
HHRP teaches participants the following:
- Harm reduction skills related to injection drug use and unprotected sexual activities
- Negotiation skills to reduce unsafe sexual behaviors
- Decision making and problem solving skills
- Goal setting and action plan development skills
- Stress management skills
- Skills to improve health, health care participation, and adherence to medical treatments
- Skills to increase clients’ access to their self-defined spiritual beliefs to increase motivation to engage in harm reduction
- Skills to increase self awareness

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HHRP is a 12-session, manual-guided, group level intervention to promote health and improve quality of life. More specific goals include a reduction of or abstinence from illicit drug use and sexual risk behaviors; reduced risk for HIV transmission; and improved medical, psychological and social functioning. Participants in the study demonstrated a decrease in addiction severity, a decrease in risk behavior, and significant improvement in behavioral skills, motivation and quality of life.

**HIV Positive High Risk Heterosexuals**

**GROUP LEVEL INTERVENTION**

The Women Involved in Life Learning from Other Women (WILLOW) Program was evaluated with HIV positive women who were predominantly African American. The intervention consisted of four 4-hour meetings that were facilitated by a health educator and an HIV positive female peer. The sessions emphasized gender pride, maintaining and expanding current social networks, HIV transmission knowledge, communication and condom use skills, and healthy relationships (social and sexual). Compared to participants in the control condition focused on HIV treatment and nutrition, at 12-month follow up women who participated in the intervention reported fewer episodes of unprotected vaginal intercourse; were less likely to report never using condoms; had a lower incidence of bacterial STD infections, reported greater HIV knowledge and condom use self-efficacy, more network members, fewer beliefs that condoms interfere with sex, and fewer partner-related barriers to condom use; and demonstrated greater skill in using condoms (Wingood et al., 2004).

**HIV Positive Youth**

**GROUP LEVEL INTERVENTION**

*Teens Linked to Care (DEBI)*

Teens Linked to Care (TLC) is an effective intervention for young people living with HIV and is delivered in small groups using cognitive-behavioral strategies to change behavior. TLC consists of three modules, each of which consists of 8-12 sessions that are delivered in a general sequence. Each module is focused on a different behavioral outcome. Module I: *Staying Healthy* targets health care utilization and health behaviors. Module II: *Acting Safe* addresses both sexual and drug-use-related transmission acts. Module III: *Being Together* focuses on improving quality of life. Young people meet regularly to provide social support, learn and practice new skills, and socialize. This program helps young people identify ways to improve their quality of life by setting new habits and daily social routines.

**Core Elements of Teens Linked to Care**

The core elements of TLC are:

- Delivery of three modules consisting of 8-12 sessions each
- Delivery of modules in interactive groups
- Exercises in each session that are designed to be meaningful personal experiences, leading to development of personal knowledge and attitudes and increased skills to support adoption of new behaviors
- Individualized homework tasks assigned following each session

[www.effectiveinterventions.org](http://www.effectiveinterventions.org)
Teens Linked to Care is based on research with HIV positive youth by Rotheram-Borus et al. (2001) which found that participants reported fewer sexual partners, including fewer HIV-negative partners, and fewer unprotected behaviors. The youth also reported a decrease in alcohol and drug use, as well as decreases in feelings of distress and anxiety, and physical symptoms of the disease, and an increase of the social support coping skill.

**INDIVIDUAL LEVEL INTERVENTION**

Rotheram-Borus et al. (2004) conducted a study to evaluate whether Teens Linked to Care could be adapted for delivery on an individual level with fewer sessions and remain effective with substance using HIV positive youth. Participants (ages 16–29) were randomly assigned to in-person delivery or phone delivery of the intervention. The intervention used the same 3 modules as Teens Linked to Care, but each module consisted of only 6 sessions lasting 2 hours each. The control condition consisted of repeated risk assessments over a period of 15 months without receiving the intervention. Youth assigned to the in-person intervention demonstrated a significantly higher increase in protected sexual risk acts, especially with HIV negative partners, than participants in the telephone or control conditions. There were no differences in number of sexual partners, disclosure of serostatus, drug use, adherence to HAART, improved healthy behaviors, or emotional health across the three intervention groups.

Although more expensive than conducting Teens Linked to Care in a small group setting, the in-person individual level intervention was shown to be effective in reducing sexual risk and the authors note that it could be more easily used in rural settings. Interestingly, the study found that most participants in the control condition consisting only of repeated risk assessments reduced their sexual and drug use behaviors over time. The authors are currently evaluating the effectiveness of this type of intervention with HIV positive persons.

**Men Who Have Sex with Men**

**Overview of Interventions for Men Who Have Sex with Men**

In general, the evaluation of programs for gay men has been of high quality, based on sound theory and has been successful in targeting specific behaviors. However, further data are needed regarding long-term behavioral change. In addition, there is a lack of evaluated interventions that focus on men of color who have sex with men, gay and bisexual youth, men who have sex with men who do not identify themselves as gay, and non-urban men who have sex with men.

Also, some more basic research needs to be done among gay men to describe attitudes and motivations, including development of good scales to measure these constructs. The wider spectrum of sexuality needs to be considered in order to affect maintenance of safer sex over time. For example, according to the CDC, research has shown that some men make false assumptions about the HIV status of their partners, assuming that partners who do not insist on a condom must not be infected, or believing that they have communicated their status by
leaving their HIV medications in visible locations. Programs must be designed to address these and other factors influencing behavior, and must ensure that messages are reinforced and adapted as needed over time.

**Men of All Races Who Have Sex with Men**

**Counseling and Testing**

A meta-analysis of 27 published studies involving 19,957 participants, including MSM, was conducted to see whether HIV counseling and testing leads to a reduction in sexual risk behavior. The results indicate that people who receive negative test results and those who do not test are less likely to reduce risky sexual behavior than persons who test positive or are in a serodiscordant couple. HIV negative participants did not reduce risk behavior any more than participants who did not test. This study suggests that counseling and testing is not effective as a primary prevention strategy (Weinhardt et al., 1999).

**Internet Outreach**

Due to the popularity among MSM of using the Internet to meet sexual partners, several studies have been conducted of Internet outreach efforts, although with limited information about their impact on behavior change. One effort was undertaken by the San Francisco Department of Health in response to increases in syphilis cases among gay men. The intervention included one-on-one discussions via instant message and e-mail with persons in chat rooms, banner ads, one-hour auditorium-style chats with questions answered by an expert, an educational site allowing for questions to be posted and then answered by a physician, message boards, and promotion of syphilis testing. This intervention measured the number of persons reached and tested for syphilis, but did not assess behavior change. The banner ads and the educational site reached the greatest number of people. Of the thousands of persons who visited the syphilis testing site, only 140 completed the test. Among these, 6 (4%) new syphilis infections were identified. The researchers note the difficulty in targeting the campaign to a specific geographic area and suggest that communities across the country may want to pool resources to develop Internet-based activities (Klausner et al., 2004).

An exploratory study was conducted of a chat room intervention in which a health educator actively participated in general chat room dialogue and announced his availability to answer questions and provide referrals related to HIV/AIDS. Six major themes evolved during chat room discussions: sexual risk reduction strategies, particularly related to barebacking; questions about HIV testing; alternatives for non-sexual social support; referrals for youth; resources related to coming out; and access to risk reduction materials and supplies. Although this study did not assess behavioral change, the author notes that this type of intervention reaches MSM in the space and time that they are looking for sexual partners and that prevention messages and negotiation skills are less likely to be
forgotten in the short time between hearing them and hooking up with a partner (Rhodes, 2004).

The study that did attempt to assess behavioral change experienced difficulties with follow-up. MSM were recruited through chat rooms, list serves, banner ads, flyers to health departments and social service agencies, and links from HIV prevention organizations’ websites. People who agreed to participate were randomly assigned to the intervention or to the control group, where they received messages about HIV and STD prevention similar to those available on numerous Internet sites. The intervention was based on the AIDS Community Demonstration Project and consisted of three tailored messages, generated according to information they provided in their risk assessment. The messages were delivered using a role model story format, and were accompanied by a photo of a man similar to the participant in terms of age and race/ethnicity. The stories encouraged the participants to consider small incremental changes towards three behavioral outcomes: condom use with non-main partners, STD testing, and HIV testing. Participants were asked to return to the website in 3 months to complete a follow-up survey. Only 15% of participants completed the follow-up. However, of these, data indicate that men in the intervention group were significantly more likely to indicate they were willing to go to an STD prevention website to get information about disease prevention, and showed a trend toward testing for HIV more frequently than men in the control group (Bull et al., 2004).

Individual Level Interventions

EXPLORE

The EXPLORE behavioral intervention assumes that different MSM will have different risk factors and that interventions need to be tailored to each individual (Chesney et al., 2003). The first three sessions of the EXPLORE model are designed to build rapport between the counselor and the individual. They focus on identifying the factors most important for the individual in relation to unsafe sex and self-protection. Based on the information gathered in the first three sessions, the counselor designs the following sessions to focus on issues that are most pertinent to the individual.

The EXPLORE model is based on 10 counseling modules. The counselor individualizes the intervention by choosing the modules that best fit the needs of each person.

Module 1 – Being HIV negative and participating in EXPLORE.

Session Focus:
- Participant states why he wants to stay HIV negative.
- Mixed feelings about sex and risk are examined and normalized.

Modules 2 and 3 – Risk: What’s acceptable to me? Crossing acceptable limits.

Session Focus:
- Knowledge of risk factors assessed.
- Personal meaning of risk reduction is explored through talking about recent sexual experiences and personal attitudes regarding acceptable risk.
- Discussion about pleasure of unprotected sex.

**Modules 4 and 5** – Sexual Communication: HIV status, spoken and unspoken messages.

*Session Focus:*
- Attitudes and skills that help or impair clear communication of risk limits.
- Communication of serostatus.
- Being part of a couple that negotiates safety arrangements or risk limits.

**Modules 6, 7, 8 and 9** – Sex, Drinking, and Drugs: Places and events as triggers, feelings and thoughts as triggers, partners as triggers.

*Session Focus:*
- Impact of substance use on risk behavior.
- How personal, social, and environmental factors may trigger either risky sex or safer behavior.
- Examination and skills training to manage risk when faced with: settings where risky sex may occur, life and social events that may encourage risk, emotions and self-talk that cue risk taking, partner characteristics that trigger risky sex.

**Module 10 and Maintenance** – Planning for maintenance and staying HIV negative.

*Session Focus:*
- Planning for how to maintain personal risk reduction efforts, including training on how to prevent relapses, applying lessons to changing life situations.

The study found that the most common factor reported by 75% of participants was enjoyment of unprotected anal sex, which presents a challenge to motivating behavior change. This model employs motivational interviewing, which is used to identify feelings of ambivalence towards reducing risk. The focus of counseling is on identifying and vocalizing pros and cons of change and reasons to engage in safer behaviors.

Compared to the control condition, consisting of two individual counseling sessions and two follow-up visits with HIV testing, the rate of acquisition of HIV infection was 16% lower among participants in the EXPLORE intervention. The effect was more favorable in the first 12–18 months of follow-up. The occurrence of unprotected receptive anal intercourse with partners of positive or unknown serostatus was 21% lower among the EXPLORE participants compared to those in the control condition (Koblin et al., 2004).
Group Level Interventions

Most group level interventions have been shown to be effective, particularly if sexually explicit materials were used and behavioral skills were an important part of the intervention. However, the studies did not measure long-term behavioral change. These interventions involved highly motivated men who self-identified as gay or bisexual, and may not be as effective for other men having sex with men.

**SMALL GROUP LECTURE PLUS SKILLS TRAINING (COMPENDIUM)**

A lecture-only intervention tested with mostly White gay men covered HIV transmission, HIV infection, relative risk for specific sexual practices, condom use, interpretation of HIV test results, and importance of reducing risk. A second intervention added a skills building component that incorporated role play, psychodrama, and group process. Both groups showed trends toward behavior change, and the skills building intervention was effective at increasing the use of condoms during insertive anal sex at 6- and 12-month follow-ups (Valdiserri et al., 1989). Additional studies have shown that not only is the incorporation of a skills building component into HIV prevention education effective in changing behavior, it is also cost effective (Pinkerton et al., 1997).

*Man-to-Man Seminar*

The Man-to-Man Seminar, developed in Illinois, is a 2-day sexual health seminar designed to provide comprehensive sexual health education to MSM. The seminar focuses on participants’ knowledge, attitudes, and behaviors as they relate to HIV prevention, risk behavior, and sexual health. The seminar provides basic information on sexual health issues including sexual identity, HIV and STD prevention techniques, relationships, intimacy, and sexual behavior. The curriculum includes multi-media, multi sensory experiences with large group discussions, small group discussions, behavioral modeling, storytelling, video, music, and PowerPoint slide presentations.

Participants in the seminar participate in the following: completion of voluntary pre-and post-test surveys, small group and large group exercises, breakout groups, and discussions with other participants of the seminar. The surveys include questions about sexual and drug experience, attitudes, beliefs, mood, and any abuse experienced and related issues. An evaluation study indicated the effectiveness of the seminar in increasing condom use among participants (Rosser et al., 2002).
COMMUNITY LEVEL INTERVENTIONS

Community PROMISE (DEBI)

Community PROMISE is based on the AIDS Community Demonstration Projects, which took place over three years in Dallas, Denver, Long Beach, New York City, and Seattle. Target communities included non-gay-identified men who have sex with men, among others. Each intervention site used peer volunteers to distribute kits featuring role model stories, brochures, condoms, and bleach kits. Significantly greater achievement in consistent condom use, and maintenance of consistent condom use with non-main partners was found in the intervention communities (CDC AIDS Community Demonstration Projects Research Group, 1999).

Community PROMISE begins with a community identification process, which involves interviewing and holding focus groups with stakeholders in the community to identify why people engage in risk behaviors, what barriers exist to changing behavior, what will encourage them to change behaviors, and locations where they engage in risk behaviors. This helps with identifying target populations and appropriate tailoring of the intervention. Members of the target population who have made positive behavior change are interviewed and role model stories are written based upon their interviews. Peer advocates from the target populations are recruited and trained to distribute the role model stories and other materials.

Popular Opinion Leader (DEBI)

The Popular Opinion Leader (POL) model is based on a study conducted by Kelly et al. (1991) and targets men who frequent gay bars, male sex workers, adolescents, and business owners who cater to gay men. POL involves the recruitment of a group of trusted, well-liked men who frequent gay bars. The “popular opinion leaders” are trained in a series of 4 sessions to endorse safer sexual behaviors in casual, one-on-one conversations with peers at the bars and other settings. During these

Core Elements of Community PROMISE
The core elements of Community PROMISE:
- Community identification process to collect information about the community, including HIV/STD risk behaviors and influencing factors
- Creating role model stories based on personal accounts from individuals in the target population who have made positive behavior change
- Recruiting and training peer advocates from the target population to distribute role model stories and prevention materials
- Continuous formative evaluation to capture behavior change

Core Elements of Popular Opinion Leader
The core elements of the POL model are:
- Identifying and enlisting the support of popular and well-liked opinion leaders to take on risk reduction advocacy roles
- Training cadres of peer opinion leaders to disseminate risk reduction endorsement messages within their own social networks
- Supporting and reinforcing successive waves of opinion leaders to help reshape social norms to encourage safer sex

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conversations, the popular opinion leader corrects misperceptions, discusses the importance of HIV prevention, describes strategies he uses to reduce his own risk (e.g., keeping condoms nearby, avoiding sex when intoxicated, resisting coercion for unsafe sex), and recommends that the peer adopt safer sex behaviors. Popular opinion leaders wear buttons displaying the project logo, which also is on posters around the bars, as a conversation-starting technique. Each leader agrees to have at least 14 such conversations and to recruit another popular opinion leader.

