Connecticut Comprehensive HIV Prevention Plan 2005-2008

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The Parisky Group
30 Arbor Street
Hartford, CT 06106

For additional copies call:
(860) 232-0641
toll free at
(877) 570-1118

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Connecticut Comprehensive HIV Prevention Plan 2005-2008

Acknowledgements

J. Robert Galvin, MD, MPH
Commissioner, Connecticut Department of Public Health

Ardell Wilson, DDS, MPH
Chief, Bureau of Community Health

Rosa M. Biaggi, MPH, MPA
Director, AIDS and Chronic Diseases Division

Connecticut HIV Prevention Community Planning Group Co-Chairs

William Behan, RN, BS
Assistant Administrator
AIDS and Chronic Diseases Division
DPH Co-Chair

Brian Libert
Community Health Services
Community Co-Chair

Stephanie Lozada
Southwest Community Health Center
Community Co-Chair

Kathey Fowler
Windham Regional Community Council, Community Co-Chair Elect

Bernadette Brown
Central AHEC, Inc.
Community Co-Chair
October 2002-November 2003

Chris Andresen
AIDS and Chronic Diseases Division
DPH Co-Chair
October 2001 – April 2004

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Department of Public Health Staff

Ken Carley, DrPH
HIV/AIDS Surveillance Program

Nadine Repinecz, MPA
Data Management and Administrative Suppport

Heidi Jenkins
Sexually Transmitted Disease Control Program

Aaron Roome, PhD, MPH
HIV/AIDS Surveillance Program

Andrea Lombard, BSN, MPH
Viral Hepatitis Program

Dorine Testori
HIV Prevention Programs Unit

Susan Major
HIV Planning Unit

Consultants: The Parisky Group

Lennon Hite **Barbara Mase** **Flora Parisky**
Alice Leibowitz **Frederic Morton** **Laura Stone**

Prepared with the Connecticut HIV Prevention Community Planning Group, a public-private partnership representing consumers and various sectors involved in the management and prevention of HIV/AIDS in Connecticut.

Connecticut HIV Prevention Community Planning Group Membership

The members and advisors of the Connecticut HIV Prevention Community Planning Group (CPG) consist of a diverse group of individuals, reflective of the HIV/AIDS epidemic in Connecticut. They are representatives from the medical, public health, service, public and private sectors, as well consumers, activists and community advocates involved in HIV/AIDS prevention and care.

MEMBERS (2003-2004)

Chris Andresen
Former DPH Co-Chair
Department of Public Health

Mark Bond-Webster
Community Services Assessment
Committee Co-Chair
Perception Programs

William Behan
DPH Co-Chair
Department of Public Health

Bernadette Brown
Former Community Co-Chair
Central AHEC, Inc.

William Castillo
Hispanos Unidos

Charles Creech
Morris Foundation

Hector Davila
University of Connecticut Health Center

Gina D'Angelo
Northwest CT AIDS Project

Pam Foster
Membership, Parity, Inclusion, Representation & Evaluation Committee Co-Chair
Department of Public Health

Kathey Fowler
Community Services Assessment
Committee Co-Chair
Windham Regional Community Council
Outreach Services Program

Richard Gonzalez
Bridgeport Health Department

Brian Goodrich
Priority Setting Ad Hoc Committee Co-Chair
Correctional Managed Health Care

Carmen LaTorre
Charter Oak Health Center

Loreen Lawrence
Birmingham Group Health Service

Edward Leduc
Finance, Policy & Procedure
Committee Co-Chair
Community Representative

Brian Libert
Community Co-Chair
Community Health Services

Matthew F. Lopes, Jr.
New Haven Health Department

Stephanie Lozada
Community Co-Chair
Southwest Community Health Center

Lee Ann Marino
Community Representative

LeRoy McIntosh
Norwalk Health Department

Arka Mikel
Willimantic Housing Authority

Maggy Morales
Latino/as Contra SIDA

Christopher Morris
Greater Bridgeport Adolescent Pregnancy Prevention Program

Rich Neal
Connecticut Children's Medical Center

Dennis O'Neill
Community Partners in Action

Louis Rudolph
Finance, Policy & Procedures
Committee Co-Chair
Community Representative

Albert Young

Membership, Parity, Inclusion, Representation & Evaluation Committee Co-Chair
Waterbury Hospital

ADVISORS (2003-2004)

William Behan
Department of Public Health

Dalia Belliveau
Visiting Nurses Association
Healthy Families Program

Richard Buika
Mid-State Behavioral Health System

Ken Carley
Department of Public Health

Freddie Close
Visiting Nurse & Health Services of Connecticut

Patricia Denardo
Community Representative

Leif Mitchell
Priority Setting Ad Hoc Committee Chair
Center for Interdisciplinary Research on AIDS

Wanda Richardson
Department of Public Health

We would also like to recognize those individuals, although not members of the CPG, who contributed to the development of this Plan:

Deborah Cornman, University of Connecticut, Center for HIV intervention and Prevention

Darrell Decker, Concerned Citizens for Humanity

Bonnie Edmondson, Connecticut Department of Education

Julie Eiserman, Hispanic Health Council

Jesse Grant, Brothers 4 Brothers, Community Health Services

Deborah Henault, Connecticut Department of Correction Addiction Services

Krista Heybruck, Behavioral and Social Service Volunteer

Cyndi Hyland, HIV Prevention Educator, York Correctional Facility

Jennifer Jainer, Holt, Wexler & Farnam, LLP

Jerimarie Liesegang, Ph.D. The Connecticut TransAdvocacy Coalition

David Paltiel, Yale University

Rich Smalley, Wheeler Clinic and HIV Youth Advisory Board Cordinator

Henry Smolinski, HIV Prevention Educator, Osborn Correctional Facility

Mel Thomas, Brothers 4 Brothers, Community Health Services

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Connecticut HIV Prevention Community Planning Group
c/o The Parisky Group
30 Arbor St. North, Hartford, CT 06106
Phone: (860) 232-0641, Toll Free (877) 570-1118, Fax: (860) 232-8321
cpg@pariskygroup.com

September 15, 2004

Angel Ortiz
Project Officer
Centers for Disease Control and Prevention
National Center for HIV/STD/TB Prevention
1600 Clifton Rd. NE, Mailstop E-58
Atlanta, GA 30333

Dear Mr. Ortiz,

The Connecticut HIV Prevention Community Planning Group (CPG) has reviewed the Department of Public Health's (DPH) application to the Centers for Disease Control and Prevention for continuing HIV prevention funding. We have voted today to **concur** that the priorities in the 2005 Cooperative Agreement Application to the CDC from DPH and the current Connecticut Comprehensive HIV Prevention Plan are consistent. This decision was made after careful deliberation, discussion and a deciding vote of **17 for concurrence, 0 for non-concurrence, 1 for concurrence with reservations, and 0 abstentions.**

The CPG has worked closely with the DPH over the past year to prepare the 2005-2008 Comprehensive Plan. In addition, CPG and DPH have constantly strived to improve communication and collaboration. We feel that the Application and the planning process strongly reflect this cooperation. DPH and CPG have also developed and fostered a productive working relationship in the following ways:

- The CPG was presented with a 2004 update of the *2003 Epidemiological Profile of HIV and AIDS in Connecticut.* This document not only provided the foundation for Chapter 2 of the Plan, it also served as a crucial foundation for the Priority Setting Ad Hoc Committee in determining and identifying target populations for prioritization.

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- DPH staff members are active participants on the CPG serving as members, advisors, consultants and co-chair. DPH staff members have also made presentations at full CPG and committee-focused meetings. A DPH staff person was elected and currently serves as co-chair of the CPG's Membership, Parity, Inclusion, Representation and Evaluation (MPIRE) Committee. Bill Behan, Assistant Administrator of the AIDS and Chronic Diseases Division, serves as the DPH Co-Chair, sits ex-officio on the Community Services Assessment Committee as well as on the Priority Setting Ad Hoc Committee for the Integration of HIV/AIDS Care and Prevention. Mr. Behan also serves as the DPH Co-Chair of The Statewide HIV/AIDS Care Consortium.

- To further enhance the effectiveness and efficiency of the community planning process, the AIDS and Chronic Diseases Division hired a new Health Program Associate in June 2004. This position is specifically directed to help guide the planning process and to work with the contractor on plan development and meeting logistics. In addition, another Health Program Associate assists in facilitating the work of the Community Services Assessment Committee. These dedicated positions are a further indication of the Department's commitment to ensuring a strong and collaborative community planning process.

- The CPG has also taken steps to improve the CPG process and communications with the DPH. Every three months, the Community co-chairs write a letter to the Director of the AIDS and

Chronic Diseases Division that expresses both satisfactions and concerns. This process assists in addressing and resolving issues before they become major crises.

All CPG members participated in the review of both the Plan and Application. The 2005-2008 HIV Prevention Plan was approved by the CPG at its August 18, 2004, meeting. Regarding the Application, CPG members were provided with the Application on September 1, 2004, and given fourteen (14) days to submit feedback and questions to both the contractor and DPH.

On September 15, 2004, CPG members reviewed and discussed the Application at a full CPG meeting. At the beginning of this meeting, Department staff members presented a review of the major highlights of the Application. Members were given an opportunity to discuss the Application.

Following this presentation and discussion, the contractor presented an overview of the Concurrence Process. This presentation included an overview of the roles and responsibilities of the Department, of the CPG and an explanation of the options of Concurrence, Concurrence with Reservations and Non-Concurrence per the CDC Guidance.

After these presentations and discussions, the Concurrence vote was taken. Seventeen (17) members voted to Concur and one (1) voted for Concurrence with Reservations. Although the ballot provided space for an explanation of a Concurrence with Reservations vote, no reason was indicated for this vote. The CPG then unanimously authorized the Co-Chairs to draft this Concurrence Letter

As the Connecticut CPG heads into an active 2005 Planning Cycle, we look forward to enhanced and expanded collaboration with the AIDS and Chronic Diseases Division. We believe that these documents address the prevention needs of priority populations and are being supported through the funding commitments of the health department. We feel strongly that the 2005 Plan and Application reflect the planning efforts of the statewide HIV Prevention Community Planning Group and that a thorough review process was used to ensure concurrence.

As co-chairs we have been designated by the CPG as signatories to this letter of concurrence.

Sincerely,

Bill Behan
Department of Public Health
Co-Chair, HIV Prevention
Community Planning Group

Stephanie Lozada
Community Co-Chair, HIV Prevention
Community Planning Group

Brian Libert,
Community Co-Chair, HIV Prevention
Community Planning Group

Connecticut Comprehensive HIV Prevention Plan 2005-2008

TABLE OF CONTENTS

Appendices

Chapter 1

Connecticut's HIV Prevention Community Planning Group (CPG)

Welcome to the Connecticut CPG

HIV prevention community planning is a collaborative process by which the Connecticut Department of Public Health (DPH) works in partnership with the Connecticut HIV Prevention Community Planning Group (CTCPG) to develop a comprehensive HIV prevention plan that best represents the needs of populations at risk for, or infected with, HIV.

OVERVIEW: HIV PREVENTION COMMUNITY PLANNING

The CDC provides HIV prevention funding to 65 health departments in the form of cooperative agreements. These recipients include all 50 state health departments, the District of Columbia; the health departments of Chicago, Houston, Los Angeles, New York City, Philadelphia, and San Francisco; Puerto Rico, the U.S. Virgin Islands and six U.S.- affiliated Pacific Islands.

Beginning in 1994, the CDC changed the way in which federally funded state and local level HIV prevention programs were planned and implemented. State, territorial, and local health departments receiving federal prevention funds through the CDC were asked to share the responsibility for developing a comprehensive HIV prevention plan with representatives of affected communities and other technical experts. This lead to the development of a process called **HIV Prevention Community Planning**.

The basic intent of the HIV Prevention Community Planning process is to:

- **increase meaningful community involvement in prevention planning,**
- **improve the scientific basis of program decisions, and,**
- **target resources to those communities at highest risk for HIV transmission/acquisition.**

CONNECTICUT HIV COMMUNITY PLANNING

The purpose of Connecticut's community planning process is for the populations most at-risk for HIV infection, and those affected by HIV/AIDS, to provide input to the DPH about HIV prevention needs and effective prevention interventions. In addition, these populations also provide guidance regarding the distribution of HIV prevention dollars among prioritized at-risk populations throughout the state. This is accomplished through the **Connecticut HIV Prevention Community Planning Group (CPG)**.

The Connecticut CPG began its work in April of 1994, and, by the following September, the first HIV Prevention Plan for the State of Connecticut was written. In October of 1994, the Connecticut Department of Public Health (DPH) sent its 1995 HIV Prevention Application for funding along with the CPG's 1995 Comprehensive Prevention Plan to the CDC with a request for $4.1 million of federal HIV prevention funding.

Since 1994, DPH has submitted twelve applications, along with the corresponding CPG HIV Prevention Plan, to the CDC for funding. Current federal HIV prevention dollars for Connecticut total $6.5 million.

The CDC supports this process by providing funding and making technical assistance available to develop the capacity of Connecticut's community planning group. CDC expects HIV prevention community planning groups to improve HIV prevention programs by strengthening the: (1) scientific basis, (2) community relevance, and (3) population-or-risk-based focus of HIV prevention interventions in each project area.

CDC HIV PREVENTION STRATEGY

HIV Prevention Community Planning plays an integral role in achieving the goals of CDC's HIV Prevention Strategic Plan Through 2005 to:

"*Reduce the number of new HIV infections in the United States from an estimated 40,000 per year to 20,000 per year by 2005, focusing particularly on eliminating racial and ethnic disparities in new HIV infections."*

To accomplish the goals of the HIV Prevention Strategic Plan, CDC expects to:

- Decrease by at least 50% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained, and evidence-based HIV prevention activities,
- Increase, through voluntary counseling and testing, the proportion of HIV-infected people in the United States who know they are infected from the current estimated 70% to 95%,
- Increase the proportion of HIV-infected people in the United States who are linked to appropriate prevention, care and treatment services from the current estimated 50% to 80%, and,
- Strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions, and evaluate prevention programs.

Two major components from this strategic plan must be considered by all CPGs: (a) targeting populations for which HIV prevention activities will have the greatest impact, and, (b) reducing HIV transmission in populations with highest incidence. CPGs are also required to consider the unique issues related to providing HIV prevention for persons living with HIV/AIDS (PLWHA).

CDC GUIDANCE

The CDC *Guidance for HIV Prevention Community Planning* functions as a blueprint for HIV prevention planning. It also provides direction to CDC grantees receiving federal HIV

prevention funds to design and implement a participatory HIV prevention community planning process. The CDC has set three major goals for Community Planning:

1. **Community planning supports broad-based community participation in HIV prevention planning.**

2. **Community planning identifies priority HIV prevention needs (a set of priority targeted populations and interventions for each identified target population) in each jurisdiction.**

3. **Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.**

The Guidance further outlines the following eight objectives, which align with the three goals, as a framework for monitoring and measuring progress in achieving a reduction of new HIV infections and reduced HIV-related morbidity:

- Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.
- Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.
- Foster a community planning process that encourages inclusion and parity among community planning members.
- Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.
- Ensure that prioritized target populations are based on an epidemiological profile and a community services assessment.
- Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.
- Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.
- Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

HIV Prevention Community Planning is one of nine required essential components of a comprehensive HIV prevention program. The primary task of the CPG is to develop a Comprehensive Prevention Plan that includes prioritized target populations and a mix or set of proven effective prevention activities or interventions for each target population. Once the Comprehensive HIV Prevention Plan is developed, the DPH uses it as a basis for writing its

application for funding under the Cooperative Agreement between the State of Connecticut and the CDC. The CPG then reviews the application and sends one of three letters to the CDC. The first option is a letter supporting the health department's application (called a "Letter of Concurrence"). The second is a letter of dissatisfaction with the health department's application (called a "Letter of Non-concurrence"), and the third is a letter of concern with the health department's application (called a "Letter of Concurrence with Reservations").

HIV Prevention Community Planning is a flexible, but accountable process based on shared decision making between the Connecticut Department of Public Health and the Connecticut CPG. It involves participation, collaboration, cooperation, inclusion, parity and representation. Connecticut's planning process plays a key role in stemming the tide of HIV/AIDS throughout the state.

Core Objectives

This chapter describes the Connecticut CPG's efforts in fulfilling five of the ten *Guiding Principles of HIV Prevention Community Planning:*

Goal 2: *The community planning process must reflect an open, candid and participatory process, in which differences in cultural and ethnic background, perspective, and experience are essential and valued;*

Goal 3: *The community planning process must involve representatives of populations at greatest risk for HIV infections and people living with HIV and AIDS (PLWHA);*

Goal 4: *The fundamental tenets of community planning are parity, inclusion and representation (PIR);*

Goal 5: *An inclusive community planning process includes representatives of varying races and ethnicities, genders, sexual orientations, ages and other characteristics such as varying educational backgrounds, and expertise; and,*

Goal 6: *The community planning process must actively encourage and seek out community participation.*

OPENNESS AND PARTICIPATORY NATURE – CPG MEMBER PARTICIPATION

Currently, the CPG is comprised of 26 members and 8 advisors who are representative of the cultural and geographic diversity of the epidemic in Connecticut. Members and advisors are expected to actively participate in all CPG-related meetings, events and activities. All CPG members and advisors serve on at least one of the three standing committees. To encourage participation in the community planning process by all CPG members, advisors and members of the public, the CPG holds its monthly meetings at different locations throughout the state. In December 2003, the CPG's Executive Committee also decided to hold its monthly meetings in various locations throughout the state (e.g. Hartford, Waterbury, Meriden, Willimantic and New Haven). During the 2003-2004 planning year, the CPG met twelve times throughout the state.

(See Figure 1-1 and Figure 1-2). In 2005**,** CPG monthly meetings will continue to be conducted at various locations throughout the state.

The CPG also supports its membership by working to eliminate potential barriers to participation. Members who are unemployed or who lose wages by attending meetings are eligible to receive a stipend. All members are eligible for mileage, transportation, and childcare reimbursements. For members and advisors who do not have reliable or available transportation to meetings, the CPG contractor provides alternate arrangements.

Members are also encouraged to carpool and provide rides for each other. The CPG works constantly to improve communications by maintaining: (1) a national toll-free telephone number (877-570-1118) that enables members to contact the CPG's central office at no cost, and, (2) a website (www.connhivcpg.com), which contains information about membership, publications, and monthly meetings.

For CPG members who are deaf and hard of hearing, American Sign Language interpreters are provided at CPG meetings The CPG also purchased a portable sound system to make meetings more audible for CPG members and the public. During the 2005 cycle, Spanish translators and translation systems, as requested, will be made available at CPG meetings to assist CPG members for whom English is a second language.

Figure 1-1
CPG meeting sites: August 2003 through December 2003.

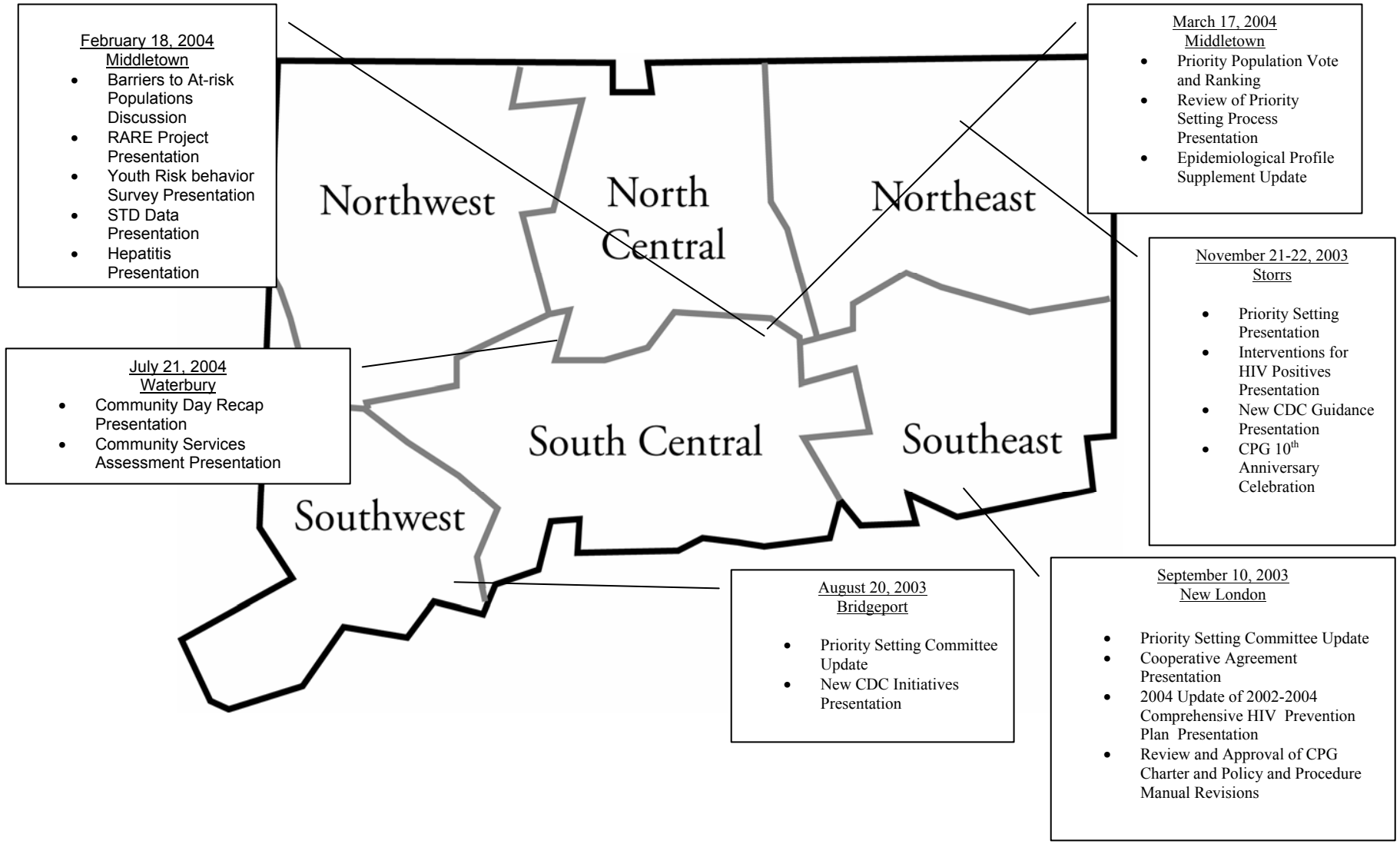
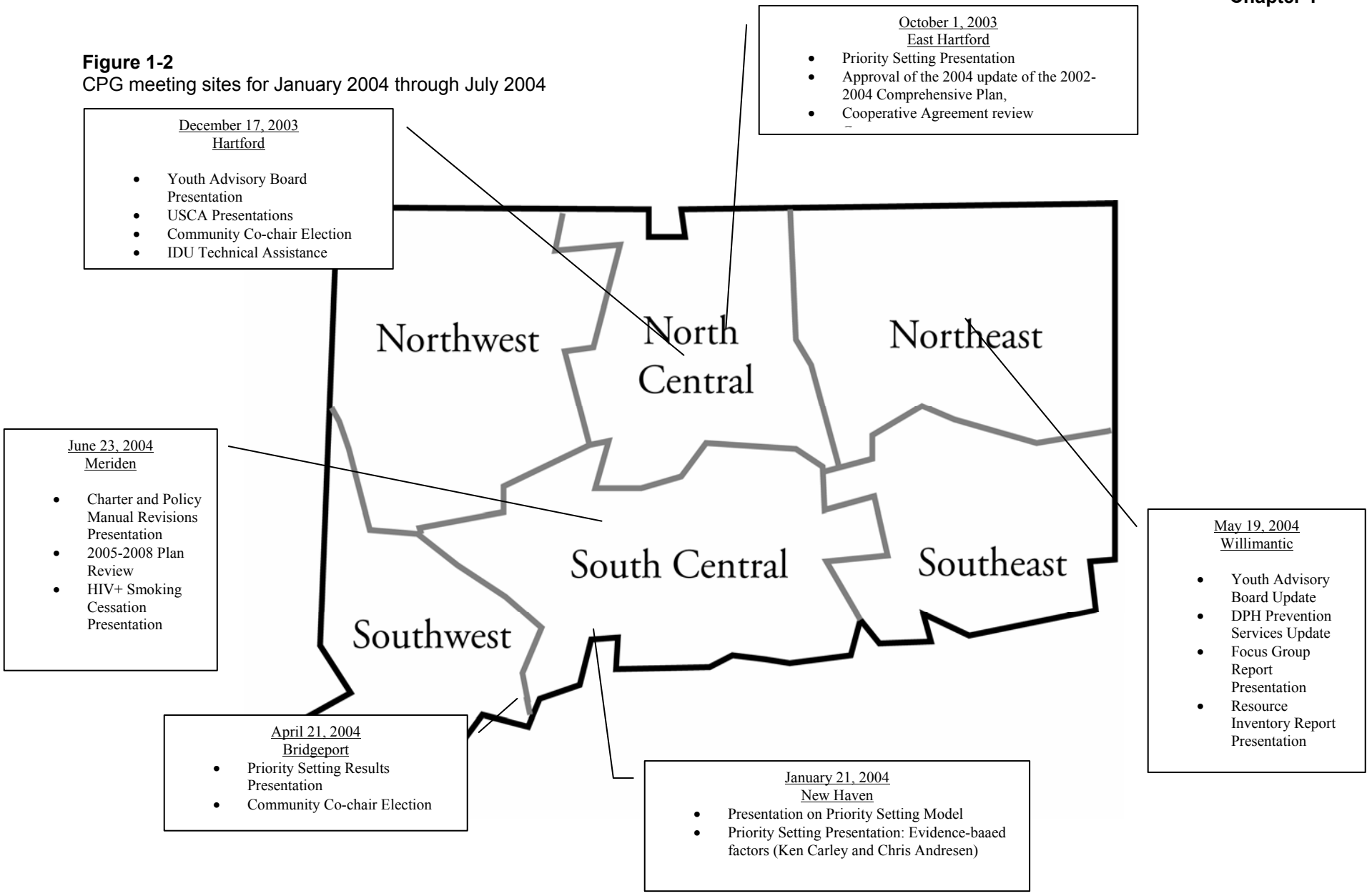


Figure 1-2
CPG meeting sites for January 2004 through July 2004



PUBLIC PARTICIPATION

Since it's inception, the Connecticut CPG has incorporated public input in several ways - public hearings, public comment periods during regular monthly meetings, focus groups, key informant interviews, and Community Days. Community Days, initiated in 1996, are a type of community hearing that involves a series of community meetings in a variety of settings on a given day in a given city. Community Days provide CPG members with the opportunity to travel to community sites and dialog with community members on their own "turf" (e.g. homeless shelters, youth centers, churches, syringe exchange programs, schools, and correctional institutions). Community Days also allow CPG members the chance to gather information about HIV risk behaviors, suggestions about unmet needs, and discuss "what will work to prevent HIV" in the respective community. The CPG plans to continue the practice of Community Days in 2005-2008.

On May 6, 2004, the CPG hosted a Community Day Event in Waterbury, Connecticut. Working in collaboration with the Planning and Policy Committee of the Greater Waterbury AIDS Consortium, the CPG's Membership, Parity, Inclusion, Representation and Evaluation (MPIRE) Committee sponsored events at New Opportunities, Inc. (a breakfast and three roundtable discussions on HIV prevention issues on HIV and the faith community, outreach services and services provided by the Waterbury Health Department). A luncheon and town hall meeting were held later in the day at Waterbury Hospital, where providers and persons living with HIV/AIDS will have an opportunity to speak up about prevention issues in their community. The daylong event was a collaborative effort co-sponsored by the CPG, New Opportunities for Waterbury, Inc., Waterbury Hospital, the Waterbury Health Department and the Waterbury AIDS Consortium. ***(See Community Day Summary in Appendix A)***

To further encourage public participation, the CPG also incorporates a public comment period in its monthly meeting agenda. This designated period not only gives members of the public an opportunity to bring concerns to the CPG, but also provides a forum for information sharing. While members of the public are not permitted to vote during CPG decision-making, they are always encouraged to take part in CPG committee meetings and activities.

The CPG publishes a monthly newsletter designed to keep interested members of the public, agencies and community-based organizations up-to-date on CPG happenings. *Meeting News and Notes* highlights major agenda items of the CPG monthly meeting as well as HIV/AIDS related announcements and activities. Monthly, the CPG contractor sends a mailing to more than 1100 Connecticut subscribers, as well as to interested individuals and organizations in several states. These mailings include the *Meeting News and Notes*, upcoming meeting agenda, and directions. ***(See sample Meeting News and Notes in Appendix A).***

To motivate public participation in the community planning process, the CPG also issues local media advisories concerning community planning related events. ***(See sample media advisory in Appendix A)***. To promote integration of prevention and care as well as encourage cross membership and participation, announcements regarding the CPG meetings and activities are also sent to Ryan White Title I Planning Councils in the Hartford and New Haven/Fairfield County Eligible Metropolitan Areas (EMA) and to the Ryan White Title II Statewide Consortium. The CPG also maintains its own website to compliment the existing DPH community planning web page. This website (www.connhivcpg.org), which features CPG-related materials (e.g. meeting schedules and directions and the Prevention Plan) and includes links to numerous resources for HIV prevention and the DPH AIDS and Chronic Diseases Division website (www.dph.state.ct.us/BCH/AIDS/HPAIDS.html)

CPG LEADERSHIP

Effective and participatory leadership is key to Connecticut's community planning process. Equal and shared responsibilities, mutual respect, collaboration and cooperation are trademarks of Connecticut's CPG leadership structure. Connecticut's CPG consists of a three co-chair format - two elected community co-chairs and a DPH designated representative.

From October 2001 until April 2004, Chris Andresen, a 15 year employee of the Department, served as the DPH Co-Chair. Chris has served as partner notification specialist in the CARE Program and as a program associate. From 1999-2003 he supervised prevention education services, and in 2003, with the reorganization of the AIDS Division into the AIDS and Chronic Disease Division, supervised the Planning Unit as well as the Cardiovascular Unit.

Bill Behan has been the DPH Co-Chair since April 2004. Bill currently oversees the Health Care Support Services and Data units of the AIDS and Chronic Diseases Division. He also functions as Assistant Division Director. In addition to his responsibilities as DPH Co-chair serves as the DPH Co-chair of the statewide Ryan White Planning Council. Bill has been with the AIDS Division for two and a half years and has worked in the HIV/AIDS field for twenty years.

The two Community Co-Chairs elected by the CPG are Brian Libert and Stephanie Lozada. Brian has been a CPG member since January 2000. He has served as community co-chair since 2002 and will complete his second term in October 2004. He was also the alternate chair of the CPG's Policy and Procedure Committee and has served on the Nomination Committee

and the Community Norms and Values Workgroup. Brian works as an HIV/AIDS outreach worker at Community Health Services in Hartford.

Stephanie Lozada is a Community Disease Prevention Counselor at Southwest Community Health Center in Bridgeport. A CPG member since October 2001, she has served on the Membership, Parity, Inclusion, Representation and Evaluation Committee (MPIRE) and was elected committee co-chair in July 2003. She was elected community co-chair in December 2003 to replace former community-co-chair who resigned because of work-related responsibilities.

Kathey Fowler is Director of Outreach Services with the Windham Regional Community Council (WRCC)/Outreach Services Program in Willimantic, CT. She has been a CPG member since April 2003 and served on the former Data Assessment and Analysis Committee. She was elected co-chair of the Community Services Assessment Committee in July 2003. Kathey was elected Community Co-chair elect in April 2004 and will assume the position currently held by Brian Libert after his term on the CPG ends in October 2004.

COMMITTEE STRUCTURE

The CT CPG has a clearly defined organizational structure, which currently includes three standing committees [Community Services Assessment (CSA), Finance, Policy and Procedures (FPP), Membership, Parity, Inclusion, Representation and Evaluation (MPIRE)], an Executive Committee, and specifically designated ad hoc committees (e.g. Priority Setting).

The governing body of the CPG is the Executive Committee. It meets on a monthly basis to discuss CPG business and strategize for the future. The Executive Committee is made up of nine members: the DPH Co-chair, two Community Co-chairs, and six standing committee chairpersons (2 co-chairs per each of the three committees). Committee co-chairs each have a vote on the Executive Committee. In January 2003, the CPG established an ad-hoc committee for priority setting, which completed its work in March 2004. The chair and co-chair of the Priority Setting Ad-hoc Committee also attended and participated at Executive Committee meetings during 2003-2004.

In April 2003, the CPG's Executive Committee approved a new proposal to restructure the CPG's six standing committees into three. The rationale behind restructuring from six to three committees was to: (1) provide more equal distribution of work among committees, (2) eliminate duplication of efforts, (3) promote more effective and efficient use of resources and better time management, (4) provide more people power and empowerment, (5) foster closer collaboration of "like" committees, (6) create better team building and partnering, (7) produce stronger and more focused outcomes, (8) focus on products, accountability, outcomes, monitoring and evaluation, and, (9) produce a smoother flow to the community planning process. The committee restructuring was approved by the full CPG at its June 2003 meeting and implemented in July 2003 ***(See Committee Responsibilities in Appendix A).***

The CPG committee structure now consists of the following three committees:

- **Community Services Assessment Committee (CSA):**
  Responsibilities: To collaborate with and provide input to the DPH in the development, collection, analysis, production, update and dissemination of a community services assessment (e.g. needs assessment, resource inventory and gap analysis) as part of the development of a comprehensive statewide HIV prevention plan.

- **Membership, Parity, Inclusion, Representation and Evaluation (MPIRE):**
  Responsibilities: To collaborate with the DPH to develop and apply criteria for the selection, interviewing and retention of CPG members and advisors, to ensure parity, inclusion and representation among the membership, to sponsor Community Days, and to oversee the evaluation of the community planning process.

- **Finance, Policy & Procedures (FPP):**
  Responsibilities: To consult with the contractor and DPH to review the annual budget and quarterly CPG expenditures, advise the CPG on cost-effectiveness of federal funds for HIV prevention, develop, review and make changes to the charter, bylaws and Policy and Procedure Manual, and recommend appropriate actions and positions for the CPG on various local and national HIV prevention related issues ***(see the Connecticut CPG's needle exchange policy statement in Appendix A).***

Each of the committees consists of two chairs that equally share roles and responsibilities. These co- chairs were elected at the July 2003 CPG meeting, were mentored for two months by the former committee chairs, and assumed leadership positions in October 2003.

Committees consist of between 7-16 members with the largest membership designated to the Community Services Assessment (CSA) Committee. The CPG Co-Chairs each serve on one committee, with the DPH chair designated to the Community Services Assessment Committee. In addition, The Parisky Group, as contractor also provides staffing for each committee.

CPG Executive Committee members and their related experiences

Member	Experience
Bill Behan 	***DPH Co-Chair*** – Bill Behan has been the DPH Co-Chair since April 2004. Bill currently oversees the Health Care Support Services and Data units of the AIDS and Chronic Diseases Division and functions as Assistant Division Director. He is also the DPH Co-chair of the statewide Ryan White Planning Council. Bill has been with the AIDS Division for two and a half years and has worked in the HIV/AIDS field for twenty years.
Chris Andresen 	***DPH Co-Chair*** – Chris Andresen served as DPH Co-Chair from January 2002 to July 2004. He was Chief of Prevention Education Services until July 2003 and was responsible for oversight of the Health Department's Heath Education Risk Reduction programs. Currently, Chris then supervised the HIV/AIDS Planning Unit, which oversaw community planning, coordinated and compiled the CDC application and progress reports and monitored the technical components of contractors' reporting status. Chris was named supervisor of the Cardiovascular Disease Unit in the AIDS and Chronic Diseases Division in April 2004.

Bernadette Brown

CPG Community Co-Chair – Bernadette served on the CPG from May 2001 to December 2003. She was elected Community Co-Chair in October 2002 and served in that capacity until her resignation in November 2003. Bernadette was a member of the Finance and Membership and Parity, Inclusion and Representation Committees. A Triage Specialist for the Central Area Education Health Center (AHEC) in Hartford, Bernadette also worked as a Ryan White Title Case Manager at the Urban League of Greater Hartford from 2002-2003.

Brian Libert

CPG Community Co-Chair – Brian Libert has been a CPG member since January 2000. He was elected Community Co-Chair in April 2002 and re-elected in April 2003. Brian's second term as community co-chair will conclude in October 2004. He was the alternate chair of the CPG's Policy and Procedure Committee and also served on the Nomination Committee and the Community Norms and Values Workgroup. Brian works as an HIV/AIDS outreach worker for Community Health Services in Hartford.

Stephanie Lozada

CPG Community Co-Chair - A CPG member since October 2001, Stephanie was elected Community Co-chair in December 2003. She has served on the Membership, Parity, Inclusion and Representation committee (MPIRE) and was elected co-chair of that committee in July 2003. Stephanie is a Community Disease Prevention Counselor at Southwest Community Health Center in Bridgeport, CT.

Kathey Fowler

CPG Community Co-Chair Elect – Kathey Fowler was elected Community Co-chair in April 2004 and the assume the position currently held by Brian Libert after a six-month mentoring period in October 2004. She has been a CPG member since April 2003 and served on the former Data Assessment and Analysis Committee. She was elected co-chair of the Community Services Assessment Committee in July 2003. Kathey is Director of Outreach Services with the Windham Regional Community Council (WRCC)/Outreach Services Program in Willimantic, CT.

Mark Bond-Webster

Community Services Assessment (CSA) Co-Chair - Mark served as a CPG advisor from October 2002 to April 2003 when he moved to CPG member status. He served on the Interventions and Resource Allocation committee and was elected co-chair of Community Services Assessment Committee in July 2003. Mark is a former Massachusetts CPG advisor and currently works as an AIDS Risk Reduction Outreach Worker with Perception Programs, where he does HIV prevention outreach to active drug users in Willimantic, CT.

Kathey Fowler

Community Services Assessment (CSA) Co-Chair - Kathey has been a CPG member since April 2003 and served on the former Data Assessment and Analysis Committee. She was elected co-chair of the Community Services Assessment Committee in July 2003. Kathey is Director of Outreach Services with the Windham Regional Community Council (WRCC)/Outreach Services Program in Willimantic, CT.

Leif Mitchell

Priority Setting Ad Hoc Committee Chair - Leif Mitchell has been a CPG member since October 1998. He served as community co-chair from April 2000 – September 2002, when he moved to advisor status. His advisor term will end In September 2004. Leif was elected the chair of the Priority Setting Ad Hoc Committee in February 2003. Leif is the Community Research Core Coordinator for the Center for Interdisciplinary Research on AIDS (CIRA) at Yale University.

Brian Goodrich

Priority Setting Ad Hoc Committee Co-Chair – Brian has been a CPG member since 2000 and served as chair of the Finance and Allocation Committee from February 2002 to September 2003. Previously he served on the CPG's Finance Committee and Needs Assessment Workgroup. Brian was elected the co-chair of the Priority Setting Ad Hoc Committee in August 2003. His term on the CPG will end in October 2004. Brian is the Program Manager for the statewide HIV prevention program in all 20 of the state's jails and prisons, where he seeks to institute a comprehensive HIV prevention program.

Edward Leduc

Finance, Policy and Procedures (FPP) Committee Co-Chair – Ed has been a CPG member since 2002 and has served on the Finance, Policy and Procedures Committee (FPP). He was elected co-chair of FPP in July 2003. Ed is also a member of the New Haven/Fairfield County Ryan White Title I Planning Council and the Center for Interdisciplinary Research on AIDS (CIRA) Community Board. Ed left the CPG in March 2003.

Louis Rudolph

Finance, Policy and Procedures (FPP) Committee Co-Chair – Louis has been a member of CPG since October 2002 and has served on the Policy and Procedures Committee. He was elected FPP Committee Co-chair in July 2003. Louis also serves on the New Haven/Fairfield County Ryan White Title I Planning Council and was elected Consortium co-chair of the Statewide HIV/AIDS Care Consortium in December 2003. Louis is a consumer organizer for the Connecticut AIDS Residence Coalition in Hartford, CT. Louis resigned as chair of the FPP Committee in April 2004.

Arka Mikel

Finance, Policy and Procedures (FPP) Committee Co-Chair – Arka has been a member of CPG since October 2002 and served on the Policy and Procedures Committee. He was elected FPP Committee Co-chair in July 2004. Arka works for the Willimantic Housing Authority in Willimantic, CT.

Gina D'Angelo

Finance, Policy and Procedures (FPP) Committee Co-Chair – Gina has been a member of CPG since October 2002 and has served on the Policy and Procedures Committee. She was elected FPP committee co-chair in April 2004. Gina was the HIV Education Coordinator at the Northwest Connecticut AIDS Project in Torrington, CT. Gina resigned from the CPG in July 2004 to accept a position in the Department of Public Health's AIDS and Chronic Diseases Division.

Richard Gonzalez

Finance, Policy and Procedures (FPP) Committee Co-Chair – Richard has been a member of CPG since April 2003 and has served on the Policy and Procedures Committee. He was elected FPP committee co-chair in April 2004. Richard is an outreach worker and works on the needle exchange van for the Bridgeport Health Department in Bridgeport, CT.

Albert Young

Membership, Parity, Inclusion, Representation and Evaluation Committee (MPIRE) Co-Chair – Albert was a CPG member from 1999 – 2001 and also served on the Executive Committee. He rejoined the CPG in 2002, served on the Evaluation Committee, and was elected co-chair of MPIRE in July 2003. Albert is a professional alcohol/drug counselor and educator and worked at Waterbury Hospital in Waterbury, CT. He currently works for the Rushford Center in Portland, CT.

Pamela Foster

Membership, Parity, Inclusion, Representation and Evaluation (MPIRE) Co- Chair – Pam has been a CPG member since 2003 and has served on the Membership, Parity, Inclusion, Representation and Evaluation Committee (MPIRE). She was elected co-chair of MPIRE in January 2004. Pam is a Health Program Associate with the Connecticut Department of Public Health AIDS and Chronic Diseases Division Prevention Clinical Services Unit.

RECRUITMENT AND ORIENTATION

During the 2003-2004 planning cycle, the Membership, Parity, Inclusion, Representation and Evaluation (MPIRE) Committee took on the task of recruiting new members for the CPG. Of particular interest to the committee was the recruitment of women, Latino/as, Native American,

Asian/Pacific Islanders, gay, lesbian and transgender individuals from the New London, Fairfield and New Haven counties. The committee conducted a quarterly review of the CPG's diversity chart, prepared by the CPG contractor, to help guide recruitment efforts **(TABLE 1-1).**

Information about current membership included on the diversity chart is collected from the original CPG member nomination forms and the annual CDC membership grid survey. Using the diversity chart, the committee identified populations needed by the CPG in order to reflect the epidemic in Connecticut. To ensure that the group's membership goals reflected the current statewide HIV/AIDS epidemic, the MPIRE committee also reviewed the best available HIV/AIDS data in the context of six of the seven CPG regions[1] **(TABLE 1-2)**, prioritized populations from the Comprehensive HIV Plan, and the considered expertise needed by the CPG to complete the community planning process.

In September 2003, the CPG approved Charter changes affecting the status of advisors. With these revisions in mind ***(See CPG Charter and Policy and Procedures in Appendix A)*****,** the MPIRE Committee decided to develop a Directory of Advisors, who could be called upon to provide consultation or technical assistance (TA) to the CPG. These advisors have expertise in such fields as health planning, evaluation, research, mental health, HIV Care and Social Services, state/local education, state/local health departments, group process, chemical dependency and others.

Unlike previous CPG advisors, the new advisors will only be required to attend meetings on an as needed basis, will have no term limits or voting rights on the CPG level, and will not be eligible for reimbursements or conferences. However, when a new advisor is requested to provide technical assistance to the CPG, that individual will then become eligible for reimbursements (e.g. stipend, travel, childcare). To maintain consistency during the advisor transition period (e.g. end of 2003 through the Fall of 2004), current CPG advisors were "grand fathered" through September 2004, and remained eligible for stipend/wage replacement, childcare, mileage reimbursement and conferences. ***(See Directory of Advisors in Appendix A).***
During the 2005 planning cycle, the MPIRE Committee will continue its recruitment of CPG members to better reflect the diversity of the epidemic in Connecticut and also refine its advisor directory to include additional expertise in behavioral and social sciences, as well as representatives of key non-governmental and governmental organizations providing prevention and care related services. The Connecticut CPG's overall membership goal is to recruit and retain 30 members. Currently, at least one member or advisor represents each CPG designated region. New members are selected on the basis of personal experience and community involvement, professional skills, knowledge of HIV prevention and care issues, commitment to HIV prevention and community planning, and a willingness to work in diverse groups on major initiatives. These membership characteristics are used as guidelines rather than requirements, and the CPG has worked tenaciously to bring its membership as close as possible to the criteria ***(See current list of CPG members in Appendix A).***

Currently, members are recruited through word of mouth, announcements at Ryan White I Eligible Metropolitan Area (EMA) Planning Council and Statewide Care Consortium meetings, direct mail via *News and Notes* and media advisories, and at regular CPG monthly meetings.

[1] The six regions include North Central (Hartford County), Northeast (Tolland and Windham Counties), Northwest (Litchfield County), South Central (New Haven and Middlesex Counties), Southeast (New London County) and Southwest (Fairfield County). The Department of Correction is recognized as the seventh region.

CPG MEMBERSHIP

To be considered for CPG membership, interested individuals must complete a nomination form and then participate in an interview conducted by members of the Membership, Parity, Inclusion and Evaluation Committee (MPIRE). Once potential members have completed the nomination process, the MPIRE Committee interviews and recommends candidates for approval to the entire CPG. During the 2003-2004 community planning cycle, the CPG received 26 nomination forms for potential members. The MPIRE Committee reviewed the nominations and scheduled interviews with 19 in August 2003, February 2004 and August 2004. Fifteen were recommended and approved by the CPG for membership positions.

Members have a term of office of two years beginning on either April 1 or October 1 and ending on March 31 or September 30, respectfully. No member may sit on the CPG for more than two consecutive terms (4 years), and after serving their second term, former members must wait one year before re-applying for member status.

ORIENTATION, MENTORING AND MEMBER TRAINING

Following each round of interviews, the CPG welcomes new members to the group with an orientation consisting of a five-hour comprehensive training that introduces them to the community planning process. Topics covered in the October 2003 and April 2004 orientations included perspectives on national and local community planning, the work of the CPG, the CDC Guidance, the role of DPH in the planning process, and group dynamics. CPG orientation is conducted in a small group interactive format facilitated by the contractor, DPH staff, and CPG members. Each orientation session is evaluated, and the results are used to improve future orientations. ***(See Orientation to Community Planning presentation in Appendix A)*.**

During orientation new members receive the following community planning related materials: AED's HIV *Prevention Community Planning: An Orientation Guide*, and *Setting HIV Prevention Priorities: A Guide for Community Planning Groups* workbook, the CDC Community Planning Guidance, CPG's Policy and Procedure Manual, the Connecticut HIV Prevention Comprehensive Plan, and the CPG bylaws.

The CPG continues to review and improve its mentoring program for new members. Recent member feedback concerning the mentoring program highlighted a lack of understanding on the part of both mentors and mentees about the program and its process. To improve communications, the CPG initiated a new procedure in which a DPH staff person follows up with assigned mentors to make certain that they are adhering to the established mentor guidelines. The Membership, Parity, Inclusion and Representation (MPIRE) Committee has developed an evaluation tool for mentors and their mentees, which is in the review stage and will be implemented during the 2004-2005 planning cycle.

The Connecticut CPG also values ongoing community planning training for all of its members. To ensure continued training opportunities, the CPG voted to allocate funding in 2003-2004 for conferences related to community planning and HIV prevention.

The following is a list of conferences attended by members and advisors from September 2003 – October 2004:

- 2003 United States Conference on AIDS (USCA): September 18-21, New Orleans, LA (3 CPG members, 1 advisor and 1 contractor staff member attended).
- 2004 HIV Prevention Leadership Summit (HPLS): June 16-19, 2004, Atlanta, GA (6 CPG members, 1 advisor, 1 DPH staff, and 2 contractor staff members attended).

- 2004 ProVisions IX, Northeast Multicultural Conference on HIV/AIDS: October 13-15, 2004, New Haven CT (5 slots approved for members)
- 2004 United State Conference on AIDS (USCA): October 21 –24, 2004, Philadelphia, PA (two members and 0 contractor staff attended)

The CPG will continue its policy of offering members the opportunity to attend community planning-related conferences during 2005.

YOUTH AND THE CPG

Currently, the Connecticut CPG has no youth representatives. It has, however, worked closely with the Wheeler Clinic in Plainville, Connecticut, as the contractor for the DPH funded Youth Advisory Board (YAB) initiative. The YAB currently has groups in Hartford, Bridgeport, New Haven, Litchfield County and the American School for the Deaf, West Hartford. These boards provide input on HIV prevention related issues from a youth perspective for the DPH and CPG. The boards were designed to consist of the following:

- Disenfranchised youth
- Racial and ethnic minority youth
- Gay, lesbian, bi-sexual, transgender and questioning youth
- Youth who attend school and youth not currently enrolled in school.

Each youth advisory board member commits to attending bi-weekly group meetings over the course of a year. Youth advisory board members have been trained in the following areas: basic HIV/AIDS education and prevention, leadership/communication skills, public speaking and presentation skills, media literacy and critiquing skills. Representatives from each board meet monthly during the school year and have also participated at CPG meetings. The Youth Advisory Board Coordinator regularly attends CPG meetings and updates the CPG on youth advisory board activities.

At the December 17, 2003 CPG meeting, Rich Smalley, Youth Advisory Board Coordinator, and three youth advisory board members from the American School for the Deaf (ASD), West Hartford, CT updated CPG members, advisors and public participants on the HIV education and awareness project initiated by ASD students.

Students surveyed ten AIDS related agencies, one national organization, six state organizations and three community non-profit organizations to assess responses to HIV/AIDS information inquiries via TTY/TDD systems for the deaf and hard of hearing community. According to the survey report:

- Three organizations repeatedly hung-up on YAB members after hearing the TTY tone,
- Seven organizations either had TTY phone lines disconnected or were inactive, and,
- One organization responded to the YAB student's AIDS related inquiries with 80% accuracy.

ASD students expressed frustration in not being able to access HIV/AIDS information via a medium appropriate to their community. Rich Smalley also suggested that because of certain reading and comprehension challenges experienced by deaf and hard of hearing individuals, that HIV prevention materials need to be designed which are visually more graphic and less textual. He also stated that agencies, which provide TTY/TDD systems also need to be more responsive to callers and provide accurate information.

At the May 19 2004, CPG meeting, YAB Coordinator Rich Smalley presented several HIV prevention public service announcements (PSAs) created by YAB members. These announcements will air on community access cable channels featuring YAB participants in the Bridgeport area.

MEETING STRUCTURE

The CPG convenes one meeting per month in various sites throughout the state. The Parisky Group, a Hartford-based consulting firm and contractor for the CPG, coordinates all meeting logistics. Each meeting follows an agenda, approved by the Executive Committee, the governing body of the CPG ***(see Sample Agenda in Appendix A)***. Either the DPH Chair or one of the Community Co-Chairs alternates the facilitation of the meetings. Meetings are conducted using the CPG bylaws and a relaxed version of Robert's Rules of Order.
Each monthly CPG meeting is evaluated for its process and content. CPG members and advisors, as well as public participants, are all given the opportunity to evaluate the CPG meetings. The contractor prepares the monthly evaluation surveys and final reports for review by the co-chairs, Executive Committee, and MPIRE Committee. ***(For more on the Evaluation Process, see Chapter 7.)***

From October 2004 to September 2005, the CPG conducted eleven meetings. The full group met monthly with the exception of November 2003, when the CPG coordinated a two-day planning retreat for members and advisors. This retreat included workshops on the CDC Guidance, Prevention for Positives, Priority Setting, and team building. Committees also met to develop 2004 committee timelines and work plans.

In March 2003, the CPG voted to change its meeting structure in order to increase CPG membership and community participation in monthly meetings. Since most of the work of the CPG is done by the standing committees, the CPG decided to make the focus of two meetings per quarter committee-oriented. Committees meet for two hours during the morning. Members of the public are encouraged to participate in these committee meetings. At the end of the session, each committee chair then reports to the full CPG body on the activities of their respective committee. This reorganization of meeting structure has proven to be very effective in assisting the CPG to meet deadlines and committee responsibilities.

Currently, the full CPG now meets once each quarter with the balance of meetings designated to the work of committees. Quarterly full CPG meeting are designed to include mini HIV prevention presentations, technical assistance and trainings, as well as important community planning information and business. Each meeting's agenda, whether committee focused or full CPG, includes time for members of the public to address the CPG on topics or concerns related to HIV prevention. In addition, beginning February 2003 and concluding in March 2004, CPG's Priority Setting Ad-hoc Committee met for two hours following the conclusion of the monthly CPG meeting to plan and implement the priority setting process for the 2005-2008 planning cycle.

Table 1-1: DIVERSITY CHART[2]

Categories	Member Goals 30 members	Current Membership 26 Members	Number of Members needed to reach goal	Current Advisors[3] 11 Advisors
Gender				
Female	11	10	1	4
Male	17	16	1	4
Transgender	2	0		0
Race/Ethnicity				
African-Americans	9	9	0	1
Latino/as	9	8	1	1
White	10	8	2	6
Native Americans, Alaskan Native, Asian, Native Hawaiian or Pacific Islander	2	1	1	0
Age				
<24		0	0	
25-29	3	0	3	0
30-49	22	16	6	6
50+	5	10	0	2
Other				
HIV+	15	7	8	0
Gay[4]	10	4	3	2
Lesbian		3	-	0
Bisexual	-	1	-	0
Deaf and Hard of Hearing	2	1	1	0
History of Substance Use	15	12	3	2
Youth	2	0	2	0

Expertise and Agency Representation	Number of Current Members and Advisors in these roles
Local Health Dept	3
Community Representative	5
Intervention Specialist	13
State/Local Education Agency	2
Corrections Agency	2
State/Local Substance Abuse Agency	2
Faith Communities	1
Academic Institutions	0
Behavioral/Social Scientist	0
Evaluation Researcher	0
Health Planner	4
STD Expert	1
TB Expert	0
Epidemiologist	1

[2] Categories separated by bold lines are not mutually exclusive.
3 The CPG has no established goals for the number advisors the group should have. The role and responsibility of an advisor varies from that of a member.
[4] Gay and Lesbian Categories have a combined goal of 30%.

Table 1-2: CPG MEMBERSHIP COMPAIRED TO CURRENT EPIDEMIC

Connecticut CPG membership vs. the current Connecticut AIDS epidemic

CPG Membership		**AIDS Cases Diagnosed in 2002-2003**	
Gender			
Male	62%	Male	68%
Female	38%	Female	32%
Transgender	0	Transgender	Unknown
Race/Ethnicity			
White	30%	White	38%
Black	34%	Black	26%
Hispanic	30%	Hispanic	36%
Other	3%	Other	<1%
Risk Category			
MSM*	15%	MSM	14%
IDU history	26%	IDU	39%
Heterosexual	42%	Heterosexual	14%
Youth/works with youth	3%	Youth (under 24)	2%
HIV positive	26%		N/A
Region			
NW	3%	NW	1%
NC	26%	NC	30%
NE	11%	NE	2%
SW	15%	SW	23%
SC	30%	SC	30%
SE	3%	SE	4%
DOC	7%	DOC	6%

* Connecticut includes Gay Men in the definition of MSMs in this table.