According to the CDC (2000), the use of peer opinion leaders has been found to be an effective strategy in the MSM community. Surveys of nearly 1,300 gay men in cities with and without a popular opinion leader program found that men in the intervention communities were 34% less likely to have unprotected sex compared to men from other control communities 3 to 6 months after intervention. When the intervention was first tested, results indicated that unprotected anal intercourse decreased from between 15–29%, condom use increased, and the number of sex partners decreased (Kelly et al., 1991).

Men of Color Who Have Sex with Men

GROUP LEVEL INTERVENTIONS

Many Men, Many Voices (DEBI)

This group level intervention is focused on behavioral self-management and assertion skills, and is based on a study conducted with primarily White gay men. Twelve group sessions addressed HIV and prevention, improving behavioral self-management, self-identification of risk behaviors and personal risk reduction strategies, assertiveness training, relationship building and social support. The intervention was effective in improving safer sex behaviors and at maintaining this improvement over an 8-month period, and in improving assertiveness skills and HIV/AIDS knowledge (Kelly et al., 1989).

The intervention has been adapted to target gay men of color as well as those on the “down low.” Many Men, Many Voices (3MV) consists of 6 or 7 group sessions designed to influence behavior change for HIV/STD prevention. A peer facilitator leads a series of 2- to 3-hour sessions. Sessions address behavioral influencing factors specific to gay men of color and encourage sharing of experiences. The participants build an understanding of how their life experiences relate to how they feel about themselves, their attitudes and beliefs, and their risky behaviors. It is a step-by-step process that relies on real dialogue and participant interactions. The program uses behavioral skills practice, group discussions, role plays, and group

Core Elements of Many Men, Many Voices
The core elements of 3MV are:
- Educate clients about HIV risk and sensitize to personal risk
- Develop risk reduction strategies
- Train in behavioral skills
- Train in partner communication and negotiation
- Provide social support and relapse prevention

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exercises. The 7 sessions address specific influencing factors in a purposeful sequence including:

- Dual identity of gay men of color
- STD/HIV prevention for gay men of color – sexual roles and risks
- STD/HIV risk assessment and prevention options
- Intentions to act and capacity to change
- Sexual relationship dynamics – partner selection, communication, and negotiation
- Social support and problem solving to maintain change
- Building a healthy community (optional)

**Group Sessions Targeting African American Gay and Bisexual Men**

African American gay and bisexual men in the San Francisco Bay Area were recruited from bars, bathhouses, erotic bookstores, and through African American organizations, street networks, newspaper advertisements, and personal referrals. Some participants were randomly assigned to an intervention consisting of three 3-hour group sessions, and included the following components: promotion of self-identity and self-pride; HIV/AIDS risk reduction education, assertiveness training (discussion and role play), and verbal commitments to reduce high risk behavior. Other participants were randomly assigned to attend one 3-hour group session or to a wait-list control group. Compared to the control group, both intervention groups reported decreased unprotected anal intercourse at 12-month and 18-month follow-up. Participants in the 3-session intervention demonstrated a 50% decrease in unprotected anal intercourse at both follow-ups. Participants in the 3-session intervention reported significantly less risk behavior than those in the single session intervention at the time of both follow-ups (Peterson et al., 1996).

**Hot, Healthy and Keeping It Up!**

Hot, Healthy and Keeping it Up! is a 3-hour single group session targeting Asian and/or Pacific Islander gay and bisexual men. The intervention is designed to increase positive ethnic and sexual identity in order to help participants acknowledge HIV risk behaviors by discussing negative experiences of being both Asian or Pacific Islander and gay. Facilitators use interactive and group process techniques to address four intervention components: development of positive self-identity and social support, safer sex education, eroticizing safer sex, and negotiating safer sex. At the 3-month follow-up, participants in the intervention were significantly more concerned about HIV infection, had significantly fewer partners, and were significantly less likely to report unprotected anal sex than participants in the control condition (Choi et al., 1996).

**Hermanos de Luna y Sol**

Hermanos de Luna y Sol is a prevention intervention targeting immigrant, Spanish-speaking Latino MSM. Participants are recruited through bar outreach to participate in 6 weekly discussion workshops that address four factors that
impact safer sex: low self-esteem, perceptions of low sexual control, lack of social support, and fatalism regarding the inevitability of HIV infection. Participants have access to follow-up resources and activities to support them in maintaining safer sexual behavior over time. These activities include an ongoing support group, specialized workshops and retreats, and access to individual level risk reduction counseling services. Evaluation of the program indicates that it has been successful in reducing by 52% the percentage of men who never use condoms for anal intercourse. The percentage of men who were firmly committed to condom use for anal sex increased from 22% to 34% (Center for AIDS Prevention Studies, 2001).

COMMUNITY LEVEL INTERVENTIONS

Intervention Targeting Puerto Rican Men

An intervention developed to target gay men in Puerto Rico involves several components. Peer volunteers are first trained to conduct outreach in gay venues in order to recruit participants to come to a 3-hour small group meeting. The small group meetings are facilitated by peer educators and allow participants to discuss issues related to HIV prevention. Small group participants are invited to participate in a 4-session workshop also facilitated by peers. The sessions focus on intimacy (relationships, self-concept and self-hatred), perception of risk (HIV/STDs and risk behaviors, sexuality and culture, eroticizing safer sex), benefits and barriers to behavior change (alcohol and drug use, self-efficacy, communication and negotiation), and homophobia (community support and development, living with HIV, commitment for change on a personal and community level). Workshop participants were encouraged to contact two friends and refer them to a small group meeting. This proved to be one of the best ways to access members of the community for the intervention. Although the evaluation of the intervention did not include follow-up, results from pre- and post-test data analysis indicate that participants reduced high risk sexual behaviors and increased safer sexual behaviors over the course of the intervention (Toro Alfonso et al., 2002).

B-BOY BLUES FESTIVAL

The B-Boy Blues Festival is a successful program designed to recognize that a significant portion of African American men who have sex with men may not self-identify as gay or bisexual. HIV prevention information is provided in a more acceptable setting. The festival, held in St. Louis, Missouri, does not advertise or identify as an HIV/AIDS event and includes entertainment and cultural programs that accompany HIV workshops, HIV counseling and testing, and distribution of condoms and HIV prevention literature. As reported by CDC (2000), surveys disseminated at the festival in 1996, 1997, and 1998 showed significant improvements in attitudes about and knowledge of HIV and AIDS by attendants, illustrating that outreach activities not promoted as HIV/AIDS programs are useful in serving these usually hard to reach men.

RECOMMENDATIONS REGARDING INTERVENTIONS FOR OLDER MSM OF COLOR

In a study of risk behaviors among older MSM of color, Jimenez (2003) recommends that in order to be effective, interventions targeting this population must be sensitive and specific to the multidimensional character of older minority MSM sexuality and role identification. Although a large proportion of the participants in this study self-identify as gay, intervention messages and strategies should be developed that address a substantial portion of the population who do not identify as gay or homosexual and includes individuals who may, in fact, engage in regular bisexual activity.

Secondly, prevention efforts must consider the perceptions of gay-related and AIDS-related stigmatization held by many of the respondents in this study. Results from numerous studies indicate that stigmatization plays an important role in increasing HIV-associated risks behaviors while decreasing the use of HIV prevention services, particularly among men of color (Ramírez Valles, 2002; Stokes and Peterson, 1998). Finally, to facilitate access to prevention services for older MSM of color, interventions may need to redirect their activities to areas
outside of traditional gay urban enclaves. Most participants in this study, particularly those who were non-gay-identified, resided in communities of color, most of which are highly disenfranchised and underserved.

**Young Men Who Have Sex with Men**

**COUNSELING, TESTING AND REFERRAL**

A study comparing recent risk behaviors and HIV seroconversion among young MSM based on the frequency of their utilization of CTR services found that compared to young MSM who were first time testers, young MSM who repeatedly tested were more likely to acquire HIV and to report recent high risk behaviors. The researchers state that providers must strengthen practices to identify, counsel and test young MSM and provide enhanced behavioral interventions for those with persistent risks (MacKellar et al., 2002).

**INDIVIDUAL LEVEL INTERVENTION**

An intervention developed in Illinois which includes individual risk assessment, risk reduction counseling, peer education, optional HIV antibody testing and counseling, referral to medical and psychosocial services as needed, and longitudinal follow-up has contributed to short-term risk reduction in HIV transmission among gay/bisexual youth, measured by reductions in the number of sex partners and their frequency of unprotected anal intercourse among the participants (Remafedi, 1994). This intervention has also been shown to be cost effective in societal terms of averting 13 HIV infections, and saving 180 Quality Adjusted Life Years over a 10-year period, at a cost of $1.1 million dollars (Tao and Remafedi, 1998).

**SCHOOL-BASED INTERVENTION**

**Gay Sensitive HIV Education**

A study of HIV education among high school students in Massachusetts points to the need for gay sensitive HIV health education in schools (Blake et al., 2001). The study compared risk factors for gay, lesbian and bisexual (GLB) youth in schools that did not offer gay sensitive HIV education with those in schools that did offer gay sensitive HIV education. A drawback of the study is that gay sensitive HIV education was not clearly defined. It was determined by teachers reporting the use of gay sensitive HIV education curricula and confidence that they could meet the needs of gay/bisexual students.

The study found that GLB students in schools with no or minimal levels of gay sensitive HIV education were more likely than their heterosexual classmates, and more likely than GLB or heterosexual students in schools with gay sensitive education to:

- Become or get someone pregnant
- Have a higher number of recent sex partners
- Make a plan to commit suicide
- Miss school for personal safety reasons
- Have property damaged or stolen
COMMUNITY LEVEL INTERVENTIONS

The Mpowerment Project (DEBI)

The Mpowerment Project is based on an intervention conducted over eight months to reach young gay men ages 18-29. Men who participated in the project reduced their frequency of unprotected anal intercourse significantly more than the men in the comparison community did (Kegeles et al., 1996). The intervention is run by a core group of 10–15 young gay men from the community and paid staff. The young gay men, along with other volunteers, design and carry out all project activities. Ideally, the project has its own physical space where most meetings and social events are held and then can be used as a drop-in space during specified hours.

Popular Opinion Leader (DEBI)

The Popular Opinion Leader (POL) model has also been shown to be effective with young gay men. As described in more depth on page 313, the POL model involves the training of popular opinion leaders who then have one-on-one conversations promoting safer sex with their peers. The popular opinion leaders also recruit another person to go through the training.

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Core Elements of the Mpowerment Project

Mpowerment consists of four integrated activities:

- **Formal outreach:** Teams of young gay men go to venues frequented by the target population to discuss and promote and discuss safer sex, deliver informational literature on HIV risk reduction, and distribute condoms. Additionally, the team creates their own social events (e.g., dances, video parties, discussion groups, etc.) to attract young gay men and promote safer sex

- **M-groups:** Peer-led, 2-3 hour small group meetings allow young gay men to discuss factors contributing to unsafe sex. Through skills building exercises, participants practice safer sex negotiation and condom use. Participants receive free condoms and lubricant and are trained to conduct informal outreach

- **Informal outreach:** Young men discuss safer sex with their friends

- **Ongoing Publicity Campaign:** The campaign attracts young gay men to the project by word of mouth and through articles and advertisements in gay newspapers

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**High Risk Heterosexuals**

**Overview of Interventions for High Risk Heterosexuals**

While some prevention interventions have been developed for use with specific subpopulations of high risk heterosexuals, a number of interventions have been evaluated and found to be effective for adult high risk heterosexuals, without being racially or ethnically specific. Others have been tested and found to be effective with more than one racial/ethnic group.

**INDIVIDUAL LEVEL INTERVENTIONS**

*Project RESPECT (Compendium)*

Project RESPECT examined the efficacy of HIV/STD prevention counseling. It enrolled 5,801 primarily heterosexual STD patients (59% African American, 19% Latino, 16% White, 6% other) from five inner-city clinics into an enhanced counseling arm (four 60-minute sessions), a brief interactive counseling arm (two 20-minute sessions), and an HIV information arm (two 5-minute sessions), all of which were followed up at 3, 6 and 12 months. All three interventions were face to face, and used a structured format to encourage consistent condom use with all sex partners. A $15 stipend was offered per intervention session.

At the 3-month and 6-month follow-up, consistent condom use was significantly higher in participants of both the enhanced and brief counseling interventions compared to those in the information intervention. After 6 months, 30% fewer participants in both counseling interventions had new STDs, and after 12 months, 20% fewer participants in both had new STDs. The STD reduction was similar for men and women. Subset analyses suggest that the counseling interventions were better for adolescents (45% fewer had new STDs) and for people who had an STD at the baseline visit (40% fewer had new STDs) (Kamb et al., 1998).

*Project Connect*

Project Connect was a study of an intervention targeting primarily African American and Latino women and their heterosexual male partners. Participants were randomly assigned to one of three interventions. The first intervention consisted of 6 weekly 2-hour intervention sessions conducted with the woman only. The second intervention consisted of 6 weekly 2-hour sessions with both the male and female partners. Both of these interventions strongly emphasized the relationship, including issues of intimacy and closeness in the relationship, the meaning of monogamy and trust, and how all of these factors act as barriers to HIV/STD prevention. The two interventions focused on the importance of communication, negotiation, and problem solving skills, and highlighted how relationship dynamics may be affected by gender roles and expectations. The control condition consisted of a 1-hour HIV/STD educational session. Participants in both intervention groups reported increased protected sexual acts and decreased unprotected sexual acts than those in the control group. There was no significant difference between the two intervention groups. The intervention demonstrated that it is feasible to conduct a couple-based intervention with
African American and Latina women and their partners, and that these men were willing to participate (El-Bassel et al., 2003).

**GROUP LEVEL INTERVENTIONS**

**Condom Skills Education (Compendium)**

Men and women (67% African American, 15% Latino, 19% other) received a 10 to 15 minute presentation while waiting for appointments at an STD clinic. The presentation emphasized three important points for effective condom use: condoms should be made of latex, condoms should have a reservoir tip or space left at the end, and condoms should be lubricated with a spermicide. The session included group discussion and a demonstration of how to put on a condom. Another 10 to 15 minutes were allowed for questions and answers. Men and women who participated were significantly less likely to return to the STD clinic within the next 12 months with a new STD (Cohen et al., 1991).

**GROUP SESSIONS FOR PREGNANT WOMEN (COMPENDIUM)**

One intervention, led by female psychologists and health educators, consisted of 4 sessions, for groups of 2 to 8 single, pregnant women (57% African American, 40% White, 3% other). Women learned negotiation and assertiveness skills, created health plans, reviewed videos, and role played risk scenarios. Incentives included cash, partial reimbursement for transportation, childcare, and participation in a lottery for a color TV. Women who participated in the intervention increased their use of condoms with partners significantly more than women in the comparison condition (Hobfall et al., 1994).

**COMMUNITY LEVEL INTERVENTIONS**

**Real AIDS Prevention Project (DEBI)**

The Real AIDS Prevention Project (RAPP) intervention is based on the Women and Infants Demonstration Trial, which targeted women in inner city communities. Women in the intervention communities were more likely to initiate condom use with steady partners, negotiate condoms with steady and casual partners, and consistently use condoms (sex workers) with both steady and casual partners (Lauby et al., 2000).

The intervention objectives are to increase consistent condom use by women and their partners, to change community norms so that safer sex is seen as the norm, and to involve as many people from the community as possible. The program has two phases: 1) community assessment, which involves learning about the community and how to talk to women and their partners about HIV risk, and 2) getting the community involved in a combination of risk reduction activities.
Community PROMISE (DEBl)

As described in more detail on page 313, Community PROMISE is based on the AIDS Community Demonstration Projects. This intervention has been tested with African American, White and Latino communities, including female sex workers, high risk heterosexuals and high risk youth.

COMMUNITY PROMISE begins with a community identification process, which involves interviewing and holding focus groups with stakeholders in the community to identify why people engage in risk behaviors, what barriers exist to changing behavior, what will encourage them to change behaviors, and locations where they engage in risk behaviors. This helps with identifying target populations and appropriate tailoring of the intervention. Members of the target population who have made positive behavior change are interviewed and role model stories are written based upon their interviews. Peer advocates from the target populations are recruited and trained to distribute the role model stories and other materials. The final core element is formative evaluation to capture behavior change within the target population (WWW.EFFECTIVEINTERVENTIONS.ORG).

COMPREHENSIVE PROGRAMMING

Safety Counts (DEBI)

As previously described on page 304, Safety Counts is a client-centered, comprehensive intervention targeting HIV positive and HIV negative individuals who are currently using non-injection or injection drugs. The intervention is not specific to gender, race/ethnicity, or sexual orientation. The goal of the program is to reduce risk of becoming infected with or transmitting HIV and hepatitis viruses, and involves individual and group level activities, as well as social events over a period of 4 to 6 months. The intervention focuses on setting personal risk reduction goals, assessing progress, discussing barriers, and identifying next steps. Staff discuss the importance of knowing HIV status upon program enrollment and offer CTR services at each session for HIV negative clients (www.effectiveinterventions.org).

African American High Risk Heterosexuals

COUNSELING, TESTING AND REFERRAL

HIV EDUCATION, TESTING AND COUNSELING (COMPENDIUM)

In a study conducted by Wenger et al. (1991), men and women (85% African American) at an urban STD clinic were offered HIV counseling and testing. The counseling consisted of a pamphlet discussing safer and unsafe sexual acts and how to use condoms; a 15-minute video examining risk behavior and promoting condom use, as well as discussing risk with sex partners; and a 10-minute one-on-one counseling session with a physician. Participants reported significantly fewer occurrences of unprotected intercourse than did those in the comparison condition.
**INDIVIDUAL LEVEL INTERVENTION**

*Intervention for African American Women Using Crack Cocaine*

African American heterosexual women who use crack cocaine were recruited to participate in one of two enhanced gender- and culturally-specific interventions. The control condition was a standard National Institution on Drug Abuse (NIDA) intervention. The motivational intervention consisted of 4 individual sessions. The first session emphasized sex and drug-related risk behaviors, risk reduction strategies, and impact of race and gender on HIV risk and protective behaviors. Over the remaining sessions, the client identified what she would be motivated to change, developed short- and long-term goals, and talked about experiences in implementing short-term goals. The enhanced negotiation intervention also consisted of 4 sessions, with the first session being the same as in the other intervention. In the remaining sessions, focus was on intended behavioral changes; skills related to communication and assertiveness; setting short-term goals related to communication, gaining control, and developing assertiveness; discussing experiences with short-term goals and identifying barriers; and skills for negotiation and conflict resolution. The enhanced interventions were found to be more effective in reducing the number of paying partners for vaginal sex, frequency of sex with paying partners, the use of crack in risky settings, and in increasing condom use with steady partners. There were some differences in outcomes based on the two enhanced interventions. At the 6-month follow-up, the percentage of women across reporting crack use in the past 30 days decreased from 100% to 61% across the three intervention groups. The findings suggest that combined components of the two enhanced interventions may be most effective in reducing risky behavior among this population (Sterk et al., 2003).

**GROUP LEVEL INTERVENTIONS**

*Group Discussion and Condom Promotion (Compendium)*

This single session group intervention with men and women (92% African American) waiting for appointments in an STD clinic began with a video that depicted condom use as being socially acceptable, followed by group discussion about methods of preventing STDs, promotion of condom use, and reasons why people like or don’t like using condoms. Role playing allowed the participants the opportunity to practice condom negotiation. Finally, participants were given 10 free condoms. Men who participated in this intervention had a significantly lower STD reinfection rate. There was no evidence of change for women (Cohen et al, 1992).

*Cognitive-Behavioral Skills Training Group (Compendium)*

This clinic-based intervention consisted of 4 weekly group sessions lasting 90 minutes with 8 to 10 women in each group (87% African American). The sessions provided detailed information about HIV risk and focused on behaviors that increase risk, common misconceptions, and how to reduce risk. Exercises emphasized cognitive-attitudinal areas, behavioral skills and social factors. Role plays were used to practice initiating conversations about HIV and condom use, and how to resist sexual pressure. Condom demonstration and practice was also
included. The women also learned how to recognize, understand, and manage personal triggers for risk behavior. Women participating in this intervention significantly increased condom use and decreased frequency of unprotected sex (Kelly et al., 1994).

**SISTA Project (DEBI)**

The SISTA Project is a social skills training intervention for African American women based on an intervention that was demonstrated to be effective in increasing consistent condom use, and in improving skills and perceived norms from partners among African American women in a low income community in San Francisco (DiClemente and Wingood, 1995). The intervention consists of a series of five 2-hour sessions facilitated by two peer health educators in a community based setting. The sessions are gender specific and include behavioral skills practice, group discussions, lectures, role playing, a prevention video, and take home exercises.

The curriculum emphasizes gender and ethnic pride and enhancement of self-worth, sexual assertion skills, proper condom use, and cultural and gender triggers that may make it challenging for women to negotiate safer sex. The importance of partner involvement in safer sex is also emphasized, and the take home exercises involve the male partner.

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**Core Elements of SISTA**
The SISTA Project consists of the following core elements:

- Conduct small group sessions to discuss the session objectives, model skills development, role play women’s skills acquisition, and address the challenges and joy of being an African American woman
- Utilize skilled facilitators to implement the SISTA group sessions
- Utilize cultural and gender appropriate materials to acknowledge pride and enhance self worth in being an African American woman (e.g., use of poetry, artwork by African American women)
- Train women in sexual assertion skills so that they can both demonstrate care for partners and negotiate safer behaviors
- Teach women proper condom use – SISTA is designed to foster positive attitudes and norms towards consistent condom use and provide women the appropriate instruction for placing condoms on their partner
- Discuss cultural and gender triggers that may make it challenging for women to negotiate safer sex
- Emphasize the importance of partner involvement in safer sex – the homework activities are designed to involve the male partner
VOICES (DEBI)

VOICES is a single-session, video-based HIV/STD prevention program designed to encourage condom use and improve condom negotiation skills among African American men and women. An evaluation of the intervention showed that VOICES is effective when delivered at a “teachable moment;” for instance, a visit to an STD clinic may motivate a person to change behavior. Health educators convene groups of 4-8 clinic patients in a room that allows privacy for discussion. Groups are gender-specific. Information on HIV risk behaviors and condom use is delivered by a video that is culturally specific for African Americans, facilitated group discussion, and a poster board presenting features of various condom brands. Skills in condom use and negotiation are modeled in the video, and then role played and practiced by participants during the discussion that follows. At the end of the single, 45-minute session, participants are given samples of the types of condoms they have identified as best meeting their needs. Participants of this intervention demonstrated an increased knowledge about the transmission of HIV and other STDS, a more realistic assessment of their personal risk, a greater likelihood of getting condoms and intending to use them regularly, and presented with fewer repeat STDs (O’Donnell et al, 1998).

Other Group Interventions for African American Heterosexual Women

One intervention consists of six 90-minute sessions, followed by three booster sessions at 3, 6 and 9 months, combined HIV risk reduction information, skills training, role playing and modeling in an attempt to increase self-efficacy and improve positive social norms. The women in the study had significantly increased their use of condoms at the 6-month follow-up, but by the 9-month follow-up, they had returned to the level of risky behavior that they demonstrated at the 3-month follow-up. The same pattern was found with the women’s level of self-efficacy. The results indicate good short-term results, but point to the need for ongoing prevention interventions (Dancy et al., 2000).

Kalichman et al. (1996) investigated the impact of interventions that were similar in time frame, but different in content, on HIV risk behavior among African American low income women. The study involved four intervention groups: 1) one HIV education session and three sessions on sexual communication skills; 2) one HIV education session and three sessions on behavioral self-management skills; 3) one HIV education session, 1.5 sessions on behavioral self-management, and 1.5 sessions on sexual communication skills; and, 4) four sessions of HIV risk education without skills training. All groups had 4 total sessions that met twice a week. At 3-month follow-up, intentions to change risk behavior and condom use had increased among participants of all 4 groups. Participants in groups involving communication skills showed increased rates of talking to partners about sex and refusing unprotected sex. The women who received both communication skills and behavioral self-management skills building demonstrated the lowest level of risk.

Core Elements of VOICES

The core elements of VOICES include:
- Viewing culturally specific video portraying condom negotiation
- Conducting small group skills building session to work on overcoming barriers to condom use
- Educating program participants about different types of condoms and their features
- Distributing samples of condoms

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**Group Intervention for African American Heterosexual Men**

An intervention for African American men in an inpatient drug treatment program consisted of HIV information, skills training, and explanations of the benefits of safer sex in an attempt to increase perceived susceptibility to HIV and to help identify barriers to changing high risk behavior. The intervention was conducted through 2-hour sessions provided on three consecutive days. The control group lasted the same length of time, but consisted of information only. At the 3-month follow-up, the intervention group reported an increase in their communication skills, an increase in their condom use skills, and a decrease in their risk behavior. Both groups reported a decrease in the number of sexual partners (Malow et al., 1994).

**Latino/a High Risk Heterosexuals**

There has been very little research done on effective interventions specifically targeting Latino/a heterosexuals. The studies that have been done have mostly focused on Latina women.

**GROUP LEVEL INTERVENTIONS**

**VOCES (DEBI)**

VOCES is a single-session, video-based HIV/STD prevention program designed to encourage condom use and improve condom negotiation skills among Latino men and women (the same intervention as VOICES for African Americans). Health educators convene groups of 4-8 clinic patients in a room that allows privacy for discussion. Groups are gender-specific. Information on HIV risk behaviors and condom use is delivered by a bilingual video that is culturally specific for Latinos, facilitated group discussion, and a poster board presenting features of various condom brands in English and Spanish. Skills in condom use and negotiation are modeled in the video, and then role played and practiced by participants during the discussion that follows. At the end of the single, 45-minute session, participants are given samples of the types of condoms they have identified as best meeting their needs. Participants of this intervention demonstrated an increased knowledge about the transmission of HIV and other STDS, a more realistic assessment of their personal risk, a greater likelihood of getting condoms and intending to use them regularly, and presented with fewer repeat STDs (O'Donnell et al, 1998).

**Core Elements of VOCES**

The core elements of VOCES include:

- Viewing culturally specific video portraying condom negotiation
- Conducting small group skills building session to work on overcoming barriers to condom use
- Educating program participants about different types of condoms and their features
- Distributing samples of condoms

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**Group Level Interventions Targeting Latina Heterosexual Women**

A study was conducted with Latina women who were mostly immigrants from Puerto Rico, Dominican Republic, Central America, Mexico, and South America. The participants were divided into 3 intervention groups, all of which lasted 12 weeks and had sessions of 90 to 120 minutes in duration. The intervention group focused on HIV and related risk, and incorporated elements of empowerment theory and group dynamics, including participatory education strategies (e.g., critical reflection). It also included discussions of partner violence and societal
risk factors such as poverty and oppression. The comparison group provided more traditional HIV education and skills training and women’s health issues, without the emphasis on empowerment and participatory education strategies. These two groups were compared to women placed in a waiting list control group. At the 3-month follow-up, women in both the intervention and comparison groups were more likely to have increased condom use and their intent to use condoms than women in the control group. Only the women in the intervention group reported increased safer sex communication. Women in the comparison group were more likely than either the intervention or control group to have been tested for HIV in the past 3 months (Raj et al., 2001).

An intervention targeting low income, primarily Spanish-speaking Mexican and Puerto Rican women in Chicago consisted of 6 group sessions that included viewing and discussing videos, role playing, skill demonstration, homework to build self-efficacy, and quizzes. Each session focused on one of the following topics: 1) importance of HIV/AIDS awareness in your community and knowing your body; 2) understanding and preventing HIV and STDs; 3) myths and misconceptions about condoms and how to use condoms correctly; 4) negotiating safer sex practices; 5) preventing domestic violence; and, 6) partner communication, review of previous sessions, and benefits of behavior change. Compared to the control group, the intervention was found to be effective in improving HIV knowledge, communication with partner, risk reduction behavioral intentions and condom use, as well as in decreasing perceived barriers in condom use (Peragallo et al., 2005).

Women at Risk is designed to help Latina women recognize their personal susceptibility to STDs, commit to changing their sexual behaviors, and acquire the skills necessary to change behaviors. The intervention consists of 3 small group sessions that address the myths about AIDS and increase awareness of the fact that minority populations are disproportionately affected by HIV and STDs. The sessions also provide information about STD prevention, help build decision making and communication skills, and encourage participants to set risk reduction goals. Of the mostly Mexican American, English speaking women who were included in the evaluation, results indicate that women who participated in the intervention had significantly lower STD infection rates at the 6-month and 12-month follow-up than women in the control group. Also, women in the intervention group were significantly less likely to have multiple partners or to have engaged in high risk sexual behaviors (Shain et al., 1999).

**Native American High Risk Heterosexuals**

Even less research has been conducted to evaluate effective prevention interventions targeting Native American heterosexuals. In fact, no randomized controlled trials appeared in response to literature searches. However, recommendations for effective prevention strategies have been developed by community leaders and studies have been conducted to assess risk behaviors and needs within Native American communities.
RECOMMENDATIONS FROM NATIVE AMERICAN COMMUNITY

A report developed by the National Alliance of State and Territorial AIDS Directors (NASTAD) with guidance from Native American leaders from across the country identified overarching recommendations for effective prevention efforts targeting Native American communities:

- Establish trust and support from tribal leaders.
- Conduct an assessment of need and meet communities where they are.
- Form collaborations with agencies working on other health and social issues.
- Recognize the distinctive cultural needs of different tribes and adjust programs accordingly.
- Become familiar with the appropriate terminology used by a particular Native American nation/community. Be cognizant of how Native Americans refer to themselves and their people.
- Remain aware of issues in the external environment that affect Native communities and recognize that these, as well as historical events, form the larger framework within which HIV prevention can be pursued (NASTAD, 2004).