Acknowledgements

The CPG would like to recognize the following individuals and groups for providing significant contributions to the CPG from October 2003 – July 2004

- **The Parisky Group**: Contractor for the CPG, coordinated and managed the community planning process.
- **Focus Group and Survey Participants:** Provided valuable information in the development of the Plan.
- **CPG DPH Co-Chair Chris Andresen:** Provided valuable leadership to the CPG and for enhancing cooperation and collaboration between DPH and the CPG
- **CPG member and Community Services Assessment Committee Co-Chair Mark Bond-Webster:** Facilitated a men's focus group at Osborn Correctional facility, an MSM focus group, and a transgender focus group.
- **Rashad Burgess, CDC Project Officer:** Attended two CPG meetings during the reporting period and prepared a workshop presentation on the CDC Guidance for the November 2003 CPG retreat.
- **CPG member Willie Castillo:** Provided key informant interview information regarding the prevention needs of Latino MSMs and co-facilitated a focus group for Latino MSMs at Hispanos Unidos, Inc. in New Haven on April 2004.
- **Debbie Cornman (former CPG member), University of Connecticut, Center for HIV intervention and Prevention (CHIP):** Developed a Resource Inventory Survey of Prevention Providers for the CPG Resource Inventory and also presented a workshop on Prevention for Positives at the November 2003 CPG Retreat.
- **Gina D'Angelo, AIDS and Chronic Diseases Division:** Presented on the Department of Public Health's Community Services Assessment at the July 2004 CPG meeting.
- **CPG member Hector Davila of the University of Connecticut Medical Adherence Program** co-facilitated and took notes during a MSM focus group in April 2004 at Latino/as Contra SIDA, Inc. in Hartford, CT.
- **Bonnie Edmondson, Connecticut Department of Education:** Presented the results of the Youth Risk Behavior Survey (YRBS) to the CPG at the March 2004 CPG meeting.
- **Julie Eiserman, Hispanic Health Council:** Presented on the Rapid Assessment, Response and Evaluation (R.A.R.E) 2003 Project in Hartford at the February 2004 CPG meeting.
- **CPG member and Community Services Assessment Committee Co-Chair, Kathey Fowler, Windham Regional Community Council:** Coordinated a transgender focus group/key interviews in January 2004.

- **CPG member and Priority Setting Ad Hoc Committee Co-Chair Brian Goodrich, University of Connecticut Correctional Managed Health Care:** Coordinated points of contact for Department of Correction focus groups at Osborn and York Correctional facilities. Brian also co-presented on the CPG's priority setting method at HPLS held June 16-19, 2004 in Atlanta, GA.
- **Jesse Grant, Brothers 4 Brothers, Community Health Services:** Provided coordination and facilitation of a Brothers 4 Brothers MSM Focus Group and key informant interview.
- **Deborah Henault, Department of Correction Addiction Services:** Coordinated security clearance and points of contact for focus groups at Osborn and York Correctional Facilities.
- **Krista Heybruck, MPH**: Served as Behavioral and Social Science Volunteer with the Priority Setting Ad Hoc Committee from July 2003 through March 2004 and presented a workshop on Priority Setting at the November 2003 CPG Retreat.
- **Lennon Hite, The Parisky Group**: Served as note taker during a men's focus group at Osborn Correctional Facility and women's focus group at York CI in February 2004. Also served as notetaker for the MSM focus group held at Hispanos Unidos, Inc. in New Haven, CT on April 14, 2004.
- **Cyndi Hyland, HIV Prevention Educator, York Correctional Facility:** Coordinated a female focus group at York Correctional Facility in March 2004.
- **Heidi Jenkins, Department of Public Health, STD Control Program:** presented information on the most recent statewide STD data at the March CPG meeting.
- **CPG Member Pam Foster:** Co Chair of the MPIRE Committee who presented on the May 6th CPG Community Day in Waterbury at the July CPG Meeting.
- **Jerimarie Liesegang, CT TransAdvocacy Coalition:** Coordinated focus groups and key informant interviews with the transgender community in Hartford.
- **Andrea Lombard, Department of Public Health,** Viral Hepatitis program: Presented an overview on Viral Hepatitis at the March CPG meeting.
- **CPG member Matthew J. Lopes, M.P.H., New Haven Health Department:**. Co-facilitated Robert's Rules of Order and Group Dynamics sessions for the October 2003 and April 2004 orientation meetings.
- **CPG member and Community Co-Chair Stephanie Lozada, Southwest Community Health Center:** Presented on HIV and Smoking Cessation Intervention at the June 2004 CPG meeting.
- **Susan Major, AIDS and Chronic Diseases Division:** Provided invaluable assistance to the Priority Setting Ad-hoc Committee during the Connecticut CPG's priority setting process. Sue also co-presented on the CPG's priority setting method at HPLS held June 16-19, 2004 in Atlanta, GA.
- **Barbara Mase, The Parisky Group:** Coordinated focus groups, conducted key informant MSM and transgender interviews, served as note-taker during an MSM focus group,

facilitated a focus group at York Correctional facility, and presented on the new CDC Guidance for Community Planning at the November 2003 CPG retreat.

- **CPG Advisor Leif Mitchell:** Co-presented on the CPG's priority setting method at HPLS held June 16-19, 2004 in Atlanta, GA.
- **CPG member Maggy Morales:** Developed and coordinated a WSW mini-survey for the Community Services Assessment Committee's Needs Assessment Process. Also distributed a transgender mini-survey that was completed on April 17, 2004 and facilitated a MSM focus group on April 26, 2004, at Latino/as Contra SIDA, Inc. in Hartford, CT.
- **Fred Morton, The Parisky Group:** Served as notetaker for an HIV positive focus group session held on May 18 at Omega House in Willimantic, CT.
- **CPG member Dennis O'Neill:** Co-facilitated Robert's Rules of Order and Group Dynamics sessions for the October 2003 and April 2004 orientation meetings and presented on the May 6th Community Day in Waterbury at the July CPG Meeting.
- **Annie Parkinson, Jest For Today:** Provided team building training at the November 2003 CPG retreat
- **Nadine Repinecz, Department of Public Health, AIDS Capacity Building and Evaluation Unit:** Presented on DPH's capacity building and evaluation efforts with contractors at the May CPG meeting.
- **Rich Smalley, Wheeler Clinic:** Updated the CPG on the activities of the Youth Advisory Board at the December 2003 and May 2004 CPG meetings.
- **Henry Smolinski, UConn Managed Care, HIV Prevention Educator, Osborn Correctional Facility**: Served as facilitator for incarcerated population focus group.
- **Janis Spurlock-McLendon, Department of Public Health, AIDS Prevention Education Services Unit:** Presented an update on the DPH's prevention efforts in the calendar year 2003 for the designated priority populations in the 2002-2004 Comprehensive HIV Prevention Plan at the May 19 CPG meeting.
- **Laura Stone, The Parisky Group:** Served as notetaker and committee facilitator of the Priority Setting Ad Hoc Committee. She was also notetaker at the CPG's town hall event at Community Day held on May 6 at Waterbury Hospital.
- **Mel Thomas**, **Brothers 4 Brothers, Community Health Services:** Provided coordination and facilitation of a Brothers 4 Brothers MSM Focus Group and key informant interview.
- **Dorine Testori, Department of Public Health:** Serves as official CPG greeter and oversees the CPG's registration desk at the monthly meetings. Also served as note taker at several MPIRE Committee meetings.

During this period the following individuals from national community planning technical assistance organizations also provided technical assistance to the Connecticut CPG:

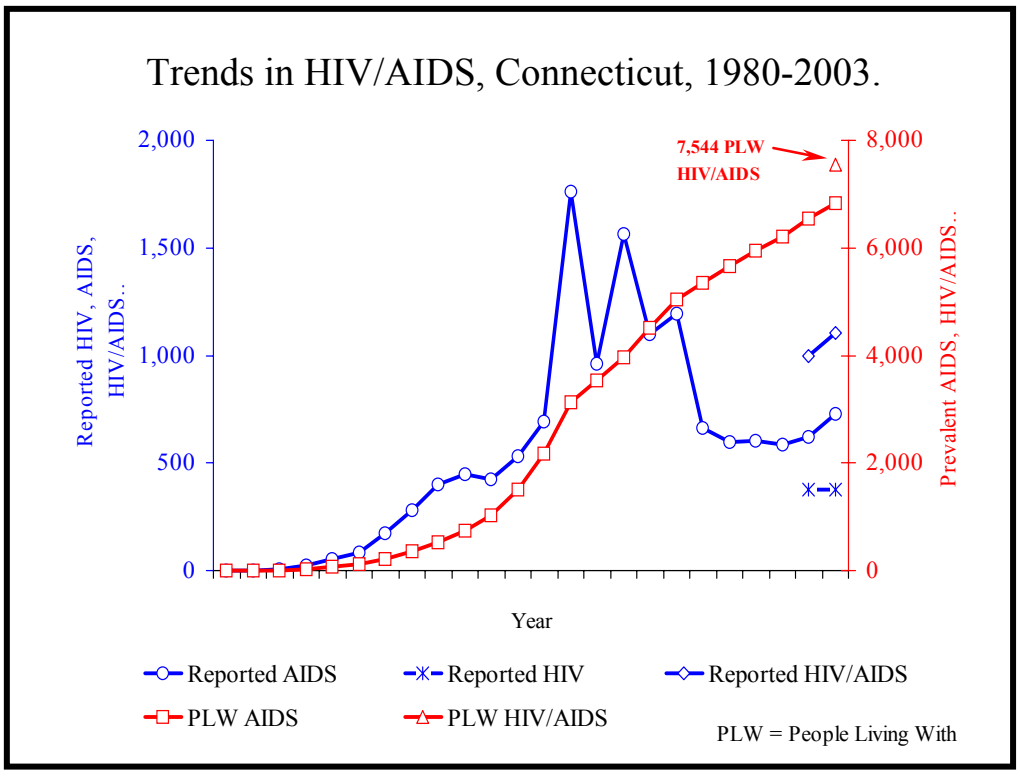
- **Academy for Educational Development**
  Rich Thompson: Presented on AED's available technical assistance for recruitment and retention of IDUs at the December 2003 CPG meeting.

Connecticut Department of Public Health
HIV/AIDS Surveillance Program

CHAPTER 2

Epidemiological Profile of HIV and AIDS in Connecticut

– 2004 Supplement –



Connecticut Department of Public Health

J. Robert Galvin, MD, MPH, Commissioner

Bureau of Public Health Science

Eleanor Travers, MD, MPH, Chief

Infectious Disease Division

James Hadler, MD, MPH, Director

HIV/AIDS Surveillance Program

Aaron Roome, PhD, MPH, Coordinator
Susan Langer, RN, MPH, Field Surveillance Supervisor
Kenneth Carley, DrPH, Data Manager
Lauren Backman, RN, MSH, Field Surveillance
Heather Noga, MPH, Field Surveillance, Enhanced Perinatal
Melinda Vazquez, Office Administration, Data Entry

How to contact us:
HIV/AIDS Surveillance Program
410 Capitol Ave MS 11ASV
PO Box 340308
Hartford CT 06134

Telephone: (860) 509-7900
FAX: (860) 509-8237
Website:
www.dph.state.ct.us

TABLE OF CONTENTS

Executive Summary

- **AIDS:** Since 1980, 13,494 cases of AIDS have been reported in Connecticut. Of these, 6,664 (49.4%) have died and 6,830 are living with AIDS. Cumulatively, AIDS cases have been 73% male, 27% female, 36.7% white, 37.3% black, and 25.5% Hispanic. Approximately 85% of reported cases have been 30 years of age or older. Risk of HIV infection is primarily associated with history of injection drug use (48.5%), men who have sex with men (21.9%), and heterosexual exposure (16.7%).

- **AIDS cases reported in 2003:** In 2003, 727 AIDS cases were reported. In 2002, 621 cases were reported. The increase in AIDS case reporting is due to an increase in facility and laboratory auditing to find unreported cases and, possibly, stimulation of reporting due to the requirement for HIV (non-AIDS) reporting by laboratories implemented in 2002.

- **Trends in AIDS case reporting:** In the past ten years, the number of AIDS cases reported has decreased from 1,564 cases reported in 1995 to 587 in 2001. From 1998 through 2003, the number of cases reported each year has ranged from 587 to 727 (average 633).

    - **Sex:** In the past ten years, the percentage of cases that are female has increased from approximately 25% in 1994-95 to 30-35% in 2001-2003.

    - **Race/ethnicity:** In 2003, for the first time, the percentage of reported cases that are Hispanic (38.9%) is higher than white (35.1%) or black (25.7%). The percentage Hispanic has been increasing gradually over the course of the epidemic from approximately 20% in the 1980's and early 90's to over 30% during 2000-2003.

    - **Age:** Age at AIDS diagnosis is continuing a long-standing trend with gradual increases in the percentage of cases in the 40-49 and 50+ year age groups with concomitant decline in the 30-39 year age group. The percentage of cases in the <20 and 20-29 year age group have remained steady at very low levels.

    - **Risk/mode of transmission:** Information about risk should be interpreted cautiously due to the significant percentage of cases for whom risk information is not available. This increase is due to limitations on case follow-up and is not due to an increase in cases with unknown sources of HIV infection. Among cases for whom risk information is known, injection drug use and sexual exposure continue to account for almost all cases.

- **HIV:** HIV reporting in adults was implemented in 2002. In 2003, 378 HIV cases were reported that had not been reported to have progressed to AIDS by the end of the year. In 2002, 374 HIV cases were reported. Of the 714 HIV cases reported since 2002 that remain HIV (not AIDS), 62.2% are male, 37.8% female, 33.2% white, 27.4% black, and 38.8% are Hispanic. In comparison with AIDS cases reported in 2003, the primary difference is a higher percentage of HIV cases in the <30 year age group (20.4% HIV versus 8.2% AIDS). By contrast, 21.5% of AIDS cases were 50+ years of age compared to only 15.3% of HIV cases.

Introduction

- ***The Epidemiological Profile of HIV/AIDS in Connecticut – 2004 Supplement***
    - The purpose of the Epidemiological Profile for HIV/AIDS is to provide HIV/AIDS surveillance information to the Community Planning Group (CPG) and others. The 2003 edition of the Epidemiological Profile was distributed in April 2003 and included surveillance information reported through the end of 2002. The purpose of the 2004 Supplement is to provide selected HIV/AIDS surveillance information through the end of 2003.

- ***Other sources of information about HIV/ AIDS surveillance data:***
    - HIV/AIDS Surveillance Program website (www.dph.state.ct.us);
        - The website contains many additional tables with data describing cumulative cases and trends in CPG regions, Ryan White Eligible Metropolitan areas.
    - The 2003 edition of the Epidemiological Profile contains additional information:
        - HIV/AIDS surveillance methods;
        - Census information for Connecticut and selected cities;
        - STD and viral hepatitis surveillance information;
        - Additional tables of HIV/AIDS surveillance information (HIV in children, people living with AIDS, deaths in persons with AIDS, AIDS incidence).
    - CDC website (www.cdc.gov);
        - The latest national HIV/AIDS surveillance report (December 31, 2002);
        - MMWR articles published in 2003:
            - Implementation of named HIV reporting --- New York City, 2001. MMWR. 52:1248.
            - Internet use and early syphilis infection among men who have sex with men --- San Francisco, California, 1999—2003. MMWR. 52:1229.
            - Partner counseling and referral services to identify persons with undiagnosed HIV --- North Carolina, 2001. MMWR. 52:1181.
            - Increases in HIV diagnoses --- 29 States, 1999—2002. MMWR. 52:1145.

HIV/AIDS Surveillance

Trends in AIDS case reporting

- Trends in the number of AIDS cases are shown in Table 1.

- The first reported AIDS cases were in 1981 (n = 2). The maximum number of AIDS cases was reported in 1993 (n=1,759). The trend in reported AIDS cases has decreased to a low of 587 reported in 2001 with increases in 2002 (n = 621) and 2003 (n = 727) (Table 1, 2).

- Trends in the AIDS epidemic have been very gradual. (Figures 1 – 4). **During the past ten years the following trends are notable**:

  - The percentage of cases that are female has increased approximately 5-10% (Figure 1). Detailed trend data in male and female AIDS cases by race and risk group can be found in Tables 4 and 5.

  - The percentage of Hispanic cases has increased from approximately 25% to 38%. The percentage of black cases has decreased from approximately 40% to about 25%. (Figure 2).

  - Risk group data after 2000 should be interpreted cautiously due to a high percentage of cases with "no reported risk" (15.1% in 2000) (Figure 3). Recent trends (to 2000) show a decline in percentage of cases that are IDU although it remains predominant (about 60% to 40%). Heterosexual transmission has increased from approximately 15% in 1994 to 25% in 2000. The percentage of cases that are MSM has decreased from approximately 20% to 15%.

Figure 1. Trend in AIDS Cases by Sex, Connecticut, 1994 – 2003.

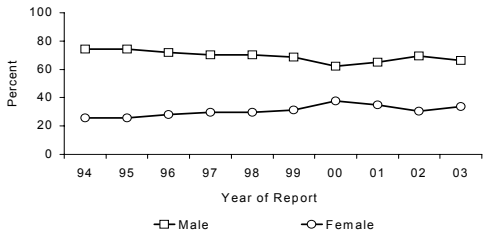


Figure 2. Trend in AIDS Cases by Race, Connecticut, 1994 – 2003.

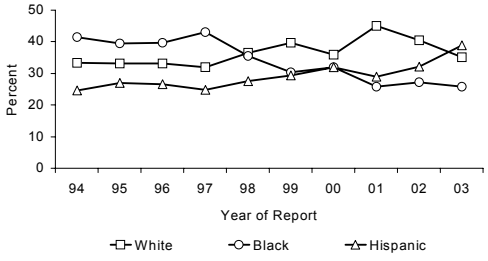
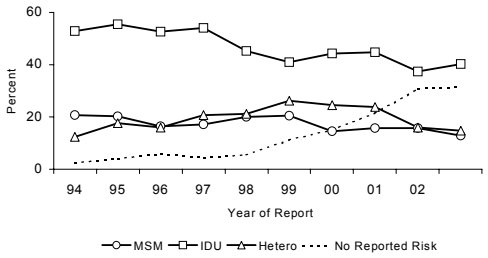


Figure 3. Trend in AIDS Cases by Risk Group, Connecticut, 1994 – 2003.



o Trends by age group are shown in Figure 4 and suggest a gradual increase in the age of newly diagnosed cases. While the percentage of cases in the 20-29 and 30-39 age groups has been decreasing, the percentage of cases that are in the 40-49 and 50+ age groups has been increasing. This change has been about 10% over the past ten years. The shift in age distribution could be due to delay in AIDS diagnosis because of successful treatment or a trend to older age at HIV infection.

Figure 4. Trends in AIDS Cases by Age Group, Connecticut, 1994 – 2003.

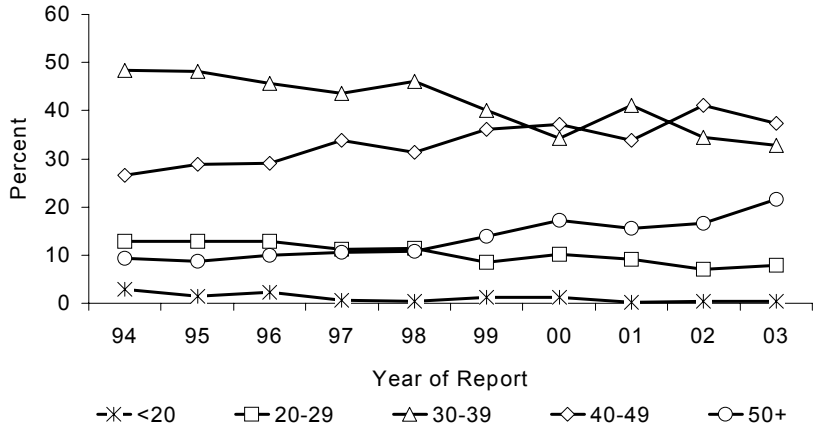


Table 1. AIDS Cases: Reported, Diagnosed, Deaths, and Prevalent; **HIV Cases**: Total Reported, Current, and Deaths; **HIV/AIDS Cases**: Prevalent HIV/AIDS, Connecticut, 1980-2003.

Year (1)	Reported AIDS	Diagnosed AIDS	AIDS deaths (2,3)	Prevalent AIDS (4)	Reported HIV (5)	Current HIV (6)	HIV deaths (2,3,7)	Prevalent HIV/AIDS (8)
1980	0	1	1	0	.	.	.	.
1981	2	7	1	6	.	.	.	.
1982	7	14	9	11	.	.	.	.
1983	22	27	10	28	.	.	.	.
1984	54	79	42	65	.	.	.	.
1985	85	134	85	114	.	.	.	.
1986	174	241	147	208	.	.	.	.
1987	278	337	197	348	.	.	.	.
1988	401	423	243	528	.	.	.	.
1989	446	534	312	750	.	.	.	.
1990	426	613	333	1,030	.	.	.	.
1991	531	884	407	1,507	.	.	.	.
1992	693	1,198	540	2,165	.	.	.	.
1993	1,759	1,606	654	3,117	.	.	.	.
1994	962	1,112	693	3,536	.	.	.	.
1995	1,564	1,217	784	3,969	.	.	.	.
1996	1,100	1,108	559	4,518	.	.	.	.
1997	1,193	809	290	5,037	.	.	.	.
1998	662	592	276	5,353	.	.	.	.
1999	598	569	269	5,653	.	.	.	.
2000	602	546	254	5,945	.	.	.	.
2001	587	496	222	6,219	.	.	.	.
2002	621	545	216	6,548	437	337	5	6,885
2003	727	402	120	6,830	421	377	1	7,544
Total	13,494	13,494	6,664		858	714	6	

(1) Data in recent years is incomplete due to delay in the reporting of cases and/or deaths.
(2) Deaths in 2003 represent only partial reporting from DPH Vital Records.
(3) Death data is obtained from death certificates or health-care providers. Deaths due to HIV/AIDS related illness that do not list HIV/AIDS as a cause of death or that occur out-of-state may not be included. Deaths due to non-HIV/AIDS causes (i.e. auto accident, drug overdose) may not be included.
(4) "Prevalent AIDS" is the current number of persons living with AIDS (PLWA) or whose mortality status is unknown.
(5) "Reported HIV" is the number of newly reported HIV cases. Included are cases subsequently reported as AIDS cases.
(6) "Current HIV" is the number of HIV cases that are living with HIV and have not been reported as AIDS cases.
(7) "HIV Deaths" is the number of deaths in HIV cases (not reported as AIDS cases).
(8) "Prevalent HIV/AIDS" is the number of HIV and AIDS cases currently living with HIV or AIDS or for whom mortality status is unknown.

Table 2. **AIDS Cases by Year of Report**, Sex, Race, and Risk/Mode of Transmission, Connecticut, 1980-2003.

		Sex		Race/ethnicity				Risk/mode of transmission					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/ IDU	Hetero	Oth/ Unk	Pedi
	Total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total
Report year													
80-93	4,878	77.9	22.1	39.1	39.9	20.4	0.6	29.3	48.1	4.7	12.5	3.2	2.2
1994	962	74.2	25.8	33.3	41.5	24.6	0.6	20.7	52.9	3.6	17.7	2.4	2.7
1995	1,564	74.2	25.8	33.2	39.5	26.9	0.5	20.3	55.4	3.1	15.9	4.0	1.2
1996	1,100	71.8	28.2	33.2	39.7	26.6	0.5	16.4	52.6	2.8	20.6	5.8	1.7
1997	1,193	70.2	29.8	31.9	43.0	24.8	0.3	17.2	54.1	3.1	21.1	4.2	0.3
1998	662	70.2	29.8	36.6	35.6	27.5	0.3	20.1	45.3	2.6	26.3	5.4	0.3
1999	598	68.7	31.3	39.6	30.3	29.4	0.7	20.4	41.0	1.5	24.6	11.2	1.3
2000	602	62.3	37.7	36.0	31.9	31.9	0.2	14.6	44.4	1.3	23.9	15.1	0.7
2001	587	65.1	34.9	45.0	25.7	29.0	0.3	15.8	44.8	1.7	16.0	21.5	0.2
2002	621	69.4	30.6	40.4	27.1	32.2	0.3	15.8	37.4	1.0	14.7	30.8	0.5
2003	727	66.2	33.8	35.1	25.7	38.9	0.3	12.9	40.3	1.2	13.6	31.5	0.4
Total	13,494	73.0	27.0	36.7	37.3	25.5	0.5	21.9	48.5	3.3	16.7	8.1	1.5

Table 3. AIDS Cases by Year of Report, and Age at Diagnosis with AIDS, Connecticut, 1980-2003.

		Age when diagnosed with AIDS					
		0-12	13-19	20-29	30-39	40-49	50+
	Total	% of total	% of total	% of total	% of total	% of total	% of total
Report year							
80-93	4,878	2.2	0.4	17.1	46.5	23.9	9.9
1994	962	2.5	0.4	12.8	48.4	26.5	9.4
1995	1,564	1.2	0.3	12.9	48.1	28.8	8.8
1996	1,100	1.7	0.6	12.9	45.7	29.0	10.0
1997	1,193	0.2	0.5	11.2	43.6	33.9	10.6
1998	662	0.2	0.3	11.5	46.1	31.3	10.7
1999	598	0.5	0.8	8.5	40.1	36.1	13.9
2000	602	0.3	0.8	10.1	34.2	37.2	17.3
2001	587	--	0.2	9.2	41.2	33.9	15.5
2002	621	0.3	0.2	7.1	34.5	41.2	16.7
2003	727	0.4	--	7.8	32.9	37.4	21.5
Total	13,494	1.3	0.4	13.2	44.1	29.4	11.5

Table 4. **AIDS in Adult Males** by Year of Report, Risk/Mode of Transmission, and Race, Connecticut, 1980-2003.

		Year of report													
		1980-1998		1999		2000		2001		2002		2003		Total	
		N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of total
Risk	Race/ethnicity														
MSM	White	1,696	68.9	80	65.6	58	65.9	71	76.3	73	74.5	72	76.6	2,050	21.0
	Black	473	19.2	15	12.3	16	18.2	9	9.7	9	9.2	11	11.7	533	5.5
	Hispanic	276	11.2	27	22.1	13	14.8	12	12.9	15	15.3	11	11.7	354	3.6
	Other	18	0.7	--	--	1	1.1	1	1.1	1	1.0	--	--	21	0.2
	Risk total	2,463	100.0	122	100.0	88	100.0	93	100.0	98	100.0	94	100.0	2,958	30.4
IDU	Race/ethnicity														
	White	807	21.0	49	29.0	46	27.2	65	35.9	45	26.2	51	25.5	1,063	10.9
	Black	1,837	47.9	57	33.7	55	32.5	53	29.3	49	28.5	56	28.0	2,107	21.6
	Hispanic	1,182	30.8	62	36.7	68	40.2	63	34.8	78	45.3	93	46.5	1,546	15.9
	Other	13	0.3	1	0.6	--	--	--	--	--	--	--	--	14	0.1
	Risk total	3,839	100.0	169	100.0	169	100.0	181	100.0	172	100.0	200	100.0	4,730	48.6
MSM/IDU	Race/ethnicity														
	White	158	39.5	5	55.6	3	37.5	8	80.0	2	33.3	4	44.4	180	1.8
	Black	152	38.0	2	22.2	3	37.5	1	10.0	3	50.0	1	11.1	162	1.7
	Hispanic	90	22.5	2	22.2	2	25.0	1	10.0	1	16.7	4	44.4	100	1.0
	Risk total	400	100.0	9	100.0	8	100.0	10	100.0	6	100.0	9	100.0	442	4.5

		Year of report													
		1980-1998		1999		2000		2001		2002		2003		Total	
		N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of total
Hetero	Race/ethnicity														
	White	180	27.3	22	40.0	11	21.2	7	26.9	9	29.0	11	35.5	240	2.5
	Black	334	50.6	17	30.9	24	46.2	7	26.9	13	41.9	8	25.8	403	4.1
	Hispanic	140	21.2	15	27.3	17	32.7	12	46.2	9	29.0	12	38.7	205	2.1
	Other	6	0.9	1	1.8	--	--	--	--	--	--	--	--	7	0.1
	Risk total	660	100.0	55	100.0	52	100.0	26	100.0	31	100.0	31	100.0	855	8.8
Oth/Unk	Race/ethnicity														
	White	171	55.3	22	42.3	27	49.1	25	34.7	48	38.7	58	40.0	351	3.6
	Black	94	30.4	15	28.8	15	27.3	27	37.5	38	30.6	29	20.0	218	2.2
	Hispanic	43	13.9	13	25.0	13	23.6	19	26.4	37	29.8	57	39.3	182	1.9
	Other	1	0.3	2	3.8	--	--	1	1.4	1	0.8	1	0.7	6	0.1
	Risk total	309	100.0	52	100.0	55	100.0	72	100.0	124	100.0	145	100.0	757	7.8
Total		7,671	100.0	407	100.0	372	100.0	382	100.0	431	100.0	479	100.0	9,742	100.0

Table 5. AIDS in Adult Females by Year of Report, Risk/Mode of Transmission, and Race, Connecticut, 1980-2003.

		Year of report													
		1980-1998		1999		2000		2001		2002		2003		Total	
		N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of total
Risk	Race/ethnicity														
IDU	White	410	29.1	27	35.5	35	35.7	46	56.1	27	45.0	23	24.7	568	16.0
	Black	683	48.5	29	38.2	29	29.6	17	20.7	15	25.0	30	32.3	803	22.6
	Hispanic	307	21.8	20	26.3	34	34.7	19	23.2	18	30.0	40	43.0	438	12.3
	Other	7	0.5	--	--	--	--	--	--	--	--	--	--	7	0.2
	Risk total	1,407	100.0	76	100.0	98	100.0	82	100.0	60	100.0	93	100.0	1,816	51.1
Hetero	Race/ethnicity														
	White	246	24.1	26	28.3	27	29.3	16	23.5	22	36.7	12	17.6	349	9.8
	Black	450	44.1	38	41.3	35	38.0	21	30.9	16	26.7	19	27.9	579	16.3
	Hispanic	320	31.3	28	30.4	30	32.6	31	45.6	22	36.7	37	54.4	468	13.2
	Other	5	0.5	--	--	--	--	--	--	--	--	--	--	5	0.1
	Risk total	1,021	100.0	92	100.0	92	100.0	68	100.0	60	100.0	68	100.0	1,401	39.4
Oth/Unk	Race/ethnicity														
	White	45	54.9	5	33.3	9	25.0	26	48.1	25	37.3	23	27.4	133	3.7
	Black	25	30.5	3	20.0	14	38.9	16	29.6	23	34.3	32	38.1	113	3.2
	Hispanic	12	14.6	7	46.7	13	36.1	12	22.2	19	28.4	28	33.3	91	2.6
	Other	--	--	--	--	--	--	--	--	--	--	1	1.2	1	0.0
	Risk total	82	100.0	15	100.0	36	100.0	54	100.0	67	100.0	84	100.0	338	9.5

	Year of report													
	1980-1998		1999		2000		2001		2002		2003		Total	
	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of total
Total	2,510	100.0	183	100.0	226	100.0	204	100.0	187	100.0	245	100.0	3,555	100.0

Table 6. People Living With AIDS by Risk, Sex, Race, and Age Group, Connecticut, 2003

	Risk/mode of transmission													
	MSM		IDU		MSM/IDU		Hetero		Oth/Unk		Pedi		Total	
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Total	1,267	18.6	3,240	47.4	162	2.4	1,324	19.4	747	10.9	90	1.3	6,830	100.0
Sex														
Male	1,267	26.8	2,283	48.4	162	3.4	477	10.1	483	10.2	47	1.0	4,719	69.1
Female	--	--	957	45.3	--	--	847	40.1	264	12.5	43	2.0	2,111	30.9
Race/ethnicity														
White	865	35.6	857	35.3	68	2.8	340	14.0	289	11.9	11	0.5	2,430	35.6
Black	205	8.7	1,283	54.3	49	2.1	551	23.3	233	9.9	43	1.8	2,364	34.6
Hispanic	187	9.3	1,091	54.5	45	2.2	425	21.2	220	11.0	35	1.7	2,003	29.3
Other	10	30.3	9	27.3	--	--	8	24.2	5	15.2	1	3.0	33	0.5
Current age	--	--	--	--	--	--	--	--	--	--	31	100.0	31	0.5

	Risk/mode of transmission													
	MSM		IDU		MSM/IDU		Hetero		Oth/Unk		Pedi		Total	
	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
0-12														
13-19	--	--	--	--	--	--	--	--	2	3.9	49	96.1	51	0.7
20-29	21	14.8	30	21.1	--	--	37	26.1	44	31.0	10	7.0	142	2.1
30-39	308	20.3	618	40.8	40	2.6	343	22.7	205	13.5	--	--	1,514	22.2
40-49	564	17.9	1,626	51.7	90	2.9	574	18.3	290	9.2	--	--	3,144	46.0
50+	374	19.2	966	49.6	32	1.6	370	19.0	206	10.6	--	--	1,948	28.5

HIV Surveillance

- HIV infection in adults was made reportable in January 2002. In 2003, 378 HIV cases were reported. In 2002, 374 cases of HIV infection were reported.

- HIV cases reported during 2002-2003 that have not been reported as AIDS cases (n = 720) are characterized in Tables 7-9 and compared with AIDS cases in Table 10.

- Of the 720 HIV cases reported in 2002-2003 (Table 7-9):

    - 62.2% are male and 37.8% are female;

    - 38.8% are Hispanic, 27.4% are black, and, 33.2% are white;

    - Three cases of HIV have been reported in the 0-19 age group;

    - Overall, 22.5% of HIV cases are in the 20-29 age group, 19.0% of males and 28.3% of females. This varied by race/ethnicity, as well, with 14.5% of white males, 18.6% of black males, and 22.5% of Hispanic males. Among females, the percentages are higher – 21.3% of white females, 29.8% of black females, and 31.1% of Hispanic females;

    - Little can be concluded about risk group because of the high proportion of cases with "no reported risk." This high percentage is due to several factors including reporting at an earlier stage of disease and limited surveillance resources for case follow-up. However, among the HIV cases for whom risk information is available, 24.1% are MSM, 53.1% are IDU, 1.1% are MSM/IDU, and 21.1% are associated with heterosexual exposure;

    - 76.4% of HIV cases have been reported from the eleven largest cities (Table 13), 167 (23.2%) from Hartford, 97 (13.5%) from New Haven, and 79 (11.0%) from Bridgeport.

- ***Comparison of HIV and AIDS:*** HIV cases are compared with AIDS cases in Table 10. Distribution of HIV and 2003 AIDS cases by race is very similar. The highest percentage of both is Hispanic, 38.8% and 38.9%, respectively. HIV cases are slightly more likely to be female (37.8% versus 33.8%) and less than thirty years of age (22.5% versus 7.8%).

- ***Progression to AIDS:*** Table 11 shows the trend in HIV cases during 2002-2003. Of the 437 total HIV cases reported in 2002, by the end of 2002, 63 were reported as AIDS cases and, by the end of 2003, a total of 95 (21.7%) had progressed to AIDS. Additional analysis will be conducted to characterize persons who progress to AIDS.

Table 7. HIV Cases by Sex, Race, and Risk/Mode of Transmission, Connecticut, 2002-2003.

		Risk/mode of transmission													
		MSM		IDU		MSM/IDU		Hetero		Oth/Unk		Pedi		Total	
		N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Sex	Race														
Male	White	56	35.2	25	15.7	4	2.5	4	2.5	68	42.8	2	1.3	159	22.1
	Black	14	12.4	42	37.2	--	--	5	4.4	52	46.0	--	--	113	15.7
	Hispanic	18	10.4	65	37.6	--	--	9	5.2	81	46.8	--	--	173	24.0
	Other	1	33.3	--	--	--	--	1	33.3	1	33.3	--	--	3	0.4
Female	White	--	--	15	18.8	--	--	17	21.3	48	60.0	--	--	80	11.1
	Black	--	--	21	25.0	--	--	19	22.6	44	52.4	--	--	84	11.7
	Hispanic	--	--	28	26.4	--	--	22	20.8	56	52.8	--	--	106	14.7
	Other	--	--	--	--	--	--	1	50.0	1	50.0	--	--	2	0.3
Race															
White total		56	23.4	40	16.7	4	1.7	21	8.8	116	48.5	2	0.8	239	33.2
Black total		14	7.1	63	32.0	--	--	24	12.2	96	48.7	--	--	197	27.4
Hispanic total		18	6.5	93	33.3	--	--	31	11.1	137	49.1	--	--	279	38.8
Other		1	20.0	--	--	--	--	2	40.0	2	40.0	--	--	5	0.7
Total		89	12.4	196	27.2	4	0.6	78	10.8	351	48.8	2	0.3	720	100.0

Table 8. HIV Cases by Sex, Race, and Age, Connecticut, 2002-2003.

		Age group											
		0-12		13-19		20-29		30-39		40-49		50+		Total	
		N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Sex	Race														
Male	White	2	1.3	--	--	23	14.5	51	32.1	56	35.2	27	17.0	159	22.1
	Black	--	--	1	0.9	21	18.6	37	32.7	33	29.2	21	18.6	113	15.7
	Hispanic	--	--	--	--	39	22.5	71	41.0	52	30.1	11	6.4	173	24.0
	Other	--	--	--	--	2	66.7	1	33.3	--	--	--	--	3	0.4
Female	White	--	--	--	--	17	21.3	30	37.5	25	31.3	8	10.0	80	11.1
	Black	--	--	--	--	25	29.8	34	40.5	18	21.4	7	8.3	84	11.7
	Hispanic	--	--	--	--	33	31.1	34	32.1	28	26.4	11	10.4	106	14.7
	Other	--	--	--	--	2	100.0	--	--	--	--	--	--	2	0.3
Sex															
Male total		2	0.4	1	0.2	85	19.0	160	35.7	141	31.5	59	13.2	448	62.2
Female total		--	--	--	--	77	28.3	98	36.0	71	26.1	26	9.6	272	37.8
Total		2	0.3	1	0.1	162	22.5	258	35.8	212	29.4	85	11.8	720	100.0

Table 9. **HIV cases** by City of Residence at Diagnosis, Risk/Mode of Transmission Race, and Sex, Connecticut, 2002-2003.

		Sex		Race/ethnicity				Risk/mode of transmission					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/ IDU	Hetero	Oth/ Unk	Pedi
	Total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total	% of total
Bridgeport	79	63.3	36.7	20.3	41.8	38.0	--	7.6	25.3	2.5	12.7	51.9	--
Danbury	12	75.0	25.0	25.0	25.0	50.0	--	25.0	25.0	--	25.0	25.0	--
East Hartford	15	73.3	26.7	26.7	26.7	33.3	13.3	13.3	13.3	--	20.0	53.3	--
Hartford	167	63.5	36.5	18.6	25.7	55.7	--	8.4	38.3	--	8.4	44.9	--
Meriden	21	76.2	23.8	23.8	4.8	71.4	--	19.0	9.5	--	--	71.4	--
New Britain	37	64.9	35.1	35.1	10.8	54.1	--	2.7	29.7	--	18.9	48.6	--
New Haven	97	56.7	43.3	35.1	34.0	28.9	2.1	12.4	36.1	--	13.4	38.1	--
New London	20	35.0	65.0	30.0	25.0	45.0	--	5.0	15.0	--	25.0	55.0	--
Norwalk	21	57.1	42.9	19.0	57.1	19.0	4.8	9.5	9.5	--	19.0	61.9	--
Stamford	27	66.7	33.3	25.9	44.4	29.6	--	22.2	25.9	--	7.4	44.4	--
Waterbury	54	55.6	44.4	25.9	20.4	53.7	--	9.3	25.9	--	11.1	53.7	--
All other towns	170	64.7	35.3	60.0	21.2	18.8	--	19.4	19.4	1.1	6.5	52.4	1.1
Total	720	62.2	37.8	33.2	27.4	38.8	0.7	12.4	27.2	0.6	10.8	48.8	0.3

Table 10. Comparison of HIV and AIDS cases by Selected Characteristics, Connecticut, 2003.

	2003 HIV (1,2)	Total HIV (1,2)	2003 AIDS	Total AIDS
Sex				
Male	67.2	62.2	66.2	73.0
Female	32.8	37.8	33.8	27.0
Race/ethnicity				
White	35.4	33.2	35.1	36.7
Black	26.5	27.4	25.7	37.3
Hispanic	37.8	38.8	38.9	25.5
Other race/ethnicity (3)	0.3	0.7	0.3	0.5
Age group (4)				
0-12 years	0.3	0.3	0.4	1.3
13-19	0	0.1	0	0.4
20-29	20.1	22.5	7.8	13.2
30-39	35.2	35.8	32.9	44.1
40-49	29.1	29.4	37.4	29.4
50 and over	15.3	11.8	21.5	11.5
Risk/mode				
MSM	13.8	12.4	12.9	21.9
IDU	23.3	27.2	40.3	48.5
MSM/IDU	0.3	0.6	1.2	3.3
Hetero	10.6	10.8	13.6	16.7
Other/no reported risk	51.9	48.8	31.5	7.1
Total	378	720	727	13,494

(1) A person with HIV infection who has not developed AIDS.

(2) HIV infection in adults was made reportable in 2002.

(3) “Other” race combines Asian, American Indian, Other, and Unknown.

(4) Age when the case was reported to DPH.

Table 11. Trends in HIV cases, progression to AIDS, and code reporting, Connecticut, 2002-2003.

Year	Total HIV (1)	Year-end HIV (2)	Current HIV (3)	HIV progressed to AIDS (4)	% HIV to AIDS (5)	Originally reported by code (6)	% Reported by code (7)	Currently reported by code (8)
2002	437	374	337	95	21.7	57	13.0	48
2003	421	378	377	43	10.2	44	10.5	41
Total	858		714	138	16.1	101	11.8	89

(1) Newly reported HIV cases by year of report. Included are cases subsequently reported as AIDS cases.

(2) Total HIV reports that have not been reported as AIDS cases by the end of the report year. This is the number of HIV cases reported by DPH each year and can be added to the number of AIDS cases reported for the total number of new HIVinfections each year.

(3) HIV cases that have not been subsequently reported as AIDS cases by the end of the most recent year and who are not known to have died. The total is the number of persons living with HIV (not AIDS).

(4) Reported HIV cases that have been subsequently reported as AIDS cases.

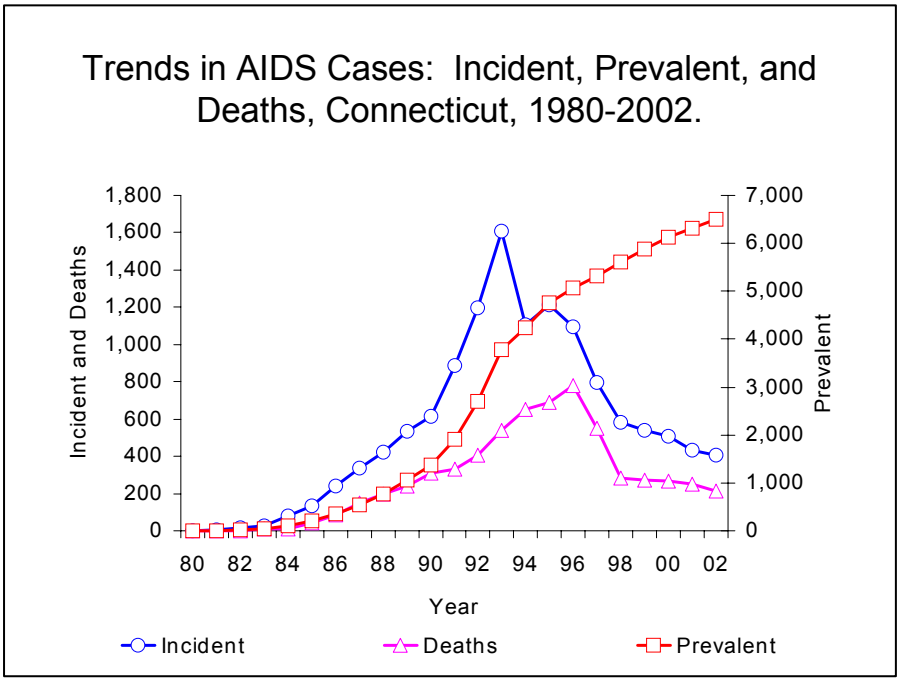
(5) (HIV progressed to AIDS / Total HIV) X 100.

(6) HIV cases reported by code instead of name.

(7) (Originally reported by code / Total HIV) X 100.

(8) HIV cases reported by code that have not been converted to names. Conversion to name occurs when a case is re-reported by name or as an AIDS case.

2003
Epidemiological Profile of HIV and AIDS in Connecticut



CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

Connecticut Department of Public Health

Joxel Garcia, MD, MBA, Commissioner

Bureau of Public Health Science

James Hadler, MD, MPH, Acting Bureau Chief

Infectious Disease Division

James Hadler, MD, MPH, Director

HIV/AIDS Surveillance Program

Aaron Roome, PhD, MPH, Coordinator

Sexually Transmitted Disease Control Program

Heidi Jenkins, Coordinator

Viral Hepatitis Program

Andrea Lombard, BSN, MPH, Coordinator

How to contact us:
HIV/AIDS Surveillance Program
410 Capitol Ave MS 11ASV
PO Box 340308
Hartford CT 06134

Telephone: (860) 509-7900
FAX: (860) 509-8237
Website: www.dph.state.ct.us

The State of the HIV/AIDS Epidemic in Connecticut –

Based on Epidemiological Markers

According to the Centers for Disease Control and Prevention's *HIV Prevention Community Planning Guidance*, the epidemiologic profile describes the impact of the HIV/AIDS epidemic within various populations and identifies characteristics of both HIV-infected and HIV-negative persons in defined geographic areas. This "epi profile" is composed of information gathered to describe the effect of HIV/AIDS on an area in terms of sociodemographic, geographic, behavioral, and clinical characteristics. In addition, it serves as the scientific basis for the identification and prioritization of HIV prevention and care needs in any given jurisdiction.

It is crucial in community planning, therefore, that an evidence-based process for setting priorities among target populations be based on the epidemiological profile and the community services assessment.

The geographic area served by Connecticut's Community Planning Group (CPG) is the entire state.

According to the CDC's *Epi Profile Guidance* the goals of an epi profile are: (1) to provide a description of the epidemic; (2) to describe current cases and provide information about possible future cases; (3) to identify characteristics of the general population and of populations with or at risk of infection, and, (4) to provide information required to conduct a community services assessment.

The 2003 Epidemiological Profile is divided into the following sections:

1. **Census Information**
2. **HIV/AIDS Statewide Surveillance**
3. **Surveillance by CPG Designated Regions**
4. **Surveillance by Ryan White Eligible Metropolitan Areas (EMAs)**
5. **Behavioral Risk Factor Survey Information**
6. **Sexually Transmitted Disease (STD) Surveillance**
7. **Viral Hepatitis Surveillance**
8. **Glossary of terms**.

The sections on STDs and viral hepatitis were included in the 2003 epi profile because they provide additional insight into risk behaviors that are capable of transmitting a variety of disease causing agents.

Table of Contents

Executive Summary

Population of Connecticut

The population of Connecticut is 1.3% of the U.S. population. Ninety-five percent of Connecticut residents live within metropolitan areas. The 2000 U.S. Census found that 77.5% of Connecticut residents are white, 9.4% Hispanic, 8.7% Black, 2.4% Asian, and 0.2% are American Indian. Connecticut residents have higher incomes, lower unemployment rates, and are more highly educated than U.S. residents as a whole.

Epidemiologic Trends in AIDS

It is estimated that as many as 18,000 Connecticut residents are currently infected with HIV. In 2001, 1.5% of the AIDS cases reported in the U.S. were among Connecticut residents. Connecticut ranks 9th among the states in the number of AIDS cases per 100,000. The annual number of AIDS cases reported in Connecticut has declined dramatically from 1,763 in 1993 to a plateau of about 600 per year since 1998. Similarly, deaths in persons with AIDS decreased by 62% from 1995 to 1999. In Connecticut, AIDS has disproportionately affected specific demographic and behavioral risk groups including males (73% of all cases reported), blacks (38%), Hispanics (25%), injection drug users (49%), and men who have sex with men (22%). Trends in the AIDS epidemic have been gradual. The percentage of reported AIDS cases in women has increased from 25% in 1993 to 31% of cases reported in 2002. The percentage in Hispanics has also increased from 25% in 1993 to 32% in 2002. There has also been a gradual shift in age distribution to older age groups. Heterosexual transmission has increased from 15% of cases in 1993 to 25% in 2000. Geographically, AIDS cases are concentrated in urban areas with the highest numbers in the three largest cities: Hartford, New Haven, and Bridgeport; but, 97% of Connecticut towns have at least one case.

HIV Infection in Adults

In 2002, HIV infection in adults became reportable. It can be expected, on average, that persons reported with HIV who do not meet the AIDS case definition, are at an earlier stage of disease progression than persons reported with AIDS. During 2002, 374 HIV cases were reported. HIV cases reported in 2002, in comparison with AIDS cases, were more likely to be female (HIV 43% vs. AIDS 30%), Hispanic (40% vs. 32%), younger (median age of 36 for HIV vs. 41 for AIDS), and were more likely to be initially reported without risk information (48% vs. 35%). An additional year or two of HIV reporting will be needed to substantiate these findings and establish trends.

Sexually Transmitted Diseases and Viral Hepatitis

Information from the STD and viral hepatitis surveillance systems also provide insight into high-risk behavior that can potentially lead to HIV infection. High numbers of chlamydia and gonorrhea cases in older teens and younger adults have been reported in recent years suggesting the persistence of unsafe sexual activity. Similarly, the connection between MSM and both syphilis and hepatitis A in Connecticut, and nationally, suggests a resurgence in high-risk behavior in MSM that could lead to increases in HIV infection.

List of Tables and Figures

Section 2.7: HIV in Children

Section 3: Community Planning Groups

Sections 3.1 – 3.7: Community Planning Group Regions

Section 4: Ryan White Eligible Metropolitan Areas: Hartford EMA and New Haven EMA

Section 5: Behavioral Risk Factor Survey

Section 6: Sexually Transmitted Diseases Surveillance

Section 6.1: Gonorrhea

Section 6.2: Chlamydia

Section 6.3 Syphilis

Section 7: Viral Hepatitis

Section 7.1: Hepatitis C

Section 7.2: Hepatitis A

Introduction

- ***What is an Epidemiological Profile?***
    - The Epidemiological Profile is a document prepared by the Department of Public Health that describes HIV/AIDS in Connecticut. As provided in the Centers for Disease Control and Prevention (CDC) *draft* guidance, the goals of the Epidemiological Profile are the following:
        - Provide a thorough description of the HIV/AIDS epidemic among the various populations (overall and subpopulations) in Connecticut;
        - Describe the current status of HIV/AIDS cases in Connecticut and provide some understanding of how the epidemic may look in the future;
        - Identify characteristics of the general population and of populations who are living with, or at high risk for, HIV/AIDS in defined geographical areas and who need primary and secondary prevention or care services;
        - Provide information required to conduct needs assessments and gap analyses.
- ***Organization of the Epidemiological Profile:***
    - ***CDC Guidance:*** The CDC has developed *draft* guidance for the production of Epidemiological Profiles. In the most recent version of CDC guidance, it is recommended that state Epidemiological Profiles provide information for both:
        - Community Planning Group Regions;
        - Ryan White Eligible Metropolitan Areas.
    - ***Population:*** This information is included to provide background about the makeup of Connecticut's population in terms of race, ethnicity, education, and economics.
    - ***HIV/AIDS Surveillance:*** The majority of the material presented is from the HIV/AIDS surveillance system. The data in this section are current through the end of 2002. This material is organized into three sections:
        - ***HIV/AIDS surveillance:*** This section includes statewide information about cumulative AIDS cases, trends in AIDS cases by year of report, incidence of AIDS, trends in AIDS deaths, people living with AIDS, HIV (made reportable in 2002), and HIV in children.
        - ***CPG regions:*** For each region there are specific HIV/AIDS data.
        - ***Ryan White:*** For each EMA there are specific HIV/AIDS data.

- ***Behavioral Risk Factor Survey:*** This survey is a random, weighted telephone survey conducted annually in Connecticut. Several questions about HIV are included in the survey and offer insight into the attitudes about HIV in the general population.

- ***Sexually Transmitted Diseases Surveillance:*** This data has not been provided in detail in previous Epidemiological Profiles. This information is relevant to HIV prevention because STDs can be transmitted in the same manner as HIV, and tend to get diagnosed and reported much sooner after infection than HIV. This connection with HIV is highlighted by the high proportion of recent syphilis cases associated with MSM.

- ***Viral Hepatitis Surveillance:*** This data has not been provided in previous Epidemiological Profiles. Although the data shown is rudimentary, it is of interest to HIV prevention and care because, in Connecticut, IDU is the predominant risk group for both hepatitis C and HIV. Indeed, co-infection with HIV and hepatitis C is an emerging care issue in Connecticut.

- ***Reading the Epidemiological Profile:*** The contents are presented in eight sections, numbered 1 - 8. Within each section, subsections are numbered, based on the number of the section in which they appear. For example, Section 2 has seven subsections, 2.1 to 2.7. Tables and figures are numbered accordingly. For example, two tables in subsection 2.1 would be numbered 2.1.1 and 2.1.2. While figures accompany the text, for the most part, tables are found at the end of the subsection. Figures and Tables are numbered in individual sequence. For example, there could be both a Table 1.1.1 and a Figure 1.1.1. Most of the tables (but not the figures) also appear on the HIV/AIDS Surveillance website **(www.dph.state.ct.us).**

- ***Other sources of information about HIV and AIDS Surveillance data:*** There are a variety of sources of HIV and AIDS surveillance data available including the following:

  - HIV/AIDS Surveillance Program website (www.dph.state.ct.us);
  - Previous Epidemiological Profiles of HIV/AIDS in Connecticut;
  - Connecticut Counseling and Testing data (www.dph.state.ct.us);
  - *Connecticut Epidemiologist* articles;
    - 20th Anniversary of AIDS in Connecticut;
    - AIDS Deaths In Connecticut – 1999;
  - CDC website (www.cdc.gov);
    - MMWR articles;
      - Unrecognized HIV infection, risk behaviors, and perceptions of risk among young black men who have sex with men – six US cities, 1994-1998. MMWR. 51:733. 2002.

- Primary and secondary syphilis – United States, 2000-2001. MMWR. 51: 971-3. 2002.
- HIV/STD risks in young men who have sex with men who do not disclose their sexual orientation – six US cities, 1994-2000. MMWR. 52: 81. 2002.
- HIV testing among pregnant women – US and Canada, 1998-2001. MMWR. 51: 1013. 2002.
- Update: AIDS – United States, 2000. MMWR. 51: 592. 2002.
- Diagnosis and reporting of HIV and AIDS in states with HIV/AIDS surveillance – US, 1994-2000. MMWR. 51: 595. 2002.
- Progress toward elimination of perinatal HIV infection – Michigan, 1993-2000. MMWR. 51: 94. 2002.
- HIV testing among racial/ethnic minorities – US, 1999. MMWR. 50: 1054. 2001.
- Prevalence of hepatitis C infection among clients of HIV counseling and testing sites – Connecticut, 1999. MMWR. 50: 577. 2001.
- First report on AIDS. MMWR. 50: 429. 2001.
- HIV and AIDS – US, 1981-2000. MMWR. 50: 430. 2001.
- HIV incidence among young men who have sex with men – seven US cities, 1994-2000. MMWR. 50: 440. 2001.

o United States HIV/AIDS surveillance data;

❖ Supplemental reports;

- AIDS cases and persons living with AIDS by state and metropolitan area provided for the Ryan White Care Act, June 2001;
- AIDS cases by state and metropolitan area of residence, 2000;
- Deaths among persons with AIDS through December 2000;
- HIV/AIDS in urban and non-urban areas of the United States, 1999;
- Characteristics of persons living with AIDS at end of 1999.