Focus groups conducted with Native American drug users in four cities identified the following recommendations for prevention strategies targeting Native American communities in general and active drug users specifically (Baldwin et al., 1999):

HIV Prevention Strategies for Native Americans and Active Drug Users

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<thead>
<tr>
<th>COMMUNITIES</th>
<th>ACTIVE DRUG USERS</th>
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<tbody>
<tr>
<td><strong>Credible Sources</strong></td>
<td></td>
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<tr>
<td>Elders and Leaders</td>
<td>Ex-drug users</td>
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<tr>
<td>Youth</td>
<td>Youth</td>
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<tr>
<td>People living with HIV/AIDS</td>
<td>People living with HIV/AIDS</td>
</tr>
</tbody>
</table>

| Messages              |                   |
| Native language, as well as English | Visual/graphic |
| Visual/graphic        | Fear-invoking     |
| Paired with alcohol prevention |                   |

| Channels              |                   |
| Chapter houses        | Street outreach   |
| Bingo halls           | Support groups    |
| Dances, powwows       | Jails/prisons     |
| Native corporations   | Needle exchange   |
| Schools               |                   |
| Family gatherings     |                   |
| Media (newsletters, posters, radio, TV) |                   |
**Community Level Intervention**

**Community Readiness Model**

While the Community Readiness Model was originally developed to address community alcohol and drug abuse prevention efforts, it has been used successfully to address a number of health issues, including HIV and STDs. The Community Readiness Model is a 9-stage model that assesses a community’s level of readiness to develop and implement prevention programming. It is based on the idea that interventions must be consistent with the community’s awareness of a problem and their readiness to address it. The interventions must be culturally and community specific and use local resources.

The process begins by identifying the issue to be addressed, followed by identifying the community (e.g., women, youth, a neighborhood). Questions are developed and then interviews are conducted with key informants in the identified community. The interviews are scored and readiness is evaluated using the 9-stage model. Implementation then begins by inviting members from various segments of the community to a workshop where they identify strategies specific to the readiness stage their community is in. The outcome is expected to be community change. As a community advances to a higher level of readiness, new activities can be implemented specific to the new stage of readiness (Vernon and Jumper-Thurman, 2002).

<table>
<thead>
<tr>
<th>Community Readiness Model</th>
<th>Goals Associated with Each</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No awareness</td>
<td>Raise awareness</td>
</tr>
<tr>
<td>2. Denial</td>
<td>Awareness that the problem is here</td>
</tr>
<tr>
<td>3. Vague Awareness</td>
<td>We can do something</td>
</tr>
<tr>
<td>4. Pre-planning</td>
<td>Assess and begin planning</td>
</tr>
<tr>
<td>5. Preparation</td>
<td>Gather information, plan and prioritize</td>
</tr>
<tr>
<td>6. Initiation</td>
<td>Focus and outreach</td>
</tr>
<tr>
<td>7. Stabilization</td>
<td>Stabilize efforts</td>
</tr>
<tr>
<td>8. Confirmation Expansion</td>
<td>Sustain and enhance</td>
</tr>
<tr>
<td>9. Professionalization</td>
<td>Maintain and expand</td>
</tr>
</tbody>
</table>

**Health Communication/Public Information**

In the Northwest Territories, a health promotion campaign was implemented focusing on healthy lifestyle choices with an emphasis on HIV. Community health workers and community members delivered information about HIV/AIDS door to door. Other approaches were also used, including broadcasts on local radio, presentations to community groups, and posters. Pamphlets were developed in 6 languages and audio cassettes were developed for the Dene, whose language is primarily oral. Also, an Inuit woman living with HIV/AIDS shared her story with many people. Band chiefs and councils were informed of the campaign and support from the elders was obtained. An evaluation of the program indicated that the program was well received, mostly because of the high level of involvement of community members. The evaluation did not assess behavioral change (Weaver, 1999).
**Young High Risk Heterosexuals**

**Adolescence and Young Adulthood Can Be a Difficult and Confusing Time As Youth Are Struggling to Establish Their Identities and Values in the Face of Peer Pressure, Parents’ Expectations, and Conflicting Messages from the Surrounding Environment. This is a Time When Many Begin to Experiment with Sex, Drugs, and Alcohol, Without Necessarily Having the Skills to Make Wise Decisions About Their Behavior. It is Important to Reach Youth with HIV Information and Risk Reduction Skills That They Can Continue to Use Throughout Their Lives.**

**Individual Level Intervention**

*Communication Between Parents and Adolescents*

Studies demonstrate the positive impact of communication between parents and adolescents on teen sexual behavior. One study found that mother-adolescent discussions about condoms before first sexual intercourse greatly increased the percentage of young people who use condoms, both for their first intercourse and for subsequent acts (Miller et al., 1998). Key findings are:

- **Less Risky Sexual Behavior Among Teens:** Parental communication can influence two primary public health strategies for preventing HIV infection among adolescents. First, parent-adolescent communication can encourage delay of sexual initiation. Second, it can promote condom use among sexually active youth.

- **Less Conformity to Peer Norms By Teens:** Parental discussions about sex and condoms can impact behavior by moderating the extent to which peer norms guide sexual behavior and condom use. Conversely, teens who do not discuss sexual issues with a parent may be influenced by peer norms to guide their sexual behavior.

- **Greater Belief that Parents Provide the Most Useful Information About Sex:** Teens who discuss sexual issues with their parents see them as the most useful source of information and norms about sex (Whitaker et al., 2000).

**Group Level Interventions**

*Street Smart (DEBI)*

Street Smart is based on research conducted of small group sessions at a recreational/ social service agency for gay/bisexual youth. Protected sex acts rose from 60% at baseline to 78% at 12-month follow-up for anal sex, and from 28% to 45% for oral sex. The intervention had no effect on those gay/bisexual youth who engaged in commercial sex; instead, their level of high risk sex increased over time (Rotheram-Borus et al., 1994).

The resulting Street Smart program is designed for runaway or homeless youth ages 11-18, but can easily be adapted for youth in other settings. It is a

**Core Elements of Street Smart**

The core elements of Street Smart include:

- Enhancing affective and cognitive awareness, expression and control
- Teaching HIV risk hierarchy and its personal application
- Identifying personal triggers, using peer support and small group skills building sessions
- Building participants’ skills in problem solving, personal assertiveness, and HIV harm reduction
skills building program designed to help runaway youth reduce unprotected sex, number of sex partners, and substance use. The intervention consists of eight 2-hour group sessions, one individual session after the group sessions are completed, and then a group trip to a community resource. It is preferred that teens attend all sessions, but the program is designed so that each session stands alone. Each group session has a specific topic:

- **Session 1:** Getting the language of HIV/AIDS and STDs
- **Session 2:** Personalized risk
- **Session 3:** Condoms and dams
- **Session 4:** Drugs and alcohol
- **Session 5:** Recognizing and coping with feelings
- **Session 6:** Negotiating safer sex
- **Session 7:** Self talk
- **Session 8:** Staying safe over time

The program utilizes role plays to act out typical situations. Quick role plays are short and usually scripted, and are mainly used to introduce a session or topic. Longer role plays may or may not be scripted, and are videotaped so that participants can see themselves as others see them. Other participants also fill out feedback forms on the role plays.

After Street Smart was implemented with runaway and homeless youth, participants reported lower rates of substance use and unprotected sex with young women self-reporting greater reductions than young men. African American youth self-reported less substance use than youth of other racial/ethnic groups (Rotheram-Borus et al., 1997).

Be Proud! Be Responsible! (Compendium)
The study of this intervention consisted of one 5-hour small group session targeting African American male adolescents. It was led by African American men and women and included culturally and developmentally appropriate materials, including a video, and an “AIDS Basketball” activity in which participants formed into teams to earn points for correctly answering questions about HIV. A condom exercise focused on the correct use of condoms, and role play activities confronted participants with potential problems in trying to implement safer sex practices. Adolescents who participated in the intervention reported more frequent use of condoms and fewer sex partners than adolescents in a comparison condition (Jemmott et al., 1992).

Focus On Kids (Compendium)
The Focus on Kids intervention is an 8-session group intervention delivered to low-income African American pre- and early adolescents in peer groups that consisted of 3 to 10 same-gender friends within three years of age of each other. The sessions were led by two African American men or women recruited from the community, at least one of whom was gender-matched to the group.
The sessions emphasized values clarification and goal setting; presented facts about AIDS, STDs, contraception, and human development; and, provided condoms. Multiple delivery formats were used including videos, games, acting, role playing, storytelling, and arts and crafts. In the seventh session, participants developed community projects with specific target audiences and intervention messages. Beginning in the first session and integrated throughout, a family genogram was used to illustrate the application of concepts to real life situations. Sexually active youth who participated in the intervention reported significantly greater condom use than sexually active youth in the comparison condition (Stanton et al., 1996).

_Becoming a Responsible Teen (Compendium)_

Group Level Interventions for African American Adolescents

DiClemente et al. (2004) evaluated the effectiveness of an intervention targeting sexually active African American adolescent females ages 14 to 18. All participants received four 4-hour group sessions. The intervention emphasized ethnic and gender pride, HIV knowledge, communication, condom use skills and healthy relationships. The control condition emphasized exercise and nutrition. At the 12-month follow-up, adolescents in the intervention group were more likely to use a condom at last intercourse, less likely to have a new vaginal sex partner in the last 30 days, more likely to apply condoms to sex partner, and had better condom application skills. Intervention participants also reported a higher percentage of condom-protected sex acts and less unprotected vaginal sex.

Another study evaluated the effects of abstinence and safer sex HIV risk reduction interventions on young inner-city African American male and female adolescents' HIV sexual risk behaviors (Jemmott III et al., 1998). The participants were African American adolescents recruited from 6th and 7th grade classes. Each intervention consisted of eight 1-hour modules divided equally over two consecutive Saturdays. Each intervention was highly structured and was implemented by facilitators who used intervention manuals. Designed to be educational, but entertaining and culturally sensitive, each intervention involved group discussions, videos, games, brainstorming, experiential exercises, and skills building activities. Each intervention incorporated the "Be proud! Be responsible!" theme that encouraged the participants to be proud of themselves and their community, to behave responsibly for the sake of themselves and their community, and to consider their goals for the future and how unhealthy behavior might thwart the attainment of their goals. The abstinence intervention acknowledged that condoms can reduce risks but emphasized abstinence to eliminate the risk of pregnancy and STDs, including HIV. The safer sex intervention indicated that abstinence is the best choice but emphasized the importance of using condoms to reduce the risk of pregnancy and STDs, including HIV, if participants were to have sex. The study found that both abstinence and safer sex interventions can reduce sexual risk behaviors, but safer sex interventions may be especially effective with sexually experienced adolescents and may have longer lasting effects.
Clinic-based Intervention for African American and Latina Adolescent Girls
In this study, sexually active African American and Latina adolescent girls in an adolescent clinic were randomly assigned into three 250-minute group interventions. One was an information-based intervention that provided information about how to practice safer sex, another was skills-based and both provided information and taught skills necessary to practice safer sex, and the third was a health promotion control intervention concerned with health issues unrelated to sexual behavior. At the 12-month follow-up, participants in the skills intervention reported significantly less unprotected sexual intercourse than both the information and control groups. They also reported fewer sexual partners and were less likely to test positive for STDs than the control group (Jemmott III et al., 2005).

SCHOOL-BASED PROGRAMS
A number of sex education curricula have been designed, some of which address HIV prevention. No evidence exists that educational programs increase sexual activity, and some programs are effective in postponing onset of intercourse or increasing contraceptive usage if students are sexually active. Decision making strategies and behavioral skills are generally not effective without the context of clear statements of norms. These norms should be age-appropriate (i.e., younger kids get more abstinence messages, while older kids get more clear messages about safer sex). Abstinence only curricula have not been effective in postponing age of intercourse onset.

Reducing the Risk (Compendium)
Reducing the Risk was implemented in 13 high schools in California through 15 sessions in health education classes. The curriculum included instruction on developing social skills to reduce sexual risk behavior and used role plays to model and practice the skills. It also emphasized decision making and assertive communication skills, encouraged students to go to stores and clinics to get relevant health information, and required students to ask their parents about their views on abstinence and birth control. Students receiving the intervention were significantly less likely to initiate sexual intercourse than those in the comparison condition. Intervention students who were already sexually active were significantly less likely to engage in unprotected sex than sexually active students in the comparison condition (Kirby et al., 1991).

Get Real About AIDS (Compendium)
Get Real About AIDS was implemented in 10 high schools in Colorado. The intervention consisted of 15 sessions covering HIV knowledge that can be used to reduce risk, teen vulnerability to HIV, normative determinants of risky behavior, condom use, and skills to help students recognize, manage, avoid, or leave risky situations. Students who participated in the intervention reported fewer sex
partners and greater frequency of condom use than students in the comparison condition (Main et al., 1994).

**Safer Choices**

Safer Choices is a 2-year, school-based HIV/STD and pregnancy prevention program for high school students. It was tested with 20 high schools, with 10 being randomly assigned to the intervention and 10 to the comparison condition. The schools in the comparison condition implemented a standard 5-session knowledge-based curriculum. Schools in the intervention condition implemented the five primary components as described in the sidebar. The actual curriculum consisted of 10 lessons provided in 9th grade and 10 lessons in 10th grade. Using many interactive activities, the curriculum provided knowledge about HIV, STDs and pregnancy; taught skills related to communication, condom use, other contraceptives, and refusing sex; and reinforced social norms supportive of safer behaviors.

Overall, Safer Choices did not significantly delay the onset of sexual intercourse, but it did appear to improve condom use. There was no difference by gender in the initiation of sex, but the intervention had a greater impact on condom use for males than females. Safer Choices did significantly delay the initiation of sex among Latino students, but not among Blacks, Asians, or Whites. The intervention also increased condom use at last sex more among Latinos and Whites than among Blacks.

Safer Choices was found to have a positive impact on students whether they initiated sex before or after the beginning of the intervention. In terms of frequency of unprotected sex, the intervention had a significantly greater impact on students who initiated sex after baseline than on youth who were sexually experienced at baseline. In terms of condom use at last sex, Safer Choices had a greater impact on youth who were sexually experienced at baseline compared to youth who initiated sex afterwards (Kirby et al., 2004).

**Components of Safer Choices**

Safer Choices includes five primary components:

- **School Organization:** Schools formed a School Health Promotion Council to support and coordinate activities. The councils included teachers, students, parents, administrators, and community members.

- **Curriculum and Staff Development:** The curriculum included 10 lessons in 9th grade and 10 lessons in 10th grade. Teachers received training on the curriculum and ongoing technical support. In-class peer leaders facilitated some of the activities.

- **Peer Resources and School Environment:** The school environment was saturated with activities, information, events, and services to reinforce key messages of the intervention. Peer resource groups implemented activities such as articles in school newspaper; school opinion polls; organizing public speakers; distributing posters, buttons, etc.; conducting small group discussions.

- **Parent Education:** Schools sent newsletters to parents 3 times a year and 9th and 10th grade students were asked to discuss sexuality topics with parents twice a year.

- **School-Community Linkages:** Homework assignments required students to gather information about local resources, schools distributed a resource guide, and HIV positive speakers from community gave presentations at school.
School-based Intervention Targeting Inner-city African American Youth
A study was conducted to evaluate the effectiveness of two culturally sensitive programs designed to reduce high risk behaviors among inner-city African American youth. The program targeted students in grades 5 through 8, as well as their parents and teachers. The social development curriculum (SDC) consisted of 15 to 21 lessons per year focusing on social competence skills necessary to manage situations in which high risk behavior occurs. The school/community intervention (SCI) consisted of SDC as well as school-wide climate and parent and community components. The control group received a health enhancement curriculum focusing on nutrition, physical activity, and general health care. For boys, the SDC and SCI both significantly reduced violent behavior, provoking behavior, school delinquency, drug use, recent sexual intercourse, and improved the rate of condom use. The SCI was significantly more effective than the SDC in improving a combined behavioral measure. There were no significant effects of either the SCD or SCI for girls (Flay et al., 2004).

University/College-based Interventions
A study by Sikkema et al. (1995) involved a series of four 90-minute sessions held over one month targeting mostly White heterosexual women recruited through classes, social groups, and the health service at a Midwestern university. Only 13% of women approached participated. Topics included risk behavior education; assertiveness, decision making, problem solving, and negotiation skills; condom use; maintenance of healthy behavior; and rehearsal and role playing. The intervention improved self-efficacy, sexual assertiveness and communication skills. There was modest reduction in sex without a condom and drug use.

A study with a racially/ethnically diverse sample of male and female university students evaluated the ability of a 20-minute self-administered intervention to increase risk reduction behaviors. Participants in the intervention group were given results from a survey of students from the university that showed that the majority of students reported using condoms most or all of the time. Data were presented in this way to emphasize that risk reduction was the prevailing social norm among their fellow students and that only a minority of students practiced high risk behavior. Participants were asked to compare their own behavior to the majority social norms and reflect on their willingness to change. Participants were given a list of specific behavior change goals (e.g., increased condom use, fewer sexual partners, increased discussion of safer sex, and decreased use of alcohol and drugs with intercourse) and were asked to select which ones they believed they could commit to over the next 30 days. In 30 days they were asked to return for a follow-up survey. Those in the control group were given a pamphlet with brief information about how to prevent HIV and STDs. Participants in both groups received $10 or a course credit both at the time of the intervention and at follow-up. Compared to participants in the control group, men in the intervention reported significantly higher condom use at follow-up, while women in the intervention group reported significantly fewer sexual partners (Chernoff and Davison, 2005).
CORRECTIONS-BASED PROGRAMS

Intensive AIDS Education in Jail (Compendium)
A group intervention was delivered to male adolescent drug users in a correctional facility. It consisted of four 1-hour sessions focusing on health education issues, including general health knowledge and HIV knowledge. Counselors were guided by a written curriculum. Counselors used techniques based on the problem-solving therapy model, where participants identified the problem, generated solutions, decided on alternatives, and used role play and rehearsal to practice alternative solutions. Participants received $5 for each session they attended. After release from jail, youth who participated in the intervention were significantly more likely to use condoms during sex and had fewer high risk sex partners than youth in the comparison condition (Magura et al., 1994).

Project START
Project START was designed specifically to target young men ages 18–29 who are leaving prison. The control condition consisted of 1 pre-release individual session where the person’s knowledge and risk was assessed and an individual risk reduction plan was developed. Men randomly assigned to the intervention received 2 pre-release sessions and 4 individual sessions post-release. The first pre-release session was the same as the control condition. The second pre-release session focused on the participant’s needs after release and included developing a post-release plan, problem solving and referrals. The 4 post-release sessions continued addressing goals identified in the post-release plan and included a review and update of the HIV/STD/hepatitis risk reduction plan developed in the very first session. Initial findings from this study indicate that men in the intervention were significantly less likely than the control group to report unprotected vaginal or anal sex with all partners since the last interview (Center for AIDS Prevention Studies, 2004).

COMMUNITY LEVEL INTERVENTIONS

Intervention Targeting Latino Youth
This intervention was focused in neighborhoods where at least 20% of the residents were Latino. The intervention was implemented over 18 months and involved several components designed to provide information about HIV and risk reduction: mass media, workshops, and distribution of risk reduction materials. The intervention also used peer educators who were trained to implement several portions of this intervention, such as the workshops. In follow-up interviews, male adolescents from the intervention city were less likely than

Framework of Project START
Project START is based on the following conceptual framework:

- **Harm Reduction**: Reducing harmful consequences to self and others
- **Problem Solving**: Generating possible solutions, determining consequences, choosing best solutions, creating realistic plan of action
- **Motivational Enhancement**: Enhancing motivation for behavior change through a client-centered but directive approach
- **Enhancing Access to Service**: Facilitating referral and reducing barriers to use of existing community services
males in the comparison city to have initiated sexual activity. There was no significant increase or decrease in the initiation of sexual activity among female adolescents, although sexually active females in the intervention city were significantly less likely to have multiple partners than those in the comparison city. The intervention also increased the likelihood that both boys and girls would have a condom with them at the time of follow-up interview compared to baseline (Sellers et al., 1994).

STAND - Peer Education for Rural Teens
STAND is a peer education training program designed for rural teens. It is consistent with the developmental characteristics of teens, including perceived unique invulnerability, limited abstract reasoning ability, and focus on present rewards over long-term consequences. STAND is an “abstinence-plus curriculum,” promoting both sexual abstinence and risk reduction strategies. It is delivered in 28 one-hour sessions, held twice per week, and can be school or community based. The training prepares teens to initiate one-on-one conversations with their peers about sexual risk reduction. Teens are taught to determine a person’s stage of change, and recommend the use of appropriate change supporting processes. Peer leaders are selected by a peer- and self-nomination technique, and this process usually results in a very diverse group of teens.

After completion of the training, STAND peer educators plan and participate in whatever formal and informal educational activities are feasible in their community setting. They also participate in the STAND club, which meets once a month to provide peer educators with peer support. STAND peer educators self-reported positive changes in knowledge, condom use self-efficacy, consistent use of condoms, and incidence of unprotected intercourse, although most of these changes were more pronounced at the beginning of follow-up than at the 8-month follow-up. STAND teens also reported significantly more conversations with friends about birth control or condoms (Smith and DiClemente, 2000).

Asian/Pacific Islander High Risk Heterosexuals

RECOMMENDATIONS FROM SOUTHEAST ASIAN COMMUNITY MEMBERS
There have been no studies conducted of effective prevention interventions targeting Asian and Pacific Islander heterosexual men and women. However, focus groups with Cambodian, Vietnamese and Laotian women, as well as providers serving these communities, provided some recommendations about effective strategies (Jemmott et al., 1999):

Skills building: Skills building training is needed for Asian/Pacific Islander women, men and youth. Particularly, the need for women to learn safer sex negotiation skills was noted.

Newspapers: Articles with information about HIV and risk reduction placed in community newspapers written in their own languages is a viable medium for reaching members of the communities who are literate in their languages.
**Appropriate services:** Prevention services need to be multilingual and culturally sensitive to HIV prevention and domestic violence issues.

**Men’s involvement:** Men need to be involved in prevention programs. They usually consider reproductive issues as only concerning women. Men may be more receptive to messages from older male professionals than from women.

**Health care providers:** Health care providers that are linked to or are part of the community would be effective agents for change. They must be able to capitalize on the cultural value of respect for age and wisdom.

**Mobile van:** A mobile van for providing CTR and other health services to avoid stigma.

**Video:** Educational video in their own languages could be used to share information with partners and friends, and addresses the lack of literacy that some people experience. Having an older Asian/Pacific Islander physician present basic facts instead of using a narrative story format was suggested.

**Programs in the home:** Women felt that members of their communities would respond positively to HIV prevention strategies offered within the privacy of their homes.

A community forum held with 13 Vietnamese participants in St. Paul yielded additional recommendations (IDPH, 2005). Participants felt that a visiting Vietnamese physician specializing in HIV/AIDS would be ideal. Having a physician who speaks Vietnamese would eliminate barriers related to using interpreters to talk about HIV-related issues. They also suggested counseling services via a phone line that offers Vietnamese interpretation services. The participants felt that the concerns related to using an interpreter would be addressed through the anonymity that a phone line offers. Participants felt that face to face counseling services would be appropriate for second generation Vietnamese, but the first generation immigrants would not be comfortable with this.

Participants also noted the nonexistence of information available in Vietnamese and suggested developing HIV informational and risk reduction brochures in both Vietnamese and English. They also suggested developing more effective and accessible Vietnamese media outlets in Illinois and having them integrate HIV/AIDS messages into their programming or print media.

Finally, the group suggested having HIV professionals train Vietnamese community leaders about HIV and risk reduction, and then having the community leaders create awareness and provide education to the community and families.

**COMMUNITY LEVEL INTERVENTION**

A program targeting Asian/Pacific Islanders in California was developed based on recommendations gathered through focus group participants who identified physicians as persons of authority and worthy of great respect and indicated a preference for receiving health care from an Asian or Pacific Islander provider. An intervention was developed to encourage testing and risk reduction behaviors, as well as to facilitate access to services for those who were positive.
The intervention was initiated with a 1-day training for Asian/Pacific Islander health care providers that addressed recognition and treatment of HIV-related symptoms, how to conduct a risk assessment, approaches to counseling patients about risk reduction, barriers to HIV prevention, and resources available in the community. Providers also viewed a video in English that tells the real life story of an adult son who learned he was positive, how his family coped with the news, and the progression of his disease. The video dealt with issues such as death, sexuality, faith, and isolation. The majority of providers felt the video would be helpful to use with English-speaking patients and they were able to get copies. The health care providers then indicated any additional training that would be useful and program developers planned trainings to address the identified concerns. Providers were also asked to indicate whether they would be willing to serve as a liaison between their particular professional community and HIV service organizations. Reactions from providers who participated in the training were positive. An evaluation of the impact of the intervention on the Asian/Pacific Islander community has not been published (Loue et al., 1996).

White High Risk Heterosexuals

Because HIV/AIDS has disproportionately impacted heterosexuals of color in the United States, studies of prevention interventions have either been conducted with racially/ethnically mixed samples or have primarily focused on African American and/or Latina women. Thus, there is a lack of information regarding effective interventions specifically targeting adult White high risk heterosexuals. In fact, only one study was found, which was conducted with mostly White heterosexual cocaine users.

Cocaine Abuse Counseling as a Prevention Intervention

The efficacy of cocaine abuse counseling alone as a strategy to reduce HIV-related sexual risk behaviors was evaluated through a study where 232 cocaine abusing or dependent individuals, mostly White heterosexuals, received up to 26 weeks of Matrix counseling, but no formal HIV prevention interventions. Matrix counseling uses a manual-driven format for teaching cognitive and behavioral skills to initiate substance use abstinence and prevent relapse. Participants who completed counseling were more likely to change to safer sex or maintain safer sex over the 6 months than those who terminated counseling prematurely. Safer sex changes included decreases in numbers of partners (Shoptaw et al., 1997).

Injection Drug Users

Overview of Interventions for Injection Drug Users

Specific behaviors associated with drug use that are risk factors for HIV transmission include shared use of drug injection equipment and unprotected vaginal or anal sex with sexual partners. Strategies to decrease these behaviors are therefore critical components of intervention strategies to reach IDUs and
MSM/IDUs. Strategies for HIV risk reduction among drug users include substance use treatment, educational interventions, and HIV counseling and testing programs. Substance use treatment programs, to the degree that they are effective, are believed to reduce the risk of HIV transmission by increasing abstinence from drug use and/or injection. Although interventions with drug users aim primarily to protect drug users from getting infected with HIV, these interventions have an indirect benefit of also protecting their sexual and needle sharing partners.

**Access to Clean Syringes**

*Syringe Access Initiative*

In 1998, Illinois passed legislation allowing for voluntary pharmacy sales of up to 10 syringes without a prescription. Impact of the legislation was assessed one year after its implementation. The study found that IDUs were more likely to purchase syringes at a pharmacy after enactment of the laws. A significant decrease in the percentage of IDUs who shared syringes was observed. This decrease did not hold true, however, for IDUs who were speedball users or had a history of incarceration. The practice of reusing syringes and the safe disposal of syringes did not differ significantly after implementation of the Syringe Access Initiative (Cotten-Oldenburg et al., 2001).

**Needle Exchange Programs**

There have been no randomized, controlled studies of needle exchange programs; however, other studies indicate that these programs are mostly positive in reducing needle sharing and other risk behaviors. How needle exchange programs impact sexual risk behavior among IDUs is not clear. Although studies contain a preponderance of evidence demonstrating the effectiveness of needle exchange as an HIV prevention intervention among injecting drug users, state and federal governments prohibit the use of public funds to support such interventions. Thus, a prior public policy intervention is necessary before needle exchange activities can be comprehensively implemented.

Several studies have demonstrated the relationship between needle exchange programs and a decrease in drug-related risk behavior. One study examined how drug injection and needle sharing practices respond when a needle exchange program is introduced into a city. The model found that needle exchange programs were associated with decreases of 13% in drug injection and 20% in needle sharing (DeSimone, 2005). A meta-analysis of data from 47 studies evaluating the effectiveness of needle exchange programs using data collected from 1986–1997 found that needle sharing consistently declined among IDUs attending needle exchange programs (Ksobiech, 2003).

Holtgrave et al. (1998) found that a policy of funding syringe exchange programs, pharmacy sales, and syringe disposal to cover all illicit drug injections would cost $34,278 per HIV infection averted, which is much less than the cost of lifetime treatment for someone with HIV, which is estimated at $154,402 (Holtgrave and Pinkerton, 2003). Cost effectiveness studies of specific needle exchange programs have consistently found them to be cost effective, and an efficient use of financial resources (Gold et al., 1997; Jacobs et al., 1999).
**Substance Abuse Treatment Programs as HIV Prevention Interventions**

A review of studies conducted over the past 20 years indicate significantly lower rates of drug use, drug-related risk behaviors, and HIV infections among drug users who remain in treatment programs. However, the studies did not address reduction in sex-related risk behaviors. The authors point out that the public health impact of drug treatment programs is limited due to the fact that access to treatment services in many areas of the United States is not sufficient to meet the need (Metzger and Navaline, 2003).

Another review of studies was conducted to assess the impact of adherence to heroin dependence treatment on HIV prevention. The review found that the best adherence rates were achieved with methadone and diacetylmorphine treatment. Studies of methadone maintenance programs found that higher treatment adherence is correlated with a reduction in HIV transmission, suggesting that patients who continuously adhere to methadone treatment are less likely to continue injecting drugs and sharing dirty needles than those who interrupt treatment (De Castro and Sabaté, 2003).

**Use of Peers in Prevention Efforts**

Based on lessons learned so far during the ongoing Urban Health Study, researchers state that IDUs can and will take responsibility for their own health and the health of their community. IDUs who provide new sterile needles to other IDUs (secondary exchange) are motivated to help prevent the spread of HIV among their peers. The researchers recommend recruiting secondary exchange providers and training them as peer educators. Based on their experience, these peer educators will help develop and pass along risk reduction messages to their friends (AIDS Research Institute, 2003).
Men Who Have Sex with Men and Inject Drugs

No studies have been conducted to evaluate the effectiveness of prevention interventions targeting MSM/IDU. However, information gathered through focus groups and individual interviews with 98 drug using (injecting and non-injecting) MSM from 6 cities provides some recommendations regarding strategies to reach MSM/IDU (Rhodes et al., 1999):

**Preferred institutional sources of HIV information:** Community health clinics and medical offices, STD clinics, drug treatment programs, HIV counseling and testing sites, gay and lesbian community centers, shelters, youth centers, street outreach programs, and needle exchange programs. Providers perceived as bureaucratic, impersonal, or lacking in respect or empathy for drug users were avoided whenever possible.