Methods in HIV/AIDS Surveillance

- ***Uses of surveillance information*:** The primary goal of the Connecticut Department of Public Health HIV/AIDS Surveillance Program is to systematically collect, analyze, interpret, and disseminate information about trends in HIV and AIDS in Connecticut. This information is used by a variety of state and federal agencies to develop policies and allocate funding for local prevention and care needs. Surveillance data are also used by media outlets such as television and newspapers to describe HIV/AIDS in Connecticut. Local health departments, non-government organizations and agencies, hospitals, physicians, students, and others also use HIV/AIDS surveillance data. Other important functions of the surveillance system at the state and national level include identification of clusters, unusual cases of transmission, emerging genetic variants, and drug-resistant strains.

- ***Reportable diseases:*** Connecticut law requires the Department of Public Health to maintain lists of reportable diseases and of related reportable laboratory findings. The lists include approximately 60 diseases and conditions of public health importance. Information is collected about each person with a disease or condition on the list. To be reported, a person with the disease or condition must meet the surveillance "case definition" for that disease. Cases are reported by the physician who diagnoses the disease and/or the laboratory that performs the test specific for the disease.

- ***Surveillance of AIDS:*** AIDS has been on the list of reportable diseases since the early 1980's. The AIDS case definition consists of either HIV positive with a low CD4-positive cell count (below 200 cells/microliter or less than 14% of total lymphocytes), or HIV positive and a diagnosis with one of several opportunistic infections or conditions (for example, *pneumocystis carinii* pneumonia or cervical carcinoma). AIDS cases are reported to the Department of Public Health by diagnosing physicians and laboratories (low CD4 counts). For each case of AIDS reported, the reporting physician or surveillance staff complete a case report form. The Department of Public Health maintains a computerized registry of AIDS cases.

- ***Surveillance of HIV:*** HIV infection has been reportable in adults (≥ 13 years of age) since January 2002. Prior to 2002, HIV was reportable only in children and persons with co-infection with tuberculosis. HIV is reported when an individual is confirmed HIV positive by Western Blot or other confirmatory test. Viral load test results are not reportable. Persons testing anonymously at one of Connecticut's HIV Counseling and Testing Sites are not counted, as they cannot be deduplicated and are likely to eventually get a non-anonymous HIV test and be reported then. Persons who tested positive prior to 2002 are not reportable. Reported HIV cases are entered into the same registry as AIDS cases.

- ***Information collected about HIV and AIDS cases:*** Various demographic and medical information is collected about each case of HIV or AIDS including: laboratory test dates, sex, race, town of residence, exposure category, AIDS indicator diseases, treatment status, pregnancy status, and provider information. Additional information about some of these data elements is below.

- ***Year of report:*** The year of report is based on the date that the case was first reported to the Department of Public Health. AIDS cases may have been diagnosed in years prior to the year in which they were reported. In 2002, for example, the median delay in

reporting of AIDS cases was two months with 66% of cases reported by 4 months after diagnosis and 78% reported by 12 months. Reporting delay results in an undercount of recently diagnosed cases.

- ***Sex:*** For each case of HIV or AIDS, information is collected about the person's sex. Male and female are the only options. Information is not collected about gender identity.

- ***Race/Ethnicity:*** For each case of HIV or AIDS, information is collected about the person's race and ethnicity. Prior to 2003 the options were the following: White (not Hispanic), Black (not Hispanic), Hispanic, Asian/Pacific Islander, American Indian/Alaska Native, and Not Specified. In 2003, in accordance with federal law, race categories have been changed to the following: White, Black, Asian, Native Hawaiian or other Pacific Islander, American Indian/Alaska Native, and Unknown. Ethnicity is now coded separately as Hispanic, Not Hispanic or Latino, and Unknown. Also in keeping with the new requirement, cases can be of more than one race. In the Epidemiological Profile the terms "Race" and Race/Ethnicity" should be considered synonymous.

- ***City of residence:*** The city of residence in the Department of Public Health HIV and AIDS tables refers to the city where the case resided at the time of their initial diagnosis. Changes in residence are not systematically monitored.

- ***Exposure categories:*** For each case of HIV or AIDS, information is collected about the most likely way in which the person acquired their HIV infection. This information is referred to as the exposure category, mode of transmission, risk group, or risk factor. This information may not always be available, especially for recently reported cases. The provider may not have reported the information, or the patient may not have volunteered the information, may not be in care, or may have died. When the exposure category is unknown, the Department of Public Health HIV/AIDS tables and graphs classify these cases in a separate category, "Oth/Unk." Over time, after additional follow-up with providers, many of these cases will be reclassified into one of the exposure categories.

  In the HIV/AIDS surveillance system, HIV/AIDS cases are only counted once in a hierarchy of exposure categories. Persons with more than one category are classified in the exposure category listed first in the hierarchy, except for men with both a history of sexual contact with other men and injecting drug use. They are in a separate category. All exposures refer to experiences of the case that took place after 1977 and before their first positive HIV test.

  - ***Men who have sex with men (MSM)*** – Men who report having sexual contact with men (homosexual contact) and men who report sexual contact with both men and women (bisexual contact).
  - ***Injection drug use (IDU) –*** Persons who have injected non-prescription drugs.
  - ***Heterosexual contact –*** Persons who have had heterosexual contact with a person with HIV infection or who is at high risk of HIV infection (IDU, bisexual male).
  - ***Other –*** Other exposure categories include received clotting factor or hemophilia/coagulation disorder, transfusion recipient, transplant recipient, and worker in a health care or clinical laboratory setting. Due to low numbers, these cases are classified together as "Oth/Unk" in HIV/AIDS tables and graphs.

- ***Opportunistic infections:*** There are 26 opportunistic infections or conditions (not all are infections) that, together with HIV infection, indicate development of AIDS. These are

also referred to as "AIDS indicator diseases." Many of these diseases result from impaired immunity. Having one of these diseases does not necessarily indicate that the person has HIV infection. The HIV/AIDS surveillance system collects information on the disease(s) that are reported with the initial diagnosis of AIDS. Indicator diseases that are subsequently diagnosed are not systematically monitored

- ***HIV and AIDS in children:*** Information specific for pediatric cases of HIV and AIDS (<13 years of age) are also collected. A pediatric case report form is used to collect this information. In addition to routine surveillance, the Department of Public Health has been conducting an enhanced surveillance project for perinatal exposure to HIV since 1999. For each case of perinatal HIV exposure, an extensive medical record extraction is conducted for the mother-child pair. Information collected about the mother includes demographics, risk behavior, HIV testing information, compliance with prenatal care, and types and duration of HIV treatment during pregnancy and labor/delivery. Information collected about the infant includes HIV preventive treatment, testing information, final HIV status, and birth defects.

- ***Incidence:*** Incidence rate is defined as the number of new cases in a defined population within a specified time period. To calculate incidence, the number of new cases of the disease and the size of the population at risk are needed. In the following example, the 2002 incidence of AIDS is calculated for Stamford and New London. Note, that in this example, the smaller city with a fewer number of cases has a higher incidence rate.

    - **Stamford:** [26 (AIDS cases) divided by 117,083 (population)] multiplied by 100,000 equals 22 per 100,000

    - **New London:** [12 (AIDS cases) divided by 25,671 (population)] multiplied by 100,000 equals 46 per 100,000

    - Incidence rates can be calculated for any group for which both the number of new cases and the size of the population are known. For example, rates can be calculated for gender, race, and age subgroups. Generally, population data is taken from the U.S. Census, conducted every ten years, most recently in 2000 (see www.census.gov).

    - Incidence rates cannot be calculated for some subgroups (i.e., IDU, MSM) because the size of these populations is unknown. Rates in populations of small size, such as small towns, can be misleading because the presence of a single case or few cases within a small population can make a rate appear large.

- ***Prevalence:*** Prevalence is the number of existing cases of a disease in a defined population at a point in time. The prevalence of people living with AIDS (PLWA) for Stamford and New London on December 31, 2002 is shown below.

    - **Stamford:** [356 (PLWA) divided by 117,083 (population)] multiplied by 100,000 equals 304 per 100,000

    - **New London:** [138 (PLWA) divided by 25,671 (population)] multiplied by 100,000 equals 537 per 100,000

Section 1: Connecticut's People

- Census 2000 data have been released including information about demographics, socio-economic status and much more. Selected information for Connecticut is shown in Table 1.1 by county and Table 1.2 by cities with populations of more than 20,000. Additional information about U.S. and Connecticut Census data can be found on the web (www.census.gov). Additional health-related measures are shown in Table 1.3.
- There are 3,405,565 residents in Connecticut.
    - The majority, 81.6%, are white (races can be Hispanic or non-Hispanic), 9.1% black, 0.3% American Indian, <0.1% Native Hawaiian, 2.2% classified themselves at "two or more races", and 9.4% Hispanic (of any race) (note, discussion of race and ethnicity in Methods section);
    - Alternatively, 77.5% are white (*non-Hispanic*), and 8.7% are black (*non-Hispanic*);
    - Hispanics constitute 9.4% of the population in Connecticut (320,323). The majority of Hispanics are Puerto Rican (194,443; 60.7%), followed by Mexican (23,484; 7.3%), Cuban (7,101; 2.2%), and Others (95,292; 29.7%);
    - Foreign born - 10.9%;
    - Other than English at home -18.3%;
    - High school or more education - 84%;
    - Live below the poverty line - 7.9%;
    - Per capita income - $28,766.
    - There are 3,559 households that include an unmarried male with a male partner.

Figure 1.1: AIDS prevalence (PLWA) by Sex, Race/Ethnicity, and Age at Diagnosis (per 100,000), Connecticut, 2002.

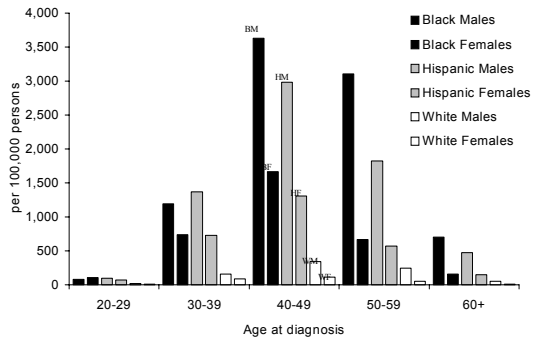
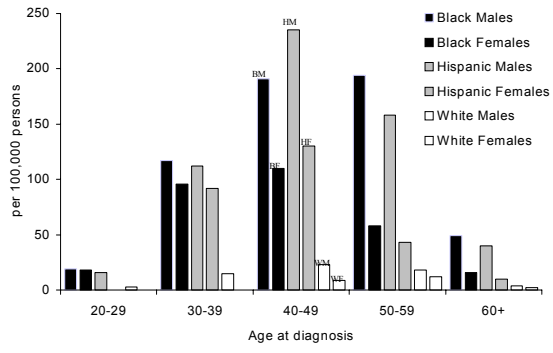


Figure 1.2: AIDS Incidence by Sex, Race/Ethnicity, and Age at Diagnosis (per 100,000), Connecticut, 2000.



- Three counties, Fairfield, Hartford, and New Haven, include 75% of all Connecticut residents. They also include the highest percentage of black (10.0-11.7%) and Hispanic (10.1-11.9%) residents, the highest percentage that speak other than English at home (17.7-23.9%), and the highest percentage of foreign born (9.0-16.9%).
- Fairfield County has the highest per capita income ($38,350) and Windham County has the lowest ($20,443).
- Census data is used by the surveillance system to make calculations of incidence and prevalence in standard populations as described in the methods section. Figures 1.1 and 1.2 are two examples.

Census Data for Cities (>20,000 Population)

- Five cities have populations greater than 100,000: Bridgeport (139,529), New Haven (123,626), Hartford (121,578), Stamford (117,083), Waterbury (107,271) (Table 1.2).

- The three largest cities have majority populations of black and Hispanic: Bridgeport (31 % black, 32% Hispanic), New Haven (37% black, 21% Hispanic), Hartford (38% black, 41% Hispanic).

- Cities under 50,000 tend to have very small black and Hispanic populations with several notable exceptions:

    - Windsor, with a population of 28,237, is 65% white, 27% black, and only 5% Hispanic;
    - Windham, with a population of 22,857, is 74% white, 27% Hispanic, and only 5% black;
    - New London, with a population of 25,671, is 63% white, 19% black, and 20% Hispanic.

- There are few American Indian and Alaskan Natives with 1.2% in Norwich and 0.8% in Groton.

- Asians are generally 1-4% of the population of towns (>20,000) with some exceptions. Stamford (5.0%), Danbury (5.5%), Greenwich (5.2%), and Mansfield (7.2%).

- Native Hawaiians and other Pacific Islanders range from less than 0.0% to 0.2% in Groton.

- "Other" race ranges from 0.3% to 26.5%. Notably, cities with high percentage of "other" tend to have a higher percentage of Hispanics.

- Few persons classify themselves as two or more races (0.9%-5.7%).

- Of respondents in cities with >20,000 population, 7-40% speak other than English at home with most cities above 10%.

- The percentage with a high-school education or more ranges from 61%-96%, in Hartford and Westport, respectively.

- The percentage below the poverty line ranges from 2-31% and per capita income ranged from $13,428 (Hartford) to $74,346 (Greenwich). Most cities are in the range of $20,000 to $40,000. There are five cities above $40,000: Glastonbury ($40,820), Fairfield ($43,670), Ridgefield ($51,795), Westport ($73,664) and Greenwich ($74,346). Four of the five are in Fairfield County.

Table 1.1: 2000 CENSUS DATA: Connecticut, Counties by Race/Ethnicity[1,2,3,4], and Socio-economic Characteristics.

		Percent												
	Population	White	Black or AA[3]	AI& AN[3]	Asian	NH& OPI[3]	Other	Two or more races[2]	Hisp or Latino[4]	Foreign born	Other than English at home	High School or more	Persons below poverty line	Per capita income
Connecticut	3,405,565	81.6	9.1	0.3	2.4	<0.1	4.3	2.2	9.4	10.9	18.3	84.0	7.9	$28,766
FAIRFIELD	882,567	79.3	10.0	0.2	3.3	<0.1	4.7	2.5	11.9	16.9	23.9	84.4	6.9	$38,350
HARTFORD	857,183	76.9	11.7	0.2	2.4	<0.1	6.4	2.3	11.5	11.7	21.7	82.4	9.3	$26,047
NEW HAVEN	824,008	79.4	11.3	0.2	2.3	<0.1	4.5	2.2	10.1	9.0	17.7	83.0	9.5	$24,439
NEW LONDON	259,088	87.0	5.3	1.0	2.0	0.1	2.1	2.7	5.1	5.4	10.3	86.0	6.4	$24,678
LITCHFIELD	182,193	95.8	1.1	0.2	1.2	<0.1	0.7	1.1	2.1	5.4	8.2	85.9	4.5	$28,408
MIDDLESEX	155,071	98.4	4.4	0.2	1.6	<0.1	1.0	1.6	3.0	4.5	9.5	88.7	4.6	$28,251
TOLLAND	136,364	92.3	2.7	0.2	2.3	<0.1	1.1	1.4	2.8	5.9	10.0	89.2	5.6	$25,474
WINDHAM	109,091	91.3	1.9	0.5	0.8	<0.1	3.6	1.9	7.1	4.3	11.7	79.6	8.5	$20,443

[1]Census respondents had the option of selecting more than one race.

[2]Data shown includes persons reporting only one race. "Two or more" includes persons who selected more than one race.

[3]AA = African American; AI&AN = American Indian and Alaskan Native; NH&OPI = Native Hawaiian and other Pacific Islander.

[4]Race groups should add to ~100% (including "Two or more"). "Hispanic or Latino" is a separate category. Race data include Hispanic and non-Hispanic. For example, 81.6% of Connecticut's population is "White" (Hispanic and non-Hispanic), as shown in the table, but 77.5% are White, non-Hispanic.

Table 1.3: Selected Health Markers[1,2] by Race/Ethnicity, Connecticut, 2001.

	Race/Ethnicity		
	White	Black	Hispanic
Low birth weight infants	6.3%	12.2%	8.2%
Teen births (per 1,000) Chapter 2	16.1	67.1	114.4
Chapter 3 Rate of non-elderly uninsured	9%	18%	23%
Chapter 4 Poverty rate	6%	24%	31%
Median family income	$40,770	$24,340	$15,390
Smoke cigarettes	20.1%	27.3%	17.1%
Heart disease deaths (per 100,000)	240.2	285.1	118.7
Cancer deaths (per 100,000)	193.8	223.8	69.4
Number of students receiving services at school-based health clinics[2]	1,630	2,451	2,374

[1]Kaiser Family Foundation (www.statehealthfacts.kff.org).

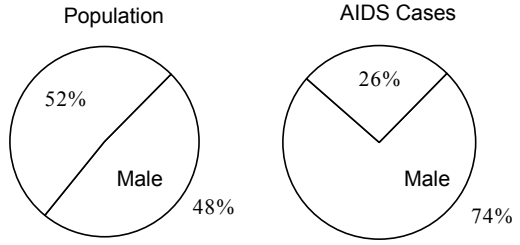
[2]Connecticut Department of Public Health. School Based Health Centers. 2000.

Section 2: HIV/AIDS Surveillance

- In this section, Connecticut HIV/AIDS surveillance data will be described. Included are sub-sections: 2.1 Cumulative AIDS Cases; 2.2 Trends in AIDS Cases; 2.3 Incidence of AIDS; 2.4 Trends in AIDS Deaths; 2.5 Persons Living with AIDS, 2.6 HIV Surveillance; and, 2.7 HIV in Children.

- AIDS was made reportable in 1981. HIV infection in children (<13 years of age) and persons co-infected with HIV and TB (of any age) were made reportable in 1993. In 2002, HIV in adults was made reportable.

Figure 2.1.1: The Percentage of Males/Females in the General Population and AIDS Cases, Connecticut, 2002.



2.1 Cumulative AIDS Cases

- Since 1981, 12,783 cases of AIDS have been reported (through December 2002). Of these, 6,285 (49.2%) have died (Table 2.1.1) and 6,498 are living with AIDS.
- AIDS cases are disproportionately male. Overall, 74% of AIDS cases are male compared to 48% of the population (Figure 2.1.1).
- AIDS cases are disproportionately black and Hispanic. While 8.7% of the population is black and 9.4% is Hispanic, 38% of AIDS cases are black and 24% are Hispanic (Figure 2.1.2).
- Cumulatively, 48.7% of AIDS cases are IDU, 22.4% are MSM, 3.4% are MSM/IDU, 16.8% are heterosexual and 7.2% are other or unknown. Only 1.5% (n=193) are in pediatric patients (<13 years), the majority of whom have resulted from perinatal transmission of HIV (Table 2.1.2).
- Among adult males the predominant risk groups are IDU (48.7%) and MSM (30.9%) and among females, IDU (51.6%) and heterosexual (39.9%) (Figure 2.1.3).
- While the majority of white males are MSM (53.3%) and a minority are IDU (15.4%), among black and Hispanic males the proportions are approximately reversed with 15% MSM and 65% IDU (Table 2.1.2).
- White and black females are more likely to be IDU and Hispanic females are more likely to be associated with heterosexual transmission (Table 2.1.2).

Figure 2.1.2: The Percentage of Race/Ethnicity Categories in the General Population and AIDS Cases, Connecticut, 2002.

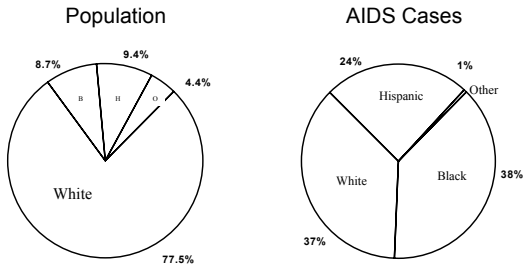
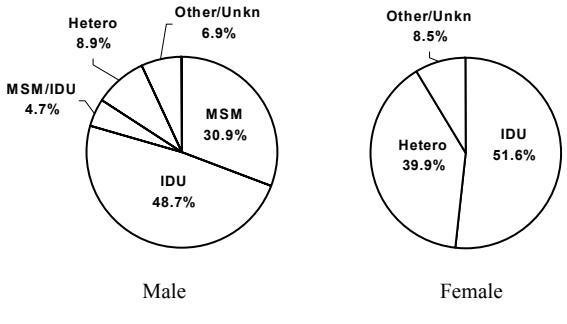


Figure 2.1.3: Cumulative Distribution of Adult Male and Female AIDS Cases, by Risk Group, Connecticut, 2000.



- 2,863 AIDS cases have been reported with MSM risk. Of these, 69.1% were white, 18.2% were black, 12.0% were Hispanic (Table 2.1.2).

- Among non-MSM males with risk known to be either IDU or heterosexual exposure (n=5,380), 78-88% are IDU and 12-22% are heterosexual depending on race. Among females with known risk (n=3,017), 48-62% were IDU and 38-52% are heterosexual depending on race (Table 2.1.2).

- Figures 2.1.4 – 2.1.6 show the distribution of AIDS cases in three age groups: 13-29, 30-49, and 50+ years at diagnosis, by sex, race and risk group.

    - Sex – In all age groups the majority of cases are male with the percentage male increasing from 63% in the 13-29 age group to 82% in the 50+ age group.

    - Race – The percentage of cases that are Hispanic decreases with increased age (34% to 17%) and the percentage of white cases increases with age (32% to 47%). The percentage black remains approximately constant in all the age groups (33% to 39%).

    - Risk - IDU risk is highest in all age groups (40%, 54%, 32%).

- Tables 2.1.2 and 2.1.3 show detailed cumulative AIDS case data by sex, race, risk group, and age group.

Figure 2.1.4: Cumulative AIDS Cases by Sex, and Age at Diagnosis, Connecticut, 2002.

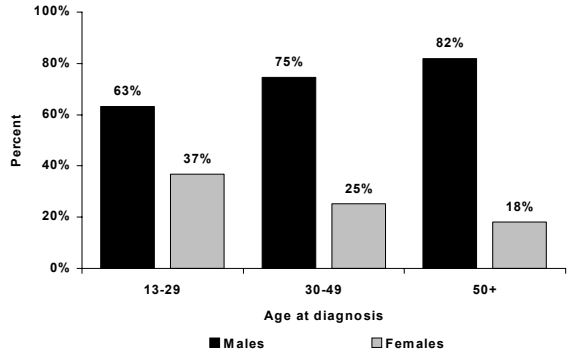


Figure 2.1.5: Cumulative AIDS Cases by Race, and Age at Diagnosis, Connecticut, 2002.

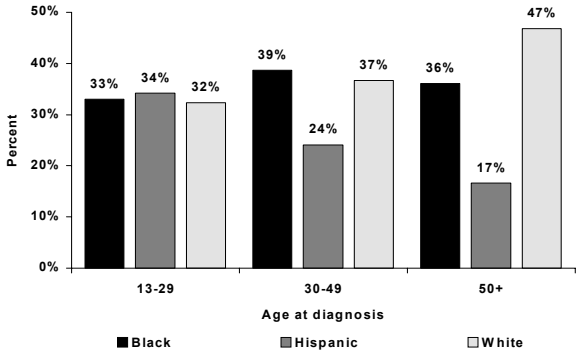


Figure 2.1.6: Cumulative AIDS Cases by Risk Group, and Age at Diagnosis, Connecticut, 2002.

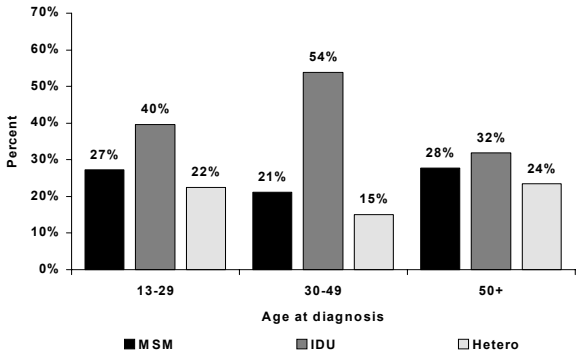


Table 2.1.1: HIV/AIDS Surveillance Data by Year of Report, Diagnosis, Death, Prevalence, Connecticut, 1980-2002.

Year[1]	Reported AIDS	Diagnosed AIDS	AIDS Deaths[2,3]	Prevalent AIDS[4]	Prevalent HIV[5,6]	HIV Deaths[2,3,4,5,6]	Prevalent HIV or AIDS[4,5,6]
80	0	1	1	0	-	-	-
81	2	7	1	6	-	-	-
82	7	14	1	19	-	-	-
83	22	27	9	37	-	-	-
84	54	79	10	106	-	-	-
85	85	134	42	198	-	-	-
86	174	242	85	355	-	-	-
87	278	337	147	545	-	-	-
88	401	423	197	771	-	-	-
89	446	534	242	1,063	-	-	-
90	427	614	311	1,366	-	-	-
91	531	885	333	1,918	-	-	-
92	694	1,196	405	2,709	-	-	-
93	1,759	1,609	540	3,778	-	-	-
94	961	1,106	650	4,234	-	-	-
95	1,565	1,214	691	4,757	-	-	-
96	1,104	1,097	778	5,076	-	-	-
97	1,197	795	551	5,320	-	-	-
98	661	583	285	5,618	-	-	-
99	598	542	273	5,887	-	-	-
00	604	506	267	6,126	-	-	-
01	587	433	250	6,309	-	-	-
02	626	405	216	6,498	370	4	6,868
TOTALS	12,783	12,783	6,285		370	4	

[1]Data in recent years is incomplete due to delay in the reporting of cases and/or deaths.
[2]Deaths in 2002 represent only partial reporting from the DPH Vital Records Section.
[3]Death data is obtained from death certificates or health-care providers. Deaths due to HIV/AIDS related illness that do not list HIV/AIDS as a cause of death or that occur out-of-state may not be included. Deaths due to non-HIV/AIDS causes (i.e. auto accident, drug overdose) may not be included.
[4]Prevalent cases are persons living with AIDS or HIV, or whose mortality status is unknown. May include persons who have moved out of state or persons who have died of non-HIV/AIDS related causes.
[5]HIV infection became a reportable disease in Connecticut on January 1, 2002.
[6]A person with HIV infection who has not developed AIDS.

Table 2.1.2: Cumulative Reported AIDS Cases by Sex, Race, and Risk Group, Connecticut, 1980-2002.

		Risk													
		MSM		IDU		MSM/IDU		Hetero		Oth/Unk		Pedi		Total	
		N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Male	White	1,977	53.3	1,011	27.3	177	4.8	228	6.2	302	8.1	11	0.3	3,706	29.0
	Black	522	15.4	2,042	60.3	158	4.7	399	11.8	203	6.0	60	1.8	3,384	26.5
	Hispanic	343	15.3	1,448	64.5	97	4.3	192	8.6	134	6.0	30	1.3	2,244	17.6
	Other	21	44.7	14	29.8	--	--	7	14.9	5	10.6	--	--	47	0.4
Female	White	--	--	541	53.9	--	--	333	33.2	118	11.8	12	1.2	1,004	7.9
	Black	--	--	770	52.6	--	--	560	38.3	85	5.8	49	3.3	1,464	11.5
	Hispanic	--	--	390	42.3	--	--	423	45.9	78	8.5	30	3.3	921	7.2
	Other	--	--	7	53.8	--	--	5	38.5	--	--	1	7.7	13	0.1
White		1,977	42.0	1,552	33.0	177	3.8	561	11.9	420	8.9	23	0.5	4,710	36.8
Black		522	10.8	2,812	58.0	158	3.3	959	19.8	288	5.9	109	2.2	4,848	37.9
Hispanic		343	10.8	1,838	58.1	97	3.1	615	19.4	212	6.7	60	1.9	3,165	24.8
Other		21	35.0	21	35.0	--	--	12	20.0	5	8.3	1	1.7	60	0.5
Total		2,863	22.4	6,223	48.7	432	3.4	2,147	16.8	925	7.2	193	1.5	12,783	100.0

Table 2.1.3: Cumulative Reported AIDS Cases by Sex, Race, and Age Group, Connecticut, 1980-2002.

		Age Group											
		0-12		13-19		20-29		30-39		40-49		50+		Total	
		N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of row total	N	% of total
Male	White	10	0.3	9	0.2	387	10.4	1,592	43.0	1,144	30.9	564	15.2	3,706	29.0
	Black	54	1.6	6	0.2	327	9.7	1,457	43.1	1,143	33.8	397	11.7	3,384	26.5
	Hispanic	29	1.3	8	0.4	375	16.7	1,076	48.0	574	25.6	182	8.1	2,244	17.6
	Other	--	--	--	--	8	17.0	21	44.7	13	27.7	5	10.6	47	0.4
Female	White	11	1.1	8	0.8	167	16.6	447	44.5	278	27.7	93	9.3	1,004	7.9
	Black	48	3.3	12	0.8	243	16.6	714	48.8	337	23.0	110	7.5	1,464	11.5
	Hispanic	27	2.9	9	1.0	213	23.1	411	44.6	210	22.8	51	5.5	921	7.2
	Other	1	7.7	--	--	1	7.7	9	69.2	1	7.7	1	7.7	13	0.1
Male		93	1.0	23	0.2	1,097	11.7	4,146	44.2	2,874	30.6	1,148	12.2	9,381	73.4
Female		87	2.6	29	0.9	624	18.3	1,581	46.5	826	24.3	255	7.5	3,402	26.6
Total		180	1.4	52	0.4	1,721	13.5	5,727	44.8	3,700	28.9	1,403	11.0	12,783	100.

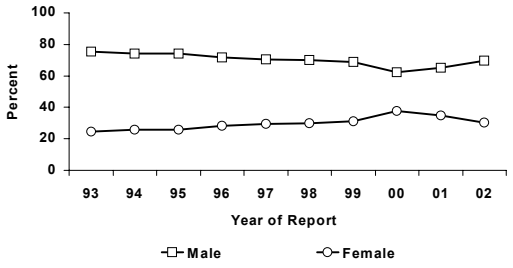
2.2 Trends in AIDS Cases

- The trend in the number of AIDS cases reported and diagnosed is shown in Table 2.1.1 in the previous section.

- The first reported AIDS case was in 1981. The maximum number of AIDS cases was reported in 1993 (n=1,759). The trend in reported AIDS cases has leveled off at about 600 per year for the past five years (range 587-661) (Table 2.2.1).

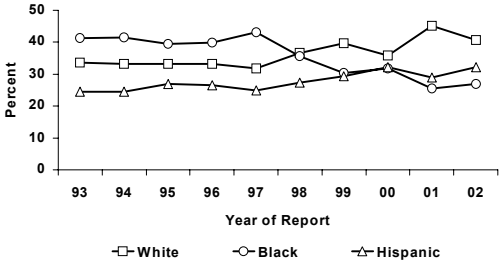
- Trends in the AIDS epidemic have been very gradual. (Figure 2.2.1 – 2.2.3). Over the past ten years the following trends are notable:

Figure 2.2.1: Trend in AIDS Cases by Sex, Connecticut, 1993 – 2002.



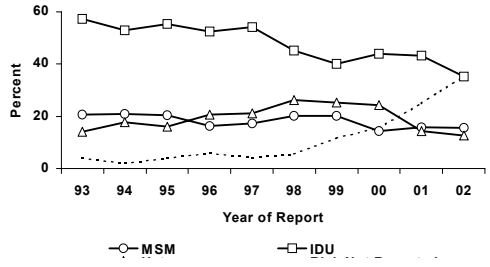
  - The percentage of cases that are female has increased about 5-10% (Figure 2.2.1).

Figure 2.2.2: Trend in AIDS Cases by Race, Connecticut, 1993-2002.



  - The percentage of white cases has increased about 10% from 33% to 40-45%. The percentage of black cases has decreased from approximately 40% to about 25%. The percentage of Hispanic cases has increased from about 25% to about 30% (Figure 2.2.2).

Figure 2.2.3: Trend in AIDS Cases by Risk Group, Connecticut, 1993-2002.



  - Risk group data after 2000 should be interpreted cautiously due to a high percentage of cases with "no reported risk" (15.6% in 2000) (Figure 2.2.3). Recent trends (to 2000) show a decline in percentage of cases that are IDU although it remains predominant (about 60% to 40%). Heterosexual transmission has increased from about 15% in 1993 to 25% in 2000. The percentage of cases that are MSM has decreased from about 20% to 15%. Heterosexual risk has increased from about 15% to 25%.

  - Trends by age group are shown in Figure 2.2.4 and suggest a gradual increase in the age of newly diagnosed cases. While the percentage of cases in the 20-29 and 30-39 age

groups has been decreasing, the percentage of cases that are in the 40-49 and 50+ age groups has been increasing. This change has been about 10 percentage points over the past ten years. This shift in age distribution could be due to delay in AIDS diagnosis because of successful treatment, a trend to older age at HIV infection, or a combination of the two.

- Detailed trend data in males and females by race and risk group are found in Tables 2.2.3 and 2.2.4.

Figure 2.2.4: Trend in AIDS Cases by Age Group, Connecticut, 1993 – 2002.

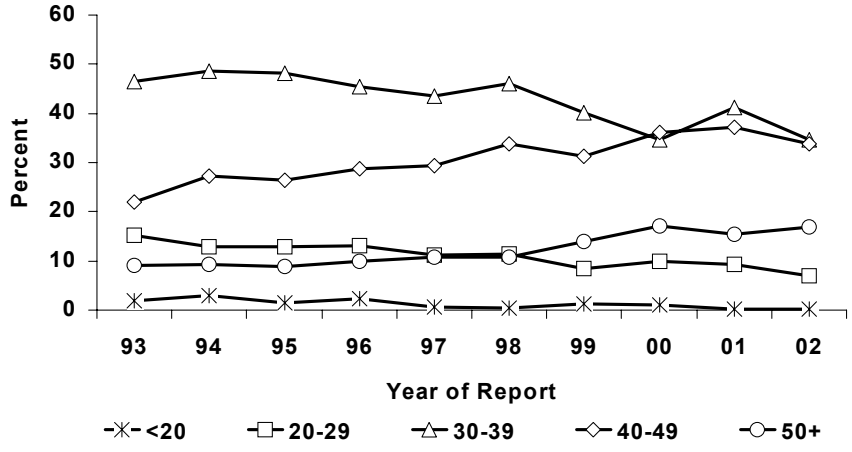


Table 2.2.1: AIDS Cases by Year of Report, Sex, Race, and Risk Group, Connecticut, 1980-2002.

		Sex		Race/Ethnicity				Risk Group					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk	Pedi
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
1980-92	3,121	79.4	20.6	42.2	39.2	18.1	0.5	34.1	42.7	4.9	11.6	3.9	2.7
1993	1,759	75.2	24.8	33.5	41.2	24.6	0.7	20.7	57.4	4.4	14.1	1.9	1.4
1994	961	74.2	25.8	33.3	41.5	24.6	0.6	20.8	53.0	3.5	17.7	2.3	2.7
1995	1,565	74.2	25.8	33.2	39.5	26.8	0.5	20.3	55.3	3.1	16.0	4.0	1.2
1996	1,104	71.9	28.1	33.2	39.9	26.5	0.5	16.4	52.5	2.8	20.7	5.9	1.7
1997	1,197	70.3	29.7	31.8	43.0	24.9	0.3	17.1	54.1	3.1	21.2	4.2	0.3
1998	661	70.2	29.8	36.6	35.7	27.4	0.3	20.1	45.1	2.6	26.2	5.7	0.3
1999	598	68.7	31.3	39.6	30.3	29.4	0.7	20.2	40.0	1.5	25.3	11.7	1.3
2000	604	62.4	37.6	35.9	31.8	32.1	0.2	14.4	43.9	1.3	24.2	15.6	0.7
2001	587	65.2	34.8	45.1	25.6	29.0	0.3	15.7	43.3	1.7	14.3	24.9	0.2
2002	626	69.5	30.5	40.7	26.8	32.1	0.3	15.5	35.3	0.8	12.6	35.5	0.3
Total	12,783	73.4	26.6	36.8	37.9	24.8	0.5	22.4	48.7	3.4	16.8	7.2	1.5

Table 2.2.2: AIDS Cases by Year of Report, and Age at Diagnosis with AIDS, Connecticut, 1980-2002.

		Age when diagnosed with AIDS					
		0-12	13-19	20-29	30-39	40-49	50+
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
1980-92	3,121	2.7	0.3	18.1	46.5	22.0	10.4
1993	1,759	1.4	0.6	15.3	46.5	27.2	9.0
1994	961	2.5	0.4	12.8	48.5	26.5	9.3
1995	1,565	1.2	0.3	12.8	48.2	28.8	8.8
1996	1,104	1.7	0.6	13.0	45.5	29.3	10.0
1997	1,197	0.2	0.5	11.3	43.6	33.8	10.7
1998	661	0.2	0.3	11.5	46.1	31.2	10.7
1999	598	0.5	0.8	8.5	40.1	36.1	13.9
2000	604	0.3	0.8	9.9	34.6	37.1	17.2
2001	587	--	0.2	9.2	41.2	33.9	15.5
2002	625	0.3	--	7.0	34.6	41.1	17.0
Total	12,782	1.4	0.4	13.5	44.8	28.9	11.0

Table 2.2.3: AIDS in Adult Males by Year of Report, Race, and Risk Group, Connecticut, 1980-2002.

		Year of Report													
		1980-1997		1998		1999		2000		2001		2002		Total	
		N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	Total	% of Total
MSM	White	1,604	68.8	93	69.9	79	65.3	57	65.5	71	77.2	73	75.3	1,977	21.3
	Black	452	19.4	23	17.3	15	12.4	16	18.4	8	8.7	8	8.2	522	5.6
	Hispanic	259	11.1	17	12.8	27	22.3	13	14.9	12	13.0	15	15.5	343	3.7
	Other	18	0.8	--	--	--	--	1	1.1	1	1.1	1	1.0	21	0.2
	Risk Total	2,333	100.	133	100.	121	100.	87	100.	92	100.	97	100.	2,863	30.9
IDU															
	White	745	20.5	63	29.4	49	29.7	46	27.2	65	36.7	43	26.7	1,011	10.9
	Black	1,758	48.4	80	37.4	57	34.5	54	32.0	50	28.2	43	26.7	2,042	22.0
	Hispanic	1,113	30.7	71	33.2	58	35.2	69	40.8	62	35.0	75	46.6	1,448	15.6
	Other	13	0.4	--	--	1	0.6	--	--	--	--	--	--	14	0.2
	Risk Total	3,629	100.	214	100.	165	100.	169	100.	177	100.	161	100.	4,515	48.7
MSM/IDU															
	White	152	39.7	7	41.2	5	55.6	3	37.5	8	80.0	2	40.0	177	1.9
	Black	146	38.1	5	29.4	2	22.2	3	37.5	--	--	2	40.0	158	1.7
	Hispanic	85	22.2	5	29.4	2	22.2	2	25.0	2	20.0	1	20.0	97	1.0
	Risk Total	383	100.	17	100.	9	100.	8	100.	10	100.	5	100.	432	4.7

		Year of Report													
		1980-1997		1998		1999		2000		2001		2002		Total	
		N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	Total	% of Total
Hetero															
	White	161	27.3	19	26.4	23	39.7	11	21.2	7	28.0	7	24.1	228	2.5
	Black	306	51.9	31	43.1	17	29.3	24	46.2	7	28.0	14	48.3	399	4.3
	Hispanic	119	20.2	20	27.8	17	29.3	17	32.7	11	44.0	8	27.6	192	2.1
	Other	4	0.7	2	2.8	1	1.7	--	--	--	--	--	--	7	0.1
	Risk Total	590	100.	72	100.	58	100.	52	100.	25	100.	29	100	826	8.9
Oth/Unk															
	White	167	59.0	5	18.5	22	40.7	28	48.3	26	32.9	54	37.8	302	3.3
	Black	79	27.9	16	59.3	15	27.8	16	27.6	31	39.2	46	32.2	203	2.2
	Hispanic	36	12.7	6	22.2	15	27.8	14	24.1	21	26.6	42	29.4	134	1.4
	Other	1	0.4	--	--	2	3.7	--	--	1	1.3	1	0.7	5	0.1
	Risk Total	283	100.	27	100.	54	100.	58	100.	79	100.	143	100.	644	6.9
Total		7,218	100.	463	100.	407	100.	374	100.	383	100.	435	100.	9,280	100.

Table 2.2.4: AIDS in Adult Females by Year of Report, Race and Risk Group, Connecticut, 1982-2002.

		Year of Report													
		1980-1997		1998		1999		2000		2001		2002		Total	
		N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	N	% of risk total	Total	% of Total
IDU	White	383	29.1	25	29.8	27	36.5	35	36.5	43	55.8	28	46.7	541	16.3
	Black	645	49.0	37	44.0	28	37.8	29	30.2	17	22.1	14	23.3	770	23.3
	Hispanic	282	21.4	22	26.2	19	25.7	32	33.3	17	22.1	18	30.0	390	11.8
	Other	7	0.5	--	--	--	--	--	--	--	--	--	--	7	0.2
	Risk Total	1,317	100.	84	100.	74	100.	96	100.	77	100.	60	100.	1,708	51.6
Hetero															
	White	220	23.8	26	25.7	25	26.9	27	28.7	15	25.4	20	40.0	333	10.1
	Black	413	44.7	39	38.6	39	41.9	35	37.2	19	32.2	15	30.0	560	16.9
	Hispanic	286	31.0	36	35.6	29	31.2	32	34.0	25	42.4	15	30.0	423	12.8
	Other	5	0.5	--	--	--	--	--	--	--	--	--	--	5	0.2
	Risk Total	924	100.	101	100.	93	100.	94	100.	59	100.	50	100.	1,321	39.9
Oth/Unk															
	White	41	56.9	4	36.4	6	37.5	9	25.0	30	44.8	28	35.4	118	3.6
	Black	22	30.6	3	27.3	3	18.8	14	38.9	18	26.9	25	31.6	85	2.6
	Hispanic	9	12.5	4	36.4	7	43.8	13	36.1	19	28.4	26	32.9	78	2.4
	Risk Total	72	100.	11	100.	16	100.	36	100.	67	100.	79	100.	281	8.5
Total		2,313	100.	196	100.	183	100.	226	100.	203	100.	189	100.	3,310	100.

Table 2.2.5: AIDS Cases 13-29 Years at Diagnosis by Year of Report, Sex, Race, and Risk Group, Connecticut, 1980-2002.

		Sex		Race/Ethnicity				Risk Group				
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
Report Year												
1980-92	573	70.0	30.0	37.2	36.3	26.2	0.3	35.6	38.2	5.8	17.3	3.1
1993	279	61.6	38.4	30.8	33.3	34.4	1.4	22.9	49.1	6.8	19.0	2.2
1994	125	60.0	40.0	32.0	33.6	33.6	0.8	23.2	39.2	6.4	28.0	3.2
1995	204	62.7	37.3	26.5	34.3	39.2	--	25.5	40.7	2.5	26.5	4.9
1996	150	66.7	33.3	32.7	28.0	39.3	--	27.3	39.3	4.7	25.3	3.3
1997	139	55.4	44.6	30.9	33.1	36.0	--	22.3	45.3	2.2	25.9	4.3
1998	77	54.5	45.5	29.9	31.2	39.0	--	26.0	29.9	1.3	28.6	14.3
1999	51	60.8	39.2	23.5	31.4	43.1	2.0	21.6	27.5	3.9	29.4	17.6
2000	63	42.9	57.1	31.7	25.4	42.9	--	9.5	36.5	--	38.1	15.9
2001	54	55.6	44.4	29.6	27.8	40.7	1.9	22.2	29.6	--	24.1	24.1
2002	44	65.9	34.1	29.5	18.2	52.3	--	25.0	27.3	--	11.4	36.4
Total	1,759	63.2	36.8	32.3	33.0	34.2	0.5	27.3	39.7	4.4	22.4	6.1

Table 2.2.6: AIDS Cases 30-49 Years at Diagnosis by Year of Report, Sex, Race, and Risk Group, Connecticut, 1980-2002.

		Sex		Race/Ethnicity				Risk Group				
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
Report Year												
1980-92	2,140	82.1	17.9	41.7	40.5	17.3	0.6	33.2	49.0	5.5	10.2	2.1
1993	1,296	77.2	22.8	34.0	42.3	23.2	0.5	19.3	62.7	4.2	12.3	1.5
1994	721	76.7	23.3	33.6	43.3	22.7	0.4	20.0	60.1	2.9	15.4	1.7
1995	1,205	75.2	24.8	33.6	39.7	26.1	0.6	18.5	60.8	3.5	13.8	3.4
1996	825	73.3	26.7	33.1	40.8	25.5	0.6	14.9	59.0	2.8	18.3	5.0
1997	926	71.2	28.8	31.2	43.8	24.7	0.2	16.0	57.6	3.6	19.4	3.5
1998	511	71.4	28.6	37.2	36.4	26.0	0.4	18.4	49.5	3.1	23.9	5.1
1999	456	68.6	31.4	41.0	29.6	28.9	0.4	21.9	42.5	1.3	22.8	11.4
2000	433	60.7	39.3	34.6	33.0	32.1	0.2	15.7	47.6	1.4	21.7	13.6
2001	441	63.9	36.1	44.9	26.3	28.6	0.2	13.4	46.0	2.0	13.6	24.9
2002	473	67.2	32.8	41.2	26.2	32.1	0.4	15.2	36.8	1.1	12.3	34.7
Total	9,427	74.5	25.5	36.7	38.7	24.1	0.5	21.1	53.9	3.5	15.1	6.4

Table 2.2.7: AIDS Cases 50+ Years at Diagnosis by Year of Report, Sex, Race, and Risk Group, Connecticut, 1980-2002.

		Sex		Race/Ethnicity				Risk Group				
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
Report Year												
1980-92	324	84.9	15.1	62.7	30.2	6.8	0.3	46.3	20.4	1.2	14.2	17.9
1993	159	86.2	13.8	39.6	42.8	17.0	0.6	31.4	37.7	3.1	22.6	5.0
1994	89	79.8	20.2	40.4	38.2	20.2	1.1	30.3	30.3	5.6	27.0	6.7
1995	138	85.5	14.5	40.6	44.9	13.8	0.7	31.2	36.2	1.4	22.5	8.7
1996	110	72.7	27.3	38.2	45.5	16.4	--	15.5	30.9	0.9	35.5	17.3
1997	128	82.0	18.0	36.7	47.7	14.8	0.8	20.3	39.8	0.8	29.7	9.4
1998	71	78.9	21.1	40.8	33.8	25.4	--	26.8	31.0	--	40.8	1.4
1999	83	75.9	24.1	44.6	30.1	24.1	1.2	12.0	37.3	1.2	38.6	10.8
2000	104	80.8	19.2	44.2	30.8	25.0	--	12.5	34.6	1.9	26.9	24.0
2001	91	78.0	22.0	56.0	20.9	23.1	--	23.1	38.5	1.1	12.1	25.3
2002	106	83.0	17.0	44.3	32.1	23.6	--	13.2	32.1	--	15.1	39.6
Total	1,403	81.8	18.2	46.8	36.1	16.6	0.4	27.8	31.8	1.6	23.5	15.3

2.3 Incidence of AIDS

- For surveillance purposes, diagnosis of AIDS is considered an incident AIDS case. Due to delay in reporting, the number of diagnosed cases in recent years can be artificially low (Figure 2.3.1).

- Calculating incidence is explained in the Methods section. Using incidence rates allows direct comparison of risk in different groups.

- Table 2.3.1 shows AIDS case rates by race/ethnicity and sex. The overall rate of AIDS in Connecticut in 2000 was 15.3 newly diagnosed cases per 100,000 population. The rate was highest in blacks (55.5/100,000) and Hispanics (48.7/100,000). There are differences by sex, with male rates highest in all race categories. It is noteworthy that, although the highest number of cases is in white males (n=124), the risk of AIDS, as evidenced by the higher rate, is higher in both black and Hispanic males and females.

- Differences in rates are also shown in Figure 2.3.2. The incidence of AIDS in 2000 is compared for various sex and race/ethnicity groups by age group. AIDS incidence is highest in Hispanic and black males in the 40-49 years age group (200-250/100,000). Among females, incidence in 2000 was highest in blacks and Hispanics in the 30-49 age groups (100-150/100,000). In contrast to the dramatic difference in incidence between males and females in the older age groups, incidence in the 30-39 age group is only slightly higher in black and Hispanic males compared to females. Incidence in white males and females is very low in all age groups (<25/100,000).

Figure 2.3.1: Trends in AIDS Cases, by Year of Diagnosis and Report, Connecticut, 1990-2002.

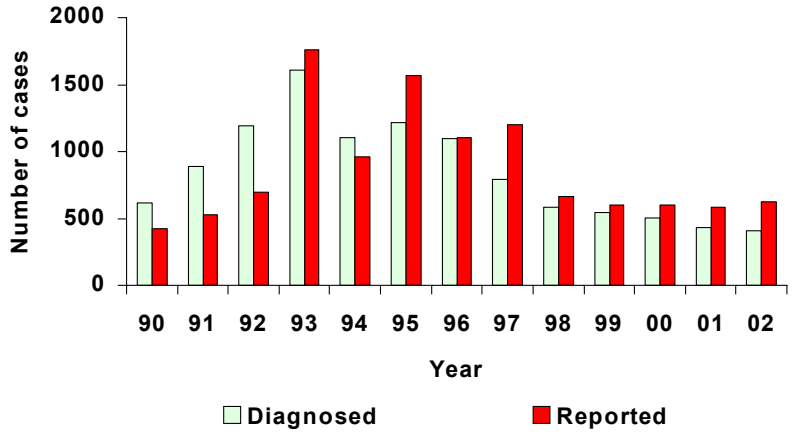
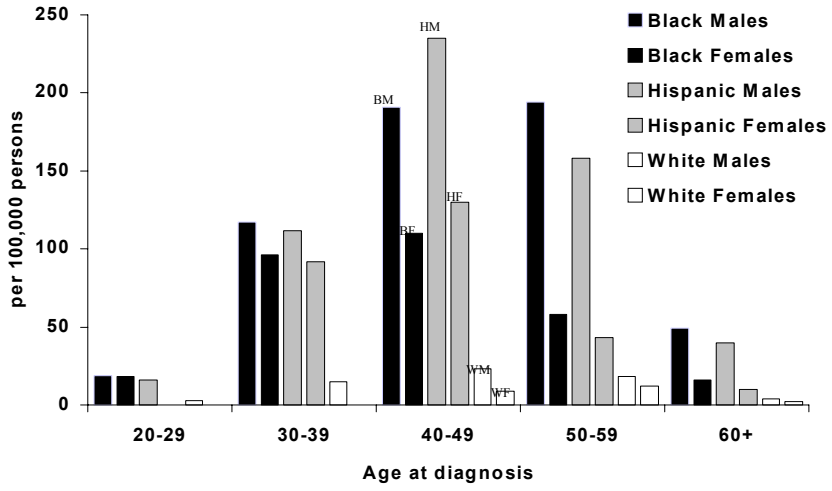


Table 2.3.1: AIDS Diagnosis and Rates per 100,000 Population, by Race and Sex, Connecticut, 2000.

	Males			Females			Total		
Race/ethnicity	N	%	Rate	N	%	Rate	N	%	Rate
White (non-Hispanic)	124	39%	9.4	64	34%	4.9	188	37%	7.1
Black (non-Hispanic)	97	30%	65.6	67	35%	45.3	164	32%	55.5
Hispanic	98	31%	61.2	58	31%	36.2	156	31%	48.7
Asian/OPI[1]	2	1%	4.9	0	0%	0.0	2	0%	0.6
AI/AN[2]	0	0%	0.0	0	0%	0.0	0	0%	0.0
Total	321	100%	19.2	189	100%	11.3	510	100%	15.3

[1]Other Pacific Islanders.
[2]American Indians and Alaskan Natives

Figure 2.3.2: AIDS Incidence by Sex, Race/Ethnicity, and Age at Diagnosis (per 100,000), Connecticut, 2000.



2.5 People Living with AIDS (Prevalence)

- It is estimated that 16,200 to 18,000 people with HIV infection (AIDS and non-AIDS) are living in Connecticut (Table 2.5.1). There are 6,498 people reported to be living with AIDS (PLWA) who were residents of Connecticut at the time of diagnosis. Of these, 5,995 are not known to have moved out of Connecticut. A total of 69.4% are male, 30.6% are female. Approximately one-third are white (34.3%), black (36.2%) and Hispanic (29.0%). Nearly half, 49.2%, are associated with IDU risk, 17.9% with MSM and 19.5% with heterosexual risk (Table 2.5.2).

- Less than 5% of the persons living with AIDS are less than 30 years of age, 25% are 30-39, approximately half of PLWA are 40-49, and 25% are 50+ years (Table 2.5.3). None of the cities shown in Table 2.5.2 have appreciable numbers of PLWA under the age of 30.

- Most, 82.5%, PLWA live in the 15 largest cities in Connecticut, with 17.5% living in all other towns (Table 2.5.2). Two cities, Hartford and New Haven, have over 1,000 PLWA. The most populous city, Bridgeport, has 678 PLWA.

- In several cities, over 50% of PLWA are IDU: Hartford (62.7%), Windham (56.2%), Waterbury (54.4%), New Haven (53.8%), and Bridgeport (50.7%).

- Notably, MSM is highest in the aggregate analysis of smaller towns not specifically listed (35.5% of cases). Also, in the smaller towns, 74.1% of PLWA are white and 30.8% are 50+ years of age (25.1% of PLWA overall are 50+) (Tables 2.5.2 and 2.5.3).

    - Figure 2.5.2 shows a comparison of racial/ethnicity gender groups by age group per 100,000 population. The highest prevalence is in blacks and Hispanic males ranging from 500 to over 3,000 per 100,000 depending on age group.

Figure 2.5.1: AIDS Prevalence (PLWA) by Sex, Race/Ethnicity, and Age at Diagnosis (per 100,000), Connecticut, 2002.

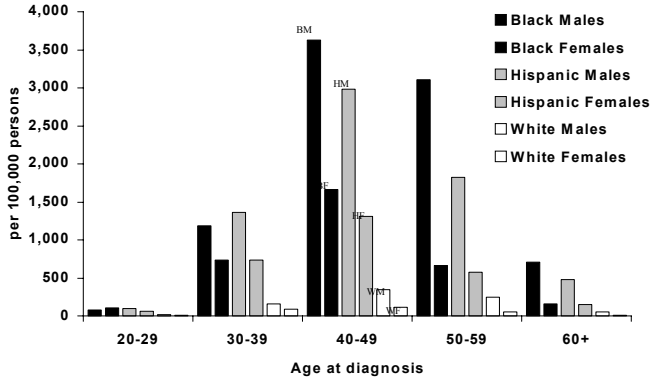


Table 2.5.1: Estimated[1] Number of People Living with HIV Infection,[2] Connecticut, 2000.

At the end of 2000, the estimated number of people infected with HIV in the United States (HIV and AIDS)[3]:	850,000 – 950,000	
At the end of 2000, the reported number of people living with AIDS in the United States[3]:	323,000	
At the end of 2000, the reported number of people living with AIDS in Connecticut[4]:	6,100	
Percentage of people in the U.S. living with AIDS that are in Connecticut:	(6,100/323,000) X 100 =	1.9%
Estimate of the number of people living with HIV infection in Connecticut:	Lower limit: 1.9% X 850,000 =	16,200
	Upper limit: 1.9% X 950,000 =	18,000

[1]Estimated as recommended by *Integrated Guidelines for Developing Epidemiologic Profiles*. CDC. Draft. 2003.

[2]HIV infection includes persons with HIV and AIDS, reported and not reported.

[3]CDC. HIV/AIDS Surveillance Report 2000: 12: 1-48.

[4]Table 2.1.1.

Table 2.5.2: People Living with AIDS (PLWA; Prevalent Cases[1]) by City of Residence at Diagnosis, Risk Group, Race, and Sex, Connecticut, 2002.