**People most capable of influencing behavior change:** Drug-using peers were most frequently mentioned as the people most capable of influencing behavior in relation to HIV prevention. Younger participants especially went to peers for advice, while a few of the older participants had no regard for the opinions of drug-using people they knew. In general, family members were not considered influential.

**Materials:** Some participants thought that brochures and written materials were not effective because many street-based drug users have limited reading skills. Pictorial materials were suggested as more effective in reaching people with low literacy skills.

**Prevention interventions and program staff:** There was general agreement from all sites that street outreach is the most important strategy for reaching MSM drug users, particularly outreach conducted at night and with a vehicle. They also suggested drop-in centers, rap groups, plays and skits, food (especially meals), and radio and TV advertising. Participants felt it was very important for outreach workers and intervention staff be former drug users, or at least members of the local community, and comfortable with people who use drugs.

**Sexual orientation of staff and programs:** The sexual orientation (or gender) of outreach and intervention staff did not matter; being treated with respect was most important. Participants did not see any benefit in implementing separate programs for MSM drug users. Men who did not self-identify as gay viewed separate programming as negative while men who identified as gay did not have a preference either way.

The recommendations from this study may indicate that MSM/IDU in Illinois would be more comfortable accessing existing programs serving IDU instead of having separate interventions targeted specifically at them. However, the following program seems to have been successful in providing programming that targets MSM/IDU, although it appears to target men who self-identify as gay or bisexual.
COMMUNITY LEVEL INTERVENTION

Project NEON
Although the program has not been evaluated in a randomized controlled trial, Project NEON has been providing services to MSM/IDU for over 10 years in Seattle. Project NEON’s services are targeted at gay and bisexual men who use crystal meth, primarily those who inject it. Project NEON offers brochures located in bars, sex clubs, and GLBT agencies in the city. A peer education team of current and former users conduct outreach and distribute safer sex and clean injection supplies, conduct needle exchange, talk about safer partying, and provide referrals. One-on-one counseling is available and focuses on drug use, sex, relationship issues, and assistance in getting needed social and medical services. The program also offers several group level intervention options. One is a weekly drop-in chat/support group. There are also two drug abstinence based support groups, one for men who want to stop using meth and another for men who have already stopped and do not want to start again (Seattle Counseling Service, 2003).

Injecting Drug Users of All Races and Genders

Counseling and Testing

Outreach Interventions
A study was conducted to determine the cost effectiveness of street outreach compared to methadone maintenance in averting HIV infections. This was done by simulating the spread of the HIV epidemic in San Francisco and New York from the mid-1980s to the mid-1990s and incorporating the behavioral effects of the two interventions. The study found that it was almost always more cost effective to spend as many resources as possible on street outreach vs. methadone maintenance (Wilson and Kahn, 2003).

In an outreach program implemented in Denver, peer volunteers were trained to share role model stories and distribute intervention kits (including brochures, pamphlets, flyers, etc.), bleach kits, and condoms to high risk individuals over the course of 2.5 years. The intervention was effective at increasing both needle cleaning and consistent condom use over the time of the study. Consistent bleach use increased from 20% to 29%, and condom use during vaginal sex increased from 2% to 24% (Reitmeijer et al., 1996).

INDIVIDUAL LEVEL INTERVENTION

Individual Level Intervention for African American Women
African American female heterosexual IDUs were randomly assigned to one of two enhanced gender and culturally specific interventions. The motivational enhanced intervention consisted of 4 individual sessions. The first session involved general risk reduction counseling as well as a discussion of the impact of race and gender on HIV risk and protective behaviors. Participants were asked to consider what things they would be motivated to change in their lives. During the second session, participants developed short-and long-term goals and discussed any ambivalences regarding change. In the third session, participants’
experiences with short-term behavior change goals were reviewed. This discussion continued in the fourth session, which also included risk reduction messages tailored to participants’ level of readiness for change.

The negotiation enhanced intervention also involved 4 individual sessions. The first session was similar to the other intervention, although it ended with a skills training component on condom use and safe injection. In addition, participants were asked to consider which intended behavioral changes would be easier or more complicated to control. During the second session the intended behavioral changes and level of control were reviewed. General communication and assertiveness skills were discussed. Short-term goals for communication, gaining control and developing assertiveness were set. In the third session, participants’ experiences with the short-term goals were discussed, as well as triggers for deviating from intended goals. Negotiation and conflict resolution skills were introduced. The fourth session built upon the previous sessions, including the development of tailored negotiation and conflict resolution styles.

In comparison to the standard informational session, those who participated in both enhanced interventions reported substantial decreases in frequency of drug use and drug injection, as well as in the sharing of injection works and water and the number of injections. Trading sex for drugs or money, having sex while high, and other sexual risk were also reduced significantly (Sterk et al., 2003).

GROUP LEVEL INTERVENTIONS

_Holistic Health Recovery Program (DEBI)_

The Holistic Health Recovery Program (HHRP) is based on an intervention study conducted by Margolin et al. (2003). Participants were inner city HIV positive IDUs with mild to moderate cognitive impairment who were dually addicted to heroin and cocaine and had a history of unsuccessful drug treatment. HHRP has since been adapted so that it can be used with HIV positive and HIV negative IDUs. HHRP is a 12-session, manual-guided, group level intervention to promote health and improve quality of life. More specific goals include a reduction of or abstinence from illicit drug use and sexual risk behaviors; reduced risk for HIV transmission; and improved medical, psychological and social functioning. Participants in the study demonstrated a decrease in addiction severity, a decrease in risk behavior, and significant improvement in behavioral skills, motivation and quality of life.

**Core Elements of HHRP**

HHRP teaches participants the following:
- Harm reduction skills related to injection drug use and unprotected sexual activities
- Negotiation skills to reduce unsafe sexual behaviors
- Decision making and problem solving skills
- Goal setting and action plan development skills
- Stress management skills
- Skills to improve health, health care participation, and adherence to medical treatments
- Skills to increase clients’ access to their self-defined spiritual beliefs to increase motivation to engage in harm reduction
- Skills to increase self awareness

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Skills Building Sessions in Methadone Treatment (Compendium)
Group Sessions Targeting Intranasal Heroin Users (Compendium)

Adult drug users (26% African American, 23% Latino, 51% White) who used heroin intranasally were recruited to a 4-session intervention to determine the effects of a small group intervention in preventing transition from sniffing heroin to injecting heroin. The intervention covered HIV information, risks of drug use and drug injection, and how to seek entry into drug abuse treatment programs. Presentations, group discussion, and role play were used. People who participated in the intervention were significantly less likely to inject drugs than those in the comparison condition (Des Jarlais et al., 1992).

Informational and Enhanced AIDS Education (Compendium)

A study was conducted to determine the effects of small group informational and enhanced education sessions on drug- and sex-related HIV risk behaviors. The informational intervention consisted of two 1-hour sessions and a 30 minute individual health educational consultation. The enhanced intervention focused on personal susceptibility, situation analysis, and skills building. Participants engaged in group discussion and practiced skills. Additional strategies included role playing, peer feedback, tension release exercises, and an emphasis on experiential learning techniques to enhance self-efficacy regarding ability to initiate and maintain HIV harm reduction behaviors. After exit from the program, participants in both interventions reported significant reduction in drug- and sex-related risk behaviors compared with baseline of risk. However, the enhanced education intervention had significantly greater effects than the informational intervention (McCusker et al., 1992).

Project Neighborhoods in Action

Project Neighborhoods in Action was a program conducted with 1,631 IDUs and crack users (97% African American) in several inner city neighborhoods in Washington DC. Participants were randomly assigned to an enhanced intervention or a standard intervention. The standard 2-session intervention consisted of risk assessment, voluntary counseling and testing, and referral to drug treatment and medical services. In addition to the standard 2 sessions, participants in the enhanced intervention participated in a group intervention that included a video with African American actors that focused on awareness of HIV, risk of transmission through needles and other injection paraphernalia, sexual transmission of HIV, and the benefits of drug treatment. The video was shown in short segments, with participants then practicing risk reduction behavior through role plays and demonstrations, and discussing the video and role plays. At 3-month follow-up, the frequency of drug use decreased. The frequency of drug injection also decreased, as did the sharing of needles and works. In addition, the number of sexual partners and having sex while high both decreased, as did trading sex for money and/or drugs. Condom use increased. These findings were found among both male and female participants. The study results indicate that the standard intervention and the enhanced intervention were about equally effective in reducing HIV-related risk behaviors among drug users (Hoffman et al., 1999).
Group Intervention in Methadone Maintenance Treatment

A 12-session harm reduction group intervention delivered in the context of a methadone maintenance treatment program was found to be effective in reducing risk behaviors. Both the control group and the intervention group received 2 hours of individual counseling/case management per month and a single session individual risk reduction intervention. Additionally, the intervention group participated in a 12-session weekly harm reduction group intervention, which covered the following topics: 1) setting and reaching treatment goals; 2) HIV transmission; 3) safer injection drug use practices; 4) condom use and eroticizing safer sex; 5) negotiating harm reduction with partners; 6) preventing drug use and HIV risk behavior relapse; 7) making healthy lifestyle choices; 8) adapting the traditional “12 steps” to include HIV prevention; 9) understanding addiction and its relationship to continued high risk behavior; 10) overcoming negative emotions, such as helplessness; 11) understanding and overcoming grief and fear; and 12) developing healthy social relationships and activities.

During methadone maintenance treatment, patients who participated in the 12-session harm reduction intervention were more likely to refrain from cocaine use and to report fewer unsafe sexual practices than participants in the control group. After treatment, the intervention group scored higher on a sexual risk quiz and reported increased self-efficacy in high risk sexual situations than the control group (Avantset al., 2004).

COMPREHENSIVE PROGRAMMING

Safety Counts (DEBI)

Safety Counts is a client-centered, comprehensive intervention targeting HIV positive and HIV negative individuals who are currently using injection or non-injection drugs. The intervention is not specific to gender, race/ethnicity, or sexual orientation. The goal of the program is to reduce risk of becoming infected with or transmitting HIV and hepatitis viruses, and involves individual and group level activities, as well as social events over a period of 4 to 6 months. The intervention focuses on setting personal risk reduction goals, assessing progress, discussing barriers, and identifying next steps. Staff discuss the importance of knowing HIV status upon program enrollment and offer CTR services at each session for HIV negative clients.

Compared to persons enrolled in the comparison condition, clients who participated in Safety Counts were about 1.5 times more likely to refrain from cocaine use and to report fewer unsafe sexual practices than participants in the control group. After treatment, the intervention group scored higher on a sexual risk quiz and reported increased self-efficacy in high risk sexual situations than the control group (Avantset al., 2004).

Core Elements of Safety Counts

The five core elements of Safety Counts are:

- **Group Sessions One and Two** involve hearing clients’ HIV risks and current stage of change, hearing risk reduction success stories, setting personal goals, identifying first steps to reduce HIV risk, and making referrals to CTR and medical/social services
- **One (or more) Individual Counseling Session** involves discussing/refining risk reduction goals, assessing client’s needs, and providing referrals
- **Two (or more) Social Events** are designed for socializing, participating in risk reduction activities, and receiving reinforcement for personal risk reduction
- **Two (or more) Follow-up Contacts** involve reviewing client’s progress, discussing barriers encountered, identifying concrete next steps and possible barriers/solutions, and referrals
- **HIV/HCV Counseling and Testing** is offered through the service or referral to another agency

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times more likely to reduce their drug and sex-related risks, were more than 2.5 times more likely to report an increase in condom use, were significantly more likely to report a reduction in the number of times they inject, and more likely to test negative for opiates through urinalysis (Rhodes and Humfleet, 1993; Rhodes and Wood, 1999).

COMPREHENSIVE PROGRAMMING

*Community PROMISE (DEBI)*

As previously described on page 313, Community PROMISE is based on the AIDS Community Demonstration Projects. This intervention has been tested with African American, White, and Latino communities, including injection drug users and their sexual partners.

COMMUNITY PROMISE begins with a community identification process, which involves interviewing and holding focus groups with stakeholders in the community to identify why people engage in risk behaviors, what barriers exist to changing behavior, what will encourage them to change behaviors, and locations where they engage in risk behaviors. This helps with identifying target populations and appropriate tailoring of the intervention. Members of the target population who have made positive behavior change are interviewed and role model stories are written based upon their interviews. Peer advocates from the target populations are recruited and trained to distribute the role model stories and other materials. The final core element is formative evaluation to capture behavior change within the target population.
Appendix E

Proposal Writing Short Course

Introduction

The subject of this short course is proposal writing. But the proposal does not stand alone. It must be part of a process of planning and of research on, outreach to, and cultivation of potential foundation and corporate donors.

This process is grounded in the conviction that a partnership should develop between the nonprofit and the donor. When you spend a great deal of your time seeking money, it is hard to remember that it can also be difficult to give money away. In fact, the dollars contributed by a foundation or corporation have no value until they are attached to solid programs in the nonprofit sector.

This truly is an ideal partnership. The nonprofits have the ideas and the capacity to solve problems, but no dollars with which to implement them. The foundations and corporations have the financial resources but not the other resources needed to create programs. Bring the two together effectively, and the result is a dynamic collaboration.

You need to follow a step-by-step process in the search for private dollars. It takes time and persistence to succeed. After you have written a proposal, it could take as long as a year to obtain the funds needed to carry it out. And even a perfectly written proposal submitted to the right prospect might be rejected for any number of reasons.

Raising funds is an investment in the future. Your aim should be to build a network of foundation and corporate funders, many of which give small gifts on a fairly steady basis and a few of which give large, periodic grants. By doggedly pursuing the various steps of the process, each year you can retain most of your regular supporters and strike a balance with the comings and goings of larger donors.

The recommended process is not a formula to be rigidly adhered to. It is a suggested approach that can be adapted to fit the needs of any nonprofit and the peculiarities of each situation. Fundraising is an art as well as a science. You must bring your own creativity to it and remain flexible.

Gathering Background Information

The first thing you will need to do in writing your proposal is to gather the documentation for it. You will require background documentation in three areas: concept, program, and expenses.

If all of this information is not readily available to you, determine who will help you gather each type of information. If you are part of a small nonprofit with no staff, a knowledgeable board member will be the logical choice. If you are in a larger agency, there should be program and financial support staff who can help you. Once you know with whom to talk, identify the questions to ask.

This data-gathering process makes the actual writing much easier. And by involving other stakeholders in the process, it also helps key people within your agency seriously consider the project's value to the organization.

Concept

It is important that you have a good sense of how the project fits with the philosophy and mission of your agency. The need that the proposal is addressing must also be documented. These concepts must be well-articulated in the proposal. Funders want to know that a project reinforces the overall
direction of an organization, and they may need to be convinced that the case for the project is compelling. You should collect background data on your organization and on the need to be addressed so that your arguments are well-documented.

Program

Here is a check list of the program information you require:

- the nature of the project and how it will be conducted;
- the timetable for the project;
- the anticipated outcomes and how best to evaluate the results; and
- staffing and volunteer needs, including deployment of existing staff and new hires.