		Sex		Race/Ethnicity				Risk Group					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk	Pedi
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
BRIDGEPORT	678	65.6	34.4	21.1	42.3	36.3	0.3	11.9	50.7	2.7	20.6	13.0	1.0
DANBURY	110	76.4	23.6	54.5	23.6	20.9	0.9	22.7	39.1	2.7	23.6	10.9	0.9
EAST HARTFORD	82	65.9	34.1	40.2	35.4	24.4	--	18.3	43.9	2.4	28.0	7.3	--
HARTFORD	1,318	70.6	29.4	14.6	37.8	47.3	0.3	10.5	62.7	2.9	15.6	7.0	1.3
MERIDEN	96	70.8	29.2	29.2	18.8	52.1	--	24.0	40.6	3.1	25.0	6.3	1.0
MIDDLETOWN	70	71.4	28.6	50.0	32.9	17.1	--	17.1	40.0	2.9	22.9	17.1	--
NEW BRITAIN	184	72.3	27.7	33.7	14.1	52.2	--	20.1	49.5	0.5	20.1	9.2	0.5
NEW HAVEN	1,063	66.2	33.8	23.6	55.2	20.9	0.3	13.8	53.8	2.8	19.3	7.8	2.4
NEW LONDON	138	63.8	36.2	31.2	34.1	32.6	2.2	14.5	49.3	3.6	23.2	8.0	1.4
NORWALK	218	69.7	30.3	43.1	43.1	12.8	0.9	21.1	40.4	1.4	24.3	11.0	1.8
NORWICH	66	54.5	45.5	60.6	28.8	10.6	--	15.2	42.4	1.5	27.3	13.6	--
STAMFORD	356	69.9	30.1	29.2	53.4	16.3	1.1	21.9	37.9	1.4	21.9	14.3	2.5
WATERBURY	397	62.7	37.3	30.7	31.2	37.8	0.3	11.8	54.4	2.3	21.2	8.6	1.8
WEST HAVEN	98	61.2	38.8	41.8	41.8	16.3	--	14.3	42.9	1.0	24.5	15.3	2.0
WINDHAM	73	60.3	39.7	38.4	16.4	45.2	--	8.2	56.2	2.7	19.2	12.3	1.4
All Other Towns	1,048	77.7	22.3	74.1	14.3	10.6	1.0	35.6	33.6	2.5	18.0	9.5	0.8
Total	5,995	69.4	30.6	34.3	36.2	29.0	0.5	17.9	49.2	2.5	19.5	9.5	1.4

Chapter 5 [1]Includes only cases non known to be dead, and not known to be currently living outside of Connecticut

Table 2.5.3: People Living with AIDS (PLWA; Prevalent Cases[1]) by City of Residence at Diagnosis and Current Age, Connecticut, 2002.

		Age as of December 31, 2002					
		0-12	13-19	20-29	30-39	40-49	50+
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
BRIDGEPORT	678	0.4	0.6	2.2	25.7	49.6	21.5
DANBURY	110	0.9	--	0.9	26.4	46.4	25.5
EAST HARTFORD	82	--	--	2.4	32.9	45.1	19.5
HARTFORD	1,318	0.7	0.7	1.6	28.7	45.8	22.5
MERIDEN	96	1.0	--	4.2	24.0	46.9	24.0
MIDDLETOWN	70	--	--	--	11.4	70.0	18.6
NEW BRITAIN	184	--	0.5	4.3	28.8	43.5	22.8
NEW HAVEN	1,063	1.4	0.9	2.2	24.6	45.2	25.7
NEW LONDON	138	--	1.4	2.2	21.7	52.2	22.5
NORWALK	218	0.5	1.4	3.7	23.9	40.4	30.3
NORWICH	66	--	--	1.5	30.3	53.0	15.2
STAMFORD	356	1.1	1.4	2.2	22.5	47.5	25.3
WATERBURY	397	0.8	0.8	2.0	25.7	46.1	24.7
WEST HAVEN	98	--	1.0	2.0	27.6	35.7	33.7
WINDHAM	73	--	--	4.1	26.0	52.1	17.8
All Other Towns	1,048	0.3	0.2	1.5	22.2	44.9	30.8
Total	5,995	0.7	0.7	2.1	25.3	46.3	25.1

[1]Includes only cases not known to be dead, and not known to be currently living outside of Connecticut

2.6 HIV Surveillance

- HIV infection in adults was made reportable in January 2002. The reader should realize that because these data are from one year of surveillance activities, one or two additional years of data will be necessary to draw firmer conclusions and establish trends.

- In the first year of reporting, 374 cases of HIV infection in adults were reported. Note, that many additional cases of HIV infection were reported that were subsequently determined to have AIDS. The 374 cases reported in 2002 represent the number of HIV cases not known to meet the AIDS case definition at the end of 2002.

- Of the 374 HIV cases reported in 2002:

    - 56.7% were male and 43.3% were female. Although the number of cases reported was small, the percentage of females was higher than males in two of the larger cities: Norwalk (n = 9 reported cases; 66.7% female) and Waterbury (n = 21; 57.1% female);

    - 31.0% were white, 27.5% were black, and 40.4% were Hispanic. Black was the majority in Norwalk (n=9; 55.6% black) and Hispanic was highest in Hartford (n=95; 55.8% Hispanic), New Britain (n=24; 66.7% Hispanic), and Waterbury (n=21; 52.4% Hispanic);

    - Only one case of HIV was reported in the 13-19 age group with 25.1% of HIV cases in the 20-29 age group. This varied by race/ethnicity and sex with 13.7% of white males, 26% of black males and 25.3% of Hispanic male cases in the 20-29 age group. Hispanic males are more likely to be younger then white or black males, but this did not hold for Hispanic females;

    - 95 (25.4%) were residents of Hartford, 54 (14.4%) from New Haven, and 53 (14.2%) from Bridgeport;

    - Little can be concluded about risk group because of the high proportion of cases with “risk not reported;”

    - Comparison of HIV and AIDS: HIV cases reported in 2002 are compared with AIDS cases reported in 2002 in Table 2.6.4. HIV cases were more likely to be female (43.3% vs. 30.5%), Hispanic (40.4% vs. 32.1%), and younger (25.1% 20-29 vs. 7% and 7.5% 50+ vs. 16.9%).

Table 2.6.1: HIV[1] (not AIDS) Cases by City of Residence at Diagnosis, Risk Group, Race, and Sex, Connecticut, 2002.

		Sex		Race/Ethnicity				Risk Group					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk	Pedi
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
BRIDGEPORT	53	56.6	43.4	20.8	34.0	45.3	--	7.5	28.3	3.8	11.3	49.1	--
HARTFORD	95	57.9	42.1	18.9	25.3	55.8	--	6.3	44.2	--	6.3	43.2	--
NEW BRITAIN	24	70.8	29.2	25.0	8.3	66.7	--	--	33.3	--	16.7	50.0	--
NEW HAVEN	54	53.7	46.3	38.9	37.0	20.4	3.7	13.0	33.3	1.9	7.4	44.4	--
NORWALK	9	33.3	66.7	--	55.6	33.3	11.1	--	22.2	--	11.1	66.7	--
STAMFORD	13	61.5	38.5	38.5	30.8	30.8	--	30.8	30.8	--	15.4	23.1	--
WATERBURY	21	42.9	57.1	33.3	14.3	52.4	--	--	38.1	--	14.3	47.6	--
All Other Towns	105	58.1	41.9	45.7	25.7	27.6	1.0	18.1	16.2	1.0	8.6	55.2	1.0
Total	374	56.7	43.3	31.0	27.5	40.4	1.1	10.7	30.5	1.1	9.4	48.1	0.3

[1]HIV became a reportable disease in Connecticut on January 1, 2002.

Table 2.6.2: Comparison of HIV and AIDS Cases by Sex, Race Age Group, and Risk Group, Connecticut, 2002.

	2002 HIV[1,2]	2002 AIDS	Total AIDS
Sex			
Male	56.7	69.5	73.4
Female	43.3	30.5	26.6
Race/ethnicity			
White	31.0	40.7	36.8
Black	27.5	26.8	37.9
Hispanic	40.4	32.1	24.8
Other race[3]	1.1	0.3	0.2
Age group[4]			
0-12 years	0.3	0.5	1.4
13-19	0.3	0	0.4
20-29	25.1	7.0	13.5
30-39	38.0	34.5	44.8
40-49	28.9	41.1	28.9
50 and over	7.5	16.9	11.0
Risk Group			
MSM	10.7	15.5	22.4
IDU	30.5	35.3	48.7
MSM/IDU	1.1	0.8	3.4
Hetero	9.4	12.6	16.8
Other/risk not reported	48.1	35.3	6.2
Number of reported cases	374	626	12,783

[1]Persons with HIV infection who have not developed AIDS.

[2]HIV infection became a reportable disease in Connecticut on January 1, 2002.

[3]"Other" race combines the Asian, American Indian, Other and Unknown Race categories.

[4]Age when the case was reported to DPH.

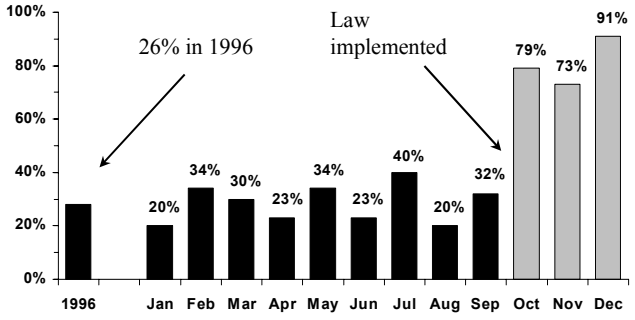
2.7 HIV in Children

- HIV infection in children (<13 years of age) has been reportable since 1993. Each case of HIV infection or exposure at birth is followed-up by DPH staff to collect detailed case information about the mother and child, and potential barriers to prevention. Table 2.7.1 shows a trend in the number of HIV exposures at childbirth and the proportion of children who are infected.

- Nationally, and in Connecticut, the rate of perinatal HIV infection has decreased by over 80% since 1993. This is due to prenatal HIV testing of pregnant women, the appropriate use of antiretroviral treatment, obstetric procedures designed to limit newborn exposure to blood during delivery, and instruction against breastfeeding.

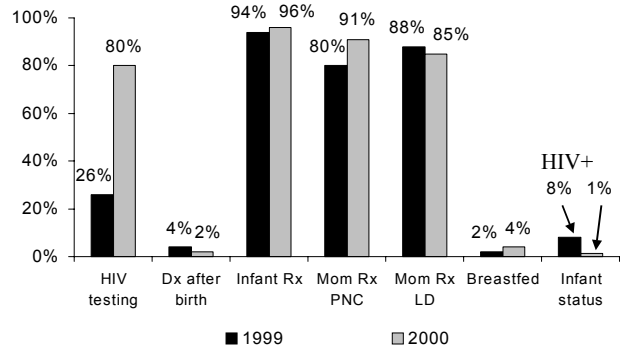
- In Connecticut, legislation was implemented in October 1999 mandating maternal HIV status be known at delivery, either through testing the mother during prenatal care or labor, or the newborn. Figure 2.7.1 shows the trend in the rate of HIV testing in pregnant women during this time. Figure 2.7.2 shows a comparison of selected outcome measures of perinatal HIV prevention in 1999 and 2000.

Figure 2.7.1: Audit of Medical Records
Percentage of Pregnant Women HIV Tested,
Connecticut, 1996 and 1999



1999

Figure 2.7.2: Enhanced Perinatal HIV Surveillance
HIV Exposures During First Nine Months of
1999 and 2000, Connecticut



- Since 1981, 286 children (<13 years of age) have been reported with HIV or AIDS. Of these, 97.2% have been due to perinatal exposure, 2.1% were hemophilia or transfusion, and 0.7% are unknown. Since 1995, 100% of pediatric HIV infections have been due to perinatal exposure.

- Since 1995, 521 perinatal HIV exposures have been reported (average 65 per year) with 23 (4.4%) HIV infections, 413 (79.3%) HIV negatives confirmed, 59 (11.3%) pending, and 26 (5.0%) unknown. Of these 521 cases of perinatal exposure, 106 (20.3%) were white, 247 (47.4%) were black, 166 (31.9%) were Hispanic, and 2 (0.4%) were unknown or other.

Section 3: Community Planning Group Regions

- There are seven CPG regions in Connecticut; six are regional based on one or more counties and one is composed of Department of Corrections (DOC) facilities (Figure 3.1).

- Tables 3.1 – 3.5 compare CPG regions by cumulative AIDS cases, HIV cases, and PLWA. Trends in each CPG region are shown in subsequent sections.

    - The majority (79.0%) of reported AIDS cases come from three CPG regions: North-Central, South-Central and South-West. CPG regions with higher numbers of cases are more likely to have higher proportions of blacks and Hispanics in their populations.
    - Except for one, IDU is the predominant risk group in all CPG regions (84.8% to 38.1%). The exception is the North-West region which, of 182 total cases reported, 52.7% are MSM and 17.6% IDU. This region also has the highest level of "no risk reported" (15.4%) and the highest percentage of cases that are 50+ years of age at diagnosis (24.2%). The DOC region has the highest percentage of IDU and lowest percentage of MSM.
    - Four CPG regions have over 1,000 PLWA: Department of Corrections, North-Central, South-Central, and South-West. The remaining regions include only 479 (7.7%) adults known to be living with AIDS.
    - The number of HIV cases is too small to form definite conclusions about the distribution of cases except to say that a large majority of cases are in the same three regions as AIDS cases: North-Central, South-Central and South-West.

Figure 3.1: Community Planning Regions, Connecticut, 2002.

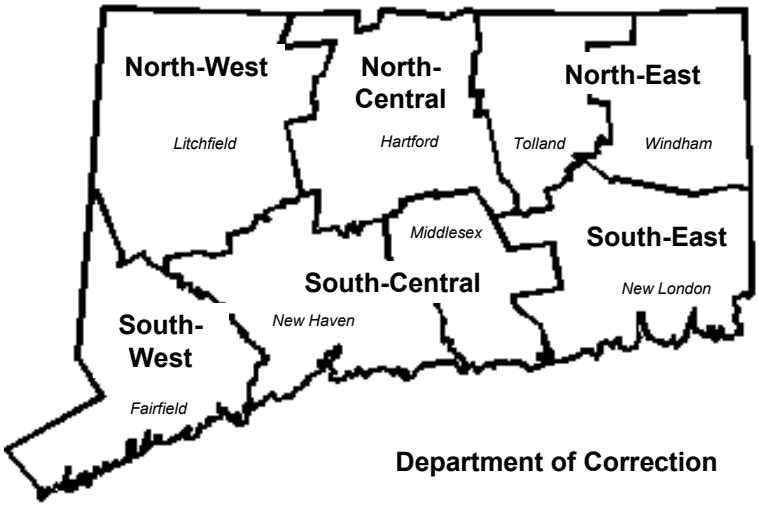


Table 3.1: Cumulative AIDS Cases by CPG Region at Diagnosis, Risk Group, Race, and Sex, Connecticut, 1980-2002.

		Sex		Race/Ethnicity				Risk Group					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk	Pedi
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
REGION													
Dept of Correction	1,647	81.5	18.5	18.8	47.2	33.7	0.2	2.1	84.8	4.1	4.1	4.8	0.1
North-Central	3,423	74.1	25.9	32.5	34.1	32.9	0.4	24.2	48.1	3.5	17.3	5.5	1.4
North-East	290	74.8	25.2	63.1	14.8	21.4	0.7	28.3	40.3	3.8	17.9	9.0	0.7
North-West	182	87.9	12.1	87.4	6.6	4.9	1.1	52.7	17.6	3.3	11.0	15.4	--
South-Central	3,796	69.5	30.5	38.4	42.0	19.3	0.4	22.8	44.9	3.5	19.6	7.2	2.1
South-East	584	70.7	29.3	56.2	26.9	15.9	1.0	29.3	40.4	2.4	18.3	8.6	1.0
South-West	2,860	72.5	27.5	40.5	38.4	20.5	0.6	27.5	38.1	2.9	19.7	9.8	2.0
Total	12,782	73.4	26.6	36.8	37.9	24.8	0.5	22.4	48.7	3.4	16.8	7.2	1.5

Table 3.2: AIDS Cases by CPG Region and Age at Diagnosis with AIDS, Connecticut, 1980-2002.

		Age when diagnosed with AIDS					
		0-12	13-19	20-29	30-39	40-49	50+
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
REGION							
Dept of Correction	1,647	--	0.3	15.3	53.4	27.6	3.4
North-Central	3,423	1.3	0.4	13.2	42.7	29.3	13.0
North-East	290	0.3	0.7	12.8	48.3	27.9	10.0
North-West	182	--	--	9.9	34.1	31.9	24.2
South-Central	3,795	1.9	0.5	13.6	44.5	28.6	11.0
South-East	584	0.9	0.7	14.2	43.7	31.3	9.2
South-West	2,860	1.9	0.3	12.7	43.5	29.2	12.5
Total	12,781	1.4	0.4	13.5	44.8	28.9	11.0

Table 3.3: HIV (not AIDS)[1] by CPG Region at Diagnosis, Risk Group, Race, and Sex, Connecticut, 2002.

		Sex		Race/Ethnicity				Risk Group					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk	Pedi
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
REGION													
Dept of Correction	40	57.5	42.5	12.5	45.0	40.0	2.5	2.5	67.5	--	2.5	27.5	--
North-Central	133	58.6	41.4	22.6	24.8	52.6	--	7.5	33.8	--	9.0	49.6	--
North-East	8	62.5	37.5	50.0	12.5	37.5	--	37.5	37.5	--	--	25.0	--
North-West	5	40.0	60.0	100.0	--	--	--	40.0	--	--	20.0	40.0	--
South-Central	100	54.0	46.0	45.0	23.0	30.0	2.0	12.0	22.0	2.0	10.0	53.0	1.0
South-East	8	37.5	62.5	37.5	37.5	25.0	--	12.5	--	--	12.5	75.0	--
South-West	80	58.8	41.3	30.0	31.3	37.5	1.3	13.8	21.3	2.5	12.5	50.0	--
Total	374	56.7	43.3	31.0	27.5	40.4	1.1	10.7	30.5	1.1	9.4	48.1	0.3

Table 3.4: Adults Living with AIDS (PLWA: Prevalent Cases) by CPG Region at Diagnosis, Risk Group, Race, and Sex, Connecticut, 1980-2002.

		Sex		Race/Ethnicity				Risk Group				
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
REGION												
Dept of Correction	1,088	80.4	19.6	19.2	46.2	34.5	0.1	1.8	83.0	3.5	4.8	6.9
North-Central	1,560	69.0	31.0	31.1	31.1	37.3	0.5	20.8	47.2	2.3	22.1	7.6
North-East	148	70.3	29.7	64.2	12.8	22.3	0.7	25.7	41.2	1.4	18.9	12.8
North-West	79	84.8	15.2	86.1	6.3	6.3	1.3	38.0	22.8	5.1	13.9	20.3
South-Central	1,750	65.0	35.0	40.0	36.6	23.1	0.2	21.3	42.5	2.5	23.7	10.2
South-East	252	61.9	38.1	56.3	23.4	18.3	2.0	26.6	37.3	2.4	24.6	9.1
South-West	1,311	69.4	30.6	41.0	35.5	22.7	0.8	25.9	34.9	2.2	24.3	12.7
Total	6,188	69.9	30.1	36.1	35.2	28.2	0.5	19.2	48.7	2.6	19.9	9.6

Table 3.5: Adults Living with AIDS (PLWA: Prevalent Cases) by CPG Region at Diagnosis and Current Age, Connecticut, 1980-2002.

		Age as of December 31, 2002				
		13-19	20-29	30-39	40-49	50+
	Total	% of Total	% of Total	% of Total	% of Total	% of Total
REGION						
Dept of Correction	1,092	--	1.6	30.3	52.2	15.8
North-Central	1,565	0.1	2.0	27.2	43.5	27.3
North-East	150	--	2.0	26.0	47.3	24.7
North-West	81	--	--	18.5	40.7	40.7
South-Central	1,769	--	1.9	23.8	45.6	28.7
South-East	253	--	2.4	24.9	52.6	20.2
South-West	1,321	--	2.3	23.2	46.7	27.8
Total	6,231	0.0	2.0	25.7	46.7	25.6

3.1 CPG Region: Department of Correction

- 40 HIV cases reported in 2002.
- 1,088 adults living with AIDS at the end of 2002.
- 1,647 AIDS cases have been reported from DOC since 1980.
    - In the last five years (1997-2002), 44-92 cases have been reported each year.
        - Over 80% male;
        - 15-30% white;
        - 35-55% black;
        - 25-45% Hispanic;
        - 60-90% IDU.

Figure 3.1.1: CPG REGION: Department of Correction: Cumulative AIDS Cases, by Sex, Race, and Risk Group, Connecticut, 2002.

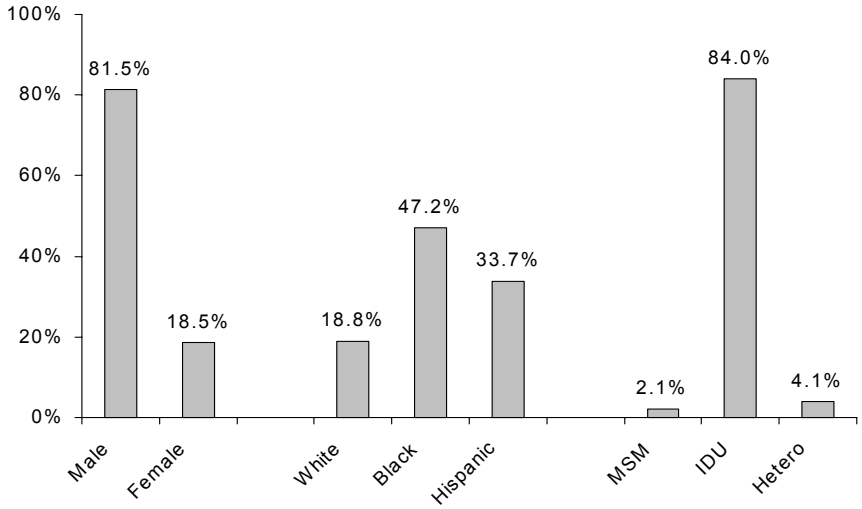


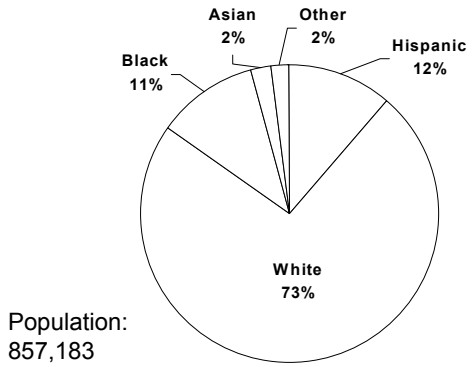
Table 3.1.1: CPG REGION: Department of Correction – Trends in AIDS Cases by Year of Report, Sex, Race, and Risk Group, Connecticut, 1980-2002.

		Sex		Race/Ethnicity				Risk Group					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk	Pedi
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
1980-92	188	83.5	16.5	13.8	50.5	34.0	1.6	2.7	83.5	9.6	3.2	1.1	--
1993	262	79.8	20.2	21.8	46.6	31.3	0.4	0.8	93.5	4.2	1.1	0.4	--
1994	153	83.7	16.3	23.5	41.8	34.6	--	3.3	83.7	6.5	5.9	0.7	--
1995	271	80.4	19.6	17.0	49.4	33.6	--	2.2	90.0	3.7	3.0	1.1	--
1996	244	82.0	18.0	17.2	49.2	33.6	--	0.8	88.5	2.0	6.6	2.0	--
1997	139	83.5	16.5	13.7	49.6	36.7	--	0.7	87.8	4.3	6.5	0.7	--
1998	121	82.6	17.4	18.2	55.4	26.4	--	3.3	65.3	3.3	9.1	19.0	--
1999	92	79.3	20.7	22.8	38.0	39.1	--	4.3	79.3	2.2	1.1	10.9	2.2
2000	63	79.4	20.6	15.9	47.6	36.5	--	1.6	61.9	3.2	6.3	27.0	--
2001	70	75.7	24.3	32.9	37.1	30.0	--	5.7	75.7	--	1.4	17.1	--
2002	44	88.6	11.4	18.2	36.4	45.5	--	--	90.9	--	--	9.1	--
Total	1,647	81.5	18.5	18.8	47.2	33.7	0.2	2.1	84.8	4.1	4.1	4.8	0.1

3.2 CPG Region: North-Central

- North-Central Region: Hartford County, 25.2% of Connecticut's population.
- 133 HIV cases reported in 2002.
- 1,560 adults living with AIDS at the end of 2002.
- 3,423 AIDS cases have been reported since 1980.
    - In the past five years (1998-2002), 140-188 cases were reported each year.
        - 60-70% male;
        - 30-35% white;
        - 20-35% black;
        - 35-45% Hispanic;
        - 15-20% MSM;
        - 40-50% IDU;
        - 15-30% heterosexual

Figure 3.2.1: CPG Region: North-Central: Population by Race/Ethnicity, 2000.



Population: 857,183

Figure 3.2.2: CPG REGION: North-Central: Cumulative AIDS Cases, by Sex, Race, and Risk Group, Connecticut, 2002.

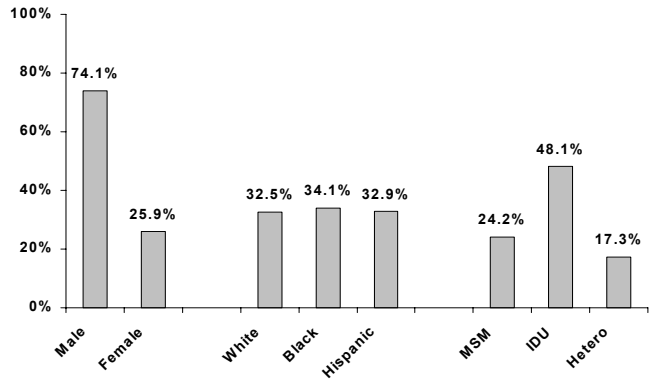


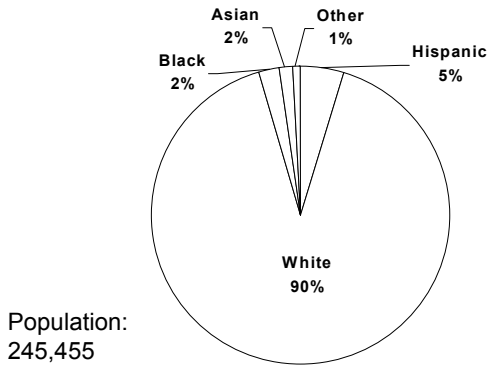
Table 3.2.1: CPG REGION: North-Central – Trends in AIDS Cases by Year of Report, Sex, Race, and Risk Group, Connecticut, 1980-2002.

		Sex		Race/Ethnicity				Risk Group					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk	Pedi
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
1980-92	785	81.7	18.3	40.4	35.5	23.8	0.3	36.6	42.5	5.7	10.7	2.4	2.0
1993	496	78.6	21.4	28.6	36.9	33.5	1.0	25.8	54.2	4.8	13.9	1.0	0.2
1994	286	72.4	27.6	31.5	37.1	31.5	--	24.5	49.0	3.5	16.8	1.7	4.5
1995	395	76.2	23.8	27.1	35.7	36.5	0.8	20.8	52.4	2.8	18.0	4.1	2.0
1996	245	68.2	31.8	28.2	36.3	35.1	0.4	18.8	46.1	4.5	22.0	6.1	2.4
1997	377	71.4	28.6	27.9	39.0	32.9	0.3	21.8	55.7	2.7	19.6	0.3	--
1998	183	65.0	35.0	32.8	29.5	37.2	0.5	15.3	51.4	2.2	29.0	2.2	--
1999	140	70.0	30.0	32.1	35.7	32.1	--	20.7	39.3	--	27.1	11.4	1.4
2000	188	62.8	37.2	30.9	27.1	42.0	--	11.2	48.9	1.1	26.1	12.8	--
2001	155	64.5	35.5	36.8	19.4	43.2	0.6	17.4	42.6	1.3	16.1	22.6	--
2002	173	72.8	27.2	37.0	21.4	41.0	0.6	16.2	38.7	0.6	16.2	27.7	0.6
Total	3,423	74.1	25.9	32.5	34.1	32.9	0.4	24.2	48.1	3.5	17.3	5.5	1.4

3.3 CPG Region: North-East

- North-East Region: Tolland and Windham Counties. 7.2% of Connecticut's population.
- 8 HIV cases reported in 2002.
- 148 adults living with AIDS at the end of 2002.
- 290 AIDS cases have been reported since 1980.
    - In the past five years (1998-2002), 10-20 AIDS cases were reported each year.
        - 60-85% male;
        - 50-100% white;
        - 0-15% black;
        - 0-35% Hispanic;
        - 5-40% MSM;
        - 25-50% IDU;
        - 10-35% Heterosexual

Figure 3.3.1: CPG Region: North-East: Population by Race/Ethnicity, 2000.



Population: 245,455

Figure 3.3.2: CPG REGION: North-East: Cumulative AIDS Cases, by Sex, Race, and Risk Group, Connecticut, 2002.

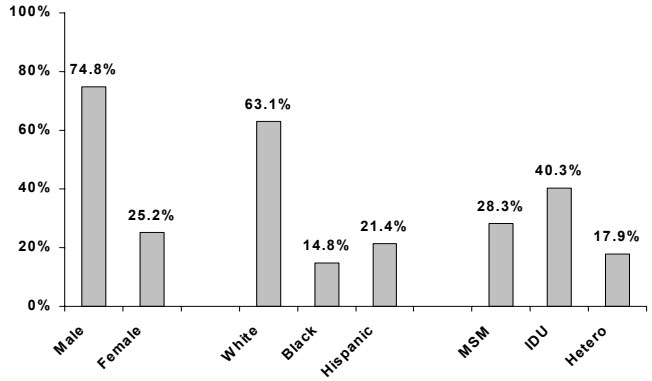


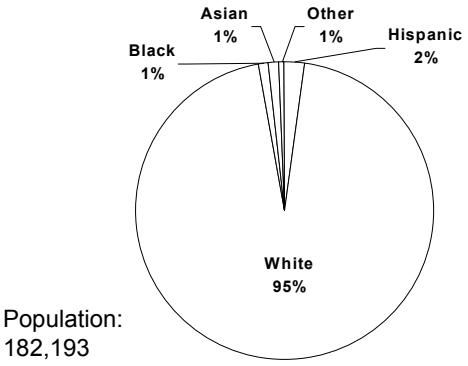
Table 3.3.1: CPG REGION: North-East – Trends in AIDS Cases by Year of Report, Sex, Race, and Risk Group, Connecticut, 1980-2002.

		Sex		Race/Ethnicity				Risk Group					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk	Pedi
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
1980-92	59	86.4	13.6	62.7	18.6	18.6	--	44.1	33.9	6.8	15.3	--	--
1993	34	85.3	14.7	70.6	14.7	14.7	--	23.5	44.1	5.9	11.8	14.7	--
1994	20	85.0	15.0	45.0	15.0	40.0	--	25.0	55.0	5.0	10.0	5.0	--
1995	38	71.1	28.9	60.5	23.7	13.2	2.6	31.6	36.8	5.3	18.4	5.3	2.6
1996	22	68.2	31.8	54.5	9.1	31.8	4.5	36.4	27.3	--	22.7	13.6	--
1997	35	62.9	37.1	62.9	22.9	14.3	--	20.0	54.3	2.9	17.1	5.7	--
1998	18	83.3	16.7	61.1	5.6	33.3	--	38.9	27.8	--	33.3	--	--
1999	21	57.1	42.9	52.4	14.3	33.3	--	4.8	38.1	4.8	33.3	14.3	4.8
2000	14	64.3	35.7	71.4	--	28.6	--	21.4	50.0	--	21.4	7.1	--
2001	10	70.0	30.0	100.0	--	--	--	30.0	50.0	--	10.0	10.0	--
2002	19	68.4	31.6	73.7	5.3	21.1	--	10.5	36.8	--	10.5	42.1	--
Total	290	74.8	25.2	63.1	14.8	21.4	0.7	28.3	40.3	3.8	17.9	9.0	0.7

3.4 CPG Region: North-West

- North-West Region: Litchfield County, 5.3% of Connecticut's population.
- 5 HIV cases were reported in 2002.
- 79 adults living with AIDS at the end of 2002.
- 182 AIDS cases have been reported since 1980.
    - In the past five years (1998-2002), 4-11 cases have been reported each year;
        - 55-100% male;
        - 50-100% white;
        - 0-50% black;
        - 0-15% Hispanic;
        - 10-50% MSM;
        - 15-45% IDU;
        - 0-20% heterosexual.

Figure 3.4.1: CPG Region: North-West: Population by Race/Ethnicity, 2000.



Population: 182,193

Figure 3.4.2: CPG REGION: North-West: Cumulative AIDS Cases, by Sex, Race, and Risk Group, Connecticut, 2002.

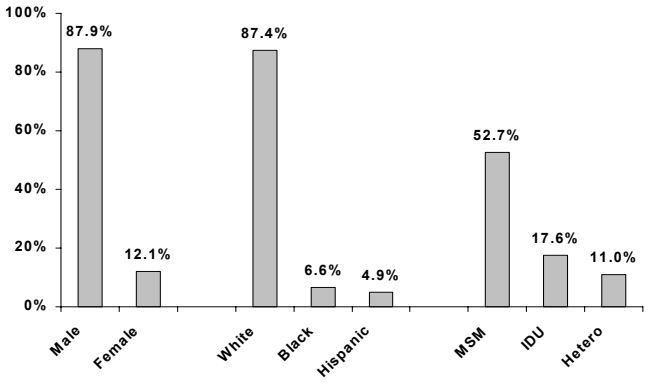


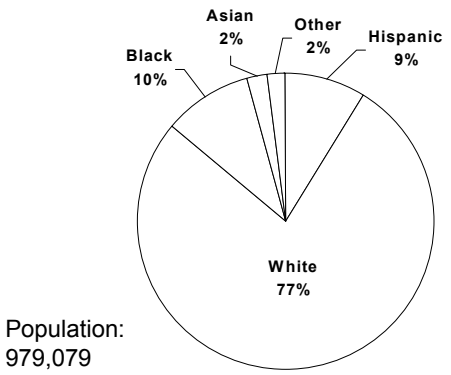
Table 3.4.1: CPG REGION: North-West – Trends in AIDS Cases by Year of Report, Sex, Race, and Risk Group, Connecticut, 1980-2002.

		Sex		Race/Ethnicity				Risk Group				
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
1980-92	54	90.7	9.3	85.2	7.4	5.6	1.9	68.5	7.4	3.7	13.0	7.4
1993	10	100.	--	90.0	--	10.0	--	60.0	30.0	--	10.0	--
1994	9	100.	--	88.9	--	--	11.1	77.8	22.2	--	--	--
1995	32	90.6	9.4	93.8	3.1	3.1	--	65.6	9.4	6.3	9.4	9.4
1996	25	76.0	24.0	88.0	--	12.0	--	44.0	12.0	4.0	20.0	20.0
1997	13	92.3	7.7	76.9	23.1	--	--	38.5	30.8	7.7	--	23.1
1998	6	83.3	16.7	50.0	50.0	--	--	50.0	33.3	--	--	16.7
1999	4	100.	--	100.0	--	--	--	25.0	25.0	--	--	50.0
2000	11	81.8	18.2	100.0	--	--	--	9.1	45.5	--	18.2	27.3
2001	7	57.1	42.9	85.7	--	14.3	--	28.6	14.3	--	14.3	42.9
2002	11	90.9	9.1	90.9	9.1	--	--	18.2	36.4	--	9.1	36.4
Total	182	87.9	12.1	87.4	6.6	4.9	1.1	52.7	17.6	3.3	11.0	15.4

3.5 CPG Region: South-Central

- South-Central Region: New Haven and Middlesex Counties, 26.8% of Connecticut's population.
- 100 HIV cases reported in 2002.
- 1,750 adults living with AIDS at the end of 2002.
- 3,796 cases have been reported since 1980.
    - In the past five years (1998-2002), 170-220 cases have been reported each year;
        - 55-65% male;
        - 35-50% white;
        - 25-35% black;
        - 25% Hispanic;
        - 15-20% MSM;
        - 30-45% IDU;
        - 15-30% heterosexual

Figure 3.5.1: CPG Region: South-Central: Population by Race/Ethnicity, 2000.



Population: 979,079

Other: American Indians and Alaskan Natives, Native Hawaiians and Other Pacific Islanders, Other race, and two or more races

Figure 3.5.2: CPG REGION: South-Central: Cumulative AIDS Cases, by Sex, Race, and Risk Group, Connecticut, 2002.

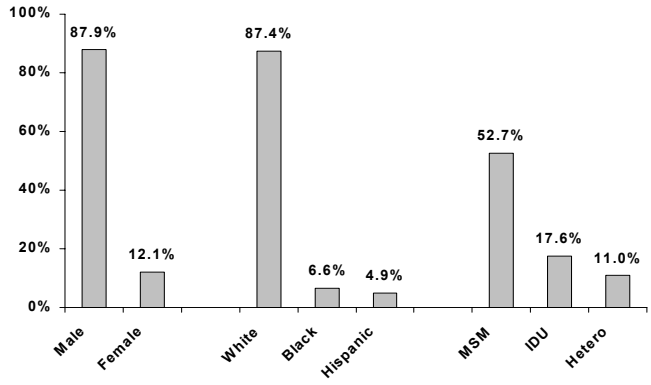


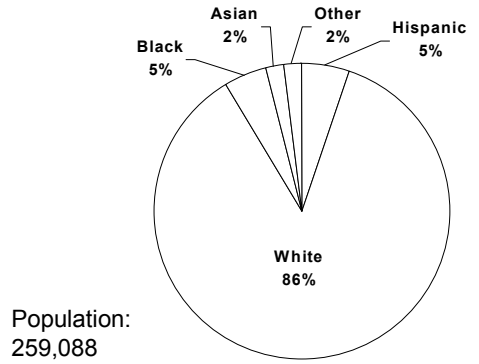
Table 3.5.1: CPG REGION: South-Central – Trends in AIDS Cases by Year of Report, Sex, Race, and Risk Group, Connecticut, 1980-2002.

		Sex		Race/Ethnicity				Risk Group					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk	Pedi
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
1980-92	1,046	76.0	24.0	40.2	45.4	14.1	0.3	30.7	43.4	4.7	12.9	4.4	3.9
1993	540	68.3	31.7	33.9	47.2	17.8	1.1	20.0	53.0	4.4	19.3	1.1	2.2
1994	237	72.6	27.4	33.8	48.9	16.0	1.3	25.7	45.6	1.7	21.9	2.1	3.0
1995	393	71.2	28.8	34.6	42.0	23.4	--	22.9	51.4	2.8	19.3	2.5	1.0
1996	292	66.8	33.2	40.1	41.8	17.8	0.3	20.5	40.4	3.8	27.4	5.5	2.4
1997	367	67.0	33.0	31.6	48.8	19.6	--	16.3	48.2	3.0	25.3	6.8	0.3
1998	158	67.7	32.3	40.5	34.8	24.7	--	22.8	41.1	4.4	28.5	2.5	0.6
1999	173	65.3	34.7	45.1	31.8	23.1	--	23.1	34.7	2.3	31.2	7.5	1.2
2000	175	57.1	42.9	36.0	37.1	26.3	0.6	13.1	46.3	1.1	25.7	12.6	1.1
2001	218	62.4	37.6	45.9	26.6	27.5	--	14.7	45.0	2.3	16.5	21.1	0.5
2002	197	63.5	36.5	50.8	24.4	24.9	--	17.8	27.9	1.5	12.2	40.6	--
Total	3,796	69.5	30.5	38.4	42.0	19.3	0.4	22.8	44.9	3.5	19.6	7.2	2.1

3.6 CPG Region: South- East

- South-East Region: New London County, 7.6% of Connecticut's population.
- 8 HIV cases reported in 2002.
- 252 adults living with AIDS at the end of 2002.
- 584 cases have been reported since 1980.
    - In the past five years (1998-2002), 20-40 cases were reported each year;
        - 35-80% male;
        - 45-70% white;
        - 10-30% black;
        - 15-30% Hispanic;
        - 15-45% MSM;
        - 20-40% IDU;
        - 10-35% heterosexual.

Figure 3.6.1: CPG Region: South-East: Population by Race/Ethnicity, 2000.



Population: 259,088

Figure 3.6.2: CPG REGION: South-East: Cumulative AIDS Cases, by Sex, Race, and Risk Group, Connecticut, 2002.

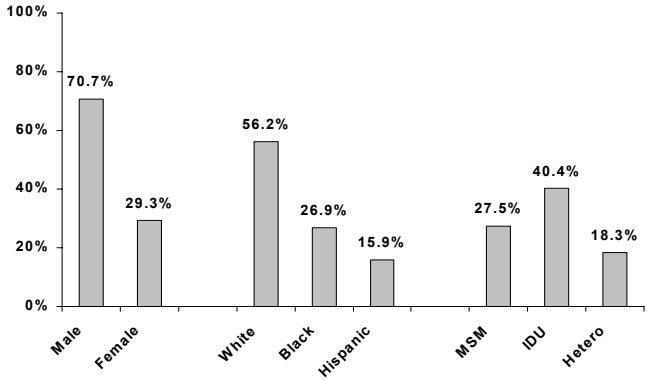


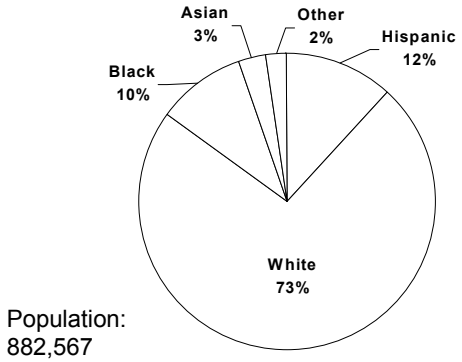
Table 3.6.1: CPG REGION: South-East – Trends in AIDS Cases by Year of Report, Sex, Race, and Risk Group, Connecticut, 1980-2002.

		Sex		Race/Ethnicity				Risk Group					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk	Pedi
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
1980-92	138	80.4	19.6	59.4	31.2	8.7	0.7	44.2	35.5	2.9	8.7	7.2	1.4
1993	96	70.8	29.2	59.4	22.9	17.7	--	25.0	52.1	2.1	16.7	4.2	--
1994	39	76.9	23.1	41.0	23.1	33.3	2.6	17.9	43.6	5.1	23.1	2.6	7.7
1995	69	78.3	21.7	44.9	40.6	13.0	1.4	24.6	46.4	2.9	18.8	5.8	1.4
1996	65	75.4	24.6	52.3	23.1	23.1	1.5	23.1	53.8	1.5	13.8	7.7	--
1997	31	61.3	38.7	61.3	29.0	6.5	3.2	19.4	35.5	--	38.7	6.5	--
1998	30	66.7	33.3	70.0	16.7	13.3	--	43.3	20.0	--	33.3	3.3	--
1999	30	56.7	43.3	66.7	16.7	13.3	3.3	33.3	23.3	3.3	26.7	13.3	--
2000	39	33.3	66.7	53.8	30.8	15.4	--	15.4	38.5	--	28.2	17.9	--
2001	24	79.2	20.8	70.8	12.5	16.7	--	37.5	25.0	4.2	8.3	25.0	--
2002	23	56.5	43.5	43.5	26.1	30.4	--	13.0	34.8	4.3	21.7	26.1	--
Total	584	70.7	29.3	56.2	26.9	15.9	1.0	29.3	40.4	2.4	18.3	8.6	1.0

3.7 CPG Region: South-West

- South-West Region: Fairfield County. 25.9% of Connecticut's population.
- 80 HIV cases reported in 2002.
- 1,311 adults living with AIDS at the end of 2002.
- 2,860 cases have been reported since 1980.
    - In the past five years (1998-2002), 103-159 cases were reported each year;
        - 60-70% male;
        - 30-50% white;
        - 25-40% black;
        - 15-30% Hispanic;
        - 25-30% MSM;
        - 20-30% IDU;
        - 10-30% heterosexual.

Figure 3.7.1: CPG REGION: South-West: Population by Race/Ethnicity, 2000.



Population: 882,567

Other: American Indians and Alaskan Natives, Native Hawaiians and Other Pacific Islanders, Other race, and two or more races

Figure 3.7.2: CPG REGION: South-West: Cumulative AIDS Cases, by Sex, Race, and Risk Group, Connecticut, 2002.

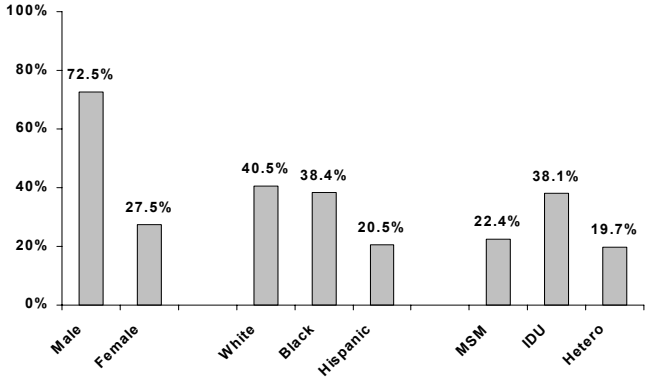


Table 3.7.1: CPG REGION: South-West – Trends in AIDS Cases by Year of Report, Sex, Race, and Risk Group, Connecticut, 1980-2002.

		Sex		Race/Ethnicity				Risk Group					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk	Pedi
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
1980-92	851	79.2	20.8	45.8	37.3	16.3	0.6	38.5	37.1	3.8	12.9	4.7	2.9
1993	321	77.3	22.7	36.8	43.0	20.2	--	27.4	44.2	4.7	15.9	4.0	3.7
1994	217	69.1	30.9	37.3	46.5	15.7	0.5	20.7	47.5	3.2	23.0	4.1	1.4
1995	367	68.7	31.3	39.8	38.1	21.3	0.8	24.5	44.7	3.0	19.9	6.8	1.1
1996	211	70.6	29.4	33.2	43.6	22.7	0.5	18.5	42.2	0.9	28.0	7.6	2.8
1997	235	67.2	32.8	38.3	42.6	18.7	0.4	18.7	44.3	3.4	25.5	6.8	1.3
1998	144	68.1	31.9	42.4	34.7	22.2	0.7	29.2	32.6	1.4	32.6	3.5	0.7
1999	138	68.1	31.9	42.0	23.9	31.9	2.2	26.1	25.4	0.7	31.2	15.9	0.7
2000	114	68.4	31.6	38.6	29.8	31.6	--	28.1	22.8	1.8	28.1	17.5	1.8
2001	103	62.1	37.9	50.5	32.0	16.5	1.0	14.6	24.3	1.9	17.5	41.7	--
2002	159	68.6	31.4	30.8	37.1	31.4	0.6	17.0	25.2	--	11.9	45.3	0.6
Total	2,860	72.5	27.5	40.5	38.4	20.5	0.6	27.5	38.1	2.9	19.7	9.8	2.0

Section 4: Ryan White Eligible Metropolitan Areas

- There are two Ryan White Eligible Metropolitan Areas (EMA) in Connecticut: Hartford EMA and New Haven EMA. In this section, HIV/AIDS surveillance data is provided for each EMA including cumulative data, trend data, PLWA, and HIV data.

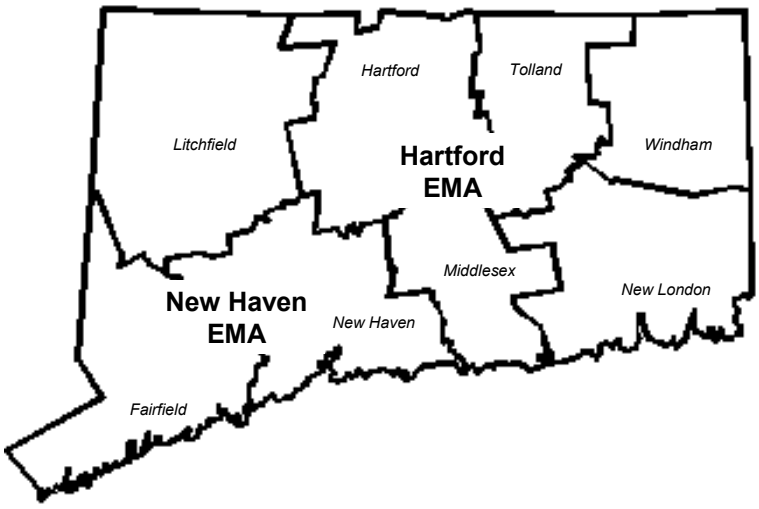
- The Hartford EMA is composed of Hartford, Middlesex, and Tolland Counties. The New Haven EMA is composed of New Haven and Fairfield Counties.

- Of the 12,783 AIDS cases reported in Connecticut, 11,710 (91.6%) are residents of one of the two EMAs. Of the 5,995 PLWA in Connecticut, 5,759 (96.1%) live in one of the two EMAs. Similarly, 94.3% of the 374 HIV cases reported in 2002 resided in one of the two EMAs (Table 4.1).

- The Hartford EMA has a higher proportion of Hispanic AIDS cases (cumulative 33.3% vs. 20.7%) reflecting a higher proportion of Hispanics in the Hartford EMA major cities.

- As with statewide data, white males in both EMAs are more likely to be MSM than IDU and black and Hispanic males are more likely to be IDU. Among non-MSM males in both EMAs with known risk of either IDU or heterosexual exposure, over 80% of males of all race ethnicities are IDU and 8-20% are heterosexual exposures. Among females, 45-64% are IDU and 36-55% are heterosexual exposures.

Figure 4.1: Ryan White Eligible Metropolitan Areas, Connecticut, 2002.



4.1 Hartford EMA

- 4,430 reported AIDS cases – 76% male, 32.3% white, 34.0% black, 33.3% Hispanic, 21.6% MSM, 53.3% IDU, and 14.9% heterosexual exposure (Figure 4.1.1 and Table 4.1.2).
- Over the past five years (1998-2002), 191-255 cases have been reported each year.
    - 65-75% male;
    - 25-40% white, 20-35% black, 35-40% Hispanic;
    - 10-15% MSM, 50-60% IDU, 20-25% heterosexual exposure.
- The Hartford EMA includes 2,171 PLWA, 36% of PLWA in Connecticut (Figure 4.2); 17.5% MSM, 53.7% IDU, 17.5% heterosexual exposure, 40% Hispanic, 31% black, and 29% white.

Figure 4.2: RYAN WHITE: Comparing the Percentage of PLWA by Demographic and HIV Infection Risk Groups, Hartford and New Haven EMA, Connecticut, 2002.

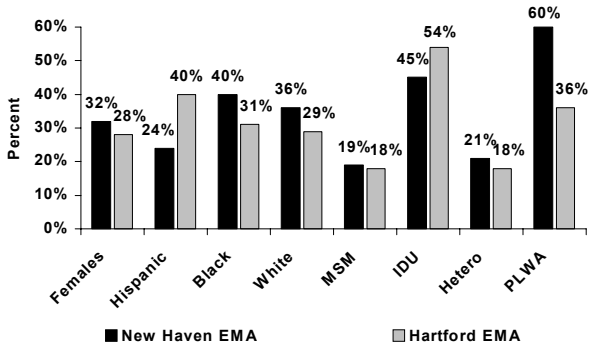
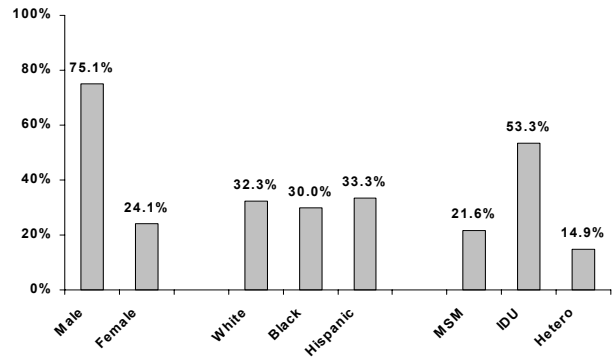


Figure 4.1.1: RYAN WHITE: Hartford EMA: Cumulative AIDS Cases, by Sex, Race, and Risk Group, Connecticut, 2002.



4.2 New Haven EMA

- 7,280 reported AIDS cases – 71.7% male, 36.3% white, 42.6% black, 20.7% Hispanic, 22.0% MSM, 46.8% IDU, 18.1% heterosexual exposure (Figure 4.2.1 and Table 4.2.2).
- Over the past 5 years (1998-2002), 308-368 AIDS cases have been reported each year.
    - 65-70% male;
    - 35-45% white, 30-40% black, 25-30% Hispanic;
    - 15-20% MSM, 35-40% IDU, 25-30% heterosexual exposure.
- The New Haven EMA includes 3,588 PLWA, 60% of PLWA in Connecticut (Figure 4.2); 19.4% MSM, 45.4% IDU, 20.9% heterosexual exposure, 24% Hispanic, 40% black, and 36% white.

Figure 4.2.1: RYAN WHITE: New Haven EMA: Cumulative AIDS Cases, by Sex, Race, and Risk Group, Connecticut, 2002.

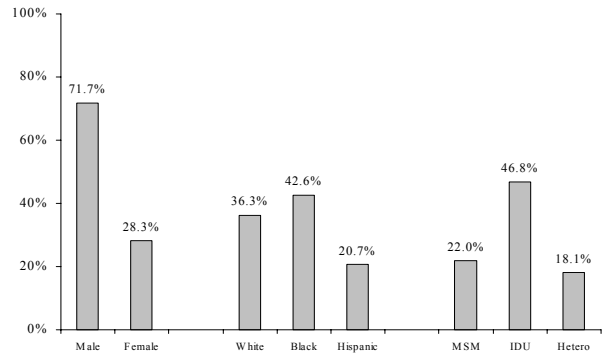


Table 4.1: RYAN WHITE: HIV (not AIDS) Cases, by Ryan White EMA of Residence at Diagnosis, Risk Group, Race, and Sex, Connecticut, 2002.

		Sex		Race/Ethnicity				Risk Group					
		Male	Female	White	Black	Hispanic	Other	MSM	IDU	MSM/IDU	Hetero	Oth/Unk	Pedi
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
EMA when diagnosed with HIV													
Hartford EMA	156	58.3	41.7	24.4	25.0	50.0	0.6	8.3	34.6	--	9.6	47.4	--
New Haven EMA	197	57.4	42.6	34.5	29.4	34.5	1.5	11.7	27.9	2.0	9.1	48.7	0.5
All other towns	21	38.1	61.9	47.6	28.6	23.8	--	19.0	23.8	--	9.5	47.6	--
Total	374	56.7	43.3	31.0	27.5	40.4	1.1	10.7	30.5	1.1	9.4	48.1	0.3

Section 5: Behavioral Risk Factor Survey

- ***Methods and limitations:*** The Behavioral Risk Factor Survey (BRFS) is a telephone survey conducted in Connecticut and most other states. The survey is funded by CDC and asks a variety of questions across a broad spectrum of behaviors that can impact diseases and conditions of public health importance. Because the BRFS is a weighted random sample of Connecticut residents, it is not intended to be able to provide information on selected high-risk individuals such as residents in specific towns or persons with specific high-risk behaviors such as MSM or IDU. The survey does, however, provide a background of HIV attitudes and testing behavior for the general population with possible stratifications by education, income, and race/ethnicity.

- A youth risk behavior survey is currently underway in Connecticut and results from that survey will be available in 2003-4. Selected data from the 2001 survey are shown in Table 5.1.

- The BRFS includes several questions that relate to HIV.

    - At what grade do you think children should begin receiving education about HIV and AIDS?
    - If you had a teenager who was sexually active, would you encourage him or her to use a condom?
    - What are your chances of getting infected with HIV, the virus that causes AIDS?
    - Have you donated blood since March 1985?
    - Did you receive the results of your last HIV test?
    - Did you receive counseling or talk with a health care professional about the results of your HIV test?
    - Except for tests, which you may have had as part of blood donations, have you ever been tested for HIV?
    - Have you ever been tested for HIV?
    - Not including blood donations, have you been tested for HIV in the past 12 months?
    - Have you been tested for HIV in the past 12 months?

- The most recent data available for Connecticut BRFS is from the survey conducted in 2000.

- Complete data is available at www.cdc.gov/brfss/index.htm.

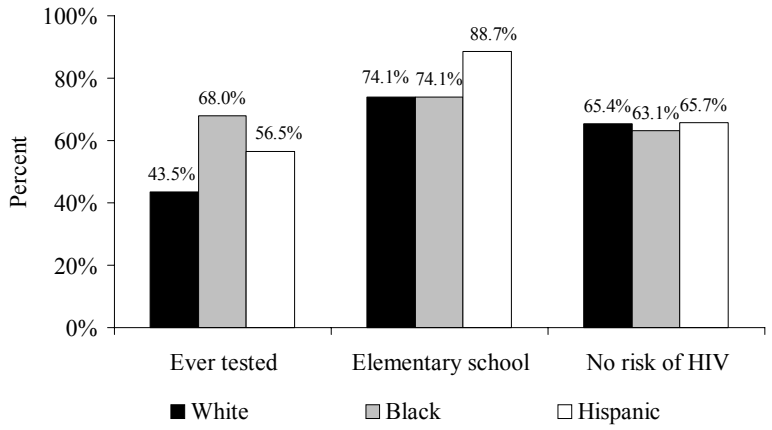
- Figure 5.1 shows the results from three of the questions asked about HIV.

    - By race/ethnicity, 68% of blacks, 56.5% of Hispanics, and 43.5% of whites responded that they had “ever” been tested for HIV. Differences were also seen when respondents were stratified by education and income. Those with lower incomes and less education were more likely to have been tested although the differences were not great.

    - When asked “what grade level children should learn about HIV,” 74.1% of whites,

74.1% of blacks, and 88.7% of Hispanics responded that children should learn about HIV in elementary school.

Figure 5.1: Results from the Behavioral Risk Factor Survey, Connecticut, 2000.



o About 65% of all respondents considered themselves at "no risk" for HIV infection. This level did not vary significantly by race, educational level or income level.

Table 5.1: Youth Risk Behavior Survey, United States,[1] 2001.

	Race/Ethnicity		
	White	Black	Hispanic
Currently sexually active	31.3%	45.6%	35.9%
Condom use during last sex	56.8%	67.1%	53.5%
Alcohol during last sex	27.8%	17.8%	24.1%
Lifetime injecting illegal drugs	2.4%	1.6%	2.5%
Lifetime cocaine use	9.9%	2.1%	14.9%

[1]CDC. Youth Risk Behavior Surveillance – United States, 2001. MMWR. 51: SS-4. Survey of high-school students in selected states. Connecticut did not participate in this survey in 2001. Connecticut previously participated in 1997 and will again in 2003.

Section 6: Sexually Transmitted Diseases Surveillance

- In this section Connecticut surveillance data for chlamydia, gonorrhea, and syphilis are provided. Surveillance for these diseases is conducted using reports from laboratories and providers similar to methods described for HIV and AIDS. Table 6.1 shows the distribution of chlamydia, gonorrhea and syphilis by county.

- ***Advantages of STD data:*** a) Unlike HIV infection, these diseases are often immediately symptomatic leading to prompt diagnosis and testing. In addition, it is recommended that all women <25 years of age receive annual screening for chlamydia and gonorrhea; b) STDs are a marker for recent high-risk sexual behavior; c) Interviews in the context of partner notification are conducted with all syphilis cases and have established MSM as an emerging risk factor.

- ***Disadvantages of STD data:*** a) Gonorrhea and chlamydia race/ethnicity information is incomplete in about one-third of reports; b) Few interviews are conducted with gonorrhea and chlamydia cases due to the high number of cases reported.
- Diagnosis with an STD after diagnosis with HIV is a marker of continuing high-risk behavior. Matching of STD and HIV/AIDS databases will provide a method for measuring the magnitude of this problem, predictors by sex, race, age group, HIV risk group, and trends over time. It is expected that this approach will begin after at least two years of HIV reporting data have been collected.

Table 6.1: Chlamydia, Gonorrhea, and Syphilis Reported in 2002 by County, Connecticut.

		Disease					
		Chlamydia		Gonorrhea		Syphilis	
	Total	N	%	N	%	N	%
County at Diagnosis							
FAIRFIELD	2,971	2,273	22.4	690	20.4	8	28.6
HARTFORD	4,559	3,338	33.0	1,212	35.9	9	32.1
LITCHFIELD	135	104	1.0	31	0.9	--	--
MIDDLESEX	249	182	1.8	67	2.0	--	--
NEW HAVEN	3,409	2,612	25.8	788	23.3	9	32.1
NEW LONDON	930	615	6.1	315	9.3	--	--
TOLLAND	159	111	1.1	46	1.4	2	7.1
WINDHAM	244	187	1.8	57	1.7	--	--
Unknown	877	708	7.0	169	5.0	--	--
Total	13,533	10,130	100.0	3,375	100.0	28	100.0

6.1 Gonorrhea

- The trend in reported gonorrhea cases for 1997-2002 is shown in Tables 6.1.1 and 6.1.2 by sex, race, and age group.
- During 1997-2002, 2,555-3,429 cases were reported each year with no significant trends.
- Overall, 45% were male, 55% female.
- In 2002, 13.2% were white, 39.2% were black and 11.2% were Hispanic (Table 6.1.1), with the highest percentage of cases occurring in black females (20.5%) (Table 6.1.2). Importantly, in 36.0% of cases race and/or sex were unknown.
- In 2002, over half (57.1%) of reported cases were persons under 25 years of age, with 29.7% in the 20-24 age group (Table 6.1.2).

Table 6.1.1: Gonorrhea Cases by Sex, Race/ethnicity, and Year of Report, Connecticut, 1997-2002.

		Sex			Race/Ethnicity				
		Male	Female	Unkn	White	Black	Hispanic	Other	Unkn
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
Report Year									
1997	3,155	47.8	52.2	--	8.6	54.2	11.3	0.4	25.5
1998	3,429	46.4	53.6	--	8.7	52.3	11.9	0.4	26.8
1999	3,311	45.7	54.3	--	10.6	44.7	10.9	0.1	33.6
2000	2,915	44.4	55.6	--	8.1	45.1	12.2	0.3	34.2
2001	2,555	44.9	55.0	0.1	8.8	47.0	12.7	0.6	30.9
2002	3,375	41.1	58.9	--	13.2	39.2	11.2	0.5	35.9
Total	18,740	45.0	55.0	0.0	9.7	47.1	11.6	0.4	31.1

Table 6.1.2: Gonorrhea Cases, Reported in 2002, by Sex and Race Combinations and Age Group, Connecticut.

		Sex and Race							
	Total	White Males % of Total	White Females % of Total	Black Males % of Total	Black Females % of Total	Hispanic Males % of Total	Hispanic Females % of Total	Other Race/Eth % of Total	Unkn Race /Sex % of Total
Age at diagnosis									
14 and younger	52	3.8	3.8	11.5	15.4	5.8	11.5	--	48.1
15-19	872	1.8	10.3	11.7	30.5	1.9	12.2	0.2	31.3
20-24	1,003	3.0	9.0	19.8	21.5	3.8	7.6	0.6	34.7
25-29	526	5.5	9.1	20.5	18.4	3.0	7.8	0.6	35.0
30-34	325	8.0	6.8	26.5	11.7	3.7	5.5	--	37.8
35-39	253	11.9	7.1	19.0	13.0	4.0	4.3	0.8	39.9
40-44	138	5.1	7.2	26.8	10.9	1.4	1.4	0.7	46.4
45 and older	108	12.0	1.9	32.4	4.6	4.6	1.9	1.9	40.7
Unkn	97	4.1	8.2	7.2	15.5	4.1	8.2	--	52.6
Total	3,374	4.7	8.6	18.6	20.5	3.2	8.0	0.5	36.0

6.2 Chlamydia

- During 1997-2002, 6,372 to 10,130 cases of chlamydia have been reported with a dramatic jump in cases seen in 2002 (n = 10,130) (almost 28 cases per day) (Table 6.2.1).

- Overall, 81.4% of cases are female with 18.5% male.

- In 2002, 12.5% are white, 28.9% black, and 16.1% Hispanic with the highest number of cases occurring in black females (21.3%) (Table 6.2.1). Importantly, in 41.7% of cases race and/or sex were unknown.

- In 2002, 69.7% of cases were less than 25 years of age, with 33.7% of cases occurring in the 15-19 age group (Table 6.2.2)

Table 6.2.1: Chlamydia Cases by Sex, Race/Ethnicity, and Year of Report, Connecticut, 1997-2002.

		Sex			Race/Ethnicity				
		Male	Female	Unkn	White	Black	Hispanic	Other	Unkn
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
Report Year									
1997	6,372	17.1	82.9	--	13.5	34.9	18.6	0.9	32.1
1998	7,498	16.5	83.5	--	12.9	34.1	18.9	0.9	33.2
1999	7,366	18.5	81.5	--	12.1	30.8	17.7	0.5	39.0
2000	7,606	18.0	82.0	--	9.7	29.4	19.1	0.7	41.0
2001	7,742	18.7	81.1	0.2	12.3	30.2	17.9	0.7	38.9
2002	10,130	21.3	78.7	--	12.5	28.9	16.1	0.8	41.7
Total	46,714	18.5	81.4	0.0	12.2	31.2	17.9	0.8	38.0

Table 6.2.2: Chlamydia Cases, Reported in 2002, by Sex and Race Combinations and Age Group, Connecticut.

		Sex and Race							
		White Males	White Females	Black Males	Black Females	Hispanic Males	Hispanic Females	Other	Unkn Race or Sex
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
Age at diagnosis									
14 and younger	182	0.5	9.9	2.7	18.7	2.7	17.6	--	47.8
15-19	3,411	1.1	11.0	5.1	25.5	1.6	13.5	0.4	41.9
20-24	3,475	2.4	10.6	7.9	21.1	3.3	13.1	0.6	40.9
25-29	1,447	2.3	10.1	10.5	17.9	2.8	15.7	0.8	39.8
30-34	737	4.1	8.0	9.6	17.6	3.1	12.3	2.3	42.9
35-39	293	4.4	7.2	10.2	20.5	4.8	9.2	1.4	42.3
40-44	145	4.8	10.3	16.6	9.7	4.1	8.3	2.1	44.1
45 and older	120	9.2	5.0	13.3	10.8	1.7	8.3	2.5	49.2
Unkn	320	3.4	9.7	8.1	13.1	3.4	15.3	1.9	45.0
Total	10,130	2.3	10.3	7.6	21.3	2.7	13.5	0.8	41.7

6.3 Syphilis

- The number of primary and secondary (infectious) syphilis cases in Connecticut has declined dramatically in recent years from 101 reported in 1996 to 12 reported in 2001 (Table 6.3.1). In the past year, however, there has been a resurgence in syphilis both nationally and in Connecticut, primarily in MSM (Figure 6.3.1).

- From 1995 to 2002, 57.1% of syphilis cases have been male (Table 6.3.1). Since 1999, however, the percentage male has increased to over 80% (88.9% in 2002). At the same time, the percentage of cases that were white increased from 18.8% in 1999 to 51.9% in 2002.

- DPH staff attempt to interview all syphilis cases. Included in the interview are questions about risk behavior. As shown in Table 6.3.1, the percentage of cases that were MSM increased from about 5% in 1995 to 70.4% in 2002. Importantly, many recent syphilis cases are also HIV positive (42.9% in 2002).

- Unlike chlamydia and gonorrhea, the majority of recent syphilis cases have been in males. In 2002, 50% were white males, 25.0% were black males and 14.3% were Hispanic males. Overall, very few syphilis cases have been seen in white females since 1997. In 2002, there were no white or Hispanic females reported, but 7.1% of reported cases were black females (Table 6.3.2).

- Also, unlike chlamydia and gonorrhea, syphilis is not predominant in a particular age group with between 10% and 30% in each of the age groups shown in table 6.3.2. More than a quarter, 28.6%, of cases in 2002 were 45+ years of age.

Table 6.3.1: Primary and Secondary Syphilis Cases by Year of Report, Sex, Race/Ethnicity, Risk, Connecticut, 1995-2002.

		Sex		Race/Ethnicity				Risk			
		Male	Female	White	Black	Hispanic	Oth/Unk,	MSM	IVDU	Other	HIV+[1]
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
1995	85	60.0	40.0	14.1	60.0	21.2	4.7	1.2	1.2	97.6	--
1996	101	44.6	55.4	11.9	68.3	19.8	--	4.0	8.9	87.1	--
1997	62	59.7	40.3	11.3	51.6	37.1	--	6.5	1.6	91.9	--
1998	25	40.0	60.0	4.0	68.0	28.0	--	--	12.0	88.0	--
1999	16	62.5	37.5	18.8	50.0	31.3	--	6.3	6.3	87.5	6.3
2000	15	60.0	40.0	26.7	53.3	20.0	--	20.0	--	80.0	--
2001	12	83.3	16.7	75.0	25.0	--	--	66.7	8.3	25.0	16.7

		Sex		Race/Ethnicity				Risk			
		Male	Female	White	Black	Hispanic	Oth/Unk,	MSM	IVDU	Other	HIV+[1]
	Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total	% of Total
2002	28	88.9	11.1	51.9	29.6	14.8	3.7	70.4	--	29.6	42.9
Total	343	57.1	42.9	18.1	57.1	23.3	1.5	11.7	4.7	83.7	--

[1]HIV testing is recommended for all syphilis cases. In 1998 (28 reported cases), 10 cases self-reported HIV+ and 18 cases were offered testing. Of these, 17 received HIV testing with two positive for a total of 12 (42.9%) in 1998.

Figure 6.3.1: Number of MALE Syphilis Cases Reported and Number Reported with MSM Risk, Connecticut, 1995-2002.

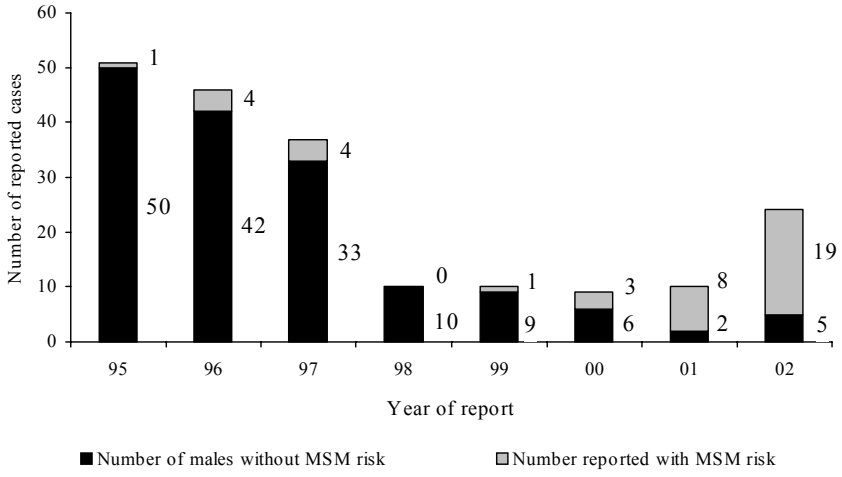


**Table 6.3.2: Primary and Secondary Syphilis Cases Reported in 2002,
by Sex and Race Combinations and Age Group, Connecticut.**

		Sex and Race[1]				
		White Males	Black Males	Black Females	Hispanic Males	Other
	Total	% of Total	% of Total	% of Total	% of Total	% of Total
Age at diagnosis						
20-24	3	66.7	33.3	--	--	--
25-29	3	33.3	33.3	--	33.3	--
30-34	4	50.0	--	--	50.0	--
35-39	6	50.0	50.0	--	--	--
40-44	4	50.0	--	25.0	--	25.0
45 and older	8	50.0	25.0	12.5	12.5	--
Total	28	50.0	25.0	7.1	14.3	3.6

[1]Missing categories indicates no cases were reported in that group.

Section 7: Viral Hepatitis Surveillance

- Viral hepatitis surveillance is included because these viruses can have modes of transmission in common with HIV. Both hepatitis C and HIV are transmitted in Connecticut primarily through sharing of injection drug equipment. Hepatitis A has recently been associated with outbreaks in MSM in Connecticut and nationally.

- Figure 7.1 shows the trends in reported cases of acute hepatitis A, B and C in the past twenty years.

Section 7.1: Hepatitis C

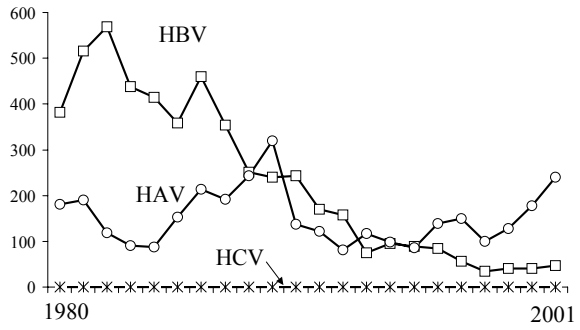
How are hepatitis C surveillance data collected in Connecticut?

- The Connecticut Department of Public Health (DPH) conducts public health surveillance for many infectious diseases including hepatitis C.

- Reportable diseases are reported to DPH and local health departments by the diagnosing physician and the laboratory that performs tests specific for the disease.

- The reportable laboratory test for hepatitis C is anti-HCV. A person who is positive for anti-HCV may be acutely or chronically infected or may have been infected in the past and is no longer infected. Unlike hepatitis A and B, there is no laboratory test for acute hepatitis C infection. Only physicians can diagnose acute hepatitis C infections.

Figure 7.1: Trends in Acute Hepatitis A, B, and C, Connecticut 1980-2001.



- No confirmed acute hepatitis C infections have been reported to DPH in many years. As a result, no hepatitis C data are shown on the DPH web site and only estimates are provided on the CDC web site.

- CDC estimates that 4,000 acute clinical hepatitis C cases occurred in the U.S. in 2001. National surveillance for hepatitis C conducted by the CDC in selected counties in the United States has shown that the number of acute hepatitis C infections has decreased significantly over the past 10 years.

- Hepatitis C infection can become chronic in a proportion of acutely infected individuals, estimated to be as high as 70-80%.

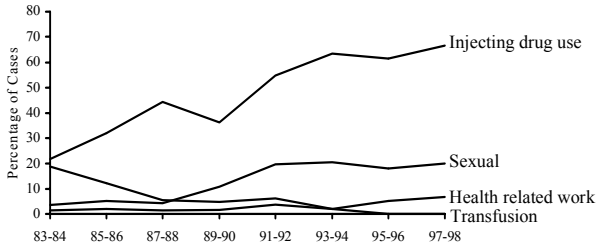
- Approximately 5-6,000 positive anti-HCV tests are reported to DPH each year. These infections may have occurred at any time in the person's lifetime.

Hepatitis C surveillance data

In the United States surveillance data for hepatitis C is obtained primarily from CDC sentinel counties (selected counties around the U.S. that conduct intensive viral hepatitis surveillance activities).

- It is estimated that 3.9 million U.S. residents (1.8%) have been infected with hepatitis C and that 2.9 million are carriers (corrections populations were not included). The rate of infection is highest among blacks (3.2%) and lowest among whites (1.5%). Assuming that 1.8% of Connecticut residents are infected with hepatitis C would mean that approximately 60,000 have been exposed.

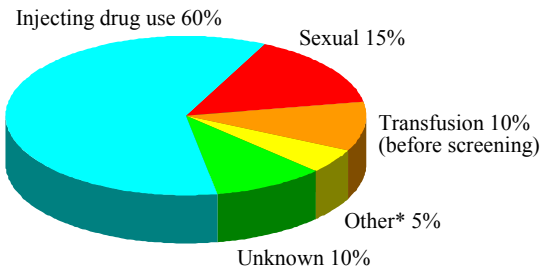
Figure 7.1.2: Reported Cases of Acute Hepatitis C by Selected Risk Factors, United States, 1983-1998.*



Source: CDC Sentinel Counties Study

- Figure 7.1.1 shows the overall trend in hepatitis C and Figure 7.1.2 shows the trend in distribution of cases by risk group. The predominant risk group is IDU (60%) with sexual contact accounting for 15% (Figure 7.1.3).
- Incidence, as shown in Figure 7.1.1, has fallen to very low levels nationally for reasons that are not entirely clear. Certain prevention measures, such as testing of the blood supply have been very effective. Another reason may be that the IDU population has been saturated with hepatitis C. As shown in Figure 7.1.4, IDU become hepatitis C infected rapidly after initiating that behavior.
- In Connecticut approximately 5-6,000 laboratory reports of hepatitis C are received annually. Table 7.1.1 shows the distribution of reports received in 2000 by county of residence. Note that approximately one quarter of reports do not include county of residence. However, similar to HIV and AIDS, the majority of reports come from the three most populous and heavily urbanized counties, Hartford, New Haven, and Fairfield, as expected.
- In a hepatitis C sero-survey conducted in Connecticut HIV counseling and testing sites in 1999, it was found that of 2,133 specimens tested, 210 (9.8%) were found to be positive for hepatitis C. This was higher than the rate of HIV positives (n=27; 1.3%). Among IDU (n=191), the majority were hepatitis C positive (66.5%) and among non-IDU, 4.3% were

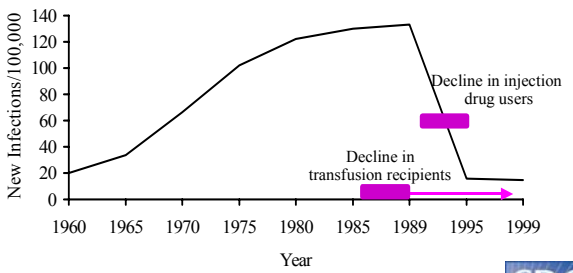
Figure 7.1.3: Sources of Infection for Persons with Hepatitis C.



*Nosocomial; Health-care work; Perinatal

Source: Centers for Disease Control and Prevention

Figure 7.1.1: Estimated Incidence of Acute HCV Infection, United States, 1960-1999.



hepatitis C positive. Additional detail about this study can be found on the DPH HIV/AIDS Surveillance Program website (www.dph.state.ct.us).

Figure 7.1.4: Risk of Bloodborne Virus Infections, IDU, *Baltimore 1983–1988.*

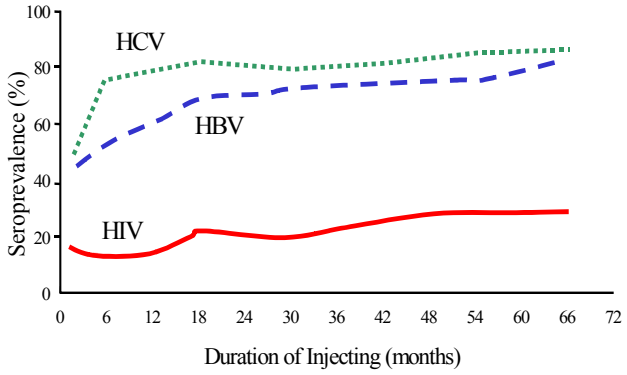


Table 7.1.1: Hepatitis C Positive Laboratory Reports, by County and Department of Correction, Connecticut, 2000.

County	*Number*	*Percent*
Corrections	61	1.0%
Fairfield	966	15.3%
Hartford	1,296	20.5%
Litchfield	171	2.7%
Middlesex	117	1.9%
New Haven	1,252	19.8%
New London	403	6.4%
Tolland	121	1.9%
Windham	126	2.0%
Unknown	1,689	26.7%
Total	6,318	100.0

Section 7.2 Hepatitis A

How is hepatitis A data collected?

- The Connecticut Department of Public Health (DPH) conducts public health surveillance for many infectious diseases including hepatitis A.
- Connecticut law requires DPH to maintain a list of reportable diseases.

- Reportable diseases are reported to DPH and local health departments by the diagnosing physician and the laboratory that performs tests specific for the disease.

- The reportable laboratory test for hepatitis A is the following: IgM anti-HAV. A positive IgM anti-HAV test indicates an acute (new) hepatitis A infection.

- Unlike hepatitis B and C, hepatitis A infections never become chronic.

Hepatitis A surveillance data

- Figure 7.2.1 shows the trend in hepatitis A cases by sex from 1993 to 2002. The number of cases ranges from 86 to 240 per year. During 1999 to 2001, the number of cases that were male increased from 83 (64% of cases) to 173 (72%). Much of this increase was localized in New Haven County, which, in 2001 had 103 cases (74% male). Preliminary interviews with several hepatitis A cases indicated that MSM risk was a common behavior. Given this information, plus the high proportion of males in the 20-49 age group (65.1%), and in the context of several hepatitis A outbreaks in MSM, nationally, efforts were made to make free hepatitis A/B vaccine available to MSM.

Figure 7.2.1: Number of Hepatitis A Cases by Sex and Year of Report, Connecticut, 1993-2002.

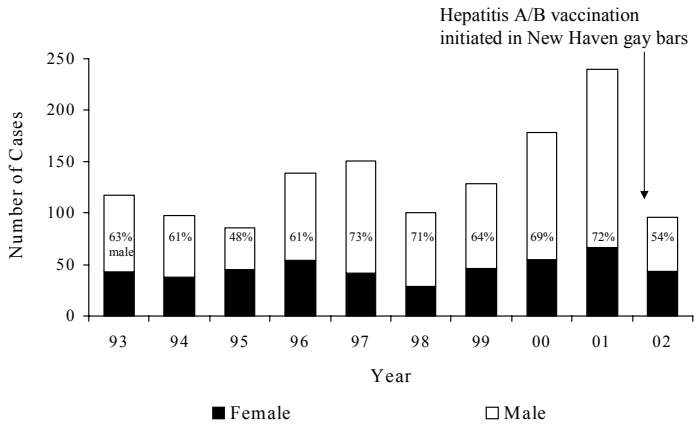
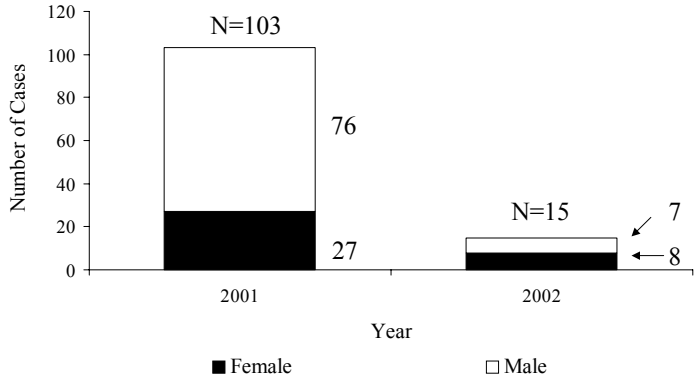


Figure 7.2.2: Number of Hepatitis A Cases by Sex and Year of Report, New Haven County, 2001-2002.



- After several months, during which the Hartford Gay and Lesbian Health Collective provided free hepatitis A/B vaccination, primarily at venues in New Haven frequented by MSM, the number of hepatitis A cases in New Haven County decreased to 15 reported cases in 2002 (47% male) (Figure 7.2.2).

- Although these observations are provocative, suggesting that MSM engaging in high-risk behavior was resulting in transmission of hepatitis A, several points should be kept in mind.

    - First, there is limited direct information suggesting that MSM were the predominant risk group involved in the outbreak. However, note that female cases remained approximately constant during 1999 to 2002 (Figure 7.2.1), state-wide, but also that the number of female cases declined significantly in New Haven County after the vaccination campaign in MSM began (Figure 7.2.2). It is possible that MSM played a role in the outbreak, but since hepatitis A is spread by the fecal-oral route, transmission can occur as a result of poor hygiene, and contaminated food and water. This could result in relatively easy transmission among household and other contacts of infected persons. Thus, it could be expected that an outbreak in MSM would not remain exclusively in that group, and that a vaccination campaign in MSM could have indirect benefits to others.

    - Second, there may have been several contributing factors responsible for the observed decrease in hepatitis A cases, in addition to use of vaccine, including a reduction in the number of susceptible persons and an increase in preventive behaviors.

- It should also be kept in mind that even though the number of hepatitis A cases has declined, that does not indicate, necessarily, that the underlying risk behavior that led to infection has decreased. Hepatitis A is vaccine preventable, and, once vaccinated, high-risk behavior will not result in infection.

Section 8: Glossary

AIDS – Acquired immunodeficiency syndrome. AIDS can affect the immune and central nervous system and can result in neurological problem, infections, or cancers. It is caused by human immunodeficiency virus (HIV).
Anonymous – In anonymous testing, client identifying information is not linked to testing information, including the request for tests or test results.
Case – a person who has a disease of interest.
CD4 (or T4) – a type of white cell that oversees the action of the human immune system and is the main target of HIV. Also called a helper T-cell.
Chlamydia - Infection caused by *Chlamydia trachomatis* are the most common bacterial sexually transmitted infection, with an calculated annual incidence of 4.5 million cases in the USA. Chlamydia can cause a spectrum of infections including conjunctivitis and pneumonia in newborn infants.
Community Planning Groups (CPGs) – groups responsible for conducting HIV Prevention Community Planning; CPGs are composed of community representatives, scientists and other technical experts, and staff of non-governmental organizations, and departments of health, education, and substance abuse prevention.
Confidential HIV Testing – A person is tested for HIV and gives his or her name; specimens are marked with a code number, but can be linked to a name.
Counseling and Testing – The voluntary process of client-centered, interactive information sharing in which an individual is made aware of the basic information about HIV/AIDS, testing procedures, how to prevent the transmission and acquisition of HIV infection, and given tailored support on how to adapt this information to their life.
Cumulative – Pertaining to the total number of persons reported or diagnosed with AIDS at a specified point in time.
Data – Specific information or facts that are collected. A data element is usually a discrete or single measure. Examples of client-level data elements are sex, race/ethnicity, age, and neighborhood.
Demographics – The statistical characteristics of human populations such as age, race, ethnicity, and sex that can provide insight into the development, culture, and sex specific issues that the intervention will need to account for.
ELISA – Enzyme-linked immunosorbent assay. A blood test, which indicates the presence of antibodies to HIV. The HIV ELISA test does not detect the disease AIDS, but only indicates if HIV infection has occurred.
Epidemic – A disease that spreads rapidly through a demographic segment of the human population, such as everyone in a given geographic area; a military base, or similar population unit; or everyone of a certain age or sex, such as the children or women of a region. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.
Epidemiologic Profile – A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area.
Epidemiology – The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems.
Exposure – Contact with or possession of a characteristic that is suspected to influence the risk of developing a particular disease.
Gender – A term to classify persons male or female.
Gonorrhea - A gram-negative bacteria which is a principal cause for sexually transmitted disease in males and females. The infection is due to *Neisseria gonorrhoeae* which is transmitted sexually in most cases, but also by contact with infected exudates in neonatal children at birth or by infants in households with infected inhabitants. It is marked in males by urethritis with pain and purulent discharge, but is commonly asymptomatic in females, although it may extend to produce suppurative salpingitis, oophoritis, tubo ovarian abscess and peritonitis. Bacteraemia occurs in both sexes, resulting in cutaneous lesions, arthritis and rarely meningitis or endocarditis.

Hepatitis C - A form of viral hepatitis, previously referred to as nonA nonB hepatitis, is the most common form of blood transfusion acquired hepatitis. Transmission through sexual contact is considered rare. Risk factors include recent blood transfusion, IV drug abuse or occupational exposure to blood products. There is no specific treatment. There is a test for hepatitis C antibody that indicates prior exposure. Unlike hepatitis B there is no marker yet identifiable for those who suffer from chronic hepatitis C.
HIV – A type of retrovirus (human immunodeficiency virus) that is responsible for the fatal illness acquired immunodeficiency syndrome. Two strains have been identified. Type 1: the retrovirus recognized as the agent that induces AIDS. Type 2: a virus closely related to HIV-1 that also leads to immune suppression. HIV-2 is not as virulent as HIV-1 and is epidemic only in West Africa.
Hepatitis B – a form of viral hepatitis, or inflammation of the liver, caused by an infectious agent called the hepatitis B virus (HBV). HBC may be transmitted through contact with infected body fluids, including blood, saliva, seminal fluid, vaginal secretions, and breast milk.
Highly Active Antiretroviral Therapy (HAART) – A combination, or cocktail, of several anti-HIV drugs, at least one of which is often a protease inhibitor.
IDU – Injection drug user; people who are at risk for HIV infection through the use of equipment used to inject drugs (e.g., syringes, needles, cookers, spoons, etc.).
Incidence – The number of new cases of a disease that occur in a specified population during a specified time period.
Jurisdictions - The power, right, or authority to interpret and apply the law; or the authority of a sovereign power to govern or legislate; or the limits or territory within which authority may be exercised.
Mortality rate – The rapidity with which persons with a given population die from a particular disease.
MSM – Men who have sex with men. Men who report sexual contact with other men (i.e., homosexual contact) or men who report sexual contact with both men and women (i.e., bisexual contact).
MSM/IDU- Men who report both sexual contact with other men and injection drug use.
Neonatal Mortality Rate - The number of children dying under 28 days of age divided by the number of live births that year.
Opportunistic Infectious (OIs) – Those diseases, which are caused by agents, that are commonly present in our bodies or environment but cause disease only when there is a change from normal, healthy conditions, such as when the immune system becomes depressed.
Perinatal - Pertaining to or occurring in the period shortly before and after birth, variously defined as beginning with completion of the twentieth to twenty eighth week of gestation and ending 7 to 28 days after birth.
PLWA – Person living with AIDS.
Prevalence- The proportion of persons in a given population who have a particular disease at a point or interval of time.
Proportion – The ratio of a part of the whole to the whole.
Public Health Surveillance – An ongoing, systematic process of collecting, analyzing and using data on specific health conditions and diseases, in order to monitor these health problems, such as the Centers for Disease Control and Prevention's (CDC) surveillance system for AIDS.
Rate – Measure of the probability of the development of a disease in a specified population during a specified period of time.
Report Delay – The period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials.
Relative Risk – The ratio of the risk of disease or death among the exposed to the risk among the unexposed; this usage is synonymous with risk ratio.
Risk Behavior – Behavior or other factor that places a person at risk for disease; for HIV/AIDS, includes such factors as sharing of injection drug use equipment, unprotected male-to-male sexual contact, commercial sex work without the use of condoms.
Sensitivity – The probability that a test will be positive when infection or condition is present.
Seroprevalence – HIV seroprevalence refers to the number of persons in a population who test HIV+ based on serology (blood serum) specimens; often presented as a percent of the total specimens tested or as a ratio per 1,000 persons tested.

Sexually Transmitted Diseases (STDs) – Diseases that spread from one sexual partner to another as a result of sexual intercourse.
Specificity – The probability that a test will be negative when the infection or condition is not present.
Surveillance – The ongoing and systematic collection, analysis, and interpretation of data about a disease or health condition. As part of a surveillance system to monitor the HIV epidemic in the United States, the Centers for Disease Control and Prevention (CDC), in collaboration with state and local health departments, other federal agencies, blood collection agencies, and medical research institutions, conducts standardized HIV seroprevalence surveys in designated subgroups of the U.S. population. Collecting blood samples for the purpose of surveillance is called serosurveillance.
Syphilis – A contagious disease that can be spread sexually and from infected mother to her child, caused by the organism *Treponema pallidum*.
Transgender – A general term for any person who adopts a gender identity that does not strictly identify with their biological sex (i.e., a biological male who identifies as a woman, or vice-versa). The term transgender includes biological males who live their entire lives as women and biological females who live their entire lives as men whether or not they have had surgical procedures to alter the appearance of their genitalia. The term also refers to individuals who either publicly or privately cross-dress (dress in clothing traditionally worn by another gender), and those who are intersexed (born with ambiguous genitalia and/or sex chromosome).
Transmission Categories – In describing HIV/AIDS cases, same as exposure categories; how an individual may have been exposed to HIV, such as injecting drug use, men who have sex with men, and heterosexual contact.
Viral Load - The number of viral particles (usually HIV) in a sample of blood plasma. HIV viral load is increasingly employed as a surrogate marker for disease progression. It is measured by PCR and bDNA tests and is expressed in number of HIV copies or equivalents per millilitre.
Voluntary HIV Testing – HIV testing that is offered free coercion. With voluntary HIV testing, participants have the opportunity to accept or refuse HIV testing.
Western Blot – A blood test used to detect HIV antibody. Compared to the ELISA, the Western blot is more specific and expensive. It is used to confirm the results of the ELISA test.

Chapter 3

Community Services Assessment

Assessing the HIV Prevention and Care Needs for Connecticut's At-Risk Populations
Resource Inventory and Gap Analysis

Assessing Connecticut's HIV Prevention Needs

COMMUNITY SERVICES ASSESSMENT

Assessing the Need for HIV Prevention Services: A Guide for Community Planning Groups (1999), published by The Academy for Educational Development (AED), describes a needs assessment as "a process for obtaining and analyzing information to determine the current status and service needs of a defined population or geographic area."

Needs assessments can be useful for: (a) obtaining information about current conditions in a defined population including problems or service needs and the resources and approaches being used to address them, and, (b) determining met and unmet service needs among specific target populations and for the overall service area or community.[1]

A needs assessment is a key element of HIV prevention community planning and is guided by information provided through the epidemiologic profile and community services assessment. A comprehensive needs assessment:

- Targets high-risk populations identified in the epidemiologic profile,
- Describes the HIV prevention and care needs of targeted populations,
- Provides an inventory of existing resources for HIV prevention and care,
- Includes a gap analysis of the met and unmet HIV prevention and care needs within targeted populations, and,

Prior to the new CDC *HIV Prevention Community Planning Guidance*, a needs assessment, resource inventory and gap analysis were considered as three separate, yet interrelated products. The new guidance, approved in April 2003, combined these separate processes into a "three-in-one-component" of community planning – the Community Services Assessment.

The Community Services Assessment provides a description of the prevention and care needs of populations at risk for HIV infection (needs assessment), the prevention/intervention and care activities implemented to address these needs, regardless of funding source (resource inventory), and the met and un-met needs or service gaps (gap analysis). The new guidance specifically states that one of the responsibilities of the Department of Public Health (DPH) and/or its designated contractor/consultant, in collaboration with the CPG, is the development of the community services assessment. The CPG and DPH are responsible for discussing the types of data to be collected, methodologies to be used, collaborative processes, and the format for the community services assessment.

[1] Assessing the Need for HIV Prevention Services: A Guide for Community Planning Groups. Academy for Educational Development, Washington, DC: 1999.

DATA COLLECTION

Data for the Community Service Assessment (Needs Assessment, Resource Inventory and Gap Analysis) were collected through a variety of ways. More often than not, a single data source yielded information valuable for more than one portion of the Community Service Assessment.

Primary data were collected by conducting; 1) focus groups, surveys and key informant interviews with MSM, HIV+, WSW, incarcerated persons, and Transgender persons; and 2) surveys of DPH and non-DPH funded providers of HIV prevention services.

Secondary data were gathered and analyzed from the following sources; 1) the DPH prevention intervention database; 2) current AIDS epidemiology; 3) current DPH funding according to region; 4) R.A.R.E. project reports from both New Haven and Hartford; 5) Information from the Connecticut Department of Education, data from the Connecticut Department of Public Health STD and Viral Hepatitis Programs; 6) Ryan White Title I 2002 Needs Assessment for New Haven/Fairfield counties and the Greater Hartford Title I Eligible Metropolitan Area (EMA) June 2002 Comprehensive HIV Health Services Plan; and 7) the Ryan White Title II Connecticut Comprehensive Statewide Care and Prevention Plan for HIV/AIDS.

POPULATION FOCUS GROUPS, SURVEYS AND KEY INFORMANT INTERVIEWS

Prevention focus groups were constructed to be ethnically diverse, segregated by male and female (Department of Correction), consisted of between 10-15 participants per group, and conducted in Spanish if required. Focus groups were conducted with the following populations; HIV positive persons, MSM's, and incarcerated individuals. Incentives, in the form of stipends and/or food were provided for all group participants, with the exception of the Department of Correction.

Discussion topics for the focus groups included the following:

- Awareness about HIV/AIDS/STDs, transmission modes, and prevention
- HIV/STD services participants would like to see implemented
- Barriers to accessing existing services
- Risk issues and concerns
- Locations where participants would like to get HIV/STD information.

Focus group questions, which had been developed by the CSA Committee in 2003, were adapted to meet the cultural needs of the respective groups (e.g. changing language, question modification and translation into Spanish). Questions were also modified to be non-gender specific.

Groups were conducted from January 2004 through June 2004. Two focus groups were conducted with incarcerated populations (a male group at Osborn Correctional Institution (CI) and a female group at York CI), two with MSM support groups. Focus group facilitators and note-takers included CPG members and CSA Committee co-chairs, Kathey Fowler and Mark Bond-Webster, CPG and CSA Committee member Maggy Morales, and Barbara Mase, Lennon Hite and Frederic Morton of The Parisky Group, contractor for the CPG.

Population surveys were conducted for WSWs. While WSW are not considered a priority population, members of the Community Services Assessment Committee expressed enough interest in this population to warrant a limited survey for informational purposes. Women were surveyed concerning sexual orientation, information regarding HIV and STDs, use of drugs, number of partners (both male and female), use of condoms and sex toys, and HIV status. This

survey was developed by the CSA Committee and administered by Maggy Morales of Latino/as Contra SIDA in Hartford.

Key Informant interviews were conducted focusing on MSMs and Transgender people. In addition to the focus groups, key informant interviews regarding MSMs and their HIV risk were conducted with Mel Thomas and Jesse Grant of the Brothers 4 Brothers Program, Hartford and Willie Castillo of Hispanos Unidos, New Haven. Three transgender individuals, all of whom are involved in transgender advocacy leadership through The Connecticut TransAdvocacy Coalition, Connecticut Outreach Society, The Twenty Club, and connecticuTView, were interviewed.

SURVEY OF PROVIDERS

In order to provide information for all three components of the Community Services Assessment, a survey was conducted among HIV prevention providers (both DPH and Non-DPH funded). Survey questions were developed by the Community Services Assessment Committee. (See 2004 Resource Inventory Questionnaire in Appendix C).
Three hundred seventy five (375) surveys were sent to community-based organizations (CBOs), AIDS service organizations (ASOs), and health care organizations throughout Connecticut. The purpose of this survey was to assess the resources available in Connecticut for HIV prevention and care services and to assess the needs and observations of providers. A total of 99 providers responded. Of these, 91 indicated that they provide HIV prevention services.

Organizations surveyed were asked to provide information regarding: (a) providers' program challenges and needs relative to providing HIV prevention and/or care services to targeted populations, (b) problems encountered by target populations in accessing services, (c) emerging needs in service area, (d) emerging at-risk populations in service area, (e) gaps in services identified in service area, and, (f) suggestions for improvement to prevention and/or care services.

Information provided by the organizations and agencies surveyed closely mirrored the findings of the population specific focus groups, key informant interviews and individual surveys. Therefore, both the populations and organizations confirmed the barriers and needs related to HIV Prevention in Connecticut.

SECONDARY SOURCES OF DATA

Secondary data consisted of findings of research collected through the Rapid Assessment, Response and Evaluation (R.A.R.E) New Haven 2001 project and the R.A.R.E. Hartford 2003 project.[2] Both R.A.R.E. projects provided information regarding the HIV/AIDS prevention and care needs of high-risk African American and Latino populations (e.g. commercial sex workers, active injection drug users, MSMs, heroin/crack users, and drug sellers).

Additional data was supplied by Bonnie Edmondson, HIV/STD Prevention Coordinator for the Connecticut Department of Education, regarding youth risk behavior and Deborah Cornman of the Center for HIV Prevention and Intervention at the University of Connecticut (HIV positive individuals and Prevention for Positives). Secondary data was also supplied by staff of the Connecticut Department of Public Health. Heidi Jenkins of the Sexually Transmitted Disease Control Program provided data regarding the state of STDs in Connecticut, Andrea Lombard of

[2] Information on the R.A.R.E. 2001 New Haven Project was supplied by Mark Kinzly of Yale University. R.A.R.E. 2003 Hartford Project information was supplied by the Hispanic Health Council, Hartford

the Viral Hepatitis Program provided information regarding Hepatitis A, B and C, and the HIV/AIDS Surveillance Programs provided HIV/AIDS epidemiological data.

Needs assessment findings were also supplemented with Connecticut data obtained from the Ryan White Title I 2002 Needs Assessment for New Haven/Fairfield counties and the Greater Hartford Title I Eligible Metropolitan Area (EMA) June 2002 Comprehensive HIV Health Services Plan. Additional data was obtained from the Ryan White Title II Connecticut Comprehensive Statewide Care and Prevention Plan for HIV/AIDS. Information from the Ryan White Title II plan was provided by Holt, Wexler and Farnum, LLC.

Finally, information from the Connecticut Department of Public Health's HIV Prevention Interventions database from DPH funded contractors, Epidemiological data concerning the number and location of People Living with AIDS (PLWA) and funding information according to region were also used in the Community Services Assessment.

LIMITATIONS

The major limitation of data is the lack of long-term data involving those who are HIV positive. Connecticut began collecting reports of HIV positive tests in 2001. Therefore, information concerning those who are HIV positive (as opposed to those who are diagnosed with AIDS) is very new. In addition, only 48 percent of HIV Incidence data includes the identified risk. This makes assessing needs and determining gaps more difficult to do. The CPG has brought this to the attention of the DPH and DPH is currently looking at ways to increase identified risk data.

In addition to the above limitation, the DPH Prevention Intervention database, the most extensive source of HIV prevention activities in the state, has its own limitations. Many times providers do not fill out the reporting forms completely and there is often missing demographic data. The DPH has recently instituted a reporting system, The Uniform Reporting System (URS) that requires submission of demographic data. Therefore, this limitation will be solved with the full implementation of the URS System.

Regarding the survey of DPH and non-DPH funded providers, it became apparent that the survey was much too long and cumbersome. This resulted in a lower than desired response and responses that often did not provide the information requested. The CSA committee will take this into consideration when designing future surveys.

Finally, the CSA committee is currently working on conducting a full focus group with Transgender people. Although this will not be completed in time for this Plan, it will be included in the next Plan update.

In addition to focus groups with Transgender people, more data regarding needs and gaps faced by those who are HIV positive would be beneficial. The CSA intends to continue to conduct focus groups and data collection among those who are HIV positive.

NEEDS ASSESSMENT

As the focus for its 2004 Needs Assessment, the Community Services Assessment (CSA) Committee, in collaboration with the DPH, chose to focus its efforts on the prioritized populations for 2005-2008 – HIV+, MSM, IDU, and Heterosexual. In addition, Incarcerated individuals, Transgender people and WSW were also focused on as emerging populations.

Rather than conduct another statewide assessment of HIV prevention needs, which had already occurred in 2000, the CSA elected to build on that needs assessment and pursue focus groups, key interviews, mini-surveys, and research presentations for the following populations:

- **HIV Positive Individuals**
- **Men who have sex with men (MSM)**
- **Late night high-risk populations (R.A.R.E. Hartford and R.A.R.E. New Haven Project Reports)**
- **Transgender (male-to-female and female-to-male)**
- **Department of Correction (male and female)**
- **Women who have sex with women (WSW)**

The assessment process was designed to obtain population specific information, which focused on related risk behaviors, attitudes and beliefs; extent of services being utilized; perceived or real barriers to accessing services; proven effective interventions, activities or programs; related appropriate services and available and accessible resources; and sub-population differences relative to prevention and care issues.

Met and Unmet Needs

A needs assessment further provides a means of defining a population's met and unmet needs. In the focus group reports that are included in this chapter, as well as in the information from the 2004 Prevention and Care Resource Inventory Survey Questionnaire, a picture of the met and unmet needs of Connecticut's prioritized populations will be highlighted. Also featured in this chapter will be the Care needs of persons living with HIV/AIDS (PLWHA) as documented in the Ryan White Title II Connecticut Comprehensive Statewide Care and Prevention Plan.

- A ***met*** need is a service within a specific target population that is currently being addressed through existing services that are (1) *available* to that target population, (2) *appropriate* for that target population, and, (3*) accessible* to the target population.

- An ***unmet*** need is a service within the target population that is not currently being addressed through existing prevention and care services or activities because: (1) no services are currently available, (2) available services are inappropriate, or (3) the service is inaccessible to the target population.

In order to assess the needs of these identified populations, key informant interviews were conducted with service providers, outreach workers and community advocates. Focus groups were conducted with HIV positive people, MSMs and incarcerated persons in addition to a survey conducted with WSW. Finally, data collected as a part of the R.A.R.E. projects in New Haven and Hartford was examined.

Information gathered by these methods, described more fully under the data collection section above and in Appendix B, Focus Group Reports, together with data obtained through the survey of providers (also described more fully under data collection) provided most of the information used to conduct the needs assessment.

STATEWIDE COORDINATED STATEMENT OF NEED (SCSN)[3]

In 2003, Connecticut conducted its first assessment process that examined doth HIV prevention and HIV care. Termed a Statewide Coordinated Statement of Need (SCSN), this document provides a mechanism to (a) collaboratively identify and address significant HIV care issues related to the needs of People Living With HIV/AIDS, and where appropriate individuals affected by HIV/AIDS; and (b) maximize planning, coordination, integration and effective linkages across the Care Act Titles with prevention.

Assessing these service gaps across the state involved the review of data sets that had been compiled through different venues and sources (e.g. studies, outreach efforts, consumer and provider surveys, seminars, as well as needs assessments and evaluations conducted by DPH, Hartford and New Haven/Fairfield Ryan White Title I Planning Councils, the Statewide Care Consortium, and the CPG). Gaps and needs identified through this assessment process were classified and prioritized by an Ad Hoc Committee, consisting of DPH staff and representatives of Ryan White Titles I, II, II and IV and the CPG, and presented to the full Statewide HIV/AIDS Care Consortium for review.

As confirmed by the SCSN, the identified statewide gaps, emerging needs and recommendations are as follows:

Cross-Cutting Themes

- Healthcare Costs
- Cultural Competency / Linguistic Complexity / Serving the Deaf and Hard of Hearing
- Education and Outreach
- Non-Medication Adherence
- People Not in Care
- Prevention Needs of PLWHA

Emerging Needs

- Maturing Population (age 50+)
- Hispanic Population
- Undocumented Population / Migrant Workers
- Primary and Secondary HIV Prevention
- Mitigating Heterosexual HIV Transmission
- Cross Training (among HIV/AIDS Case Management and Outreach workers)
-

Disproportionately Represented and Underserved Populations

- Men
- African American
- Hispanic
- Men who have Sex with Men (MSM)
- Injection Drug Users (IDU)
- Women
- Adults age 50+
- Dually diagnosed
- Prison inmates
- Youth (13-24 years old)

[3] Executive Summary, The Connecticut Comprehensive Statewide Care and Prevention Plan for HIV/AIDS, 2004-2007

Critical Gaps

Physical Needs:

- Help Paying for and Help Finding Housing
- Emergency Financial Assistance

Medical Needs:

- Dental Services
- Alternative Therapy
- Nutritional Counseling
- Links to Other Systems of Care
- Information About Available Services

The preceding Statewide Care Consortium Needs Assessment data suggests that important care services are being used, but that significant unmet needs exist, particularly in housing, dental, emergency financial assistance, and HIV prevention/risk reduction. Data also indicates that unmet needs exist for outreach efforts to move individuals into primary medical care and connect new clients with systems of care. This Statewide Care Consortium assessment of met and unmet needs is extremely consistent and compatible with the findings of the 2004 CPG Needs Assessment process.

Recommendations developed by the Statewide Consortium are also reflective in many ways of the recommendations brought forth in the CPG 2004 Needs Assessment:

- Services will be culturally sensitive, geographically accessible and offer flexible hours.
- Providers will reflect the HIV/AIDS population they serve.
- Individuals will receive culturally appropriate and comprehensive information on HIV/AIDS, primary and secondary prevention, and the full range of services available at each and every portal of entry into the continuum of care.
- System of care linkages will be strengthened through collaborative planning, co-location, cross-training and referral strategies among all service categories, with a particular emphasis on collaboration between substance abuse treatment, mental health treatment, housing, case management, and across medical providers to coordinate the delivery of care and prevention.
- Providers will improve efforts to prevent relapse and improve medication adherence.
- Providers will increase efforts to engage and bring individuals into care, especially individuals that are Hispanic, female, migrants, and among the 50+ age populations.
- Providers will make best efforts to bring under- and un-insured individuals into care, especially minorities.
- Providers should be increasingly aware of and plan to meet the needs of an aging AIDS population.

Further Information regarding the process of integrating care and prevention services is addressed in Chapter 6: Linkages, Surveillance and Research, Technical Assistance and Capacity Building.

2004 PREVENTION AND CARE NEEDS ASSESSMENT FINDINGS

The prevention and care needs assessments findings contained in Connecticut's 2005-2008 comprehensive plan, provide a snapshot of the prevention and care needs of

Connecticut populations that most closely resemble the statewide priority populations - injection drug users (IDUs), men who have sex with men (MSMs – gay and non-gay identified), heterosexual males and females, people living with HIV, and three emerging populations at risk for HIV infection – transgender, women who have sex with women (WSW) and incarcerated populations.

Focus Group Themes: Commonalities and Needs

Upon review of the focus group reports, it became apparent that common themes regarding barriers to services and population issues, as well as prevention needs, appeared across all populations. These include individual barriers, community-level barriers and systems barriers.

Prevention Barriers

Populations are mostly aware of the need for risk behavior change and for the need to use condoms/dental dams, but actually making and sustaining behavior changes is the challenge (e.g. difficulty in sustaining safer-sex behaviors). Barriers to prevention and services identified include:

Individual Level Barriers

- Dislike being "labeled"
- Distrust of medical providers, doctors and health care environment
- Feelings of isolation and depression
- Fear of identifying and loss of anonymity
- Fear of being judged and of being rejected by family, friends and church
- Internalized racism, homophobia and heterosexism
- Multiple sex partners and infrequent condom use
- No perceived risk for HIV infection
- Mental health and substance abuse issues
- AIDS-fatigue
- Undocumented immigrants
- Inadequate or no health insurance
- Problems with reading comprehension
- Misconceptions about HIV

Community Level Barriers

- Cultural, family, religious, and economic issues and influences affect an individual's ability or willingness to access prevention and care services
- Racism, homophobia and heterosexism
- Stigma, discrimination and violence
- Lack of safe "gathering spaces" and effective support groups
- Misconceptions about HIV

Systems Barriers

- No bilingual or culturally sensitive prevention staff
- Culturally incompetent medical and service providers and personal physicians
- Inadequate transportation, housing and health care
- Gaps in hours of services and few late night services

- Sharing needles for injecting drugs and hormones (e.g. need to expand needle exchange programs)
- Language barriers – cultural and population generated (e.g. Transgender terminology and vocabulary)
- Misconceptions about HIV

Prevention Needs

Based on feedback provided by the focus groups, key informant interviews and surveys, Connecticut's HIV prevention needs include:

- HIV/AIDS information and prevention programs/outreach services need to be culturally appropriate to populations and sub-populations.
- More mental health, substance abuse, and detox programs and shorter waiting lists
- Culturally appropriate medication adherence programs for HIV+ individuals
- Peer educators and identified "role models" and "spokespersons"
- More innovative outreach and information strategies (e.g. use of the internet)
- Holistic approaches to intervention, which include basic needs
- Bilingual prevention information – especially in dialect of populations
- Better access to transportation (e.g. longer hours of service)
- Condom availability in prisons and in high-risk locations (e.g. parks, on the street, bars)
- Access to clean needles
- Late-night services and outreach
- Culturally appropriate safer sex workshops
- Mandatory HIV testing in prisons
- Address cultural, social, economic and psychological issues of populations and not just HIV.
- Wider availability of HIV counseling & testing in non-medical settings (e.g. bars, clubs, community locations)
- Creation of "safe spaces"

Provider Survey Themes: Commonalities and Needs

Upon review of the provider survey results, it became apparent that common themes regarding challenges, barriers, needs and gaps were encountered or observed by a large number of providers, regardless of population served.