Expenses

You will not be able to pin down all the expenses associated with the project until the program details and timing have been worked out. Thus, the main financial data gathering takes place after the narrative part of the master proposal has been written. However, at this stage you do need to sketch out the broad outlines of the budget to be sure that the costs are in reasonable proportion to the outcomes you anticipate. If it appears that the costs will be prohibitive, even with a foundation grant, you should then scale back your plans or adjust them to remove the least cost-effective expenditures.
## Components of a Proposal

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary:</td>
<td>umbrella statement of your case and summary of the entire proposal</td>
<td>1</td>
</tr>
<tr>
<td>Statement of Need:</td>
<td>why this project is necessary</td>
<td>2</td>
</tr>
<tr>
<td>Project Description:</td>
<td>nuts and bolts of how the project will be implemented and evaluated</td>
<td>3</td>
</tr>
<tr>
<td>Budget:</td>
<td>financial description of the project plus explanatory notes</td>
<td>1</td>
</tr>
<tr>
<td>Organization Information:</td>
<td>history and governing structure of the nonprofit; its primary activities, audiences, and services</td>
<td>1</td>
</tr>
<tr>
<td>Conclusion:</td>
<td>summary of the proposal's main points</td>
<td>2</td>
</tr>
</tbody>
</table>
The Executive Summary

This first page of the proposal is the most important section of the entire document. Here you will provide the reader with a snapshot of what is to follow. Specifically, it summarizes all of the key information and is a sales document designed to convince the reader that this project should be considered for support. Be certain to include:

**Problem** - A brief statement of the problem or need your agency has recognized and is prepared to address (one or two paragraphs).

**Solution** - A short description of the project, including what will take place and how many people will benefit from the program, how and where it will operate, for how long, and who will staff it (one or two paragraphs).

**Funding requirements** - An explanation of the amount of grant money required for the project and what your plans are for funding it in the future (one paragraph).

**Organization and its expertise** - A brief statement of the history, purpose, and activities of your agency, emphasizing its capacity to carry out this proposal (one paragraph).

The Statement of Need

If the grants decision-maker reads beyond the executive summary, you have successfully piqued his or her interest. Your next task is to build on this initial interest in your project by enabling the funder to understand the problem that the project will remedy.

The statement of need will enable the reader to learn more about the issues. It presents the facts and evidence that support the need for the project and establishes that your nonprofit understands the problems and therefore can reasonably address them. The information used to support the case can come from authorities in the field, as well as from your agency's own experience.

You want the need section to be succinct, yet persuasive. Like a good debater, you must assemble all the arguments. Then present them in a logical sequence that will readily convince the reader of their importance. As you marshal your arguments, consider the following six points.

First, decide which facts or statistics best support the project. Be sure the data you present are accurate. There are few things more embarrassing than to have the funder tell you that your information is out of date or incorrect. Information that is too generic or broad will not help you develop a winning argument for your project. Information that does not relate to your organization or the project you are presenting will cause the funder to question the entire proposal. There also should be a balance between the information presented and the scale of the program.

Second, give the reader hope. The picture you paint should not be so grim that the solution appears hopeless. The funder will wonder whether an investment in your solution would be worthwhile. Here's an example of a solid statement of need: "Breast cancer kills. But statistics prove that regular check-ups catch most breast cancer in the early stages, reducing the likelihood of death. Hence, a program to encourage preventive check-ups will reduce the risk of death due to breast cancer." Avoid overstatement and overly emotional appeals.

Third, decide if you want to put your project forward as a model. This approach could expand the base of potential funders. But serving as a model works only for certain types of projects. Don't try to make this argument if it doesn't really fit. Funders may well expect your agency to follow through with a replication plan if you present your project as a model.
If the decision about a model is affirmative, you should document how the problem you are addressing occurs in other communities. Be sure to explain how your solution could be a solution for others as well.

Fourth, determine whether it is reasonable to portray the need as acute. You are asking the funder to pay more attention to your proposal because either the problem you address is worse than others or the solution you propose makes more sense than others. Here is an example of a balanced but weighty statement: "Drug abuse is a national problem. Each day, children all over the country die from drug overdose. In the South Bronx the problem is worse. More children die here than any place else. It is an epidemic. Hence, our drug prevention program is needed more in the South Bronx than in any other part of the city."

Fifth, decide whether you can demonstrate that your program addresses the need differently or better than other projects that preceded it. It is often difficult to describe the need for your project without being critical of the competition. But you must be careful to do so. Being critical of other nonprofits will not be well received by the funder. It may cause the funder to look more carefully at your own project to see why you felt you had to build your case by demeaning others. The funder may have invested in these other projects or may begin to consider them, now that you have brought them to the funder's attention.

If possible, you should make it clear that you are cognizant of, and on good terms with, others doing work in your field. Keep in mind that today's funders are very interested in collaboration. They may even ask why you are not collaborating with those you view as key competitors. So at the least you need to describe how your work complements, but does not duplicate, the work of others.

Sixth, avoid circular reasoning. In circular reasoning, you present the absence of your solution as the actual problem. Then your solution is offered as the way to solve the problem. For example, the circular reasoning for building a community swimming pool might go like this: "The problem is that we have no pool in our community. Building a pool will solve the problem." A more persuasive case would cite what a pool has meant to a neighboring community, permitting it to offer recreation, exercise, and physical therapy programs. The statement might refer to a survey that underscores the target audience's planned usage of the facility and conclude with the connection between the proposed usage and potential benefits to enhance life in the community for audiences the funder cares about.

The statement of need does not have to be long and involved. Short, concise information captures the reader's attention.

The Project Description

This section of your proposal should have five subsections: objectives, methods, staffing/administration, evaluation, and sustainability. Together, objectives and methods dictate staffing and administrative requirements. They then become the focus of the evaluation to assess the results of the project. The project's sustainability flows directly from its success, hence its ability to attract other support. Taken together, the five subsections present an interlocking picture of the total project.

Objectives

Objectives are the measurable outcomes of the program. They define your methods. Your objectives must be tangible, specific, concrete, measurable, and achievable in a specified time period.
Grantseekers often confuse objectives with goals, which are conceptual and more abstract. For the purpose of illustration, here is the goal of a project with a subsidiary objective:

Goal: Our after-school program will help children read better.

Objective: Our after-school remedial education program will assist 50 children in improving their reading scores by one grade level as demonstrated by standardized reading tests administered after participating in the program for six months.

The goal in this case is abstract: improving reading, while the objective is much more specific. It is achievable in the short term (six months) and measurable (improving 50 children's reading scores by one grade level).

With competition for dollars so great, well-articulated objectives are increasingly critical to a proposal's success.

Using a different example, there are at least four types of objectives:

1. Behavioral - A human action is anticipated.
   
   Example: Fifty of the 70 children participating will learn to swim.

2. Performance - A specific time frame within which a behavior will occur, at an expected proficiency level, is expected.
   
   Example: Fifty of the 70 children will learn to swim within six months and will pass a basic swimming proficiency test administered by a Red Cross-certified lifeguard.

3. Process - The manner in which something occurs is an end in itself.
   
   Example: We will document the teaching methods utilized, identifying those with the greatest success.

4. Product - A tangible item results.
   
   Example: A manual will be created to be used in teaching swimming to this age and proficiency group in the future.

In any given proposal, you will find yourself setting forth one or more of these types of objectives, depending on the nature of your project. Be certain to present the objectives very clearly. Make sure that they do not become lost in verbiage and that they stand out on the page. You might, for example, use numbers, bullets, or indentations to denote the objectives in the text. Above all, be realistic in setting objectives. Don't promise what you can't deliver. Remember, the funder will want to be told in the final report that the project actually accomplished these objectives.
Methods

By means of the objectives, you have explained to the funder what will be achieved by the project. The methods section describes the specific activities that will take place to achieve the objectives. It might be helpful to divide our discussion of methods into the following: how, when, and why.

How: This is the detailed description of what will occur from the time the project begins until it is completed. Your methods should match the previously stated objectives.

When: The methods section should present the order and timing for the tasks. It might make sense to provide a timetable so that the grants decision-maker does not have to map out the sequencing on his or her own. The timetable tells the reader "when" and provides another summary of the project that supports the rest of the methods section.

Why: You may need to defend your chosen methods, especially if they are new or unorthodox. Why will the planned work most effectively lead to the outcomes you anticipate? You can answer this question in a number of ways, including using expert testimony and examples of other projects that work.

The methods section enables the reader to visualize the implementation of the project. It should convince the reader that your agency knows what it is doing, thereby establishing its credibility.

Staffing/Administration

In describing the methods, you will have mentioned staffing for the project. You now need to devote a few sentences to discussing the number of staff, their qualifications, and specific assignments. Details about individual staff members involved in the project can be included either as part of this section or in the appendix, depending on the length and importance of this information.

"Staffing" may refer to volunteers or to consultants, as well as to paid staff. Most proposal writers do not develop staffing sections for projects that are primarily volunteer run. Describing tasks that volunteers will undertake, however, can be most helpful to the proposal reader. Such information underscores the value added by the volunteers as well as the cost-effectiveness of the project.

For a project with paid staff, be certain to describe which staff will work full time and which will work part time on the project. Identify staff already employed by your nonprofit and those to be recruited specifically for the project. How will you free up the time of an already fully deployed individual?

Salary and project costs are affected by the qualifications of the staff. Delineate the practical experience you require for key staff, as well as level of expertise and educational background. If an individual has already been selected to direct the program, summarize his or her credentials and include a brief biographical sketch in the appendix. A strong project director can help influence a grant decision.

Describe for the reader your plans for administering the project. This is especially important in a large operation, if more than one agency is collaborating on the project, or if you are using a fiscal agent. It needs to be crystal clear who is responsible for financial management, project outcomes, and reporting.
Evaluation

An evaluation plan should not be considered only after the project is over; it should be built into the project. Including an evaluation plan in your proposal indicates that you take your objectives seriously and want to know how well you have achieved them. Evaluation is also a sound management tool. Like strategic planning, it helps a nonprofit refine and improve its program. An evaluation can often be the best means for others to learn from your experience in conducting the project.

There are several types of formal evaluation. One measures the product; others analyze the process and/or strategies you've adopted. Most seek to determine the impact on the audiences you serve and the measurable outcomes of your grant project. Either or both might be appropriate to your project.

The approach you choose will depend on the nature of the project and its objectives. Whatever form your evaluation takes, you will need to describe the manner in which evaluation information will be collected and how the data will be analyzed.

Most sound evaluation plans include both qualitative and quantitative data. You should also present your plan for how the evaluation and its results will be reported and the audience to which it will be directed. For example, it might be used internally or be shared with the funder, or it might deserve a wider audience. A funder might even have an opinion about the scope of this dissemination. Many funders also have suggestions about who should conduct the evaluation, whether it be your own program staff or outside consultants. Some funders allow for the inclusion of the cost of evaluation as part of the project budget.

Sustainability

A clear message from grantmakers today is that grantseekers will be expected to demonstrate in very concrete ways the long-term financial viability of the project to be funded and of the nonprofit organization itself.

It stands to reason that most grantmakers will not want to take on a permanent funding commitment to a particular agency. Rather, funders will want you to prove either that your project is finite (with start-up and ending dates); or that it is capacity-building (that it will contribute to the future self-sufficiency of your agency and/or enable it to expand services that might generate revenue); or that it will make your organization attractive to other funders in the future. Evidence of fiscal sustainability is a highly sought-after characteristic of the successful grant proposal.

It behooves you to be very specific about current and projected funding streams, both earned income and fundraised, and about the base of financial support for your nonprofit. Here is an area where it is important to have backup figures and prognostications at the ready, in case a prospective funder asks for these, even though you are unlikely to include this information in the actual grant proposal. Some grantmakers, of course, will want to know who else will be receiving a copy of this same proposal. You should not be shy about sharing this information with the funder.
The Budget

The budget for your proposal may be as simple as a one-page statement of projected revenue and expenses. Or your proposal may require a more complex presentation, perhaps including a page on projected support and notes explaining various items of expense or of revenue.

Expense Budget

As you prepare to assemble the budget, go back through the proposal narrative and make a list of all personnel and nonpersonnel items related to the operation of the project. Be sure that you list not only new costs that will be incurred if the project is funded but also any ongoing expenses for items that will be allocated to the project. Then get the relevant costs from the person in your agency who is responsible for keeping the books. You may need to estimate the proportions of your agency’s ongoing expenses that should be charged to the project and any new costs, such as salaries for project personnel not yet hired. Put the costs you have identified next to each item on your list.

Your list of budget items and the calculations you have done to arrive at a dollar figure for each item should be summarized on worksheets. You should keep these to remind yourself how the numbers were derived. These worksheets can be useful as you continue to develop the proposal and discuss it with funders; they are also a valuable tool for monitoring the project once it is under way and for reporting after completion of the grant.

A portion of a worksheet for a year-long project might look like this:

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive director</td>
<td>Supervision</td>
<td>10% of salary = $10,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25% benefits = $ 2,500</td>
</tr>
<tr>
<td>Project director</td>
<td>Hired in month one</td>
<td>11 months at $35,000 = $32,083</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25% benefits = $ 8,025</td>
</tr>
<tr>
<td>Tutors</td>
<td>12 working 10 hours per week for three months</td>
<td>$7,020</td>
</tr>
<tr>
<td>Office space</td>
<td>Requires 25% of current space</td>
<td>25% x $20,000 = $ 5,000</td>
</tr>
<tr>
<td>Overhead</td>
<td>20% of project cost</td>
<td>20% x $64,628 = $12,926</td>
</tr>
</tbody>
</table>

With your worksheets in hand, you are ready to prepare the expense budget. For most projects, costs should be grouped into subcategories, selected to reflect the critical areas of expense. All significant costs should be broken out within the subcategories, but small ones can be combined on one line. You might divide your expense budget into personnel and nonpersonnel costs; your personnel subcategories might include salaries, benefits, and consultants. Subcategories under nonpersonnel costs might include travel, equipment, and printing, for example, with a dollar figure attached to each line. Overhead, or indirect costs, is important to include because projects do not exist in isolation. Funders may have policies regarding the percentage of overhead they will allow in a project budget, if they allow it at all.
Support and Revenue Statement

For the typical project, no support and revenue statement is necessary. The expense budget represents the amount of grant support required. But if grant support has already been awarded to the project, or if you expect project activities to generate income, a support and revenue statement is the place to provide this information.

In itemizing grant support, make note of any earmarked grants; this will suggest how new grants may be allocated. The total grant support already committed should then be deducted from the "Total Expenses" line on the expense budget to give you the "Amount to Be Raised" or the "Balance Requested."

Any earned income anticipated should be estimated on the support and revenue statement. For instance, if you expect 50 people to attend your performance on each of the four nights, it is given at $10 a ticket, and if you hope that 20 of them will buy the $5 souvenir book each night, you would show two lines of income, "Ticket Sales" at $2,000 and "Souvenir Book Sales" at $400. As with the expense budget, you should keep backup worksheets for the support and revenue statement to remind yourself of the assumptions you have made.

Budget Narrative

A narrative portion of the budget is used to explain any unusual line items in the budget and is not always needed. If costs are straightforward and the numbers tell the story clearly, explanations are redundant.