Table 3a: 2004 Needs Assessment Findings

Program Challenges and Needs (in rank order of importance)	• Funding/resources • Insufficient staffing • Coordination with other agencies • Dual diagnosis/complicated problems • Difficulties in accessing populations • Referrals • Lack of bilingual staff • Target population not aware of services • Lack of bilingual or culturally appropriate material • Limited hours of operation • Evaluation • Duplication of services • Lack of available training for staff • Quality assurance/improvement programs • Small size of target population • Staff retention/turnover
Problems encountered by clients in accessing services	• Lack of service coordination among agencies providing services • No continuity of care • Lack of transportation • Insurance (insufficient or lack thereof) • Cultural/language barriers • Lack of knowledge about services available • Lack of safe, affordable housing • Long waiting lists for services and treatment programs (drug treatment, mental health, substance abuse and detox) • Stigma • Fear of arrest

Table 3a: 2004 Needs Assessment Findings

Emerging Needs in Service Area (provider identified)	• Relevant HIV/STD prevention education and materials • Nutritional components addressing PLWHAs • Safe and affordable housing (rural and urban) • HIV prevention services for immigrant communities • Mental health services for youth • Accessible, affordable and dependable public transportation • Hepatitis testing • Counseling (e.g. mental health counseling for families) • Insufficient resources and funding to address needs of populations underserved • Primary care (e.g. state and uninsured patients) • Employment related services for PLWHAs • High rate of co-occurring mental health and substance abuse • Lack of medical insurance • Long waiting lists for services and programs • Coordinated substance abuse treatment
Emerging Populations (provider identified)	• MSM • IDU • Undocumented immigrants • Newly diagnosed patients with AIDS – never in care • Over 50 Population • Homeless • Hispanic • Pregnant women • Migrant and immigrant populations • Deaf and hard of hearing • Youth at risk and out of system (e.g. drop outs, run away, homeless) • Elderly • Sexual minority youth • HIV+ heterosexual males • Africans, Jamaicans, Haitians, persons from Central and South America • Caribbean Islanders • Asian population • Young Latinas and Latinas in committed relationships

Table 3a: 2004 Needs Assessment Findings

Gaps in service areas (provider identified)	• Services for undocumented clients • Inter-agency collaboration • Foreign born and undocumented with no insurance for prenatal care • Lack of psychiatric and dental services in rural areas; insufficient in urban areas • Staffing • Cultural and language understanding • Housing • Bilingual mental health services • Medication follow-up • Needle exchange programs • Transportation • Insufficient shelter and detox beds • Spanish services in DOC health areas • Methadone program • Voucher programs with supports (e.g. community case managers) • Hotlines not accessible or responsible to deaf and hard of hearing • Home care services for undocumented and uninsured • Lack of public school HIV education and information
Suggestions for improvement of prevention and/or care services	• Increase funding for emergency care needs • Increase case management • Provide honest, open and relevant communications that address issues leading to risky behavior • Establish a rural-based needle exchange program • Develop affordable, safe and accessible housing for PLWHAs with appropriate supportive services • Augment/implement mental health services for affected/infected children • Create better collaborations and client follow-up between agencies • Provide more accessible mental health care • Connect the prevention/wellness message with other initiatives such as coordinated public school health. • Closer linkage of prevention and care services • Increase secondary prevention programs/activities and services for HIV+ • Early identification of individuals at very high risk with unknown serostatus • Increase area-specific education around resources available to HIV+ individuals

Barriers Discussion
As part of the subjective factor component of the 2004 Priority Setting Process, an open discussion was facilitated between CPG members and members of the public concerning barriers to accessing services and barriers to serving populations. Once again, common themes emerged:

Barriers to accessing services – transportation; social isolation; services not available; lack of support for basic needs; fear; lack of culturally sensitive or age-appropriate services; denial; no access to clean syringes; waiting lists, and lack of youth-driven services.

Barriers to serving the population: hours of operation; lack of culturally sensitive providers; lack of training, funding and staffing; lack of collaboration/ cooperation between organizations and professional resources; lack of relevant educational materials and curriculum; lack of services targeting specific populations.

RESOURCE INVENTORY

The CDC's *Guidance on HIV Prevention Community Planning* defines a resource inventory as one of the three components of a Community Services Assessment. A resource Inventory assesses existing community resources for HIV prevention and care to determine the community's capability and capacity for responding to the HIV epidemic.

According to the Academy for Educational Development (AED), a resource inventory is more than just a list of prevention and care programs and their respective funding levels and sources. As a source for determining and defining existing HIV prevention and care services within a particular jurisdiction, the resource inventory should also detail information about service providers included in the inventory:

Contact information: provider name, address and other relevant contact information

Resources: funding sources and amounts/values of resources

Program focus: HIV prevention and/or care or other related services (e.g. pregnancy prevention, domestic violence, substance abuse)

Project area: geographic area served (e.g. Ryan White Title I EMA, Title II Statewide, Titles III and IV, and CPG Region)

CPG target populations served: demographic and risk behavior of individuals served
Service capacity: number of different individuals served per year

Prevention/care intervention or strategies: specific interventions such as counseling and testing, behavior modification, risk reduction, prevention for positives, perinatal, etc

Assessment: accessibility and suitability for targeted populations

During the 2003-2004 planning cycle, the CPG engaged in the development of a statewide resource inventory of prevention and care providers, as well as the creation of a gap analysis, which documented both the met and unmet prevention and care needs in the state. This year-long process laid the framework for the roll-out of Connecticut's new HIV resource inventory for the 2005-2008 Comprehensive Prevention Planning Cycle.

The CPG's resource inventory is designed to define current HIV prevention/care and related resources and activities, regardless of the funding source (federal, state, private). It also includes information regarding HIV prevention and care activities throughout the state, as well as other education, prevention and care services and activities that are likely to contribute to HIV risk reduction. These resources, either directly or indirectly HIV related, include the existence of social networks, educational institutions, businesses or other community-building activities.

The CPG's statewide resource inventory of prevention and care services and resources will serve as a comprehensive reference tool for providers as well as people living with HIV/AIDS (PLWHA). As part of the community services assessment, the resource inventory will provide an understanding of current community resources and capacity for HIV prevention and care.

2004 CPG Resource Inventory Process

The 2003 resource inventory workplan, covering the period from July 2002 through May 2003, called for the creation of a resource inventory survey tool for DPH funded providers as well as one for private and state funded providers of prevention and care related services. Since a data base of 65 DPH funded providers already existed, which reflected interventions, targeted populations, number of clients served, and geographic region, the Community Services Assessment (CSA) Committee, in collaboration with AIDS Project Hartford, Dr. Deborah Cornman of the University of Connecticut, and the DPH developed a survey tool in August 2003 to help glean additional information about prevention services, interventions provided, targeted populations, collaborations, capacity to provide services, and funding streams.

This prevention inventory of HIV prevention interventions was pre-formatted with known contractor-specific prevention intervention data, emailed to providers for their review and update, and returned to the Department of Public Health for processing and analysis. (See Inventory of HIV Prevention Interventions survey tool included in Appendix B). From these surveys, the DPH was able to assess intervention specific needs and gaps in services, numbers of clients and populations served, as well as the capacity of providers to implement prevention interventions and activities.

The survey tool determined both DPH-funded and non-DPH funded statewide prevention and care providers (e.g. social service agencies, educational institutions, health centers and other community-based organizations) was developed by the Parisky Group (contractor) and CSA Committee. (See Connecticut HIV Prevention Community Planning Group 2004 Resource Inventory Questionnaire in Appendix B).

Designed to be completed on line and returned electronically, the survey also had a Business reply/postage-paid return ability. This questionnaire contained both prevention intervention and care service-related questions: agency types; services provided; geographic areas served; client demographics; number of patients/clients served in a 12 month period; percentage of clients who are HIV+ (not AIDS diagnosed) and the number of clients who are HIV+ and AIDS diagnosed; service capacity (number of clients served in various categories ranging from Gay/Lesbian/Bisexual to Deaf and Hard of Hearing); HIV prevention interventions provided; populations targeted with HIV prevention and care services; program challenges and needs; funding sources (private and public) , and care services offered through Ryan White Titles I, II, III, and IV.

Because no one central information repository existed of comprehensive statewide prevention and care services, an Access database was developed by the contractor, which contained a listing of the 375 statewide agencies and organizations. Additional fields were also included in the database to record the information contained on the survey forms. Agencies and organizations included on this database, as potential prevention intervention and care providers, were emailed and mailed a copy of the provider survey for their input and return to the Parisky Group for processing and analysis.

RESOURCE INVENTORY FINDINGS

Northcentral Region

The Northcentral CPG Region consists of Hartford County. Hartford County is the capital region of Connecticut consisting of the City of Hartford, Connecticut's third largest city and its surrounding suburbs. The total population of this region is 857,183. Of this population, approximately 77 percent are white and 12 percent African American. Close to 12 percent of the population is Latino of any race.

A total of 25 HIV prevention service providers, both DPH funded and non-DPH funded, were identified in this region. Total DPH HIV prevention funding for this region is $1,871,076. Other funding sources for HIV prevention identified through the survey totaled $ 976,671.
DPH prevention funds spent on programs for youth ages 13-24 totals $482,937, or 26 percent of total funds for the region. DPH prevention funds spent on programs for positive people is $202,031, representing 11 percent of total funds for the region.

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
AIDS Project Hartford Ed Paquette Director, Prevention Services 110 Bartholomew Ave. Hartford CT 06106 860-951-4833 860-951-4779 DPH Contractor	Health Communications Public Information Community Level Interventions Prevention Case Management Individual Level Intervention Group Level Intervention Needle exchange Outreach Specific interventions for HIV+	Bisexual, Black Heterosexual, Black IDU, Black MSM, HIV Positive Adults Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latinos/as MSM, Lesbian, People over 50, Recently released or on parolee, Transgender, White Heterosexual, White IDU, White MSM
Bristol Burlington Health Dist Dr. Patricia J. Checko, Director 240 Stafford Avenue Bristol, CT 06010 860-584-7682 DPH Contractor	Individual Level Intervention Outreach Group Level Intervention	Black Heterosexual, Black MSM, Latino MSM, Youth 13-19,Youth 20-24

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Catholic Charities Migration and Refugee Services Sister Dorothy Strelchun 125 Market St. Hartford CT 06103 860-548-0059 860-549-8696 DPH Contractor	Outreach	Asian, People over 50, Pregnant Women, Youth 13-19, Youth 20-24
Center City Churches Peters Retreat Ron Krom Program Director 40 Pratt St., Suite 210 Hartford CT 06103 860-247-4140 860-247-5177	Prevention Case Management Health Communications Public Information Individual Level Intervention Specific interventions for HIV+	Commercial sex workers, HIV Positive Adults, Homeless, Latinos/as Heterosexual, Latinos/as IDU White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24
Central Connecticut AHEC Brenda DelGado 30 Arbor Street North Hartford, CT 06106 860-233-7561 DPH Contractor	Individual Level Interventions Community Level Intervention Group Level Intervention	American Indian/Alaskan Native, Asian, Bisexual, Black Heterosexual, Black IDU, Black MSM, Commercial sex workers, HIV Positive Adults, Homeless, Incarcerated, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian, Native Hawaiian or Pacific Islander, People over 50, Recently released or on parole, Transgender, Undocumented, White Heterosexual, White IDU, White MSM, Youth 20-24, Youth 13-19
Charter Oak Health Center Angelique Croasdale HIV Progam Manager 21 Grand St. Hartford CT 06106 860-550-7500 x6568 DPH Contractor	Health Communications Public Information Individual Level Intervention Partner Counseling and Referral Services Outreach Specific interventions for HIV+	Black Heterosexual, Homeless, Latinos/as Heterosexual, Latinos/as IDU, White IDU, Youth 13-19
Chrysalis Center, Inc. Michele Psutka Services Director 278 Farmington Ave. Hartford CT 06060 860-525-1261 860-527-0297	Prevention Case Management Health Communications Public Information Individual Level Intervention Outreach Group Level Intervention	American Indian/Alaskan Native, Asian, Bisexual, Black Heterosexual, Black IDU, Black MSM, Commercial sex workers, Deaf/hard of hearing, HIV Positive Adults, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latinos/as MSM, Lesbian, Migrant farm workers, Native Hawaiian or Pacific Islander, People over 50, Pregnant women, Recently released or on parole, Transgender White Heterosexual, White IDU, White MSM, Youth 20-24

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
City of Hartford, Hartford Health & Human Services 131 Coventry Street Hartford CT 06112 860-543-8822 860-722-6713 DPH Contractor	Prevention Case Management Community Level Interventions Individual Level Intervention Group Level Intervention Partner Counseling and Referral Services School-based health clinic	Asian, Bisexual, Black Heterosexual, Black IDU, Black MSM, Commercial sex workers, Deaf/hard of hearing, HIV Positive Adults, Incarcerated, Latinos/as Heterosexual, Latinos/as IDU, Latinos/as MSM, Lesbian, People over 50, Pregnant women, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24
Community Child Guidance Mary Montany LCSW 317 North Main St. Manchester CT 06040 860-643-2101 860-645-1470 DPH Contractor	Individual Level Intervention Group Level Intervention	Children, HIV Positive Adults
Community Health Services Michael Sherman, CEO 500 Albany Avenue Hartford, CT 06120 860-808-8703 860-808-1540 DPH Contractor	Community Level Interventions Individual Level Intervention Group Level Intervention Outreach	Bisexual, Black heterosexual, Black IDU, Black MSM, Homeless, Latinos/as heterosexual, Latino MSM White IDU, White MSM
East Hartford Health Dept Baker Salsbury, Director 740 Main Street East Hartford, CT 06108 860-291-7293 860 291-7304 DPH Contractor	Individual Level Intervention Outreach	Black heterosexual, Black IDU, White IDU, Latino IDU
Hartford Behavioral Health Susan R. Niemitz Acting Executive Director 1 Main St. Hartford CT 06106 860-727-8703 860-548-2045	Prevention Case Management Individual Level Intervention Partner Counseling and Referral Services	Asian, Bisexual, Black Heterosexual, Black IDU, Black MSM, Commercial sex workers, HIV Positive Adults, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian, People over 50, Pregnant women, Recently released or on parole, Transgender, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Hartford Dispensary Cheryl Sposito, ID Coordinator 345 Main Street Hartford, CT 06120 860-527-5100 DPH Contractor	Prevention Case Management Individual Level Intervention Partner Counseling and Referral Services Outreach Group Level Intervention Community Level Interventions Specific interventions for HIV+	Black IDU, Latinos/as IDU, Pregnant Women, White IDU
Hartford Gay & Lesbian Health Collective Joseph Simard Director of Clinical Svcs P.O. Box 2094 Hartford CT 06145-2094 860-278-4163 860-278-5995 DPH Contractor	Community Level Interventions Individual Level Intervention Outreach Partner Counseling and Referral Services Prevention Case Management Health Communications Public Information	Bisexual, Black MSM, HIV Positive Adults, Lesbian, Latino MSM, Lesbian, Transgender, White MSM, Youth 13-19, Youth 20-24
Hispanic Health Council 175 Main Street Hartford CT 06106 860-527-0856 860-724-0437 DPH Contractor	Community Level Interventions Individual Level Intervention Outreach Group Level Intervention	Bisexual, Latino MSM, Transgender
Human Resources Agency of New Britain, Inc. Deborah Gosselin, Director AIDS Prevention Program 336 Arch St. New Britain CT 06051 860-826-4482 860-832-4663 DPH Contractor	Prevention Case Management Community Level Interventions Group Level Intervention Specific interventions for HIV+	Asian, Bisexual, Black Heterosexual, Black IDU, Black MSM, Commercial sex workers, HIV Positive Adults, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian People over 50, Pregnant women, Recently released or on parole, Transgender, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24
Latinos/as Contra SIDA 184 Wethersfield Avenue Hartford, CT 06114 860-296-6400 860-728-3782 DPH Contractor	Prevention Case Management Community Level Interventions Individual Level Intervention Group Level Intervention Outreach Partner Counseling and Referral Services Specific interventions for HIV+	Bisexual, Commercial sex workers, HIV positive adults, HIV positive children/youth, Homeless, Latinos/as heterosexual, Latinos/as IDU, Latino MSM, Lesbian, Migrant farm workers, Transgender, Youth 13-19
McKinney Shelter Mria Rajos 34 Huyshope Avenue Hartford CT 06106 860-722-6921	Prevention Case Management Community Level Interventions Individual Level Intervention	Bisexual, Black Heterosexual, Black IDU, Black IDU, HIV Positive Adults, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latinos/as MSM, People over 50, Recently released or on parole, Undocumented

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
New Britain Health Department Gail Ide, Project Director 31 High Street New Britain, CT 06051 860-826-3464 DPH Contractor	Individual Level Intervention Outreach	Black Heterosexual, Black IDU
Open Hearth Association, Inc. Mary Barnes P.O. Box 1077 Hartford CT 06143-1077 860-525-3447 860-920-0011	Prevention Case Management Individual Level Intervention Group Level Intervention	Homeless All Homeless men over 18
Salvation Army – AIDS Ministries Program 855 Asylum Avenue Hartford, CT 06142 860-543-8400	Group Level Intervention Health Communications Public Information Community Level Intervention Individual Level Intervention Outreach	HIV Positive Adults, Latino/as Heterosexual, Black Heterosexual, Homeless, Youth 13-19
UCONN/CCMC HIV Pediatric and Youth Program Clara Acosta-Glynn, Family Support Services Coordinator CCMC-2-L 280 Washington St, Hartford CT 06106 860-547-7477 860-545-7490 DPH Contractor	Community Level Intervention Individual Level Intervention Group Level Intervention Outreach Partner Counseling and Referral Services Specific interventions for HIV+	Black Heterosexual, HIV Positive Children, Homeless, Incarcerated, Latinos/as Heterosexual, Pregnant women, White Heterosexual, Youth 13-19, Youth 20-24
Urban League of Greater Hartford Suzette Benn, Dir of Community Health 140 Woodland Street Hartford, CT 06105 860-527-0147 x147 DPH Contractor	Individual Level Intervention Community Level Interventions Health Communications Public Information	Black heterosexual, Black IDU
Village for Families and Children 1680 Albany Ave Hartford CT 06105 860-236-4511 DPH Contractor	Prevention Case Management Specific interventions for HIV+ Community Level Interventions Outreach Group Level Intervention	Black heterosexual, HIV positive adults, HIV positive children, Latinos/as heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Wheeler Clinic, Inc. Laura Minor Prevention & Wellness Program Coordinator 334 Farmington Avenue Plainville CT 06062 860-793-2164 860-793-9813 DPH Contractor	Group Level Intervention Health Communications Public Information Community Level Interventions Individual Level Intervention	Youth 13-19 Youth 20-24 Deaf and hard of hearing

Southcentral Region

The Southcentral CPG Region consists of New Haven and Middlesex Counties. Major metropolitan areas in this region include New Haven, Waterbury and Middletown. Both counties have a combined population of 995,336 people making it the CPG Region with the largest population. Approximately 10 percent of the population is African American and 81 percent white. Nine percent of the population is Latino of any race.

A total of 24 HIV prevention service providers, both DPH funded and non-DPH funded, were identified in this region. Total DPH HIV prevention funding for this region is $1,713,545. Other HIV prevention funding sources identified through the survey totaled 870,065.

DPH prevention funds spent on programs for youth ages 13-24 totals $565,468, or 33 percent of total funds for the region. DPH prevention funds spent on programs for positive people is $193,679, representing 11 percent of total funds for the region.

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
AIDS Interfaith Network Joyce Poole Executive Director 1303 Chapel Street, New Haven, CT 06511 (203) 624-4350 DPH Contractor	Community Level Interventions Group Level Intervention Outreach	Black Heterosexual, People over 50 Youth 13-19
AIDS Project New Haven Ellen Gabrielle Executive Director 1302 Chapel Street New Haven, CT 06511 203-624-0947 DPH Contractor	Group Level Intervention Community Level Interventions Prevention Case Management Outreach	Black Heterosexual, Black IDU, Black MSM, Latinos/as IDU, Latinos/as MSM, White MSM, White IDU, Youth 13-19, Youth 20-24

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
APT Foundation, Inc Bob Freeman Coordinator Clinical Services 1 Long Wharf Drive New Haven CT 06511 203-781-4600 203-781-4624 DPH Contractor	Prevention Case Management Individual Level Intervention Group Level Intervention Specific interventions for HIV+	Black Heterosexual, Black IDU, HIV Positive Adults, Latinos/as Heterosexual, Latinos/as IDU, White Heterosexual, White IDU
Birmingham Group Health Services 435 East Main St Ansonia, CT 06401 203-736-2601 DPH Contractor	Health Communications Public Information Outreach	Black Heterosexual
Clifford Beers Guidance Clinics Toni Nixon 93 Edwards St. New Haven, CT 06511 203-772-1270 DPH Contractor	Individual Level Intervention Group Level Intervention	Children, HIV Positive Adults
Community Health Center Inc Yvette Francis-Highsmith 635 Main Street Middletown, CT 06457 860-347-6971 DPH Contractor	Group Level Intervention Individual Level Intervention Outreach Specific interventions for HIV+	Youth 13-19, Youth 20-24, Black Heterosexual, Latino MSM, Homeless, Black IDU, Latino/a IDU, White IDU
Fair Haven Comm Health Ctr Magalys Perez HIV Program Coordinator 374 Grand Avenue New Haven CT 06513 203-777-7411 203-777-8506 DPH Contractor	Individual Level Intervention Outreach School-based health clinic Specific interventions for HIV+	HIV Positive Adults, Latinos/as Heterosexual, Latinos/as IDU, Latinos/as MSM, Undocumented, Youth 20-24
Fellowship, Inc. 441 Elm Street New Haven, CT 06511 (203) 401-4227 DPH Contractor	Group Level Intervention Individual Level Intervention Outreach Health Communications Public Information Community Level Intervention	Bisexual, Black Heterosexual, Homeless, Latinos/as Heterosexual, Latino MSM, White Heterosexual, White MSM.

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Family Intervention Center Community Promise Program 1875 Thomaston Avenue Waterbury CT 06704 203-756-6032 DPH Contractor	Community Level Intervention Individual Level Intervention Outreach	Bisexual, Black Heterosexual, Black IDU, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latinos/as MSM, Lesbian, People over 50, White IDU, Youth 13-19, Youth 20-24
Hill Health Center: HIV/AIDS Division 428 Columbus Ave New Haven, CT 06519 203-503-3183 DPH Contractor	Prevention Case Management Individual Level Intervention	Black Heterosexual, Hispanic Heterosexual
Hispanos Unidos Inc. Luz Gonzalez Executive Director 116 Sherman Avenue New Haven CT 06511 203-781-0226 203-781-0229 DPH Contractor	Health Communications Public Information Prevention Case Management Community Level Interventions Individual Level Intervention Partner Counseling and Referral Services Group Level Intervention Outreach Specific interventions for HIV+	Black Heterosexual, Black IDU, Black MSM, HIV Positive Adults, Homeless Incarcerated, Latinos/as Heterosexual, Latinos/as IDU, Latinos/as MSM, Migrant farm workers, People over 50, Recently released or on parole, Transgender, Undocumented, White MSM, Youth 13-19, Youth 20-24
Hospital of Saint Raphael Annette E. Hird Grants Specialist 1450 Chapel Street Scranton 107 New Haven, CT 06511 203-789-3596 DPH Contractor	Community Level Interventions Individual Level Intervention Partner Counseling and Referral Services Group Level Intervention Outreach School-based health clinic Specific intervention for HIV+	American Indian/Alaskan Native, Latinos/as Heterosexual, Asian, Bisexual, Black heterosexual, Black IDU, Black MSM, Commercial sex workers, HIV Positive Adults, HIV Positive Children/Youth, Incarcerated, Latino MSM, Latinos/as IDU, Lesbian, Native Hawaiian or Pacific Islander, People over Fifty, Pregnant Women, Recently released or parole, Undocumented, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24
Meriden Dept. of Health/Human Services Beth Vumbaco Director 165 Miller St. Meriden CT 06450 203-630-4221 203-639-0039 DPH Contractor	Prevention Case Management Community Level Interventions Individual Level Intervention Group Level Intervention Outreach Partner Counseling and Referral Services Specific interventions for HIV+	American Indian/Alaskan Native, Asian, Bisexual, Black Heterosexual, Black IDU, Black MSM, Commercial sex workers, HIV Positive Adults, HIV Positive Children, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, People over 50, Pregnant women, Recently released or on parole, Transgender, Undocumented, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Middletown Health Department Louis Carta, Health Educator 245 DeKoven Dr P.O. Box 1300 Middletown, CT 06457 860-344-3588 DPH Contractor	Health Communications Public Information Individual Level Intervention Community Level Interventions Outreach	American Indian/Alaskan Native, Latinos/as Heterosexual, Undocumented, Asian, Latinos/as IDU, White Heterosexual, Bisexual, Latino MSM, White IDU, Black heterosexual, Lesbian, White MSM, Black IDU, Youth 13-19, Black MSM, Commercial sex workers, Deaf /Hard of Hearing, People over Fifty, HIV Positive Adults, Pregnant Women, HIV Positive Children/Youth, Recently released or parole, Homeless, Transgender
Midstate Behavioral Health System John W. Sykes 883 Paddock Avenue Meriden CT 06450 203-630-5266 203-634-7083 DPH Contractor	Health Communications Public Information Prevention Case Management Community Level Interventions Individual Level Intervention Group Level Intervention Outreach	Bisexual, Black MSM, HIV Positive Adults, Homeless, Incarcerated, People over 50, Recently released or on parole, Transgender, White Heterosexual, White IDU
Morris Foundation Dr. Donald Edwardson Director of Prevention 95 Scovill Street Waterbury, CT 06706 203-755-1143 203-753-3274 DPH Contractor	Prevention Case Management Group Level Intervention	Black IDU, White IDU, Hispanic IDU, HIV positive adults
New Haven Health Department Matthew Lopes, Coordinator of AIDS Services 54 Meadow Street New Haven, CT 06519 203-946-8351 DPH Contractor	Health Communications Public Information Community Level Interventions Individual Level Intervention Prevention Case Management Partner Counseling and Referral Services Group Level Intervention Needle exchange Outreach	Bisexual, Black Heterosexual, Black Heterosexual, Black IDU, Black MSM, Commercial sex workers, HIV Positive Adults, HIV Positive Children, Homeless, Incarcerated, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian, Migrant farm workers, People over 50, Recently released or on parole, Transgender, Undocumented, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Planned Parenthood of CT HIV Prevention Education Services Sarah Hendon Planning and Grants Associate 345 Whitney Avenue New Haven CT 06511 203-865-5158 203-624-1333 DPH Contractor	Individual Level Intervention Group Level Intervention	Asian, Black heterosexual, Latinos/as heterosexual, White heterosexual, Youth 13-19, Youth 20-24
Positive Solutions Norman Bishop President 381 Main Street Middletown CT 06457 860-704-8067 860-704-8068	Community Level Interventions Health Communications Public Information	HIV Positive Adults
Quinnipiack Valley Health Dist Debbie Culligan Deputy Dir. 1151 Hartford Turnpike North Haven CT 06473 203-248-4528 203-248-6671 DPH Contractor	Community Level Interventions School-based health clinic	Youth 13-19
The Connection, Inc. Stacey Barriault Health Service Provider 196 Court Street Middletown CT 06457 860-343-5510 860-343-5507	Prevention Case Management Health Communications Public Information Community Level Interventions Individual Level Intervention Partner Counseling and Referral Services Group Level Intervention Specific interventions for HIV+	American Indian/Alaskan Native, Asian, Bisexual, Black Heterosexual, Black IDU, Black MSM, Commercial sex workers, HIV Positive Adults, HIV Positive Children, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian, Native Hawaiian or Pacific Islander, People over 50, Pregnant women, Recently released or on parole, Transgender, Undocumented, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24
Visiting Nurses Association of South Central CT Ellen Rubin Comm. Health Clin. Specialist One Long Wharf Drive New Haven CT 06511 203-777-5521 203-787-5198 DPH Contractor	Community Level Interventions Group Level Intervention	HIV Positive Adults, HIV Positive Children, Homeless, People over 50, Pregnant women

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Waterbury Health Department Elizabeth Davis Program Coordinator 95 Scovill Street Waterbury CT 06706 203-597-3417 203-573-6680 DPH Contractor	Community Level Interventions Individual Level Intervention Group Level Intervention Outreach	Bisexual, Black Heterosexual, Black IDU, Black MSM, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Recently released or on parole, White Heterosexual, White IDU, White MSM, Youth 20-24
Yale New Haven Hospital Carla Giles 135 College Street, Suite 323 New Haven, CT 06510-2483 203-688-3184 203-688-3211 DPH Contractor	Individual Level Intervention Partner Counseling and Referral Services	American Indian/Alaskan Native, Asian, Bisexual, Black Heterosexual, Black IDU, Black MSM, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24

Northeast Region

The Northeast CPG Region is made up of Tolland and Windham Counties. These counties are mostly rural areas and the eastern suburbs of Hartford. These counties have a combined population of 252, 429. Of these, 92 percent are identified as white, 2.4 percent African American and 4.7 percent as Latino of any race.

A total of 5 HIV prevention service providers, both DPH funded and non-DPH funded, were identified in this region. Total DPH HIV prevention funding for this region is $211,117. Other funding sources identified through the survey totaled $170,000.

DPH prevention funds spent on programs for youth ages 13-24 totals $60.657, or 29 percent of total funds for the region. DPH prevention funds spent on programs for positive people is $9,118, representing 4 percent of total funds for the region.

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Covenant Soup Kitchen Paul Doyle, Director 220 Valley Street Willimantic CT 06226 860-423-1643 860-423-1644	Health Communications Public Information Community Level Interventions Individual Level Intervention Partner Counseling and Referral Services Outreach Group Level Intervention	Entire community
Perceptions Program Linda Gorman, Director P.O. Box 407 1003 Main Street Willimantic CT 06226 860-450-7248 DPH Contractor	Health Communications Public Information Prevention Case Management Community Level Interventions Individual Level Intervention Group Level Intervention Outreach Specific interventions for HIV+	Bisexual, Black Heterosexual, Black IDU, Black MSM, Commercial sex workers, HIV Positive Adults, HIV Positive Children, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian, Migrant farm workers, Recently released or on parole, White IDU, White MSM, Youth 20-24

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Rockville General Hospital Linda J. Parkany 145 Union Street Vernon CT 06066 860-872-5158 860-872-5626	Individual Level Intervention Group Level Intervention	Bisexual, HIV Positive Adults, Latinos/as Heterosexual, People over 50, Recently released or on parole, White Heterosexual, White IDU, White MSM
Visiting Nurse and Health Svcs of Connecticut Fredericka Close AIDS Program Director 8 Keynote Drive Vernon CT 06066 860-872-9163 860-872-2419 DPH Contractor	Individual Level Interventions	HIV Positive Adults
Windham Regional Community Council Kathey Fowler, Director Outreach Services Program 872 Main St. Willimantic CT 06226 860-423-4534 x320 860-423-2601 DPH Contractor	Health Communications Public Information Community Level Interventions Individual Level Intervention Group Level Intervention Outreach Specific interventions for HIV+	Bisexual, Black Heterosexual, Black Heterosexual, Black MSM, Commercial sex workers, Deaf/hard of hearing, HIV Positive Adults, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian, People over 50, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24

Northwest Region

The Northwest CGP Region consists of Litchfield County. This county has a population of 186,515 making it the CPG Region with the smallest population. Of these, approximately 96 percent are white and 1.1 percent African American. A total of 2.1 percent are identified as Latino of any race.

One HIV prevention service provider, both DPH funded and non-DPH funded, was identified in this region. Total DPH HIV prevention funding for this region is $122,115. Other funding sources identified through the survey totaled 48,105

DPH prevention funds spent on programs for youth ages 13-24 totals $43,706 or 36 percent of total funds for the region. DPH prevention funds spent on programs for positive people is $2,389, representing 2 percent of total funds for the region.

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Northwestern Connecticut AIDS Project Debi Thibeault, Executive Dir. 100 Migeon Avenue Torrington CT 06790 860-482-1596 860-482-3606 DPH Contractor	Health Communications Public Information Community Level Interventions Prevention Case Management Individual Level Intervention Group Level Intervention Outreach Specific interventions for HIV+	Black IDU, HIV Positive Adults, Latinos/as Heterosexual, Latinos/as IDU, People over 50, White IDU, Youth 13-19, Youth 20-24

Southwest Region

The Southwest Region consists of Connecticut's most populous county – Fairfield. 896,202 people live in Fairfield County. Of these 10 percent are African American and 79 percent are identified as white. A total of 12 percent are identified as Latino of any race.

A total of 22 HIV prevention service providers, both DPH funded and non-DPH funded, were identified in this region. Total DPH HIV prevention funding for this region is $1,669,795. Other HIV prevention funding sources identified through the survey totaled $946,500.

DPH prevention funds spent on programs for youth ages 13-24 totals $592,897, or 36 percent of total funds for the region. DPH prevention funds spent on programs for positive people is $169,339, representing 10 percent of total funds for the region.

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
AIDS Project Greater Danbury Tanya Medve 30 West Street Danbury CT, 06810 203-778-2437 DPH Contractor	Individual Level Intervention Group Level Intervention Outreach Prevention Case Management	Black Heterosexual, Black IDU, Black MSM, HIV Positive Adults, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24
Bridgeport Community Health Center Raphael Munz HIV Counselor 471 Barnum Avenue Bridgeport CT 06608 203-696-3260 203-615-0085 DPH Contractor	Case management Community awareness Community-wide HIV events Condom distribution Counseling and testing Multi-session workshops Outreach Peer counseling Physician intervention Prevention case management Risk reduction counseling Street outreach Support groups	Bisexual, Black Heterosexual, Black IDU, Black MSM, HIV Positive Adults, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian, People over 50, Pregnant women, Recently released or on parole, Transgender, Undocumented, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Bridgeport Health Department Robin Clark-Smith AIDS Program Director 752 E. Main St. Bridgeport CT 06610 203-576-7679 203-332-5507 DPH Contractor	Community Level Interventions Individual Level Intervention Group Level Intervention Outreach Needle exchange PCRS Prevention Case Management School-based health clinic Specific interventions for HIV+	Asian, Bisexual, Black Heterosexual, Black IDU, Black MSM, Commercial sex workers, HIV Positive Adults, HIV Positive Children, Homeless, Incarcerated, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian, People over 50, Pregnant women, Recently released or on parole, Transgender, Undocumented, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24
Bridgeport Hospital Mary Unfricht HIV Prevention Nurse 226 Mill Hill Avenue Bridgeport CT 06610 203-384-3347 203-384-4362 DPH Contractor	Individual Level Intervention Group Level Intervention Specific interventions for HIV+	HIV Positive Children, Pregnant women
Casey Family Services Linda Gardeni Berg Division Director 789 Reservoir Avenue Bridgeport CT 06606 203-372-3722 203-372-3558 DPH Contractor	Individual Level Intervention Group Level Interventions	Black Heterosexual, HIV Positive Adults, Latinos/as Heterosexual, People over 50, Pregnant women, Recently released or on parole, Undocumented, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24
Child Guidance Center of Greater Bridgeport L. Philip Guzman Executive Director 180 Fairfield Avenue Bridgeport CT 06604 203-367-5361 203-339-4522 DPH Contractor	Specific interventions for HIV+ Individual Level Intervention	Black Heterosexual, HIV Positive Children, Latinos/as Heterosexual, Transgender, Undocumented, Youth 13-19, Youth 20-24
Child Guidance Center of Southern Connecticut 103 West Broad Street Stamford, CT 06902 203-324-6127 DPH Contractor	Individual Level Intervention Group Level Intervention	Children, HIV Positive Adults

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Connecticut Counseling Centers, Inc. Rochelle Bolton Health Educator 20 North Main St. Norwalk CT 06854 203-838-6508 203-852-7021	Prevention Case Management Individual Level Intervention PCRS Group Level Intervention Specific interventions for HIV+	Bisexual, Black Heterosexual, Black Heterosexual, Black MSM, Commercial sex workers, HIV Positive Adults, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian, People over 50, Pregnant women, Recently released or on parole, Transgender, Undocumented, White Heterosexual, White IDU, White MSM
FSW - Formerly Family Services Woodfield Dorothy Timmermann Director HIV Services 475 Clinton Avenue Bridgeport CT 06605 203-368-4291 203-332-7247 DPH Contractor	Community Level Interventions Individual Level Intervention Group Level Intervention Prevention Case Management Prevention case management Specific interventions for HIV+	Bisexual, Black Heterosexual, Black IDU, Black IDU, Deaf/hard of hearing, HIV Positive Adults, HIV Positive Children, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian, People over 50, Pregnant women, Recently released or on parole, Transgender, Undocumented, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24
Greater Bridgeport Adolescent Pregnancy Pgm, Inc. Tom Goldring Director of Programs 200 Mill Hill Ave. Bridgeport CT 06610 203-384-3629 203-338-8453 DPH Contractor	Prevention Case Management Community Level Interventions Individual Level Intervention Group Level Intervention Outreach	Black Heterosexual, Black IDU, Black MSM, HIV Positive Adults, HIV Positive Children, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Pregnant women, Youth 13-19, Youth 20-24, Youth in all categories Black & Latino
Greenwich Health Department 101 Field Pit Rd Greenwich, CT 06830	Individual Level Intervention	All
Interfaith AIDS Ministry of Greater Danbury Miozotis Galarza Director of AIDS Education 46 Main Street Danbury CT 06810 203-748-4077 203-748-2841 DPH Contractor	Community Level Interventions Individual Level Intervention Group Level Intervention Outreach	Bisexual, Black MSM, HIV Positive Adults, HIV Positive Children, Latino MSM, White MSM, Youth 13-19, Brazilian MSM, Brazilian Heterosexual, General Community

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Mid-Fairfield AIDS Project, Inc. Stuart Lane, Director 16 River Street Norwalk, CT 06850 203-855-9535 203-855-1531 DPH Contractor	Individual Level Intervention Group Level Intervention Prevention Case Management Specific Intervention for HIV+	White MSM, Black MSM, Latino MSM Latinos/as IDU, HIV Positives
Norwalk Health Department Beverly Gibson-Mohamed Program Coordinator 137 East Avenue Norwalk CT 06851 203-854-7979 203-854-7926 DPH Contractor	Street outreach Risk reduction counseling Multi-session workshops Outreach Community-wide HIV events Counseling and testing Distribution of bleach kits	Migrant farm workers, Homeless Latinos/as Heterosexual, Latino MSM, Pregnant women, White IDU White MSM Black IDU
Regional Network of Programs Center for Human Services Cathy Fowles, LPN 1549 Fairfield Avenue Bridgeport CT 06605 203-335-2171 203-394-6275 DPH Contractor	Individual Level Intervention PCRS	All Populations
Shelter for the Homeless Elton Perry DTA 597 Pacific Street Stamford CT 06901 203-348-2792 203-348-5813 DPH Contractor	Individual Level Intervention Outreach	Black Heterosexual, Black IDU, Black MSM, HIV Positive Adults, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Undocumented, White Heterosexual, White IDU, Black MSM
Southeastern Fairfield Co. Chapter - ARC Trisha Piacentini, Asistant Dir. Comm. Ed. & Youth Council 158 Brooklawn Avenue Bridgeport CT 06604 203-576-1010 203-576-0080	Community Level Interventions	Youth 20-24, Hispanic Teens, African-American Teens

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Southwest Community Health Center Stephanie Lozada 351 Birch Street Bridgeport CT 06605 203-330-6000 203-576-8444 DPH Contractor	Prevention Case Management Community Level Interventions Individual Level Intervention Group Level Intervention Outreach Specific interventions for HIV+	Bisexual, Black Heterosexual, Black IDU, Black MSM, HIV Positive Adults, Incarcerated, Latinos/as IDU, Latino MSM, Lesbian, People over 50, Transgender, White Heterosexual, White IDU, White MSM, Youth 20-24
Southwestern AHEC Meredith C. Ferraro Executive Director 5151 Park Avenue Fairfield CT 06825-1000 203-396-8381 203-396-8383	Outreach	All
St. Luke's LifeWorks Bread & Roses Suzanne Curto Chief Program Officer 141 Franklin Street Stamford CT 06902 203-388-0151 203-359-2517	Community Level Interventions Individual Level Intervention Outreach	Bisexual, Black IDU, Black MSM, Commercial sex workers, HIV Positive Adults, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian
Stamford CARES Megan E. Cassano Project Director 888 Washington Blvd 8th fl Stamford CT 06901 203-977-5096 203-977-5460	Case management Community-wide HIV events Condom distribution Couples counseling Outreach Street outreach Support groups	American Indian/Alaskan Native, Asian, Bisexual, Black Heterosexual, Black IDU, Black IDU, Commercial sex workers, Deaf/hard of hearing, HIV Positive Adults, HIV Positive Children, Homeless, Incarcerated Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian, People over 50, Pregnant women, Recently released or on parole, Transgender, Undocumented, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24
Stamford Health Department Debra Katz Director of Prevention Program 888 Washington Blvd 8th floor Stamford CT 06901 203-977-4387 203-9775460 DPH Contractor	Community Level Interventions Individual Level Intervention Health Communications Public Information Group Level Intervention Needle exchange Outreach Prevention Case Management	Asian, Bisexual, Black Heterosexual, Black IDU, Black MSM, Commercial sex workers, HIV Positive Adults, HIV Positive Children, Homeless, Incarcerated, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian, People over 50, Pregnant women, Recently released or on parole, Transgender, Undocumented, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24

Southeast Region
The Southeast CPG Region consists of New London County. This county has a total population of 262,689. Of these, 87 percent are identified as white and 5.3 percent as African American. A total of 5.1 percent are identified as Latino of any race.

A total of 7 HIV prevention service providers, both DPH funded and non-DPH funded, were identified in this region. Total DPH HIV prevention funding for this region is $409,046. Other HIV prevention funding sources identified through the survey totaled $397,008.

DPH prevention funds spent on programs for youth ages 13-24 totals $26,521, or 6 percent of total funds for the region. DPH prevention funds spent on programs for positive people is $112,946, representing 27 percent of total funds for the region.

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
A Moveable Feast Maude Pellegrino Executive Director 76 Fereal Street New London CT 06320 860-444-1278 860-444-1099	Individual Level Intervention	Homebound
Alliance For Living Mike Giconi, Assistant Director 154 Broad Street New London, CT 06320 860-447-0884 DPH Contractor	Broadcast media Case management Condom Distribution Prevention case management Support Groups	American Indian/Alaskan Native, Asian, Bisexual, Black Heterosexual, Black IDU, Black MSM, Commerical sex workers, HIV Positive Adults, HIV Positive Children, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Lesbian, People over 50, Pregnant women, Recently released or on parole, Transgender, White Heterosexual, White IDU, White MSM, Youth 13-19, Youth 20-24
Child & Family Agency of Southeastern CT, Inc. Amy Sizer Clinician & Grant Coordinator 75 Granite St New London CT 06320 860-437-4550 860-437-4552 DPH Contractor	School-based health clinic	Youth 13-19

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
New London Dept of Health & Social Services Lizabeth Love Ryan, Coordinator 120 Broad St. New London CT 06320 860-447-5233 860-447-5246 DPH Contractor	Individual Level Intervention PCRS Group Level Intervention Outreach Prevention Case Management Specific interventions for HIV+	Black Heterosexual, Black IDU Black MSM, HIV Positive Adults
OIC Of New London 106 Truman Street New London, CT 06320 DPH Contractor	Group Level Intervention Prevention Case Management Individual Level Intervention Community Level Intervention	Black MSM, Black Heterosexual, Latino MSM, White MSM, HIV Positive Adults, Youth
Stonington Institute Donna Leedham 75 Swantown Hill Road North Stonington CT 06359 860-535-1010 860-535-4820	Individual Level Intervention Group Level Intervention	All
William W. Backus Hospital Ann Hartman, RN IDC Coordinator 326 Washington St. Norwich CT 06360 860-889-8331 860-823-6582 DPH Contractor	Community Level Interventions Individual Level Intervention Group Level Intervention	Black Heterosexual, Black IDU, HIV Positive Adults, General Population at risk thru C&T program

STATEWIDE

A total of 6 HIV Prevention service providers were identified as providers of prevention services with a statewide scope.

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
211 Infoline Melanie Lowewnstein Senior Vice President 1344 Silas Deanne Hwy Rocky Hill CT 06067 860-571-7500 860-571-6093	Clearinghouse Referrals	Statewide

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
CT AIDS Residence Coalition John Merz Executive Director 58 Arbor Street Hartford CT 06106 860-231-8212 860-231-9745 DPH Contractor	Community Level Interventions Individual Level Intervention	Statewide HIV Positive
Connecticut Council on Occupational Safety & Health Eddie Sapiain Labor Educator/Migrant Health Coordinator 683 North Mountain Road Newington CT 06111 860-953-2674 860-953-1053 DPH Contractor	Community Level Interventions Individual Level Intervention Group Level Intervention Outreach PCRS Prevention Case Management	Bisexual, Homeless, Latinos/as Heterosexual, Latinos/as IDU, Latino MSM, Migrant farm workers, People over 50, Pregnant women, Undocumented, White Heterosexual, Youth 13-19, Youth 20-24
Connecticut Department of Edcuation Bonnie J. Edmonson HIV/STD Prevention Coordinator 25 Industrial Park Road Middletown CT 06457 860-807-2077	Community Level Interventions	Youth 13-19
Guardian Health Association Rev. Alexander R. Garbera P.O. Box 365 West Haven CT06516 203-937-8085 203-937-8085	Health Communications Public Information Community Level Interventions Individual Level Intervention Group Level Intervention Outreach	All
True Colors, Inc. Sexual Minority Youth and Family Services of CT Robin McHaelen, MSW Executive Director 945 Main Street, Suite 211 Manchester, CT 06040 860-649-7386 860-649-7386 DPH Contractor	Community Level Interventions Health Communications Public Information	Youth 13-19, Youth 20-24, General population

DEPARTMENT OF CORRECTION

A total of 2 HIV prevention service providers were identified as providers of services to incarcerated people. Total DPH prevention funding for HIV prevention amounts to $749,174.

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(s)
Community Partners in Action Beyond Fear Program Dennis O'Neill Pgm Manager 110 Bartholomew Suite 4020 Hartford CT 06106 860-293-3985 860-293-3952 DPH Contractor	Individual Level Intervention Group Level Intervention Outreach	Incarcerated, Youth 13-19 Youth 20-24
UCONN Correctional Managed Healthcare Brian Goodrich, LCSW HIV Prevention Program Manager 263 Farmington Ave. Farmington CT 06030 860-679-5545 860-679-5505 DPH Contractor	Individual Level Intervention Group Level Intervention Specific interventions for HIV+	Incarcerated

Number of providers who conduct the following interventions per region	Northcentral	Northeast	Northwest	Southcentral	Southwest	Southeast	TOTAL
Broadcast Media	1	2	1	0	0	2	6
Capacity Building	2	1	0	1	1	2	7
Case management	13	0	1	4	6	1	25
Clearinghouse	1	1	0	1	0	2	5
Community awareness	11	3	1	6	6	5	32
Community mobilization	1	1	0	2	0	1	5
Community-wide HIV events	9	2	0	4	6	3	24
Condom distribution	11	4	1	6	12	5	39
Counseling and testing	7	3	1	11	10	4	36
Couples counseling	2	1	0	5	3	1	12
Distribution of bleach kits	3	3	0	5	3	0	14
Drug treatment advocacy	5	1	0	3	2	2	13
Drug/alcohol counseling	6	3	0	6	6	2	23
Hotlines	2	0	1	1	2	0	6
Methadone Maintenance	1	1	0	1	2	0	5
Motivational interviewing	5	0	0	3	1	1	10
Multi-session workshops	7	2	1	8	10	5	33
Syringe Exchange	1	0	0	1	0	0	2
Outreach Count	12	3	1	10	11	3	40
Partner counseling & referral	4	1	0	4	4	2	15
Peer counseling	8	3	0	6	4	3	24
Physician intervention	2	2	0	5	4	1	14
Policy intervention	2	1	0	0	0	3	6
Prevention case management	9	0	0	4	8	4	25
Risk reduction counseling	11	2	1	11	11	7	43
School-based health clinic	1	0	0	3	1	1	6
Social marketing	2	1	0	2	0	1	6
Specific interventions for HIV+	7	2	1	8	7	3	28
Street outreach	8	3	1	6	10	3	31
Support groups	9	2	1	5	5	5	27

Number of Providers target the following populations	Northcentral	Northeast	Northwest	Southcentral	Southwest	Southeast	Statewide & DOC	TOTAL
American Indian/Alaskan Native	1	0	0	6	1	1	0	9
Asian	4	0	0	6	2	1	0	13
Bisexual	10	2	0	11	8	1	1	33
Black Heterosexual	14	3	0	18	13	4	0	52
Black IDU	13	1	1	14	14	3	0	46
Black MSM	7	2	0	11	12	3	0	35
Commercial sex workers	6	2	0	6	4	1	0	19
Deaf/hard of hearing	3	1	0	1	2	0	0	7
HIV Positive Adults	11	4	1	15	15	4	0	50
HIV Positive Children	3	1	0	7	8	1	0	20
Homeless	12	2	0	11	7	1	2	35
Incarcerated	2	0	0	5	3	0	2	12
Latinos/as Heterosexual	13	3	1	13	13	1	1	45
Latinos/as IDU	10	2	1	13	12	1	1	40
Latino MSM	11	2	0	13	14	2	1	43
Lesbian	7	2	0	5	7	1	0	22
Migrant farm workers	0	1	0	2	1	0	1	5
Native Hawaiian or Pacific Islander	0	0	0	1	0	0	0	1
People over 50	6	2	1	10	7	1	1	28
Pregnant women	6	0	0	5	10	1	1	23
Recently released or on parolee	5	2	0	8	6	1	0	22
Transgender	7	0	0	6	7	1	0	21
Undocumented	1	0	0	7	9	1	1	19
White Heterosexual	7	2	0	11	10	1	1	32
White IDU	10	3	1	13	11	1	0	39
White MSM	6	3	0	11	12	2	0	34
Youth 13-19	10	0	1	14	10	2	4	41
Youth 20-24	9	0	1	13	11	1	3	38

Gap Analysis

A thorough gap analysis identifies and quantifies met and unmet needs of target populations in order to assist community planning groups and other planning bodies in the priority setting process. The unmet needs are identified by a comparison of the needs assessment and resource inventory components of the Community Services Assessment.
The Academy for Educational Development lists the following steps for carrying out a gap analysis:

- List and review each target population identified through the epidemiology profile
- Estimate total need for that target population
- Estimate major differences between need and demand for services for the target population
- Identify barriers to HIV prevention and care services for the target population
- Assess the suitability of available prevention and care services for the target population.
- Estimate met need for the target population.
- Identify the portion of met need that CDC HIV prevention and HRSA Ryan White Care dollars are responsible for meeting
- Estimate unmet need: compare total needs and met needs and determine the gap between the two (TOTAL NEED – MET NEED = UNMET NEED)

2004 Gap Analysis for the 2005-2008 Comprehensive HIV Prevention Plan

In order to prepare the Gap Analysis for the 2005-2008 Plan, the CSA Committee and DPH reviewed the Connecticut 2003 Epidemiological Profile and 2004 Update, the DPH Interventions Database, the 2004 Needs Assessment, as well as the data about population specific prevention and care services and resources provided throughout the state (2004 Resource Inventory).

GAPS in Services- DPH Funded Providers

The Department of Public Health maintains an HIV prevention interventions database for DPH funded programs. This database was analyzed to determine gaps in services for HIV prevention services throughout the State. Prevention services funded by DPH were labeled as gaps if more than 2 CPG regions reported no interventions for the specific target population. DPH providers received funding based on the previous CPG priority populations, however this gap analysis uses the populations that CPG labeled a priority in 2004. The gaps for HIV prevention services are as follows:

HIV+ persons: Gaps in services were found in Individual Level Interventions including Peer Counseling, Motivational Interviewing, and Couples Counseling; Prevention Case Management; and Peer and Non-Peer Outreach.

Men who have Sex with Men (MSM): Gaps in services were found in Individual Level Interventions including Peer Counseling and Motivational Interviewing; Group Level Interventions including Support Groups, Multiple Session Workgroups, and Single Session Workgroups; Prevention Case Management; and Peer and Non-Peer Outreach.

Intravenous Drug Users (IDU): Gaps in services were found in Individual Level Interventions including Peer Counseling and Motivational Interviewing; Prevention Case Management; Peer and Non-Peer Outreach; and Drug Treatment Advocacy.

Heterosexuals: Gaps in services were found in Individual Level Interventions including Peer Counseling and Motivational Interviewing; Prevention Case Management; and Drug Treatment Advocacy.

GAPS IN SERVICES- ALL HIV PREVENTION AND CARE PROVIDERS

Forty-five agencies filled out the survey and listed emerging populations that they feel are at-risk for HIV infection in their region of the state. Some of the populations that have been identified as new and emerging represent populations that have been identified as statewide priority populations both in this and previous plans. Therefore, these populations represent new and emerging populations the service areas of individual agencies. The populations are as follows:

Population	Percentage of Providers who Listed this Emerging Population
Undocumented Immigrants	35%
Youth	29%
MSM	16%
Over 50	13%
Latinos/as	13%
IDU	4%
Dual Diagnosis (Psychiatric and HIV+)	4%
Homeless	4%
Immigrants from Africa	2%
Immigrants from Eastern Europe	2%
Partners of Incarcerated People	2%
Women	2%
Deaf and Hard of Hearing	2%
Pregnant Women	2%
Caribbean Islanders	2%
Asians	2%
Transgender	2%
Heterosexuals	2%
HIV+	2%

The populations viewed at highest risk for HIV transmission are the undocumented, youth, people over the age of 50, Latino/as, and MSM. It is important to note that although youth was mentioned as an emerging population that needs HIV prevention information, currently 59% of all DPH funded interventions target youth.

Programs Needs and Challenges: Problems Encountered in Accessing Services
Thirty-one programs responded to the statewide survey to care and prevention providers with problems encountered in accessing services for clients and their families. The problems are as follows:

Problem Encountered	Percentage of Providers who Listed this problem
Lack of support services (housing, psychiatric, medical, mental health)	26%
Lack of transportation	23%
Lack of appropriate staff (bi-lingual, bi-cultural)	23%
Limited coordination of services between agencies	16%
Lack of funding	10%
Limited hours of operation	10%
Duplication of services between agencies	6%
Lack of HIV prevention services (drug treatment advocacy, prevention case management)	6%
Providing services for undocumented clients	6%
Cultural Issues	6%
Lack of training	3%

The most identified problems are lack of coordination of services, supportive services, transportation, and appropriate staff. Quite a few respondents indicated that with funding becoming scarce, it is important for agencies to collaborate in order to continue to offer an array of services.

Programs Needs and Challenges: Emerging Needs
Fifty programs responded to the statewide survey to care and prevention providers with emerging needs in their service area. The needs are as follows:

Emerging Need	Percentage of Providers who Listed this Need
More support services (medical, housing, mental health)	50%
Transportation	12%
More research-based HIV prevention interventions	10%
Qualified staff	10%
Increased coordination between agencies	8%
HIV Positive people with mental health issues	6%
Increased funding	6%
Medical care for undocumented	6%
MSM Outreach/Services	4%
Training	2%
Needle Exchange	2%
HIV Positive Women and Youth	2%
Undocumented Immigrants	2%
Respite Care for Family/Caregivers	2%

Emerging Need	Percentage of Providers who Listed this Need
Bilingual staff	2%
Recreation/Mentoring programs for youth	2%
More rapid testing	2%

The most identified needs are support services, appropriate interventions, additional staff, and increased coordination between agencies.