If you decide a budget narrative is needed, you can structure it in one of two ways. You can create "Notes to the Budget," with footnote-style numbers on the line items in the budget keyed to numbered explanations. If an extensive or more general explanation is required, you can structure the budget narrative as straight text. Remember though, the basic narrative about the project and your organization belongs elsewhere in the proposal, not in the budget narrative.

Organizational Information

Normally a resume of your nonprofit organization should come at the end of your proposal. Your natural inclination may be to put this information up front in the document. But it is usually better to sell the need for your project and then your agency's ability to carry it out.

It is not necessary to overwhelm the reader with facts about your organization. This information can be conveyed easily by attaching a brochure or other prepared statement. In two pages or less, tell the reader when your nonprofit came into existence; state its mission, being certain to demonstrate how the subject of the proposal fits within or extends that mission; and describe the organization's structure, programs, leadership, and special expertise.

Discuss the size of the board, how board members are recruited, and their level of participation. Give the reader a feel for the makeup of the board. (You should include the full board list in an appendix.) If your agency is composed of volunteers or has an active volunteer group, describe the function that the volunteers perform. Provide details on the staff, including the numbers of full and part-time staff, and their levels of expertise.
Describe the kinds of activities in which your staff engage. Explain briefly the assistance you provide. Describe the audience you serve, any special or unusual needs they face, and why they rely on your agency. Cite the number of people who are reached through your programs.

Tying all of the information about your nonprofit together, cite your agency's expertise, especially as it relates to the subject of your proposal.

**Letter Proposal**

Sometimes the scale of the project might suggest a small-scale letter format proposal, or the type of request might not require all of the proposal components or the components in the sequence recommended here. The guidelines and policies of individual funders will be your ultimate guide. Many funders today state that they prefer a brief letter proposal; others require that you complete an application form. In any case, you will want to refer to the basic proposal components as provided here to be sure that you have not omitted an element that will support your case.

As noted, the scale of the project will often determine whether it requires a letter or the longer proposal format. For example, a request to purchase a $1,000 fax machine for your agency simply does not lend itself to a lengthy narrative. A small contribution to your agency's annual operating budget, particularly if it is a renewal of past support, might also warrant a letter rather than a full-scale proposal.

What are the elements of a letter request? For the most part, they should follow the format of a full proposal, except with regard to length. The letter should be no more than three pages. You will need to call upon your writing skills because it can be very hard to get all of the necessary details into a concise, well-articulated letter.

As to the flow of information, follow these steps while keeping in mind that you are writing a letter to another person. It should not be as formal in style as a longer proposal would be. It may be necessary to change the sequence of the text to achieve the correct tone and the right flow of information.

Here are the components of a good letter proposal:

- **Ask for the gift:** The letter should begin with a reference to your prior contact with the funder, if any. State why you are writing and how much funding is required from the particular foundation.
- **Describe the need:** In a very abbreviated manner, tell the funder why there is a need for this project, piece of equipment, etc.
- **Explain what you will do:** Just as you would in a fuller proposal, provide enough detail to pique the funder's interest. Describe precisely what will take place as a result of the grant.
- **Provide agency data:** Help the funder know a bit more about your organization by including your mission statement, brief description of programs offered, number of people served, and staff, volunteer, and board data, if appropriate.
- **Include appropriate budget data:** Even a letter request may have a budget that is a half-page long. Decide if this information should be incorporated into the letter or in a separate attachment. Whichever course you choose, be sure to indicate the total cost of the project. Discuss future funding only if the absence of this information will raise questions.
- **Close:** As with the longer proposal, a letter proposal needs a strong concluding statement. Offer to provide more details or meet with the funder.
• Attach any additional information required: The funder may need much of the same information to back up a small request as a large one: a board list, a copy of your IRS determination letter, financial documentation, and brief resumes of key staff.

It may take as much thought and data gathering to write a good letter request as it does to prepare a full proposal (and sometimes even more). Don't assume that because it is only a letter, it isn't a time-consuming and challenging task. Every document you put in front of a funder says something about your agency. Each step you take with a funder should build a relationship for the future.

**Conclusion**

Every proposal should have a concluding paragraph or two. This is a good place to call attention to the future, after the grant is completed. If appropriate, you should outline some of the follow-up activities that might be undertaken to begin to prepare your funder for your next request. Alternatively, you should state how the project might carry on without further grant support. This section is also the place to make a final appeal for your project. Briefly reiterate what your nonprofit wants to do and why it is important. Underscore why your agency needs funding to accomplish it. Don't be afraid at this stage to use a bit of emotion to solidify your case.

**What Happens Next?**

Submitting your proposal is nowhere near the end of your involvement in the grantseeking process. Grant review procedures vary widely, and the decision-making process can take anywhere from a few weeks to six months or more. During the review process, the funder may ask for additional information either directly from you or from outside consultants or professional references. Invariably, this is a difficult time for the grantseeker. You need to be patient but persistent. Some grantmakers outline their review procedures in annual reports or application guidelines. If you are unclear about the process, don't hesitate to ask.

If your hard work results in a grant, take a few moments to acknowledge the funder's support with a letter of thanks. You also need to find out whether the funder has specific forms, procedures, and deadlines for reporting on the progress of your project. Clarifying your responsibilities as a grantee at the outset, particularly with respect to financial reporting, will prevent misunderstandings and more serious problems later.

Nor is rejection necessarily the end of the process. If you're unsure why your proposal was turned down, ask. Did the funder need additional information? Would they be interested in considering the proposal at a future date? Now might also be the time to begin cultivation of a prospective funder. Put them on your mailing list so that they can become further acquainted with your organization.

Remember, there's always next year.

This short course in proposal writing was adapted from The Foundation Center's Guide to Proposal Writing, 5th ed. (New York: The Foundation Center, 2007), by Jane C. Geever, chairman of the development consulting firm, J. C. Geever, Inc.

The Foundation Center's Guide to Proposal Writing and other resources on the subject are available for free use in Foundation Center libraries and Cooperating Collections.

See also in the FAQs "Proposal Writing" and among the Guides "Web Sites for Proposal Writers."
The Foundation Center offers full-day Proposal Writing Seminars at various locations throughout the country and free one-hour introductions to the process, entitled Proposal Writing Basics, at all of its library locations.

The Foundation Center also offers a number of online training courses to help you learn to write grant proposals:

- Proposal Writing: The Comprehensive Course
- Proposal Writing: The Statement of Need
- Proposal Writing: The Project Description
- Proposal Writing: The Budget
A. Please present a justification for the budget items requested. Include an explanation of how costs were determined. If more space is required, attach another sheet. Each line item from the budget must clearly relate to the project objectives described. Keep in mind that this is a 12-month budget.

List Project Name and Target Population:

1. **Salaries**: Indicate for each position the name and title, the full time equivalent on this project, the expected rate of pay, and the total amount for a 12-month period. State each staff person’s salary per year. Funds can be used for salary of staff members directly involved in the proposed project (planning, developing, delivering, or evaluating). Salaries should be based on qualifications and experience.

   "Full time equivalent" (or FTE) is defined as the percentage of time a person will work on the proposed project. To calculate the FTE, divide the hours the person will work by the standard number of work hours, which is 40 hours per week, 174 hours per month, or 2,088 hours per year. For example, a person who works 20 hours per week on this project is a 0.5 FTE (20/40 = 0.5).

   Example: .75 FTE Health Educator, $35,000 per year x 12-months = $ 26,250

2. **Fringe**: All other costs, except for compensation, for full- or part-time employees of the applicant agency with project responsibilities, except those funded from administrative costs. These may, but do not have to, include: employer portion of FICA and Medicare, medical and dental insurance, long-term disability insurance, life and accidental death and dismemberment insurance, workers compensation insurance, and unemployment insurance. State each staff person’s fringe per year.

3. **Contractual Services**: If you plan to hire independent contractors for specific services on a fee basis, please indicate: (1) the name(s) of the contractor(s) or consultant(s) and their credentials relevant for the proposed project; (2) the dollar amount(s) proposed for payment for each contractor or consultant; (3) the specific expense line items; and, (4) the service(s) being provided. Please use additional pages if necessary. Note: Sub-contracts require prior written approval by IDPH.
4. **Travel and Subsistence:** All costs related to the transportation of project employees for approved project activities. Mileage should be calculated at the current State of Illinois reimbursable rate which can be found at http://www.state.il.us/cms/2_servicese_oth/trvlguid.htm.

5. **Supplies:** All project costs related to the purchase of items with a cost of less than $100.00 each. Examples: office supplies (paper products, clips, pencils), condoms & lube, copying costs, brochures and educational material, computer software, client incentives, etc.

6. **Printing:** Indicate the cost for printing according to major item. Examples: brochures, pamphlets, handouts, manuals etc.

7. **Equipment:** Itemize and justify all costs of equipment that is tangible, and has a useful life of more than one year with a cost greater than $100.00.

8. **Telecommunications:** All project cost items related to land line, cellular, or internet should be listed on this page.

9. **Administrative Costs:** Administrative Costs are defined as costs that represent the expenses of doing business that are not easily identified with a particular grant, contract, project, function, or activity but are necessary for the general operation of the organization and the conduct of activities it performs. Examples: accounting, human resources, general agency administration, and costs to operate and maintain facilities (including occupancy). Describe what kinds of administrative costs are expected. **

** This line is not to exceed 10% of the total of the proposed expenses.

---

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ALLOWABLE COSTS FOR REIMBURSEMENT

To be reimbursable under IDPH/OHP Grant Agreement, expenditures must meet the following general criteria:

a. Be necessary and reasonable for proper and efficient administration of the program and not be a general expense required to carry out the overall responsibilities of the agency.
b. Be authorized or not prohibited under federal, state or local laws or regulations. Federal regulations can be found at [www.whitehouse.gov/omb/circulars/a087](http://www.whitehouse.gov/omb/circulars/a087).
c. Conform to any limitations or exclusions set forth in the applicable rules, program description or grant agreement.
d. Be accorded consistent treatment through application of generally accepted accounting principles appropriate to the circumstances.
e. Not be allocable to or included as a cost of any other state or federally financed program in either the current or a prior period.
f. Be specifically identified with the provision of a direct service or program activity.
g. Be an actual expenditure of funds in support of program activities, documented by check number and/or internal ledger transfer of funds.

**Unallowable costs include, but are not limited to:**

a. Bad debts
b. Building Alarm or security systems
c. Costs for rental, lease or purchase of office space or buildings (unless prior approval is obtained from the Department)
d. Capital Improvements to Buildings
e. Contingencies or provision for unforeseen events
f. Contributions and donations
g. Major Equipment (unless prior approval is obtained from the Department)
h. Depreciation and use allowance
i. Entertainment, food, alcoholic beverages, gratuities
j. Fines and penalties
k. Interest and financial costs related to accounting or auditing activities
l. Legal, Legislative and lobbying expenses
### Illinois Department of Public Health

**Office of Health Protection**

**Budget Worksheet**

<table>
<thead>
<tr>
<th>Line Item</th>
<th>Original Sub Total by Line Item</th>
<th>Grantee Contribution Sub Total by Line Item</th>
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</thead>
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<td>Salary</td>
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<td>Fringe</td>
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<td><strong>Total</strong></td>
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</tbody>
</table>

**Justification**

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These cells will be calculated from the worksheets. Do not enter values here.

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Authorized Grantee Official: [Name]

Date: [Date]
<table>
<thead>
<tr>
<th>Position Title and Name</th>
<th>Projected Monthly Salary</th>
<th>Percentage of Time on Grant</th>
<th>Number of Months in Year</th>
<th>Amount Requested From IDPH</th>
<th>Total Grantee Contribution</th>
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Justification: Salaries and Wages
<table>
<thead>
<tr>
<th>Illinois Department of Public Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office of Health Protection</td>
</tr>
<tr>
<td>Budget Detail Template</td>
</tr>
</tbody>
</table>

Provide Justification for salaries and wages included in grant budget.
### Illinois Department of Public Health
#### Office of Health Protection
#### Budget Detail Template

<table>
<thead>
<tr>
<th>Fringe Benefit</th>
<th>Salaries</th>
<th>Rate</th>
<th>Amount Requested From IDPH</th>
<th>Total Grantee Contribution</th>
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</thead>
<tbody>
<tr>
<td>Justification: Fringe Benefits</td>
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</table>

Describe the particular fringe benefit and how fringes were calculated.
Illinois Department of Public Health  
Office of Health Protection  
Budget Detail Template

<table>
<thead>
<tr>
<th>Contractor Name</th>
<th>Contracted Service</th>
<th>Amount Requested From IDPH</th>
<th>Grantee Contribution</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

Justification: Contractual

Explain contractual allocation including how contractors were selected.
<table>
<thead>
<tr>
<th>Trips</th>
<th>Purpose of Travel</th>
<th>Mode of Transportation</th>
<th>Amount Requested From IDPH</th>
<th>Grantee Contribution</th>
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<tbody>
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<td></td>
<td>In-State Travel</td>
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</table>

**Justification: In-State Travel**

Describe in state travel purpose, method of calculation, and relevance to the grant program.

<table>
<thead>
<tr>
<th>Trips</th>
<th>Purpose of Travel</th>
<th>Mode of Transportation</th>
<th>Amount Requested From IDPH</th>
<th>Grantee Contribution</th>
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<td></td>
<td>Out-of-State Travel</td>
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</table>

**Justification: Out-of-State Travel**

Describe out-of-state travel and its relevance to the grant program. *All Out of State travel must be pre approved by IDPH. Justification for Out-of-State Travel must be very detailed.*
<table>
<thead>
<tr>
<th>Item(s) Requested</th>
<th>Amount Requested From IDPH</th>
<th>Grantee Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplies</td>
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</table>

Justification: Supplies

List all supplies separately and indicate how they relate to the program/service provided.
<table>
<thead>
<tr>
<th>Item(s) Requested</th>
<th>Amount Requested From IDPH</th>
<th>Grantee Contribution</th>
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</thead>
<tbody>
<tr>
<td>Printing</td>
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</table>

Justification: Printing

List all major print orders separately and indicate how they relate to the program/service provided. Example: pamphlets, brochures, manuals, etc should all be on separate lines.
<table>
<thead>
<tr>
<th>Item(s) Requested</th>
<th>Unit(s)</th>
<th>Amount Requested From IDPH</th>
<th>Grantee Contribution</th>
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<tr>
<td>Justification: Equipment</td>
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</tbody>
</table>

Indicate any equipment purchases and also describe how this purchase is necessary to complete the objectives.
<table>
<thead>
<tr>
<th>Item(s) Requested</th>
<th>Rate</th>
<th>Months</th>
<th>Amount Requested From IDPH</th>
<th>Total Amount Requested From IDPH</th>
<th>Total Grantee Contribution</th>
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<tbody>
<tr>
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<tr>
<td>Telecommunications</td>
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</tbody>
</table>

**Justification: Telecommunications**

Explain costs for telecommunications and describe relevance to grant program. Each item (cellular, fax, land line, internet, etc) should be on a separate line.
<table>
<thead>
<tr>
<th>Item(s) Requested</th>
<th>Total Amount Requested From IDPH</th>
<th>Total Grantee Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Justification: Administration**

Explain costs for administration and describe relevance to grant program. Please note that administrative costs must not exceed 10% of overall budget.