Programs Needs and Challenges: Important Changes
Forty-three programs responded to the statewide survey to care and prevention providers with important changes needed to improve prevention and care services.

Important Change	Percentage of Providers who Listed this as a change
Support services	26%
Funding	33%
Education in the schools	19%
Improved collaboration	12%
Appropriate staff	12%
Respite Care for Caregivers/Families	5%
More Services after business hours	5%
Needle Exchange	2%
More media exposure	2%
Transportation	2%
Duplication of services	2%
Working with the uninsured	2%

Providers felt that there needs to be more HIV education in the schools, increased access to support services, improved collaboration between agencies, and more funding for programs in order to improve care and prevention services for individuals and families infected or affected by HIV/AIDS.

Gaps in Services Summary
Most providers felt that more services for HIV infected individuals, increased collaboration between and within agencies, and appropriate staff were needed to better meet their client's needs. There was also a concern about the duplication of services being offered, lack of funding, and working with undocumented clients. The importance of collaboration and ensuring there is no duplication of services was stressed by agencies, especially with reduced levels of funding.

GAPS AND NEEDS – FUNDING FOR PREVENTION WITH HIV POSITIVE PEOPLE
As Stated above, gaps in services for prevention with HIV positive people were found in Individual Level Interventions including Peer Counseling, Motivational Interviewing, and Couples Counseling; Prevention Case Management; and Peer and Non-Peer Outreach. In addition to gaps in services, a significant gap in funding for prevention with positives exists.

The highest percent of funds spent on prevention interventions specific to HIV positive people is found in the Southcentral CPG region. In this region, 7.6 percent of all HIV prevention funds

were spent on interventions for HIV positive people. The Southeast region follows with 2.3 percent of funds spent on prevention interventions with positives. The Northeast and Southwest follow with 2.5 percent and 2 percent of total funds spent for prevention with HIV positives respectively. The Northcentral region, at 1.2 percent, and Northwest region, 1 percent, had the lowest percent of funds used for prevention interventions for HIV positive people.

GAPS AND NEEDS IDENTIFIED THROUGH FOCUS GROUPS

Throughout all populations, there emerged a strong common theme concerning the need for support groups, a supportive ongoing "community," to help people discuss, implement and sustain prevention behaviors. For those who were HIV positive, it also included creation of a supportive group to help people deal with living with HIV/AIDS.

In addition to helping people implement and sustain prevention behaviors and/or help with living with HIV, participants indicated that helping people deal with mental health issues, issues related to self esteem, reducing isolation, helping people deal with racism and positive/supportive spiritual help were crucial. Participants stressed that these need to be integrated into HIV/AIDS specific programs since these factors are all interconnected with prevention and/or living with HIV.

Another additional theme that emerged across populations was the need for culturally and population appropriate services. Interventions tailored to the factors affecting target populations are needed. For example, programs for MSMs of color must take into account factors such as self esteem problems caused by racism, acceptance by one's community, and the effects of religion and spirituality on individuals and their behaviors.

MSMs who do not identify as gay also require population-specific interventions. This population is often hard to reach in "traditional" settings where HIV prevention interventions are conducted nor do they respond to messages tailored for men who identify as gay. Moreover, since this population is often not easily identifiable and often does not have a sustained social support system, prevention interventions are even more difficult to conduct.

Women who have sex with women are often overlooked as a target population. Based on focus group/surveys with WSWs, there appears to be a need for communicating how WSWs can be at risk and the steps that can be taken to prevent transmission.

Transgender individuals require interventions that take into account their needs and the special characteristics of the Transgender community. Like MSMs who do not identify as gay, the Transgender community is widely scattered and often does not have easily identified places in which to conduct prevention activities. Like Black and Latino MSMs, Transgender people have to deal with a high level of societal discrimination and discrimination from certain lesbian, gay and bisexual individuals.

The restrictions placed on incarcerated individuals also require population-specific interventions. The lack of condoms in prisons and HIV prevention programs with waiting lists require crafting programs that take these factors into account. Moreover, any potential prevention intervention program would have to at least consider trying to make changes that would secure access to condoms and the adoption of other policy changes that would enhance prevention efforts.

HIV positive individuals indicated that aside from medial assistance programs and support groups, issues specific to HIV positive people such as dealing with HIV in relationships, dating

issues, and finding people to establish a positive relationship with were also identified. These population-specific needs must be taken into account when planning effective interventions.

The New Haven and Hartford R.A.R.E. reports stressed the need for culturally and population relevant interventions. Programs conducted on weekends and late at night will be necessary to reach IDU's, commercial sex workers, and other at risk populations. One recommendation included a late night drop in program/shelter. This program or shelter would not only help to provide a setting for prevention, it would also help individuals access other services and provide a safe place for those at risk of becoming a victim of violence.

In addition to holistic support groups and culturally competent and population-specific prevention interventions, the focus group participants also indicated that they believe there is a great need for outreach services. Other issues identified as needs included funding, housing and education of faith groups.

GAPS IDENTIFIED BY COMPARING FUNDING AMOUNT PER PLWA BY REGION
The following tables identify funding amount according to behavioral risk and race/ethnicity per persons living with AIDS in each region. It should be noted that that the number of PLWA does not include those who are HIV positive without an AIDS diagnosis.

In addition, it must be noted that the ratio of PLWA per behavioral risk/ethnicity has not been taken into account due to the inability to determine the people who identify as MSMs, IDUs or Heterosexuals in Connecticut. It is impossible to determine an accurate total number of each population according to behavioral risk factor. Therefore, actual numbers of PLWA are being used rather than the rate of PLWA per population.

STATEWIDE

HIV Risk	Funding Amount	Number of PLWA	Funding Amount Per Number of PLWA
Heterosexual African Americans	$1,333,000	539	$2473
Heterosexual Latinos/as	$930,000	412	$2257
Heterosexual Whites	$837,000	332	$2521
African American IDU	$777,000	1248	$623
Latino/a IDU	$819,000	1018	$805
White IDU	$504,000	819	$615
African American MSM	$300,000	200	$1500
Latino MSM	$420,000	183	$2295
White MSM	$280,000	828	$338
HIV+ African Americans	$238,500	2270	$105
HIV+ Latinos/as	$103,500	1870	$55
HIV+ White	$108,000	2303	$47

Department of Correction Region

Heterosexuals

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$24,721	40	$618
Latino	$17,979	7	$2568
White	$29,215	5	$5843

Injection Drug Users (IDU)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$109,521	399	$274
Latino	$156,980	336	$467
White	$98,569	183	$539

Men Who Have Sex with Men (MSM)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$0	10	$0
Latino	$0	3	$0
White	$0	11	$0

Northeast Region

Heterosexuals

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$14,304	4	$3576
Latino	$35,817	7	$5117
White	$44,909	19	$2364

Injection Drug Users (IDU)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$7456	10	$746
Latino	$9177	22	$417
White	$12,044	38	$317

Men Who Have Sex with Men (MSM)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$0	5	$0
Latino	$0	3	$0
White	$0	36	$0

Northcentral Region

Heterosexuals

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$360,551	127	$2839
Latino	$257,536	159	$1620
White	$58,866	88	$669

Injection Drug Users (IDU)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$114,531	278	$412
Latino	$264,302	387	$683
White	$48,455	158	$307

Men Who Have Sex with Men (MSM)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$49,821	67	$744
Latino	$109,606	55	$1993
White	$64,767	211	$307

Northwest Region

Heterosexuals

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$4580	0	$0
Latino	$3989	2	$1995
White	$63,552	9	$7061

Injection Drug Users (IDU)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$1944	7	$278
Latino	$1020	4	$255
White	$14,141	14	$1010

Men Who Have Sex with Men (MSM)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$1944	0	$0
Latino	$1020	1	$1020
White	$14,141	26	$544

South Central Region

Heterosexuals

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$299,954	199	$1507
Latino	$183,646	147	$1249
White	$67,337	118	$571

Injection Drug Users (IDU)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$271,358	348	$780
Latino	$242,794	210	$1156
White	$178,525	265	$674

Men Who Have Sex with Men (MSM)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$271,358	70	$3877
Latino	$242,794	66	$3679
White	$178,525	285	$626

Southeast Region

Heterosexuals

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$20,020	19	$1054
Latino	$2107	22	$96
White	$2180	27	$81

Injection Drug Users (IDU)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$81,012	33	$2455
Latino	$21,761	19	$1145
White	$43,862	46	$954

Men Who Have Sex with Men (MSM)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$18,465	5	$3693
Latino	$4616	4	$1154
White	$4328	69	$63

Southwest Region

Heterosexuals

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$344,348	167	$2062
Latino	$226,640	94	$2411
White	$346,568	85	$4077

Injection Drug Users (IDU)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$150,634	196	$769
Latino	$82,504	140	$589
White	$45,970	165	$279

Men Who Have Sex with Men (MSM)

Race/Ethnicity	Funding Amount	Number of PLWA	Funding Amount per Number of PLWA
Black	$51,798	50	$1036
Latino	$43,952	61	$721
White	$68,370	232	$295

SUMMARY AND FINDINGS REGARDING PREVENTION NEEDS

Because of the richness of information collected in the 2004 Needs Assessment, some conclusions can be drawn regarding barriers to services, emerging needs, emerging populations, perceived and/or real gaps in services, and recommendations for change.

Barriers to services (populations): Fear; isolation; cultural, family, religious and economic issues; stigma; language barriers; culturally incompetent service and medical providers; inadequate transportation; insufficient or lack of insurance; mental health and substance abuse issues.

Emerging needs/issues: service coordination among agencies; affordable, accessible and adequate housing; mental health services, substance abuse and detox services; case management; accessible and dependable transportation; funding; resources; staffing; medical insurance; long waiting lists; dual diagnosis or co-occurring issues; culturally competent and/or bilingual materials.

Emerging populations: MSM; IDU; undocumented; over 50 population; migrant/immigrants/refugees; Hispanic; individuals from Africa; Asians; at risk youth/sexual minority youth.

Perceived and/or real gaps in services: services for undocumented individuals; interagency collaboration; lack of insurance or sufficient medical coverage; culturally competent and population appropriate services, staffing, medical providers and information; transportation; housing; needle exchange programs; psychiatric and dental services; and shelter and detox beds.

RECOMMENDATIONS REGARDING PREVENTION NEEDS

Recommendations are classified into three categories; 1) Primary prevention, steps to prevent HIV among those who are not HIV positive; 2) Secondary prevention, steps to prevent or minimize the effects of HIV; and 3) Supportive, steps that would promote both primary and secondary prevention efforts.

Primary Prevention

- Prevention efforts must address environmental and individual factors that effect the target population(s) and that are barriers to adoption and continuance of prevention behaviors. These factors include, but are not limited to, racism, economic issues, fear, isolation, homophobia and religious/spiritual issues.
- Establish more needle-exchange programs (particularly in rural areas).
- Establish prevention programs that focus on religious and faith communities and their role in prevention.
- Establish prevention programs for white MSMs.
- Establish prevention programs for documented and undocumented immigrants.

Secondary Prevention

- Increase funding for emergency care needs and emergency financial assistance.
- Increase programs for HIV+ individuals that address factors that are barriers to prevention and care.
- Develop affordable, accessible and safe housing for PLWHAs.
- Expanded counseling and testing services (in non-medical settings)

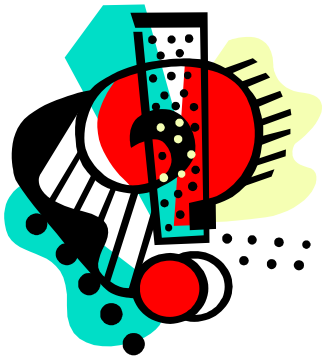
Supportive

- Ensure that programs are holistic in nature, addressing all aspects effecting participants**.**
- Establish programs that provide a supportive environment for participants.
- Ensure programs that are culturally and linguistically competent
- Develop systems of affordable and accessible public transportation.
- Provide cultural competency training for medical providers and agency staff and insure that agencies institutionalize policies and practices that ensure cultural competency.
- Develop culturally competent and population appropriate interventions and information.
- Create better collaborative efforts across agencies.
- Provide more accessible mental health, substance abuse, and detox services.

Chapter 4

What Works in HIV Prevention?

Identifying HIV prevention strategies and interventions for Connecticut's most-at-risk populations



Literature Review
What Works in HIV Prevention?

The Centers for Disease Control and Prevention (CDC) expects HIV prevention community planning to improve HIV prevention programs by strengthening the: (1) scientific basis, (2) community relevance, and (3) population-or risk-based focus of HIV prevention interventions in each project area. According to the Goals, Objectives and Guiding Principles of the new CDC Guidance (2003), community planning should:

- Identify priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction,
- Identify prevention interventions/activities for prioritized target populations, which have the potential to prevent the greatest number of new infections
- Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance and acceptability.

The new CDC Guidance further indicates that rather than prioritizing interventions for priority target populations as in previous priority setting processes, CPGs should instead "conceptualize interventions/activities as a set or mix of interventions/activities versus one specific intervention/activity for each target population." However, all selected prevention interventions/activities must still be science-based, proven effective, and culturally/ethnically appropriate.

In 2003, the CDC issued evaluation guidelines to which all states receiving federal funding must comply. This is required in order to measure the effect of HIV prevention intervention as well as to collect uniform data across all states and jurisdictions in the United States. The CDC recommends that federal funding support priority populations and interventions as determined and identified by the respective CPG in its comprehensive plan. Currently Connecticut's comprehensive plan for 2005-2008 supports a broad range of interventions targeted to priority populations. The majority of the interventions meet the CDC's HIV Prevention Research Project criteria for relevance and methodological rigor (e.g. interventions must aim to reduce sex-or drug-related risk behaviors or incidence rates of HIV or other STD and must directly impact the transmission of HIV). Others, although not included in the CDC's *Compendium of HIV Prevention Interventions*, are research-based and have an identified positive and significant behavior/health component. The *CDC Compendium of HIV Prevention Interventions with Evidence of Effectiveness* (revised August 31, 2001) defines three broad categories of interventions:[1]

- **Behavioral interventions** aim to change risk behaviors or reduce incidence rates of HIV or other sexually transmitted diseases (STDs). These interventions tend to emphasize individual and small group approaches, e.g. counseling, small group discussions, and skills demonstrations.
- **Social interventions** aim to change risk behaviors or decrease incidence rates of HIV or other STDs and also include explicit and direct attempts to change peer or community norms related to HIV risk. These interventions, while using individual or small group approaches, emphasize peer influence and community-level approaches. This category also includes any interventions aimed at changing environmental factors or structures related to HIV risk.

[1] Centers for Disease Control and Prevention, HIV/AIDS Prevention Research Synthesis Project. Compendium of HIV Prevention Interventions with Evidence of Effectiveness. Atlanta, GA, November 1999, Revised august 31, 2001.

- **Policy** studies aim to change risk behaviors or decrease incidence rates of HIV or STDs as a function of administrative or legal decisions, e.g. condom availability in public settings, HIV education in schools.

In the 2001 planning cycle, Dr. Deborah Cornman, CPG member and Behavioral Scientist with the Center for HIV Intervention and Prevention (CHIP) at the University of Connecticut, conducted an extensive literature review to research interventions that had been proven effective based on the CDC criteria for populations prioritized by the CPG. The list of Interventions defined in the 2002-2004 Connecticut HIV Prevention Plan, was based on her work plus extensive additional research, which included the following:

- AED's *Setting HIV Prevention Priorities* Manual
- CDC's Evaluation Guidance
- CDC's *Compendium of HIV Prevention Interventions* (1999)
- CDC's *Replicating Effective Programs Plus* (REP+)

In reviewing additional literature for effective interventions, Dr. Cornman utilized CDC's criteria for assessing intervention effectiveness. According to the CDC, for an intervention to be termed "effective" it must meet certain criteria:

- Have a clearly defined audience
- Have clearly defined goals and objectives
- Be based on sound behavioral and social science theory
- Be focused on reducing specific risk behaviors
- Be evaluated with pre- and post- intervention data.

Dr. Cornman's extensive and comprehensive review of the literature for effective HIV prevention interventions resulted in the prioritization of interventions for Connecticut's CPG identified target populations for the 2002-2004 Connecticut HIV Prevention Plan.

In 2002, Dr. Cornman and the Interventions and Resource Committee (IRC), reviewed the 2001 research findings, Chapter 4 of the Comprehensive Plan, the prioritized populations and interventions, and identified significant literature gaps for three of the populations – youth, individuals living with HIV, and men of color who have sex with men. Two populations, youth and HIV positive individuals, were chosen for expanded research, which resulted in 19 additional interventions being identified for these populations. Although the expanded criteria was much less rigorous than that of the CDC, the IRC committee felt that local prevention service providers could improve program development, implementation, and delivery by being exposed to a greater number of interventions.

For the 2005-2008 Comprehensive HIV Prevention Plan, the Community Services Assessment (CSA) Committee decided to utilize both the intervention research and literature review conducted in 2001 and 2002 with particular intervention recommendations focused on prevention for positives. *(**See Interventions section of Chapter 5:Connecticut's Priorities for 2005-2008**).*

This chapter will provide the reader with insight into Connecticut's research findings on prevention strategies and interventions. Included is background information on scientific theories used as the foundation for many of the proven effective HIV prevention interventions, descriptions of nationally recognized intervention levels and practical examples, as well as updated findings from the CPG's literature review, including effective or evaluated prevention interventions (although limited) for HIV positives, IDUs, MSM and Heterosexual tables. Effective interventions for populations identified by the CPG in 2001 – incarcerated population and people

over 50 – are also included. **(See Comparison of CPG/DPH interventions and CDC Interventions in Appendix C).**

Scientific Theory

Sound scientific theory for HIV prevention interventions takes the form of behavioral science theory. Behavioral sciences comprise a broad field of studies including psychology, sociology and anthropology among others. These sciences examine human activities in an attempt to discover patterns and to formulate rules about social behavior (CPLOT Manual 2000).[2] More simply stated, behavioral science seeks to understand why people behave as they do. Since many health problems are linked to human behavior, behavioral theory can be used to understand how to prevent health problems, such as HIV.

Many theories seek to explain how and why individuals and/or the societies in which they live modify behaviors to improve their health status. Behavioral theories are useful for HIV prevention because they can serve as road maps for designing effective interventions. Suppose for example that prevention service providers acknowledge an individual or population's need for a specific behavior change. They can then examine behavioral theories that take into account the characteristics of the population and the intended behavior change, and choose a theory selected on which to base the intervention. The selected theory is comprised of many elements such as a description of what individuals, groups or communities may need to make a behavior change more easily and the barriers that they may encounter along the way. Just as road maps are designed to assist travelers in getting the most from a trip by providing a visual aid of a journey's infrastructure, behavioral theories present the framework for effective intervention design. Examples of relevant behavioral social science theories are described in the following tables.

COGNITIVE THEORIES AND MODELS OF HEALTH-RELATED BEHAVIOR		
Description of theory	Things to consider when using this theory	Example of the theory is used in practice
1. Health Belief Model (HBM)		
HBM- *(Rosenstock, 1974; Maiman & Becker, 1974)* The HBM is the most commonly used model to predict and explain individual health behaviors. Applying a cost-benefit perspective to explain preventive health behaviors, the HBM is based upon the idea that health behavior is a function of an individuals perception and interaction of (1) threat (susceptibility and severity of illness); (2) perceived benefits (preventive benefits weighed against perceived barriers to behavioral change); and, (3) cue to action in the form of internal (e.g. physical symptoms) or external	**HBM-** This theory is limited in a number of ways. It does not address the influence of culture, class, economics, environment, and life experience in shaping health behaviors. It fails to consider the role of both habit and social network influence in health behavior decisions. It also does not provide recommendations for ways to persuade persons to change their behaviors. Finally, it does not examine the interaction between multiple risk factors (i.e. sex and drugs) and its impact on HIV risk and precautionary behavior. An important component of the HBM is that the	**HBM-** A Hepatitis C prevention program for active IDUs based in HBM would demonstrate the dangers and ease of Hep C transmission to IDUs, and highlight the ease of practicing safer needle using behaviors.

[2] National Minority AIDS Council, Community Planning Leadership & Orientation Training Manual, 2000.

COGNITIVE THEORIES AND MODELS OF HEALTH-RELATED BEHAVIOR		
Description of theory	Things to consider when using this theory	Example of the theory is used in practice
(e.g. social experience) stimuli.	individual must feel the need to change (perceived susceptibility and severity) and believe that change will be advantageous and that they are competent to make that change. With respect to adoption of needle-use risk-reduction behavior, at least three studies of injection drug users found that avoidance of AIDS (an indirect measure of susceptibility) was a significant factor in influencing behavior change.	
2. Social Learning Theory (SLT)		
SLT- *(Bandura, 1977, 1986)* The SLT assumes that behavior and environment are reciprocal systems that interact continuously and is based upon the concept of *reciprocal determinism*: interaction among a person, his or her behavior, and the environment in which the behavior takes place. Self-efficacy is an important mediating factor between beliefs and behavioral change. Self-efficacy encompasses an individual's reasons, knowledge, resources, social supports, and skills. According to the SLT, risk-reduction campaigns should be directed to peer networks (e.g. racial, ethnic, and socio-economic segments of the population) and their existing social networks of organizations, schools, workplaces and religious groups. Enhancing communication skills is also an important goal.	**SLT-** Self-efficacy is behavior-specific and does not necessarily extend to all health behavior situations. Therefore, factors such as previous observations and reinforcement experience, coupled with perceptions of the environment may impact positively or negatively on one's self-efficacy. Studies using the SLT have shown that social norms, peer pressure, and communication have been found to be successful in delaying adolescent's sexual activity and in adoption of condom use. Low self-efficacy has been associated with engaging in unprotected intercourse.	**SLT-** A pregnancy prevention program for youth based in social learning theory would direct pregnancy prevention messages to peer networks at risk of having an unwanted pregnancy, targeting these groups in their natural gathering places, encouraging communication among the group members about the risks, and building skills among the group members to reduce their risk.
3. Theory of Reasoned Action (TRA)		
TRA- *(Fishbein & Ajzen, 1975)* The TRA helps to explain how people make decisions. Its underlying premise is that humans are rational thinkers and systematically process and weigh the results of their health actions before they take one. It is essential to identify the individual's attitudes and/or community's normative system that is maintaining a behavior. Changing a behavior is viewed as changing the underlying cognitive structure,	**TRA-** One limitation to TRA is it assumes people systematically think about behavior (as part of a rational decision-making model). This may not be applicable to emotionally based impulsive behaviors such as sex and drugs. The TRA has been used to prove that male partner resistance or reluctance to use birth control is a significant determinant of a woman's nonuse of oral contraception. The TRA has been used in studies that demonstrate	**TRA-** A weight loss program based in TRA would focus on giving overweight individuals information on the importance and benefits of increased exercise and healthy food choices – seeking to demonstrate the reasons that they should take these steps for a healthier life.

COGNITIVE THEORIES AND MODELS OF HEALTH-RELATED BEHAVIOR		
Description of theory	Things to consider when using this theory	Example of the theory is used in practice
an essential part of the risk-reduction process.	that female African-Americans who had more favorable attitudes towards condoms, perceived subjective norms more supportive of condom use, and who had firmer intentions to use condoms reported using condoms more consistently compared with other female adolescents.	
4. Information-Motivation-Behavioral Skills Model		
IMB- *(Fisher & Fisher, 1992, 2000).* The information-motivation-behavioral skills model argues that HIV prevention Information, Motivation, and Behavioral Skills are critical factors in HIV preventive behavior. According to the model, HIV risk behavior is generally caused by deficits (or weaknesses) in an individual's level of HIV prevention information, motivation, and behavioral skills. In order to increase preventive behavior, these deficits must be identified and addressed. The model asserts that specific informational, motivational, and skills factors will vary as a function of culture, class, economics, environment, and life circumstances, and for that reason, interventions need to be population specific. Further, the critical factors required for prevention will vary depending on the particular HIV preventive behavior.	**IMB-** The IMB model has received support with diverse populations and an array of different HIV preventive behaviors. It offers a set of procedures to use to identify population specific deficits in critical factors necessary for HIV prevention, and for designing and evaluating interventions. Research with the model has been inconsistent in documenting the role of information, likely because at this point in the HIV epidemic, most people have most of the critical information about HIV prevention and transmission. Earlier in the epidemic information was an important factor in prevention, and it may be in the future (e.g., if and when an effective vaccine is found).	**IMB-** An adolescent drunk driving prevention program based on the IMB model would seek to effect change by giving at risk teens information on the risks of drinking and driving, providing them with the motivation (perhaps threat of loss of license) to avoid that behavior, and giving them the skills (negotiating with parents a safe ride program if they choose to drink) to avoid the behavior.
5. Protection Motivation Theory (PMT)		
PMT- *(Rogers, 1975)* The PMT initially addressed the effects of fear on attitude change through use of persuasive messages. Fear arousal is no longer thought to be essential for behavior change. The focus is now on the cognitive process. PMT was modified to incorporate the concepts of self-efficacy from the SLT, and perceived barriers and costs from the HBM. The PMT integrates the cognitive,	**5. PMT-** Adding social norms and behavioral history to the model improved the prediction of AIDS-related behavior for both heterosexuals and homosexuals.	**PMT-** PMT has been used to show the differences in cognitive mediating processes between persons engaging in adaptive (condom use or restraint from high-risk sexual behavior) and maladaptive (unprotected sex) HIV risk-related behaviors.

COGNITIVE THEORIES AND MODELS OF HEALTH-RELATED BEHAVIOR		
Description of theory	Things to consider when using this theory	Example of the theory is used in practice
behavioral, and social processes that underlie the gradual adoption of HIV risk-reduction. Protection motivation is measured by behavioral intentions to adopt the communicator's suggestions.		

COGNITIVE THEORIES AND MODELS OF HEALTH-RELATED BEHAVIOR		
Description of Theory	Things to consider when using this theory	Example of the theory is used in practice
6. Behavioral Relapse Prevention Theory (BRP)		
BRP- *(Marlatt & Gordon, 1985)* The BRP theory focuses on the maintenance stage of the behavioral change process. Therefore, it specifically focuses on persons who have already identified their high-risk behavior and have taken steps to make changes. Behavior coping skills training and reasoning techniques are the foundation of interventions geared to changing patterns of sexual expression and drug use. Problem-solving exercises, role-playing, and buddy-systems are just some examples of the techniques used with the BRP theory.	**BRP**- With the BRP theory, after relapse, decreased perception of risk is an important factor in continuing the relapse behavior. Therefore, a BRP intervention needs to focus on maintaining or increasing perceptions of risk.	**BRP**- Alcoholics anonymous seeks to utilize the BRP model. By providing sponsors, group support, and having individuals share strategies, struggles, and model coping behaviors, it includes all the key components of the model.
Stage Models and Theories		
7. Transtheoretical or Stages of Change Model ™		
TM- *(Prochaska & DiClemente, 1983, 1986)* The TM is based on the assumption that individuals pass through stages in considering health-related behavior change and that determinants of each of these stages differ. The TM is three-dimensional in that it addresses (1) stages (when changes occur); (2) processes (how individuals make changes); (3) levels of behavioral change (what people change) from initial adaptation to maintenance. The five stages of change that are not necessarily linear or exclusive include: Pre-contemplation, Contemplation, Preparation, Action, and Maintenance. The TMs focus is interpersonal and therefore fails	**TM-** The TM is focused on interpersonal behavioral change and fails to consider structural influences on behavior. Also, the TM fails to consider the mediating role of social norms, social networks, the media, community and organizational participation, gender roles, culture, and power, in bringing about changes in sexual and drug-related behavior. Often referred to as "meeting people where they are," TM seeks to only ask individuals to make changes that they are ready for.	**TM-** Training for a marathon must be undertaken using the stages of change model and would begin by considering running, be followed by actually looking into running and to training, and then by actually beginning the training process. While training you may consider quitting, have to go back to thinking about why you wanted to run in the first place, and then recover from missed days of training again. If you were trying to recruit others to run with you, then you would design your message to fit what they were thinking about marathons when you approached them. You would approach a marathon enthusiast

to consider the structural influences on behavior. It is often this theoretical construct that is used in addiction recovery programs.		differently than a couch potato.

COGNITIVE THEORIES AND MODELS OF HEALTH-RELATED BEHAVIOR

Description of Theory	Things to consider when using this theory	Example of the theory used in practice
8. AIDS Risk-Reduction Model (ARRM)		
ARRM- *(Catania et al., 1990)* The ARRM identifies behavior change as a multi-step process with different psychological and social determinants for each stage. According to the ARRM, the three stages in behavior change are: *Labeling* of high-risk behavior (becoming knowledgeable about HIV transmission and HIV risk behaviors), *Commitment* to changing high-risk behaviors, and *Enactment* of risk-reduction behavior. Movement from one stage to the next is predicated on achieving the goals of the prior stage. Emotions, alcohol and drug use, and environmental clues impact behavior motivation over time.	**ARRM-** The ARRM is applicable to diverse populations such as gay men, bisexuals, heterosexuals, teens, and communities of color. Originally designed to predict sexual risk reduction, the AARM can be modified to predict drug-related risk reduction.	**AARM-** A program seeking to decrease cholesterol intake modeled on the ARRM would first seek to teach participants that taking in cholesterol is a risky behavior. Then it would seek to get participants to commit to eating foods lower in fat and cholesterol. Finally it would seek to help people take the steps (cooking lower fat foods) to actually undertake the new diet.
9. Modified AIDS Risk-Reduction Model (M-ARRM)		
M-AARM- *(Ehrhardt et al., 1992)* The M-ARRM is based on the belief that there are different determinants for each stage of behavior change because of the complexity of sexual risk behavior. The first stage is *Susceptibility* and is a modification of the labeling stage in the ARRM. Second is the *Prioritizing* stage where prevention is seen within the context of competing life issues. Third is the *Intention* stage, a modification of the ARRMs Commitment stage. Next is the *Enactment* stage, which takes into account sexual negotiation, sexual behavior, sexual functioning, and self-efficacy. Last is the *Maintenance* stage, which addresses long-term behavior change. There are different determinants for each stage of behavior change because of the complexity of sexual risk behavior.	**M-AARM-** This model is HIV/AIDS specific and therefore has a much more focused approach in terms of initiation, application, and maintenance.	**M-AARM-** If the cholesterol intake reduction program above used the modified ARRM it would change the first step into two steps: realizing that continued intake of high fat foods has serious health implications and then prioritizing reducing the fat intake to avoid those implications. Moreover once the individual committed to change, a step would be added to help participants maintain the lower risk behavior.

COGNITIVE THEORIES AND MODELS OF HEALTH-RELATED BEHAVIOR

Description of Theory	Things to consider when using this theory	Example of the theory used in practice
Organizational Models and Theories		
10. Diffusion of Innovation Model (DIM)		
DIM- (Rogers, 1983) *The DIM is based upon a process of communicating (via opinion leaders) new ideas (changes in social norms) through channels among members of a particular social system or within society over a period of time. There are four main elements to the DIM: 1) Innovation that is considered a new idea; 2) Communication channels that facilitate the diffusing of a message; 3) Time or process; and 4) a social structure. Diffusion is based on social patterns rather than on geographic ones.*	***DIM****- A drawback to the DIM is that disparity of access to diffusion of innovation is based on socioeconomic status, education level, and community integration. Those who have access to numerous media channels and community opinion leaders are in the best position to reap the advantages of diffusion of innovation.*	***DIM-*** *DIM was used to explain the role of popular opinion leaders in communicating the desirability of HIV risk reduction to gay men. The intervention consisted of identified leaders in gay social settings being trained in HIV prevention education, and in turn imparting this information to men who visited the social settings (e.g. bars and social clubs). Participants in the intervention city reported a significant decrease in unprotected anal intercourse and a decrease in multiple sex partners compared with cities where the intervention was withheld.*
11. Social Action Theory (SAT)		
SAT- *(Ewart, 1991, 1995)* SAT applies theory to practice as it guides program design. It provides the program planner with a task analysis of the specific steps that must be taken to make change happen. The SAT model guides the intervention planner through a three-step process: 1) define desired health protective habits as "action steps"; 2) identify and alter relevant personal and interpersonal habits to achieve those action steps; 3) alter actual personal social environment to promote and sustain self and interpersonal changes. The SAT identifies the macro-social and environmental conditions that empower or constrain adoption of preventive health behavior. Several researchers are currently using the SAT as a framework for HIV preventive interventions.	**SAT-** This theory is useful and important because it provides a conceptual framework for examining the cognitive processes, social transactions, and environmental contexts and moderators that promote or impede HIV risk reduction.	**SAT-** Weight Watchers is a weight management program modeled on SAT. It seeks to take the overall goal of losing weight and break it down into manageable pieces, which include: controlling calorie intake, increasing whole grain foods (which break down slowly and make you feel full longer), and increasing physical activity. The program also seeks to help participants identify emotional triggers that cause them to make unhealthy food choices or to skip exercising and to substitute those reactions with healthier choices.

COGNITIVE THEORIES AND MODELS OF HEALTH-RELATED BEHAVIOR		
Description of Theory	Things to consider when using this theory	Example of the theory used in practice
12. Organizational Stage Theory (OST)		
OST- *(Kaluzny & Hernandez, 1988)* According to the OST, when applied to community organizations, theories can provide a framework for understanding how their social systems function, the interrelationships among various interest groups and subsets of culture, and how they can be mobilized to promote community-wide HIV prevention. Like the Transtheoretical Model, the OST outlines the following four important organizational stages of change: 1) Problem identification; 2) Identification of alternatives and their solutions and development of those alternatives along with the allocation of resources for change; 3) Implementation of change; and 4) Institutionalization of change.	**OST-** Similar to the stages that individuals pass through in the Transtheoretical model, organizations also go through sequential stages of change. A drawback to the OST stems from its social-psychological orientation and does not address the various sources of shared power and authority in an organization or community for specific issues, the value orientations of influential persons and groups, the environment within an organization or community, and the constraints and sources of resistance to change.	**OST-** This theory can be adapted to understand the ecology of HIV-affected communities based on a specific geographic area or target population, such as homeless women, injection drug users, gay men, and sex workers.
13. Organizational Development Theory (ODT)		
ODT- *(Tichy & Beckhard, 1982; Brown & Covey, 1987)* The ODT addresses the limitations of the OST. It seeks to identify problems that are barriers to the organizations healthy functioning, rather than to initiate specific behaviors. Intervention is directed towards changing organizational processes and structures and worker's behavior and roles so as to improve organizational effectiveness. Quality-of-life issues and human relationships are the targets of the problem diagnosis, action planning, intervention, and evaluation stages. Other organizational issues that are taken into account include environmental factors, cultural values, ideologies and social norms effecting organizational change.	**ODT-** Both OST and ODT can guide the development of specific intervention strategies tailored to a community's stage of readiness and can identify appropriate community leaders, health care providers, and groups that would be most likely to promote community-wide HIV behavioral change.	**ODT**- Programs seeking to reduce underage smoking often rely on ODT – as they seek to make it more difficult for teenagers to purchase tobacco products. The "We Card" program – now visible at many retailers who sell tobacco products is one example of this theory in action.

COGNITIVE THEORIES AND MODELS OF HEALTH-RELATED BEHAVIOR		
Description of Theory	Things to consider when using this theory	Example of the theory used in practice
14. Precede-Proceed Model (PPM)		
PPM -- *(Green & Kreuter, 1991)* The PPM is a comprehensive planning model that provides a framework for assessing a community's needs. There are nine phases of action: (1) Social Diagnosis (subjective problems and priorities of an individual or community are addressed); (2) Epidemiological Diagnosis (the health of the individual or community is evaluated); (3) Behavioral and Environmental Diagnosis (e.g. risk factors); (4) Educational and Organizational Diagnosis (predisposing, enabling, and reinforcing factors that facilitate or hinder motivation for change and maintenance); (5) Administrative and Policy Diagnosis (of service providers and organizations and their link to the community; (6) Implementation; (7) Process Evaluation; (8) Impact Evaluation; and (9) Outcome Evaluation (long-term changes).	**PPM –** This model is all encompassing in that it identifies factors that contribute to health problems that must be changed to initiate and sustain the process of behavior and environmental change, analyzes policies and resources that can facilitate or hinder development of health promotion programs, and identifies strategies for implementation and evaluation of interventions. Also, the two pieces of the model, Precede and Proceed, can be used together or separately, as each piece is a comprehensive model in itself.	**PPM** has been used to develop objectives to decrease the incidence of new HIV infections among women enrolled in a drug treatment program. Intervention objectives were to discuss alternative stress-reduction techniques, identify sources of peer and social support for continued drug-free behavior, and to inform women about perinatal HIV transmission. These objectives were translated into intervention activities that included support groups and peer educator training among other activities. Three indicators of intervention impact were identified: use of condoms, cessation of drug use, and, for women who continued to inject drugs, sterilization of needles or participation in a needle-exchange program.

Chart created by Sefa Martinez, Marta Moret and Kristin duBay Horton for the HIV Evaluation Bank Training – **Designing Effective Interventions: Using Science and Experience**, November 2001. Primary source for above chart: Mantell, Joanne E., DiVittis, Anthony T., Auerbach, Marilyn I., Evaluating HIV Prevention Interventions, Plenum Press, New York, 1997

SUMMARY SHEET

The following intervention summary sheet lists interventions proven to work with Connecticut's priority populations. A number of the interventions that the Connecticut CPG and the DPH utilize are not included in the CDC Evaluation Guidance – i.e. counseling and testing, drug treatment advocacy, and methadone maintenance.(Note: SEP= Syringe Exchange Program)

Interventions that have been proven to work by population.		IDU	MSM	Heterosexual	Youth	Mother to Child	HIV+
Indvidual Level Interventions (ILI)	Counseling and Testing	X	X	X	X	X	X
	Individual Drug/Alcohol Counseling	X					
	Methadone Maintenance	X					
	Peer Counseling		X				
	Couples Counseling						X
	Motivational Interviewing						
	Intervention by Physicians					X	
Group Level Interventions (GLI)	Peer and Non-peer Multiple Session Workshops	X	X	X	X		X
	Support Groups						
Outreach	Peer and Non-Peer		X	X			
PCM	Prevention Case Management						
PCRS	Partner Counseling and Referral Services						
Health Comm/ Public Info (HC/PI)	Broadcast Media						
	Hotlines						
	Single Session Workshops		X	X	X		
	Clearinghouses						
	Print and Other Media						
Community Level Interventions (CLI)	Community Mobilizations		X	X	X		
	Social Marketing Campaigns		X	X	X		
	Single Session Workshop						
	Community Wide Events		X	X	X		
	Policy Interventions		X	X	X		
	Structural Interventions	X (SEP)	X	X	X		

*SEP - Syringe Exchange Program

In addition to the above list of interventions, other interventions also exist, which do not fit exactly into the previous matrix because of the location at which services are delivered. These include:

- ***School-based clinic for HIV testing and prevention***: general health clinics within the school campus that deal with a variety of health issues including HIV
- ***Programs in prisons***: individual or group level interventions, which occur in prisons including prevention education classes.
- ***Religious support:*** usually comprised of religious leaders and congregations who deliver HIV education and prevention messages and provide emotional support and motivation, consistent with religious doctrine, to assist individuals in behavior change (e.g. The Balm in Gilead's Black Church Week of Prayer for the Healing of HIV/AIDS).
- ***Capacity Building interventions***: do not necessarily seek to reduce HIV risk, but rather support organizations and individuals who provide HIV risk reduction services. These efforts include linkage of community-based organizations (CBOs) and AIDS-service organizations (ASOs) and can involve the use of experts to provide technical assistance (TA) in such areas as training and hiring, planning and evaluation capacity, fiscal development and administration.

Effective interventions for Connecticut's targeted populations as identified by the Connecticut CPG in the 2005-2008 are included in **Appendix D**. The tables reflect CDC interventions from the 1999 Compendium of HIV Prevention Interventions with Evidence of Effectiveness (updated, 2001) as well as those, which are non-Compendium, but research-based interventions.

Effective Interventions: Findings from CDC Compendium & Connecticut CPG's Literature Review

Key to Cognitive Models & Theories
HBM: Health Belief Model

IMB: Information, Motivation, Behavioral Skills Model

TRA: Theory of Reasoned Action Model

TM: Transtheoretical or Stages of Change Model

ARRM: AIDS Risk Reduction Model

SLT: Social Learning Theory

PMT: Protection Motivation Theory

BRP: Behavioral Relapse Prevention Theory

Chapter 2 Summary and Lessons Learned

The following table summarizes the intervention Levels and Types demonstrated as effective in the review of behavioral science literature. These effective interventions are grouped by population.

Figure 4-3 Summary: Interventions Demonstrated as Effective in Literature Review –by Population

Population	Intervention Level	Intervention Type
Injection Drug Users (IDU)	Community Level Intervention	Syringe Exchange Program
		Outreach
		Methadone Maintenance
		Social Marketing
	Group Level Intervention	Multiple Session Workshop
Heterosexuals	Individual Level Intervention	Counseling and Testing
		Single Session Workshop
		PCM
		Motivational Interviewing
		One on One Peer Counseling
	Group Level Intervention	Single Session Workshop
		Multiple Session Workshop
	Community Level Intervention	Media Campaign
		Outreach
		Single Session Workshop
		Community Mobilization
		Social Marketing
Men who have sex with men (MSM)	Individual Level Intervention	Counseling and Testing
	Group Level Intervention	Single Session Workshop
		Multiple Session Workshop
	Community Level Intervention	Social Marketing
		Natural Opinion Leader
Youth	Group Level Intervention	Single Session Workshop
		Multiple Session Workshop
	Community Level Intervention	Social Marketing
	ILI	One on One peer counseling
		Counseling and Testing
	CLI	Capacity Building
HIV-Positive	ILI	Couples Counseling
	ILI	Case Management
	ILI	Peer/Non-Peer Counseling
	GLI	Multiple Session workshops and Support Groups
Incarcerated Population	ILI	Counseling and Testing
		PCM
	Group	Single session workshop
		Multiple Session Workshop
Adults over 50	GLI	Structural Intervention
		Multiple Session Group

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Chapter 5

Connecticut's Priorities for 2005-2008

Priority Setting in Connecticut

Priority Populations and Interventions for 2005-2008

The Academy for Educational Development (AED) in its priority setting tool, *Setting HIV Prevention Priorities: A Guide for Community Planning Groups,* defines priority setting as a process, which produces a list of ranked priority target populations and interventions proven appropriate and effective. This process ultimately assists the Department of Public Health in appropriating CDC designated and statewide prevention funds to those CPG identified populations most at risk for HIV.

In the CDC's 2003 Guidance for *HIV Prevention Community Planning* a number of goals, guiding principles and objectives are established for the priority setting process:

The primary task of the CPG is to develop a comprehensive HIV prevention plan that includes prioritized target populations and a set of prevention activities/interventions for each target population. Priority setting in community planning is based on a review of all existing and new elements prior to decision-making (e.g. epidemiologic profile, community services assessment, previously prioritized target populations, selected set of prevention activities/interventions, and the 2004 Update to Connecticut's Comprehensive HIV Prevention Plan for 2002-2004). The outcome of the CPG priority setting function is that the DPH will have a data-driven process, which it can use in allocating prevention funds to those populations most at risk for HIV.

2002 - 2004 Priority Setting History
In 2001, the Connecticut CPG leadership developed a prioritization process that was designed to meet the guidelines of the 1998 CDC Guidance and take into account the expertise of CPG membership. That prioritization process, grounded in the work of three workgroups (Epidemiological Profile and Priority Setting, Interventions, and Resource Allocation), established Connecticut's priorities (populations and targeted interventions) for the HIV Comprehensive Prevention Plan for 2002 – 2004.

For that process, the CPG used the basic prioritization method described in AED's *Setting HIV Prevention Priorities* and adapted a modified version of the model for use in prioritizing populations, interventions and resources. The CPG eventually settled on 12 populations for prioritization[1], and utilized four quantitative datasets (AIDS prevalence, AIDS incidence, counseling & testing seroprevalence, and STD case rates) and one subjective factor (CPG member knowledge and experience with the populations) in prioritizing populations for the seven CPG regions. Recognizing that different regions of Connecticut faced different epidemics, the priority setting workgroups and CPG leadership felt that setting statewide priorities would not adequately serve populations at-risk. Therefore, populations, interventions, and resources were prioritized or allocated by CPG region.

Following the priority setting process for populations in June 2001, the Connecticut CPG prioritized interventions for all possible priority populations. These prioritized interventions were recommended for the federal HIV prevention funds. Unlike prioritizing populations, interventions

[1] The twelve populations consisted of: White injection drug users (IDUs), Latino/a IDUs, African American IDUs, White men who have sex with men (WMSM), MSM of color (including African American and Latino), White heterosexuals, Latino/a heterosexuals, African American heterosexuals, Youth 13-19 years old; Youth 20-24 years old, HIV-positive individuals, and children infected perinatally.

were examined strictly by population without taking into account the specific regional needs of each population. The CPG decided that the prioritized interventions should serve as guidelines to HIV prevention service providers in each of Connecticut's regions. It was felt that service providers would be more knowledgeable of the priority populations' specific regional needs when developing interventions. To prioritize interventions the CPG used a comparable tool to that which was used for populations, however, the data used to determine intervention priorities differed. In prioritizing interventions, the CPG members wanted to consider not only proven effective interventions based on the literature review, but also the results of the 2001 statewide needs assessment, the findings from the 2002 resource inventory and gap analysis, "cutting edge" interventions, and members' and advisors' experience **about the effectiveness of the interventions for each population. The majority of these** interventions will be used in the establishment of population specific interventions for populations prioritized for 2005-2008.

2004 CPG PRIORITY SETTING PROCESS: Focus on the Future

In April 2003, the CDC announced a new initiative aimed at reducing the number of new HIV infections each year in the United States. This initiative consists of four parts and includes:

(a) making HIV testing a routine part of medical care,
(b) creating new models for diagnosing HIV infections outside medical settings,
(c) ©preventing new infections by working with people diagnosed with HIV and their partners, and,
(d) further decreasing mother-to-child HIV transmission by incorporating HIV testing in the routine battery of prenatal tests.

This new focus, *Advancing HIV Prevention Initiative*, set the foundation for Connecticut's HIV Prevention Community Planning Priority Setting Process. According to the Community Planning Guidance, CPGs must now consider two major components from the CDC's HIV *Strategic Plan Through 2005*:

(1) to target populations for which HIV prevention activities will have the greatest impact, and,
(2) to reduce HIV transmission in populations with highest incidence.

The CDC Guidance clearly states that because of the new initiatives potential to substantially reduce HIV incidence, **CPGs will be required to prioritize HIV-infected persons as the highest priority population for appropriate prevention services.** In addition, uninfected, high-risk populations such as sex or needle-sharing partners of people living with HIV/AIDS (PLWHA) will need to be prioritized based on local epidemiology and community needs. However, as it relates to interventions, the Guidance clearly states that CPGs are no longer required to prioritize interventions for specific populations. As a result, for its 2005-2008 Plan, the Connecticut CPG developed a set or mix of interventions for prioritized target populations (Injection Drug Users, Men who Have Sex with Men, Heterosexual Sex, and HIV-Positives) that will have the potential to prevent the greatest number of new infections. This mix of interventions utilized the prioritized interventions developed for the 2002-2004 Plan, with additional activities included for HIV positive individuals. All interventions are based on behavioral and scientific theory, outcome effectiveness, and/or have been adequately tested with the targeted populations for cultural appropriateness, relevance and acceptability. ***(Additional information related to effective interventions is included in Chapter 4: "What Works in HIV Prevention?")***

Priority Setting Ad Hoc Committee

In February 2003, the CPG formally resumed its priority setting process for the 2005-2008 Connecticut HIV Prevention Comprehensive Plan with the establishment of a Priority Setting Ad Hoc Committee. The Committee was charged with the following:

- **To research and recommend, based on the available literature, a priority setting mechanism to identify priority populations, prevention needs and interventions for the Connecticut HIV Prevention Community Planning Group.**

The committee's related duties consisted of:

- Reviewing available literature on priority setting methods developed by other community planning groups, Ryan White Planning Councils and the Academy for Educational Development (AED).
- Presenting a recommendation for a priority setting mechanism to the CPG for adoption.
- Creating and reviewing the priority setting timeline for workgroup tasks throughout the year.

At the February 2003 Priority Setting Ad Hoc Committee meeting, committee members elected CPG advisor Leif Mitchell as chair and CPG member LeeAnn Marino as co-chair. In June of 2003, resigned from her position as the Priority Setting Ad Hoc Committee co-chair. Brian Goodrich, CPG member and former chair of the Finance and Allocations Committee, was voted in as new committee co-chair at the July 2003 CPG meeting.

Members of the 2003-2004 Priority Setting Ad Hoc committee included: Leif Mitchell, chair; Brian Goodrich, co-chair; Dalia Belliveau, CPG advisor; Ken Carley (DPH) CPG advisor; Debbie Cornman, CPG member; Pat Denardo, CPG advisor; Kathey Fowler, CPG member; Matt Lopes, CPG member; Susan Major (DPH), Dennis O'Neill, CPG member, Richard Spears (DPH), and Albert Young, CPG member. DPH Co-chair Chris Andresen and Community Co-Chairs Brian Libert, Bernadette Brown, and Stephanie Lozada served as ex-officio members. The Parisky Group, as contractor for the CPG, also staffed the priority setting committee (Laura Stone and Barbara Mase).

In April 2003, the committee began the process of reviewing literature and other priority setting mechanisms including:

- Chapter 6 - *Priority Setting in Connecticut* - of the 2002-2004 Comprehensive HIV Prevention Plan;
- NASTAD's HIV decision making tool;
- Mechanisms on priority setting presented at the March 2003 Community Planning Leadership Conference (e.g. Washington, DC and Hawaii);
- Ryan White priority setting matrix from the Title I Planning Council, New Haven/Fairfield County;
- AED's *Setting HIV Prevention Priorities: A Guide for Community Planning Groups;*
- Priority setting models and prioritized population samples from Florida, Pennsylvania, Chicago, and Iowa; and,
- The 2003 Epidemiological Profile of HIV and AIDS in Connecticut.

Discussions and decision-making further ensued which focused on committee timelines and work plans **(See Priority Setting Timeline in Appendix D)**, confirmation of a priority setting method, technical assistance and priority-setting committee/CPG trainings, prioritization of populations by risk behavior, further break-out of populations by race (Black, Latino/a, and White), weighting and rating scales, evidence-based and subjective factors, what additional types of data to consider and review for the prioritization process, and incorporation of the priority setting methodology into the CPG bylaws and policy /procedure manual.

Following a lengthy method review, the Priority Setting Committee decided to use the AED model as a basis for the priority setting process and build upon that method. Krista Heybruck, Behavioral and Social Science Volunteer for the CPG, provided five hours per month of training and facilitation for both the Priority Setting Ad Hoc Committee and the CPG regarding the priority setting model and its adaptation to Connecticut's process. Specially designed priority

setting trainings and exercises were conducted with the Priority Setting Ad Hoc Committee, the Executive Committee, and the full CPG membership beginning in August 2003, and, culminated with the prioritization of populations in March 2004.

Beginning in August 2003, mini-Priority Setting 101 Power Point presentations and exercises were implemented during monthly CPG meetings to better acquaint and train CPG members about the various components of priority setting. ***(See Priority Setting 101 PowerPoint samples in Appendix D)***. A 90-minute priority setting workshop was also included in the CPG's annual planning retreat in November 2003 ***(See Dining for Decision training exercise in Appendix D).***

After reviewing many of the difficulties encountered with the 2001 Priority Setting Process, and also taking into account CPG member evaluation of the process, the Priority Setting Ad Hoc Committee agreed on the following as a foundation for Connecticut's 2004 priority-setting process:

To implement a Priority Setting Process that:

1. **Is understandable**
2. **Has a clear purpose**
3. **Is data-driven**
4. **Supports allocations that will have the greatest impact**
5. **Is not based on politics or emotions**

The Priority Setting committee further decided, that unlike the 2001 process, which used a regional model in prioritizing populations, the 2004 process would be focused on setting statewide priorities, thus allowing contractors to determine the most at-risk populations in their region. It was made evident from HIV/AIDS Surveillance data, the 2003 Epi Profile and the 2004 Epi Update, that what drives the epidemic in Connecticut is injection drug use (IDU), followed by men who have sex with men (MSM), and heterosexual sex. AIDS in Connecticut has disproportionately affected specific demographic groups including males (70% of all reported cases), Blacks and Hispanics. Trends in AIDS cases (2002) show an (a) increase in female cases, (b) an increase in Hispanic cases, (c) an increase in heterosexual transmission, (e) and an increase in the age of newly diagnosed cases (e.g. particularly in the 40-49 and 50+ age groups). In 2002, HIV infection in adults became reportable, and, based on the 374 reported HIV cases, it was noted that, in comparison to AIDS cases, HIV cases were more likely to be female (43% HIV vs. 40% AIDS), Hispanic (HIV 40% vs. AIDS 32%), younger (median age of 36 for HIV vs. 41 for AIDS0, and were more likely to be initially reported without indicated risk information (48% HIV vs. 35% AIDS). Based on this information, the committee, after much discussion and review, decided to prioritize populations by risk behavior with a further breakout by race. Age and gender were not considered in these population specifics, because it was determined that further breakouts could potentially eliminate populations/groups from consideration. Aspects, such as age and gender, were designated as part of the contractor decision-making process in targeting interventions to specific at risk regional populations.

As a result of the Priority Setting Committee's review of data, the following nine populations, based on behavior, were proposed for prioritization and ranking, with the understanding that HIV-positive individuals would receive highest priority. Because of this priority status, HIV-

positives would not be rated, scored or ranked as the other populations. The nine populations are:

Men Who Have Sex with Men (MSM)	Injection Drug Use (IDU)	Heterosexual Sex
◆ Black	◆ Black	◆ Black
◆ Latino	◆ Latino/a	◆ Latino/a
◆ White	◆ White	◆ White

Datasets Utilized in Priority Setting

The following six evidence-based (driven by data) factors and one subjective factor, which allowed for CPG member preference and experience, were utilized by the CPG in weighting, rating, scoring and ranking the nine populations. Because not all data sets were applicable for each of the populations, the following rationale was developed to support the decision-making ***(See Data Sheets in Appendix D).***

Evidence-based Factors

- **AIDS Incidence:** The number of **NEW AIDS** cases diagnosed in a defined population in a specified period (often a year) The number of new cases was available for all populations.
-
- **AIDS Prevalence**: The number of people LIVING WITH AIDS in a defined population on a specified date, regardless of when they were diagnosed. AIDS prevalence data was available for all populations.

Rationale: AIDS Incidence and AIDS Prevalence data are among the most complete data collected by DPH and can be used as an indicator for HIV prevalence.

- **HIV Incidence:** The number of new HIV cases diagnosed in a defined population in a specific period, usually a year. HIV incidence data was available for all populations.

Rationale: HIV incidence is an important piece of information for planning, but there are some problems: (1) a high percentage of cases (2002) were reported without identified risk (NIR), (2) DPH has only been collecting data since 2002; trends cannot be projected, (3) the system still reports "new reports of HIV infection" meaning some late-testers rather than actual "new infections", and (4) there is a lag-time in reporting from testing locations. While important data, HIV incidence must be interpreted in the light of the previously mentioned issues.

- **Syphilis Data:** Sexually transmitted diseases are reliable indicators of high-risk behaviors (unprotected sex). Syphilis is the only STD with identified risk behavior information, and also has a higher co-morbidity than either gonorrhea or chlamydia. The data used was reflective of NEW Syphilis cases reported in a one-year period. Data was only available for MSM and Heterosexual Sexual behaviors.

Rationale: Although only presenting with a small number of syphilis cases in 2002, the data does indicate a risk behavior among the MSM population. Because no risk behavior is identified for gonorrhea or chlamydia cases, this data will be included as part of the subjective factor (value-based). The presence of gonorrhea and chlamydia cases is an indicator of high-risk behavior among identified populations, but the data alone does not indicate a risk for HIV infection.

Counseling and Testing Data: Both positive and negative test results were reviewed for reported and perceived risk behavior. This data shows is getting tested. **(See Counseling and Testing PowerPoint in Appendix D)**

Rationale: One of the CDC's new strategies is the focus on HIV testing. Its goal is to reduce barriers to early diagnosis of HIV infection and increase access to quality medical care, treatment and ongoing prevention services. In Connecticut, unduplicated CTS reports comprise about 20% of the total HIV reports – a minority percentage of the total HIV tests actually done. While this data only represents a portion of the whole picture, it can provide some insight into identified and perceived risk behaviors.

- DPH Interventions Data Base: **Based on input from the various DPH funded contractors, one can gain a picture of the number of interventions per population as well as the cost and number of people served per intervention. (**See Interventions Database Funding information in Appendix D)

Rationale: With this data, one is able to relate interventions/funding allocations and determine gaps in service. Currently DPH funded interventions by populations break out as follows:

Populations	# of interventions	Funding	# of PLWHA(6/30/03)	Dollars per PLWHA
Heterosexual	204	$3.1 million	1,291	$2,401
IDU	95	$2.1 million	3,094	$ 679
MSM	57	$1.0 million	1,221	$ 819
HIV Positive	19	$ 450,000	6,476	$ 69

Subjective Factor:

This value-based factor took into account CPG member preference, experience and expertise, as well as incomplete data that did not cross all populations, but could be considered as indicators of risk behavior for HIV infection. A brainstorming session, facilitated by Behavior Social Science Volunteer (BSSV), Krista Heybruck, regarding barriers to accessing HIV prevention services for the nine at-risk priority populations also provided CPG members and members of the public with an opportunity to provide input on both the perceived and real barriers to services. The additional data component included presentations on the Rapid Assessment, Response and Evaluation (R.A.R.E.) Project in Hartford ***(See R.A.R.E. Project Mini-Report in Chapter 3),*** the Youth Risk Behavior Survey (YRBS) and Connecticut School Health Survey, the most recent statewide STD data, and Viral Hepatitis information***. (See***

PowerPoint presentations on youth, STDs, and Viral Hepatitis, as well as the Barriers Discussion in Appendix D).

Weighting, Rating, and Scoring

The dictionary defines prioritization as an arrangement or a dealing with something in order of importance or urgency. In order to facilitate the final ranking of the nine populations, the Priority Setting Committee developed weighting and rating scales to assist in the prioritization process.

- **Weighting** indicates a level of importance or influence for the selected evidence-based factors and subjective factor relative to each targeted population. For the process, the committee developed an "importance weighting scale" of 1-3, with 1as LOW, 2 as MEDIUM, and 3 as HIGH. Using this weighting scale, the various factors were weighted as follows:

  Evidence-based factors:
  - AIDS Incidence: 3
  - AIDS Prevalence: 3
  - HIV Incidence: 2
  - Syphilis Data: 2
  - Counseling and Testing Data: 1
  - DPH Interventions Database: 3

  Subjective Factor: 2

- **Rating** "scores" each factor as a measure within each target populations (e.g. establishes a level of "how much"). The rating scale determined for the evidence-based factors differed from that of the subjective factor on the basis of data-driven information versus value-based. Evidence-based factor rates were calculated using the existing and most recent data available for each population, and then a mathematical formula was applied to compute the rate. For the subjective factor, CPG members were given a total of 50 points to rate the nine populations, with the caveat that the total for the populations must equal 50. Members were permitted to distribute the 50 points among the nine populations based on their experience, knowledge and information received during the subjective factor presentations. Populations could be given similar points, different points or no points. ***(See Subjective Factor Rating Sheet in Appendix D)****.* Once the rate for each evidence-based factor was determined, that number was multiplied by the weight set for that factor (Weight x Rate) to give a population a specific score.

- **Scoring** is the result of multiplying the **Population Factor Weight** by the **Population Factor Rate.** The individual population evidence-based score was then added to the individual population subjective factor score to provide an overall population total score. This resulting population score permitted the final priority ranking of the nine populations. A calculation spreadsheet, which included the nine populations, evidence-based factors, and subjective factor, was developed to assist the Priority Setting Committee in weighting, rating, scoring and ranking the nine populations. A copy of that document with scoring results and ranking is included at the end of this chapter.

  Scoring for evidence-based factor was extremely more complicated to calculate than the subjective-factor **(See Priority Setting: It's Here PowerPoint in Appendix D).**

The following is the process used to determine evidence-based factor and subjective factor scoring:

Evidence-based:

- **AIDS Incidence:** Total number of cases in population (e.g. Black MSM) was divided by the grand total of AIDS cases and resulting number was then multiplied by 100 to provide an indicated strength of the infection in the population. This number was then multiplied by the weight of 3 to give a population score.
- **AIDS Prevalence:** Total number of cases in population (e.g. Black MSM) was divided by the grand total of AIDS cases and resulting number was then multiplied by 100 to provide an indicated strength of the infection in the population. This number was then multiplied by the weight of 3 to give a population score.
- **HIV Incidence:** Total number of cases in population (e.g. Black MSM) was divided by the grand total of HIV cases and resulting number was then multiplied by 100 to provide an indicated strength of the infection in the population. This number was then multiplied by the weight of 2 to give a population score.
- **Syphilis Data:** Total number of cases in population (only MSM and Heterosexual Sex) was divided by the grand total of Syphilis cases and resulting number was then multiplied by 100 to provide an indicated strength of the infection in the population. This number was then multiplied by the weight of 2 to give a population score. IDUs received a score of "0" because no IDUs tested had tested positive for Syphilis.
- **Counseling and Testing:** Total number of cases in population (e.g. Black MSM) was divided by the grand total of testing cases and resulting number was then multiplied by 100 to provide an indicated strength of the infection in the population. This number was then multiplied by the weight of 1 to give a population score.
- **DPH Interventions Database**: The cost of intervention dollars per PLWA/population was divided by the total cost of intervention dollars per PLWA and the resulting number was then multiplied by 100. The resulting number was multiplied by the weight of 3 and then subtracted from the totals of the five preceding evidence-based factors.

Subjective factor:
Subjective factor scoring, which was more value-based, was accomplished by dividing the specific population score by the grand total subjective factor score (50 points x # of CPG members participating in the process) and then multiplying that number by 100. This number was multiplied by the subjective factor weight of 2 for a final population specific score. The subjective factor population score was then combined with the evidence-based factor population score for a final population specific score.

At the March 2004 Priority Setting Process, CPG members were provided with a final priority setting process presentation ***(See Priority Setting: It's Here in Appendix D)***, which reviewed the priority setting steps, Connecticut HIV/AIDS statewide information, basic concepts of priority setting (factors, weighting, rating, scoring and ranking), the factors used for decision making and the accompanying rationale, weighting and rating scales, scoring, applicable data used for decision-making, and the process for subjective factor rating. Members were instructed in the use of the Subjective-Factor Population Rating Sheet ***(See Rating Sheet in Appendix D)*** and then asked to individually rate the nine populations using a pool of 50 points. Member scores were input into a Subjective Factor calculation spreadsheet and the resulting scores were incorporated into the larger Priority-Setting Scoring spreadsheet.

This document was then displayed on a large screen so that CPG members could see the final outcome of the scoring process. Populations were then ranked from high to low.

The ranked results of the Connecticut CPG 2004 Priority Setting process are as follows:

HIV-Positive Highest Priority

1. White MSM
2. Latino/a IDU
3. Black IDU
4. White IDU
5. Black Heterosexual
6. Latino/a Heterosexual
7. White Heterosexual
8. Black MSM
9. Latino MSM

Interventions

The new CDC Guidance for Community Planning indicates that rather than prioritizing interventions for priority target populations as in previous priority setting processes, that CPGs should instead "conceptualize interventions/activities as a set or mix of interventions/activities versus one specific intervention/activity for each target population. Regardless of the mix or set of interventions selected, all interventions, however, must be science-based, proven effective and culturally/ethnically appropriate. For this process, the Connecticut CPG utilized the intervention charts developed during the 2001 Priority Setting Process since all of the interventions included were reflective of the CDC's *Compendium of HIV Prevention Interventions* (2001) and *Replicating Effective Programs Plus* (REP+). Other interventions, also included in the mix, although not necessarily in the CDC's list, are research-based and have a positive and significant behavior/health component. (e.g. Needle Exchange Program, Drug Treatment Advocacy and Methadone Maintenance.) The Connecticut CPG has identified injection drug users (IDUs) as a priority population, and has found that based on extensive research syringe exchange programs (SEPs) are an effective, cost-efficient HIV prevention intervention for IDUs. In addition, research also shows that syringe exchange programs have not been associated with increased drug use or initiation of injection drug use. Therefore, the CPG has identified SEPs as an effective HIV prevention intervention for IDUs ***(See the CPG Position Statement on Syringe Exchange Programs in Appendix D)***

Based on the CDC's *Advancing HIV Prevention: New Strategies for a Changing Epidemic*, HIV service and health care providers are also strongly encouraged to include the following concepts/programs within the mix of selected population specific interventions/activities:

- **Incorporation of HIV testing as a routine part of care in traditional medical settings** (e.g. encouraging all health care providers to include HIV testing, when indicated, as part of routine medical care),
- **Implementation of new models for diagnosing HIV infections outside medical settings** (e.g. use of the rapid HIV test),
- **Prevention of new infections by working with people diagnosed with HIV and their partners** (e.g. get HIV positive individuals into care and treatment, provide prevention case management and counseling for people with HIV, promote and institute prevention education and risk reduction activities for people living with HIV, and promote and implement partner counseling and notification),
- **Further decrease mother-to-child HIV transmission** (e.g. promote screening of every pregnant woman for HIV, using the "opt-out" approach, make prenatal screening a routine part of medical care, and promote screening of newborns whose mother's HIV status is not known).

Given the complexity involved in developing evidence-based interventions as well as trying to understand the social, economic, cultural and individual variables associated with human behavior across Connecticut, designing and assigning interventions which promote positive behavior change can be an enormous challenge. The interventions chosen for the priority populations were selected with a statewide view, thus giving HIV prevention service providers the flexibility to adapt the interventions to the specific population and region wide needs of their service area.

Prevention for Positives
The CDC has identified prevention for HIV-positive individuals as the highest priority for CPGs. Because HIV-positive individuals are living longer and healthier lives, maintaining safer sexual and drug use behaviors can be challenging. The result is AIDS-fatigue, which can lead to dropping out of care, non-adherence to medications, co-infection with STDs and Hepatitis, development of drug-resistant strains of the HIV virus, and exposure to opportunistic infections.[2]

According to the CDC, although numerous effective prevention interventions have concentrated on HIV-negative populations, only a small number have focused on HIV-positive persons. (e.g. support group/ structured risk-reduction, skills building group, couples or individual-level intervention).

It is crucial in "Prevention for Positives" that individuals both newly and currently diagnosed with HIV be enrolled or referred to medical care. This emphasizes the role of linking prevention and care services into a continuum of care *(**See Integration of Prevention and Care in Chapter 6: Linkages).***

In the 2001 Institute of Medicine's (IOM) report *No Time to Lose: Getting More from HIV Prevention*,[3] the authors emphasize the need for enhanced HIV prevention efforts in the clinical setting as part of the standard of care for HIV-infected persons. Care services have traditionally focused on treatment and support services related to primary care. But according to IOM, health care providers should incorporate effective prevention counseling within their care services. A

[2] Madhavi Reddy Patt, M.D., M.P.H., Prevention is Treatment: Prevention with Positives in Clinical Care, HRSA CARE ACTION, March 2003.

[3] MS Ruiz, AR Gable and EH Kaplan, et al. No Time to Lose: Getting More from HIV Prevention, Washington, D.C.: Institute of Medicine, 2001.

better connect between the two worlds of prevention and care needs to be addressed and measures put into place in order to meet the care and prevention needs of HIV-positive individuals. As part of the CDC's strategic plan, it has developed the SAFE project (Serostatus Approach to Fighting the HIV Epidemic), which calls for efforts to:[4]

1. **Increase the availability of prevention services for people with HIV,**
2. **Teach health care practitioners to perform HIV and sexually transmitted disease (STD) risk assessments in HIV-infected patients, and,**
3. **Increase delivery of prevention messages to HIV-infected patients by health care workers.**

In its *Interim Technical Guidance for Selected Interventions*, the CDC suggests the following ancillary services, obtainable through referrals from a Ryan White Case Manager, for consideration as interventions with HIV-positive persons:

- **Behavioral interventions to reduce risk behavior**
- **Interventions to improve adherence to complex medication schedules**
- **Substance abuse treatment**
- **Mental health treatment**
- **Domestic violence prevention**
- **Family planning services**
- **Housing**

Prevention providers face new challenges in providing prevention interventions for HIV-positive individuals. Not only must consideration be given to getting people into care and maintaining their "in-care status", but providers must also take into account the stigma, barriers, psychological, social, cultural and economic factors that impact PLWHAs and ultimately affect sexual and risk-reduction behaviors.

According to research **(*See Working with HIV-Positive Individuals: Risk Behavior and Prevention Strategies in Appendix D)*** conducted by Deborah H. Cornman, PhD at the University of Connecticut's Center for Health/HIV Intervention and Prevention (CHIP), current estimates indicate that one out of three individuals who are HIV-positive engages in unsafe sex. A sample of HIV-positive patients in clinical care in Connecticut, indicated that 22% reported unprotected vaginal or anal sex on at least one occasion during a three-month period. Factors associated with risky behavior among HIV-positive individuals include relationship status, economics, emotional states, substance abuse, personality dispositions (e.g. mental health, etc), and perceptions of infectivity. Based on Dr.Cornman's studies, the types of interventions found to be effective with HIV-positive individuals include:

- **Counseling and Testing**
- **Individual counseling**
- **Couples counseling**
- **Single and multi-session group workshops**
- **Prevention case management**

[4] Carlos del Rio, MD. New Challenges in HIV Care: Prevention Among HIV-Infected Patients. Topics in HIV Medicine, International AIDS Society-USA, Volume 11, Issue 4, July/August 2003.

- **Syringe exchange programs (SEPs)**
- **Drug treatment**
- **Methadone maintenance**

Several other programs exist for HIV-positive persons ranging from less intensive, group-based to intensive individualized interventions. Researchers are currently testing more than ten other interventions. Included in these innovative interventions are social marketing campaigns for gay men, five-session group interventions for HIV-positive women, internet chat rooms, 12-session group workshops for HIV-positive youth, group session workshops for HIV-positive Asian American-Pacific Islander Americans, eight session group interventions for gay male serodiscordant couples and prevention case management programs. In Connecticut, the following four interventions show promise and proven effectiveness in reducing risk behaviors in HIV-positive individuals: ***(See Working with HIV-Positive Individuals: Risk Behavior and Prevention Strategies in Appendix D)***

- **Four Positive Prevention Interventions** (Developed by Seth Kalichman, Ph.D): Based on the Information-Motivation-Behavior (IMB) Model of Health Behavior Change. A five-session risk reduction intervention.
- The Options/Opciones Project: Clinician-Initiated Risk Reduction Intervention for HIV+ Patients in Clinical Care ***(Developed as a collaborative project between researchers at the University of Connecticut and Western Ontario and Yale University)*** A collaborative discussion between the clinician and patient in order to assess the patient's risk behaviors, understand the patient's ambivalence about change, elicit strategies for change, and negotiate a behavior change plan of action.
- Project M: A Positive Intervention (Developed by the University of Connecticut and AIDS Project Hartford). A sex-positive approach for risk reduction among HIV+ Gay and Bisexual Men.
- Project Athena (Developed by AIDS Project Hartford). An HIV risk continuum program for HIV-positive women.

Prevention for Positives represents a new and challenging opportunity for prevention providers to make an impact on the epidemic. Additional information regarding effective interventions for HIV-positive persons can also be accessed through the CDC's Replicating Effective Programs (REP) and the Diffusion of Effective Behavioral Interventions (DEBI) projects.

The following charts list the prevention interventions/activities recommended for Connecticut's 2005-2008 priority populations, based on research, literature reviews, the CDC's Compendium and REP, and the CPG's 2001 Priority Setting Process for Interventions.

☑HIV positives
***Individual Level Interventions (ILI)* --** counseling and testing, individual drug/alcohol counseling, peer counseling, methadone maintenance, couples counseling, motivational interviewing
***Group Level Interventions (GLI)* –** peer and non-peer multiple session workshops, support groups
Peer and Non-Peer Outreach
Prevention Case Management (PCM)
Partner Counseling and Referral Services (PCRS)
***Community Level Interventions (CLI)* --** social marketing campaigns, community wide events, policy interventions, structural interventions

☑ African American Injection Drug Users

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, methadone maintenance, motivational interviewing
Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups
Peer and Non-Peer Outreach
Prevention Case Management (PCM)
Health Communications (HC/PI) -- one shot presentations
Community Level Interventions (CLI) -- community wide events, policy interventions, structural interventions

☑ White Injection Drug Users

Individual Level Interventions (ILI) **--** counseling and testing, individual drug/alcohol counseling, peer counseling, methadone maintenance, motivational interviewing
Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups
Peer and Non-Peer Outreach
Prevention Case Management (PCM)
Health Communications (HC/PI) **--** one shot presentations
Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ Latino/as Injection Drug Users

Individual Level Interventions (ILI) **--** counseling and testing, individual drug/alcohol counseling, peer counseling, methadone maintenance, motivational interviewing
Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups
Peer and Non-Peer Outreach
Prevention Case Management (PCM)
Health Communications (HC/PI) **--** one shot presentations
Community Level Interventions (CLI) **--** social marketing campaigns, community wide events, structural interventions

☑ African American Men who have Sex with Men

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, motivational interviewing
Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups, single session workshops
Peer and Non-Peer Outreach
Health Communications (HC/PI) **--** one shot presentations
Community Level Interventions (CLI) **--** community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ Latino Men who have Sex with Men
***Individual Level Interventions (ILI)* --** counseling and testing, individual drug/alcohol counseling, peer counseling, motivational interviewing
Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups, single session workshops
Peer and Non-Peer Outreach
***Health Communications (HC/PI)* --** one shot presentations
***Community Level Interventions (CLI)* --** community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ White Men who have Sex with Men
***Individual Level Interventions (ILI)* --** counseling and testing, individual drug/alcohol counseling, peer counseling, couples counseling, motivational interviewing
Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups
Peer and Non-Peer Outreach
Prevention Case Management (PCM)
Health Communications (HC/PI) – broadcast media, hotlines, one-shot presentations, print and other media
***Community Level Interventions (CLI)* --** community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ African American Heterosexuals
***Individual Level Interventions (ILI)* --** counseling and testing, individual drug/alcohol counseling, peer counseling, motivational interviewing
Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups, single session workshops
Peer and Non-Peer Outreach
Health Communications (HC/PI) -- one shot presentations
***Community Level Interventions (CLI)* --** community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ Latino/a Heterosexuals
Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, methadone maintenance, peer counseling and couples counseling
Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups
Peer and Non-Peer Outreach
Health Communications (HC/PI) – one-shot presentations
***Community Level Interventions (CLI)* --** community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ White Heterosexuals
***Individual Level Interventions (ILI)* --** counseling and testing, individual drug/alcohol counseling, methadone maintenance, peer counseling, motivational interviewing
Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups
Peer and Non-Peer Outreach
Partner Counseling and Referral Services
***Health Communications (HC/PI)* --**one-shot presentations
***Community Level Interventions (CLI)* --** community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

Intervention Descriptions ***– as taken from CDC Evaluation Guidance and the Connecticut DPH 2002 Request for Proposal***	**Key Elements of Intervention**	**Examples of Possible Programs under this Intervention**
Individual Level Interventions (ILI) – health education and risk-reduction counseling provided to one individual at a time. Individual Level Interventions help clients to make ongoing appraisals of their own behavior, motivate clients to make changes in their behavior, and assist clients in making plans for individual behavior change. 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 help clients make plans to obtain these services.	• Provided to one individual at a time • Assists clients in making individual behavior change • Facilitates linkages to services in clinic and community settings	• One-to-one peer counseling • Motivational interviewing • Couples Counseling
Group Level Interventions (GLI) – health education and risk reduction counseling (see above) shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide range of skills, information, education and support. GLIs do not include one-shot education presentations or lectures that do not contain a skills component.	• Delivery of service to groups of varying sizes • Use peer and non-peer models	• Multiple session workshops • Single session workshop with skills building component • Self Help/Support Groups
Outreach (peer or non-peer) – HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators (paid person with training on educational interventions) face-to-face with high risk individuals in the clients' neighborhoods or other areas where clients typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits and educational materials.	• Face-to-face contact with individuals in the neighborhoods or other areas	

Intervention Descriptions ***– as taken from CDC Evaluation Guidance and the Connecticut DPH 2002 Request for Proposal***	**Key Elements of Intervention**	**Examples of Possible Programs under this Intervention**
Prevention Case Management (PCM) – client centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a combination of HIV risk-reduction counseling and traditional case management that provide intensive ongoing, and individualized prevention counseling, support and service brokerage.	• Adoption of HIV risk-reduction behaviors by clients • Combination of HIV risk-reduction counseling and traditional case management	
Health Communication/ Public Information - (HC/PI) – delivery of prevention messages through one or more channels (broadcast, print, or other media) to target audiences. Messages are intended to build support for safer behaviors, support personal risk reduction efforts, and to tell at-risk individuals how to obtain services.	• Delivers prevention messages through media	• Radio, television announcements and broadcasts • Newspapers, magazines, pamphlets and billboards • Hotlines • Clearinghouse • Presentation and lectures (one shot education)
Counseling and Testing – the voluntary process of client-centered, interactive information sharing in which an individual is made aware of the basic information about HIV/AIDS, testing procedures, how to prevent the transmission and acquisition of HIV infection and given tailored support on how to adapt this information to his/her life. Clients who request testing must be provided with pre-test counseling that enables them to make informed decisions that meet the requirement of the Connecticut HIV Confidentiality Law. through ***Partner Counseling and Referral Services (PCRS)***.	• Voluntary • Client-centered • Interactive information sharing • Clients who ask for testing must receive pre-test counseling	
Partner Counseling and Referral Services (PCRS). - Clients should be assisted with notification of sex and needle-sharing partners of their risk and of the availability of HIV counseling and testing services	• Partner notification is an option	

Intervention Descriptions ***– as taken from CDC Evaluation Guidance and the Connecticut DPH 2002 Request for Proposal***	**Key Elements of Intervention**	**Examples of Possible Programs under this Intervention**
Other Interventions including Community Level Interventions (CLI)—other interventions are interventions that cannot be described by the other types listed above. CLIs seek to improve risk conditions and behaviors in a community by focusing on the community as a whole rather than on individuals or small groups. CLI often attempts to alter social norms, policies, or characteristics of the environment.	• CLIs improve risk conditions and behaviors by focusing on the community	• Community mobilization • Social marketing campaigns • Community-wide events • Policy interventions • Structural interventions

Proven effective interventions for Connecticut's targeted populations as identified by the Connecticut CPG for the 2005-2008 HIV Prevention Comprehensive Plan are included in Appendix D. The table reflects CDC interventions from the 1999 Compendium of HIV Prevention Interventions with Evidence of Effectiveness (updated 2001), as well as those that are non-Compendium, but research-based interventions.

Appendix D: Effective Interventions: Findings from CDC Compendium & Connecticut' CPG's Literature Review.

Key to Cognitive Models and Theories

HBM: Health Belief Model
IMB: Information, Motivation, Behavioral Skills Model
TRA: Theory of Reasoned Action Model
TM: Transtheoretical or Stages of Change Model
ARRM: AIDS Risk Reduction Model
SLT: Social Learning Theory
PMT: Protection Motivation Theory
BRP: Behavioral Relapse Prevention Theory

Recommended Federal HIV Prevention Resource Allocation

The HIV Prevention Community Planning Guidance clearly defines the roles and responsibilities of both CPGs and Health Departments. According to the Guidance, the DPH is responsible for supporting the HIV prevention community planning process (via funding, staff and/or consultant/contractor resources, and leadership). The DPH's role in community planning is to:

- Develop an application to the CDC for federal HIV prevention cooperative agreement funds based on the comprehensive HIV prevention plan, and,
- Allocate, administer and coordinate public funds (including state, federal and local) to prevent HIV transmission and reduce HIV-associated morbidity and mortality.

The latter responsibility includes the awarding of HIV prevention funds to implement the HIV prevention services stated in the comprehensive HIV prevention plan and health department application and to monitor contractor (service provider) activities and document contractor compliance.

HIV Prevention Community Planning Groups are responsible for developing a comprehensive HIV prevention plan and reviewing the health department's application for federal HIV prevention funding for concurrence with the plan. While CPGs are not responsible for determining the allocation of funds for HIV prevention services, it is important for the CPG to know and understand the extent and array of prevention funds that will be allocated as a result of both the health department's and other funders' implementation of the CPG's target population priorities and set of prevention activities/interventions, as described in the Comprehensive HIV Prevention Plan.[5]

With the roll-out of the CDC's new initiatives for advancing HIV prevention, Connecticut HIV prevention contractors have been asked by the DPH to review their currently funded interventions, with a view to increasing or implementing prevention intervention for HIV positive individuals, as well as augmenting expanded counseling and testing opportunities. Federal funding for 2005-2008 will strongly reflect adherence to these new initiatives, but not at the expense of abandonment of funding for interventions targeting HIV-negative individuals. According to CDC Director Julie Gerberding, the CDC is not "abandoning its support for effective programs to prevent infection among HIV negative people, but instead is strengthening existing efforts by encouraging more HIV testing and helping HIV positive people to develop tools to stay healthy and to protect their partners from infection."[6]

For the 2002-2004 Comprehensive HIV Prevention Plan, the CPG's Resource Allocation Workgroup decided that resource allocations should be determined by CPG region since populations had been prioritized by region. Once the CPG allocated specific percentages of federal funding by region, the expectation was that the DPH would award that funding to regional HIV prevention service providers, who in turn would implement the prioritized interventions among the regionally specific prioritized populations. Ten percent (10%) of the state's federal HIV prevention funding was also designated as "set-aside funds" for populations not named in the specific region's top five priority populations or for regional emerging populations.

[5] 2003-2008 HIV Prevention Community Planning Guidance.

[6] Gerberding, *Los Angeles Times*, 10/11/03

Table 1 – 2002-2004 Resource Allocation by CPG Region. (Allocation for 2004)

Region	Percent of Federal Funds	Percent of State Funds
Correction	12%	11%
North Central	27%	26%
North East	3%	3%
North West	2%	2%
South Central	29%	27%
South East	5%	4%
South West	22%	20%
DPH Identified Priorities		7%
TOTAL	100%	100%

Chapter 6

Putting the Plan Into Practice –

Linkages, Surveillance and Research, Technical Assistance, and Capacity Building Integration of Prevention and Care

Putting the Plan into Practice

Linkages, surveillance and research, technical assistance, and capacity building

The CDC recommends that HIV Prevention Plans include information about how the Comprehensive Plan is put into practice within the jurisdiction. The following chapter discusses how Connecticut utilizes its Comprehensive HIV Plan by addressing three distinct areas that include: **(1)** the link between community planning and primary and secondary prevention efforts; **(2)** the participation of governmental and non-governmental agencies in the development and implementation of the Plan; and **(3)** a description of ongoing surveillance and research activities directly related to community planning. The CDC encourages and promotes community planning groups ***"to foster strong, logical linkages between the community planning process, the Comprehensive HIV Prevention Plan, the application for funding, and the allocation of resources."***

Primary and Secondary Prevention Efforts

To ensure that the Comprehensive Plan is relevant to both prevention and care services providers, the Connecticut CPG has worked to enhance the links between primary and secondary prevention efforts in Connecticut. The continued recruitment and participation of providers offering both care and prevention services in the HIV prevention community planning process is one method the CPG employs to ensure this linkage is achieved

Current CPG members and advisors who provide both care and prevention services include:

- Fredericka Close: Fredericka has been a CPG advisor since October 2002. She is the AIDS Program Director of Visiting Nurse and Health Services of Connecticut. As an AIDS Certified Registered Nurse, Fredericka provides clinical care to infected and affected individuals. She also supervises a staff of Ryan White case managers. Fredericka has served on the Data Assessment and Analysis Committee and is currently a member of the CPG's Community Services Assessment Committee (CSA).
- Charles Creech: Charles has been a CPG member since October 2003. He is an HIV Case Manager for the Morris Foundation in Waterbury, Connecticut. Charles is currently a member of the CPG's Membership Parity Inclusion Representation and Evaluation Committee (MPIRE).
- Hector Davila: Hector joined the CPG in October 2001. He is a Medical Adherence Specialist at the University of Connecticut Health Center in Farmington. Hector currently serves on the Community Services Assessment Committee (CSA).
- Brian Goodrich: Brian has been involved in HIV care and prevention for over 15 years. He is the Program Manager for the University of Connecticut Health Center/Correctional Managed Health Care's HIV Prevention Program. Brian manages HIV prevention efforts for all 21 of Connecticut's State correctional facilities. He supervises a staff of 15 prevention counselors who provide Connecticut's incarcerated population with individual HIV prevention counseling, HIV-positive support/secondary prevention groups and HIV prevention

educational classes. Brian has been a CPG member since March 2000, and is currently a member of the Community Services Assessment Committee (CSA). Brian has also served as chair of the Finance, Policy and Procedures Committee and co-chair of the Ad Hoc Priority Setting Committee.

- Stephanie Lozada: Stephanie joined the CPG in October 2001. She is a Community Disease Prevention Counselor for Southwest Community Health Center in Bridgeport, Connecticut. Stephanie has served on the Membership and Parity, Inclusion and Representation Committee, and was elected co-chair of the Membership Parity Inclusion Representation and Evaluation Committee (MPIRE) in July 2003. In December 2003, she was elected CPG Community Co-Chair.
- Maggy Morales: Maggy has been with the CPG since October 2001. She is the Project PACE Coordinator at Latinos Contra SIDA, Inc. in Hartford, Connecticut. Project PACE provides prevention case management services, group level interventions, and health education services to youth ages 16-24, injection drug users and women. Maggy has served on the Interventions and Resources Committee since joining the CPG, and currently serves on the Community Services Assessment Committee (CSA).
- Rich Neal: Rich has been with the CPG since May 2001. He is a social worker for the Connecticut Children's Medical Center in Hartford in the Identification Family Support Unit. Rich served on the CPG's Data Assessment and Analysis Committee and now serves on the Community Services Assessment Committee.

Integration of Prevention and Care

The Ryan White Care Act Title II Manual[1] clearly states that coordination of care and prevention planning can help bridge gaps across prevention and care and thus help individuals learn their HIV status and enter care if infected. The Care Act further expects Title II to coordinate with prevention planning bodies and programs in the areas of planning body membership, conducting planning activities (e.g. needs assessments), and service delivery coordination (e.g. early intervention services, outreach, etc.). CDC expects CPGs not only to be aware of Title II activities, but to also identify opportunities for collaboration. While the CDC does not require merger of the two planning bodies, it highly recommends consideration of merging prevention planning activities with those of other local planning bodies that already exist.

In August 2003, an Ad Hoc Integration Committee comprised of Ryan White Title II Planning Council and CPG leadership met to discuss the development of an integrated Comprehensive HIV/AIDS Plan for Prevention and Care for 2009. Members of the Ad Hoc Integration Committee discussed areas of collaboration, differences in processes between the Ryan White Title II (Statewide) Planning Council and the CPG, and potentials for linkage and integration. During this meeting, the Integration Committee identified the following areas for cross collaboration and potential integration of activities: Needs Assessment, Epi Profile, Resource Inventory and Gap Analysis, and Comprehensive Planning and Evaluation.

[1] HIV/AIDS Bureau: Ryan White Care Act Title II Manual: Section VII, Chapter 3: Care/Prevention Collaborative Planning.

The Committee agreed that care providers should be more involved with primary prevention and that the prevention of secondary infection for HIV-positive individuals is of primary importance. In addition, the committee members also identified counseling and testing, prevention outreach and health education/risk reduction (HERR) as the primary areas where prevention and care efforts overlap and noted that these areas require a more concerted collaborative effort. The intent of the future integration of prevention and care is to move beyond information sharing across planning bodies to the establishment of better protocols for making referrals and serving clients in a well coordinated continuum of care.

Multi-Year Strategies: The Comprehensive Plan – An Ideal System of Care and Prevention

Funders, systems and providers throughout the state recognize the importance of collaboration to creatively and effectively respond to the needs of target populations. That shared vision creates an ideal care and prevention system in which the rate of new HIV infections is significantly reduced, and those who are living with and affected by HIV/AIDS are connected to appropriate care and support services. The Ad Hoc Integration Committee, in an effort to guide the development of the 2009 integrated Comprehensive Plan for Prevention and Care, put forward the following recommendations in the Statewide Care Consortium's Statewide Coordinated Statement of Need (SCSN) contained in the 2004-2007 Ryan White Title II Comprehensive Plan:

- Services will be culturally sensitive, geographically accessible and offer flexible hours of operation.
- Providers will reflect the HIV/AIDS population they serve.
- Individuals will receive culturally appropriate information on HIV/AIDS, Mental Health and Substance Abuse Treatment services at each and every portal of entry into the continuum of care.
- System of care linkages will be strengthened through co-location, cross-training and referral strategies among substance abuse treatment, mental health treatment, and case management, outreach and medical providers.
- Relapse prevention will be an ongoing consideration for providers.
- Efforts to engage and bring into care the Hispanic population will be increased.
- Providers will strategize and make best efforts to bring under- and uninsured individuals, especially people of color, into care and become increasingly aware of the needs of an aging AIDS population.

Recognizing that both HRSA and CDC have expectations that care and prevention will be integrated in their planning processes, the goals outlined by the Ad Hoc Integration Committee acknowledge that to address prevention effectively, care communities need to be engaged. The following are the goals of that future integration process:

- To create an ideal system of care and prevention that creatively responds to the needs of the target population.
- To respond to the new directives (CDC and HRSA).
- To decrease the number of new infections.
- To create appropriate links for a comprehensive continuum of care that increases efficiency and avoids duplication of efforts.
- To strengthen care and prevention efforts.
- To better identify and address the statewide unmet needs.
- To maximize resources.

Essential to the development of this integrated 2009 Comprehensive Plan for Prevention and Care will be not only the implementation of the common goals (indicated above), but also the adoption of a totally integrated care and prevention system – an ideal continuum of care.

To that end, the Ad Hoc Integration Committee developed the following definition of a totally integrated system:

The Statewide Plan's ideal Continuum of Care and Prevention is one that is:

- Comprehensive;
- Culturally and developmentally appropriate;
- Easily accessible and coordinated through multiple points of entry;
- High quality and evidence-based;
- Cost effective; and
- Is actively engaged in providing current and accurate information, services and support, appropriate referral mechanisms, skill building techniques for both clients and providers, decision making involving standards of care, and a coordinated system to assess individuals at various points of entry.

Efforts are already underway toward accomplishing the 2009 Prevention and Care Plan Integration. Title II's Comprehensive Plan for 2004-2007 included CPG Needs Assessment information, identified prevention needs and gaps, listed prioritized populations, and featured HIV/AIDS surveillance data. The CPG's 2005-2008 Comprehensive Plan has included prevention/care integration strategies, as well as Care identified gaps, emerging needs and recommendations. The 2004 CPG Resource Inventory was designed as a joint effort to assess both prevention and care services. For the future, the Ad Hoc Integration Committee, Statewide Care Consortium committees and the CPG will continually review and reassess the integration process for ongoing planning, revision and implementation of the goals, strategies and vision to ensure a seamless and coordinated effort in the production of a fully integrated care and prevention plan for 2009. **(See Executive Summary, Comprehensive Title II Plan, 2004-2007 in Appendix E).**

CPG/DPH Collaboration

The DPH received funds from the CDC to establish a Health Program Associate position to work directly with the CPG. The Health Program Associate works with the CPG contractor to support the HIV prevention planning process and the development of the comprehensive plan. A major responsibility of this DPH staff person is to work with the CPG to develop the Community Services Assessment. The presence and participation of additional DPH staff in the community planning process has helped to keep communication open and to foster the collaborative spirit of community planning in Connecticut.

For the first time in Connecticut's community planning history, a DPH staff person is a voting member on the CPG. This staff person was also elected by the group to chair one of the CPG committees. Prior to this, the DPH co-chair was the only voting CPG member on the group.

Agency and Organization Participation

Participation of governmental and non-governmental organizations in the development and implementation of the plan exists on two levels. First, 80% of the CPG members and advisors who developed the 2005-2008 Comprehensive Plan come to the table on behalf of their agencies throughout the state. Second, between 60%-100% of the public who regularly participate in the community planning process at each meeting are agency representatives and serve as the link between the CPG and their respective organizations. Table 6-1 displays the current CPG members and advisors, their respective organization and category (governmental or non-governmental).

If a contractor of the DPH AIDS Division does not have a staff member who serves as a CPG member or advisor, then each contracting agency for HIV prevention services is expected to attend at least three annual CPG meetings in order to establish a link between the plan and agencies.

The three directly CDC funded organizations in the state (Greater Bridgeport Adolescent Pregnancy Prevention Program, AIDS Interfaith Network, and Latinos Contra SIDA) are expected to promote the plan-agency linkage through attendance at CPG meetings. Currently, two of the three organizations fulfill their obligations on a regular basis. To further foster the plan-agency relationship, the CPG continues its practice of issuing media advisories (see sample Appendix A) as well as community alerts regarding the upcoming meeting to all HIV-related service organizations in the respective geographic area. Increasing attendance at CPG meetings by members of public and area agencies will not only continue to foster stronger linkages between the community planning process, agencies and the public, but also serve to expand the base of prevention knowledge in the wider community.

Connecticut's linkage between the Comprehensive Plan and governmental and non-governmental agencies continues to grow stronger as the CPG increases its community planning knowledge and puts the new information into action. Moreover, seeing the results of the planning work reflected in the DPH 2004 funding cycle brought to the

forefront the importance of the coordination between government and non-governmental agencies and the Comprehensive Plan.

Ongoing Surveillance and Research

In the coming year, the CPG will continue its involvement on the Ryan White Collaborative Planning Committee, the Statewide Care Consortium, and the Evaluation Advisory Committee, and, thus, continue to offer input and support to these ongoing evaluation, planning and coordination efforts. In addition, the DPH has agreed to keep the CPG informed of these efforts with presentations to the full CPG as warranted.

Examples of this collaboration include:

- The AIDS Surveillance Unit has hired an epidemiologist through federal surveillance funds to work closely with the CPG and other statewide planning bodies on data issues relevant to their work.
- The AIDS Surveillance Unit of the DPH presented the 2004 Update to the 2003 Epidemiological Profile of HIV and AIDS in Connecticut at the March 2004 CPG meeting. The Update was distributed to the CPG in February 2004 for review in preparation for the March 2004 Priority Setting Process.
- Dr. Deborah Cornman, PhD, University of Connecticut, Center for HIV Intervention and Prevention (CHIP) presented on Prevention for Positives at the November 2003 CPG Retreat. (See Appendix D)
- Julie Eiserman and Merrill Singer of the Hispanic Health Council presented on the 2003 R.A.R.E. Project in Hartford.
- URS UPDATE: the Connecticut Department of Public Health has implemented the Universal Reporting System (URS) to collect all care and prevention data on one database. The system was phased in over the past year. As of January, 2004, all contractors were required to report all activities using the URS. The URS will provide Connecticut with more accurate and standardized data that will allow better tracking and analysis of HIV prevention and care service delivery.
- The research based UCONN Center for HIV Interventions and Preventions (CHIP), in collaboration with AIDS Project/Hartford, received supplemental federal funds from DPH through a competitive bid. The grant is to build the capacity of agencies that serve people with HIV to provide prevention services. Deborah Cornman, PhD, is working on this project, and linking some of the assessments through this grant to the Community Services Assessment process of the CPG.
- The CPG's Community Services Assessment Committee (CSA) recommended that the CPG gather information on priority populations (MSM, HIV+) as well as on DOC populations, Transgender, and Women Who Have Sex With Women (WSW). From January to June 2004, the CPG conducted focus groups and key informant interviews with Men Who Have Sex With Men (MSM) support groups, male and female inmates at York and Osborn Correctional facilities, and Male to Female and Female to Male transgender support groups. Mini-surveys were conducted through Latino/as Contra SIDA and the Hartford Gay and Lesbian Health Collective (Women's Services Division) regarding Women Who Have Sex With Women (WSW). ***(See Chapter 3 Community Services Assessment for reports)***

- More than 190 copies of the updated 2004 version of the 2002-2004 Comprehensive HIV Prevention Plan were distributed via phone requests, at health fairs, conferences, Community Days and CPG meetings to DPH contractors and other interested parties. Copies of the 2002-2004 plan, 2003 and 2004 Plan Updates are also available on the CPG's website at www.connhivcpg.org. The 2005-2008 Plan will also be posted on both the CPG and DPH websites.

Table 6-1: Members and advisors *representing governmental non-governmental agencies

	Organization	Governmental	Non-Governmental
Members			
Chris Andresen	Department of Public Health	X	
Mark Bond-Webster	Perception Programs (Willimantic, CT)		X
William Castillo	Hispanos Unidos		X
Charles Creech	Morris Foundation		X
Gina D'Angelo	Northwest CT AIDS Project		X
Evelyn Anna Figueroa	AIDS Project New Haven		X
Pamela Foster	Department of Public Health	X	
Kathey Fowler	WRCC		X
Richard Gonzalez	Bridgeport Health Department	X	
Brian Goodrich	University of Connecticut, Correctional Managed Health Care	X	
Carmen LaTorre	Charter Oak Health Center		X
Loreen Lawrence	Birmingham Group Health Services		X
Brian Libert	Community Health Services		X
Matthew Lopes	New Haven Health Department	X	
Stephanie Lozada	Southwest Community Health Center		X
LeRoy McIntosh	Norwalk Health Department	X	
Maggy Morales	Latino/as Contra SIDA, Inc.		X
Christopher Morris	Greater Bridgeport Adolescent Pregnancy Program		X
Rich Neal	Connecticut Children's Medical Center		X
Dennis O'Neill	Community Partners in Action		X
Albert Young	Waterbury Hospital		X
Advisors			
Bill Behan	Department of Public Health	X	
Richard Buika	Mid-State Behavioral Health System		X
Ken Carley	Department of Public Health	X	
Fredericka Close	Visiting Nurse & Heath Services of CT		X
Leif Mitchell	Center for Interdisciplinary Research on AIDS at Yale University		X
Wanda Richardson	Department of Public Health	X	

*Community and consumer members and advisors of the CPG are not listed in the above table

Chapter 7

Evaluation

Evaluating the Community Planning Process in Connecticut

Introduction

The Centers for Disease Control and Prevention's (CDC) new *Guidance on HIV Prevention Community Planning* states ***"the monitoring and evaluation of HIV prevention community planning is based on three goals and eight objectives for HIV Prevention Community Planning."*** According to the Guidance, monitoring and evaluation of HIV Prevention Community Planning is a shared responsibility between the health department and the CPG. In Connecticut, the DPH relies on The Parisky Group, a private consulting firm, to oversee and facilitate the community planning process and to conduct all evaluation activities related to community planning. The Parisky Group works in conjunction with members of the CPG's Membership, Parity, Inclusion, Representation and Evaluation Committee (MPIRE) to ensure that community planning members and advisors participate fully in the design of the process evaluation.

Evaluation of the August 2003 though July 2004 planning activities has been an ongoing process. The goals of the evaluation of the CPG planning process were to assess participant satisfaction with a number of elements in Connecticut's HIV prevention community planning, and to determine whether the community planning process met CDC's guidelines.

Methodology

The CPG evaluates the community planning process by employing a number of data collection methods including monthly meeting evaluations from CPG members, advisors and members of the public, mid-year and end-of-year surveys, exit interviews and small group discussions.

- **CPG member and advisor meeting evaluations** – At the end of each CPG meeting and technical assistance session, CPG members and advisors complete and return an evaluation form, which evaluates the environment and atmosphere, the flow and organization, group interaction, presentations/group work, and committee meeting process. The form also includes a feedback section on the "best part" of the meeting, a comment section designed to solicit suggestions for improving meeting effectiveness, and "talk-back" message boxes where statements can be addressed to co-chairs, committee chairs, members, the contractor and presenters.

- **Public meeting evaluations** – Guiding Principle #6 of the CDC Guidance states that the "community planning process must actively encourage and seek out community participation." Members of the public who attend CPG meetings are also asked to submit evaluations at the end of the session. This helps gather information on several levels: (1) who attends (individuals/agencies), (2) how many times individuals have previously attended, (3) ways individuals heard about the CPG meeting, (4) reasons for attending the meeting, (5) if the meeting met the needs of the individual, and, (6) a message box section for statements to co-chairs, members, committee chairs, contactor and presenter.

- **Mid-year evaluation** – The mid-year evaluation is a self-administered survey, which evaluates parts of the planning process including the membership process, membership policies and procedures, group process, parity, inclusion, representation, as well as attendance and participation at full group CPG and committee-focused meetings. The

mid-year evaluation is designed in a way that allows the results to be compared to the end-of-year evaluation***. (see Appendix F).***

- **Exit interviews** – CPG members and advisors who left the CPG from August 2003 through July 2004 were given exit interviews. Each one was asked their reason for leaving, the effectiveness of the planning experience and leadership, and steps that would help CPG accomplish its goals.

- **Public end of the year evaluation tool –** Members of the public, attending the August 20, 2003, CPG meeting completed an evaluation designed to give them input into the planning process. Members of the public were asked to state their reasons for attending the CPG meetings, to provide suggestions for making the meetings more effective, and to provide insights regarding how the CPG could better promote community planning. A sample of the end of the year public evaluation tool is attached in **Appendix F.**

- **CDC Community Planning Evaluation Tool** – In 2003, the Connecticut CPG was one of the jurisdictions chosen by the CDC to test its draft community planning evaluation tool of CPG members and advisors. In 2004, CDC required jurisdictions to implement this community planning evaluation tool. The CPG decided to add several questions from the mid-year CPG member-advisor evaluation tool to the end of the CDC evaluation tool for an end of the year survey of community planning members and advisors. Evaluations using this revised tool were completed by members and advisors at the August 18 CPG meeting. A sample of the tool is attached in **Appendix F**

- **Quarterly Co-Chair Letter to the AIDS and Chronic Diseases Division Director –** The Community Co-Chairs have implemented a quarterly letter to the DPH AIDS and Chronic Diseases Division Director, which outlines the progress the CPG has made and also defines its relationship to the DPH. The purpose of this letter is to ensure that communication, collaboration and cooperation remain open and active, and that any issues that arise are addressed in a timely manner. A copy of the letter is attached in **Appendix F.**

The remaining portion of this chapter describes how well the Connecticut CPG has met CDC's three goals and eight objectives of HIV Prevention Community Planning over the past year.

Goal One: Community planning supports broad-based community participation in HIV prevention planning

- **Objective A: Implement an open recruitment process (outreach, nominations, and selection) for CPG membership**

The CPG has achieved Objective A. During the last planning cycle, the Membership Parity Inclusion Representation and Evaluation (MPIRE) Committee implemented several measures to recruit new members and advisors.

The committee conducted a quarterly review of the CPG's diversity chart, prepared by the CPG contractor, to help guide recruitment efforts. Information about current membership included on the diversity chart is collected from the original CPG member nomination forms and the annual CDC membership grid survey.
Using the diversity chart, the committee identified populations that needed to be represented on the CPG in order to reflect the epidemic in Connecticut. To ensure that the group's membership goals reflected the current statewide HIV/AIDS epidemic, the MPIRE committee reviewed the

best available HIV/AIDS data in the context of six of the seven CPG regions, the list of priority populations from the Comprehensive HIV Plan, and determined the additional expertise needed by the CPG to complete the community planning process. The CPG used various recruiting methods including word of mouth, media advisories, Community Days, the CPG's recruitment brochure, announcements in the monthly *News and Notes*, and the CPG website maintained by the contractor and DPH.

Members are voted on to the CPG two times annually. Prior to their official entry to the CPG, each new member class completes a comprehensive orientation process. Many new members felt a bit overwhelmed with all of the material and information presented during the orientation process. The CPG contractor implemented member suggestions that the actual orientation only be focused on the basics of community planning. CPG also has a mentoring program. Many members, however, feel that it needs strengthening and enhancement. According to the mid-year survey, members and advisors identified mentoring as a priority for the orientation session. The CPG's MPIRE Committee is currently examining the mentor program and will present recommendations to the CPG on revision of the program in the fall of 2004.

During the 2005 planning cycle, the MPIRE Committee will continue its recruitment efforts to achieve a roster of CPG members that better reflect the diversity of the epidemic in Connecticut. The committee will also refine its advisor nomination and selection process to include additional expertise in behavioral and social sciences, as well as representatives of key non-governmental and governmental organizations providing prevention and care related services.

CPG Structure

Since the last planning cycle, CPG committees have been restructured down to three. The first committee restructuring occurred in November 2001, when the process streamlined the work of five committees and six workgroups into six committees. The majority of the feedback on this restructuring was positive and most members thought the CPG functioned better. However, several concerns did arise such as too few members doing all of the work, time constraints and last minute deadlines, and the need to find more effective ways of accomplishing committee tasks. The flow and organization of the meeting, and, in particular, members staying on task and completing the meeting agenda were also two items that varied widely depending on the meeting. Other comments pointed to the need for more time for committee meetings. In June 2003, the six committees were once again restructured into three, which merged together committees with overlapping commonalities and tasks. To address the concern regarding completion of work plans, CPG meetings were reorganized around two committee-focused and one full CPG meeting per quarter, thus allowing for more committee concentrated work to occur. Eighty-nine percent of the members and advisors surveyed in the mid-year evaluation of community planning indicated they were satisfied with the current meeting structure.
The Executive Committee structure, which consists of the three co-chairs and two co-chairs from each committee, meets on a monthly basis to discuss business and issues around Connecticut's community planning process.

CPG Timeline and Work Plan

A few obstacles were identified over the past year for the CPG to address. The general consensus was that major tasks needed to be distributed more evenly on the committee and CPG timelines in order to avoid a time-crunch as deadlines approached. One factor prompting this concern was the late start time of meetings (e.g. 20 minutes late). As a result of the late start of CPG meetings, committee meetings were shortened and important work was not being accomplished. With the restructuring of the committees into three standing committees as well

as the reorganization of monthly meetings into a more committee-oriented process, these issues hopefully were resolved during the 2004 planning cycle. Feedback from CPG members and committee chairs has been very positive and supportive about the new structures and committees. During the November 2003 CPG Retreat, the three committees discussed and refined timelines and work plans for the 2004 planning year. The review of timelines is now a standing item on the full CPG meeting and all committee meeting agendas.

CPG Logistics
Behind every process, there are basic needs to be met and things that have to happen to ensure that the group can move forward. Although these are not frontline issues, they do have the potential to adversely affect the group and its progress. The CPG's satisfaction with the meeting and logistics are tracked by monthly meeting evaluations. One of the changes that have been made to make meetings more effective is having a sound system available at every meeting. Other logistical needs listed on evaluations were addressed during the 2004 planning cycle including the need for better parking, having a more stable meeting room temperature, and fewer items on agendas. Having too many agenda items has resulted in less group discussion and participation. It should be noted, however, that during the 2004 planning cycle, meeting sites were pre-screened for adequate meeting space, breakout rooms, and ample parking in order to better accommodate the physical needs of CPG members. In addition, the CPG implemented meeting structure recommendation changes in 2003-2004 planning cycle: that guest speakers present before lunch, and more interactive presentations be reserved for after lunch when member attention spans tend to shorten.

- **Objective B: Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies**

The majority of CPG members interviewed agreed that CPG membership attempts to reflect the populations most affected by the HIV/AIDS epidemic in Connecticut, but that some groups were missing – e.g. transgenders, Asians, Native Hawaiians or other Pacific Islanders, American Indians/Alaskan Natives, deaf/hard of hearing, HIV-positive Latinas, injection drug users, and youth. It was also mentioned that expertise and agency representation is needed in STDs, commercial sex workers, mental/behavioral health, tuberculosis, faith community, researchers, and minority CBOs. The formation of the HIV Youth Advisory Board (YAB) has helped to fill the youth representation void; however, a youth CPG member is still considered a priority. The YAB coordinator at Wheeler Clinic in Farmington, CT updates the CPG on YAB activities quarterly. A more flexible meeting schedule, with times convenient for youth might be key to achieving this objective. Another suggestion that has been made during the 2003 was that the Executive Committee should also be more reflective of the membership of the CPG. The CPG elected all new standing committee chairs in the fall 2003 and the Executive is now more reflective of the diverse membership of the CPG. During the 2004-2005 planning cycle, the MPIRE Committee will continue to focus its recruiting efforts on addressing membership gaps.

- **Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.**

Member Participation
The CPG has, in many ways achieved objective C. According to meeting evaluations, 84% to 100% (median of 88%) of the membership was in agreement that participation within the group was encouraged during meetings, that everyone's opinion was respected, and that members of the public had an opportunity to speak. Great strides have also been made in the area of

clarifying member roles. The Finance Policy and Procedure Committee (FPP) reviewed and recommended changes on the role of advisors in the community planning process. The FPP Committee recommended that the CPG narrow its definition of advisor to "a pool of experts in specific predetermined fields for use in the development of the comprehensive HIV prevention plan or community planning group process issues. CPG advisors elected under the old system were "grand fathered" for a year (ending September 2004). During the "grand fathered" year advisors under the old system were eligible for stipends/wage replacement, childcare, mileage reimbursement and conference attendance. The CPG approved the recommended changes at its September 2003 meeting. In September 2004 advisors under the old system will either apply for CPG membership or be listed in the 2005 CPG Directory of Advisors. The advisors under the old system will not be given preference for membership slots since the MPIRE Committee's priority is to reflect the HIV epidemic in the state of Connecticut.

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

- **Objective D: Carry out a logical, evidence-based process to determine the highest priority population, population-specific prevention needs in the jurisdiction.**

Chapter 5, Connecticut's Priorities for 2005-2008, contains a description of the CPG's 2003-2004 priority setting methodology. During this process, the CPG used a modified version of the Academy of Educational Development's *Setting HIV Prevention Priorities: A Guide for Community Planning Groups*. The co-chairs of the CPG Priority Setting Ad-hoc Committee Leif Mitchell and Brian Goodrich and DPH staff person Susan Major presented a workshop on the Connecticut CPG's priority setting method at the 2004 HIV Prevention Leadership Summit held June 16-19 in Atlanta, GA.

- **Objective E: Ensure that the prioritized target populations are based on an epidemiological profile and community services assessment.**

In February 2004, the DPH distributed a 2004 supplement to the 2003 epidemiological profile for the state of Connecticut (updated in May 2003), which included information for the CPG Planning Group Regions as well as the Ryan White Eligible Metropolitan Areas (EMAs), sexually transmitted diseases surveillance, and viral hepatitis surveillance data. Chapter two includes the 2004 supplement and a modified version of the *Epidemiological Profile of HIV and AIDS in Connecticut for 2003*. The CPG conducted focus groups during the 2003 planning cycle for two populations identified by the former Data Assessment and Analysis Committee as emerging populations: migrant farmer workers and people over 50 (**see Chapter 3 for a description of the focus groups**). The Community Services (CSA) Committee conducted focus groups with Men who have sex with men and inmates (both male and female) of the Department of Correction. The CSA Committee also surveyed Women who have sex with women on their perceptions of HIV risk. In addition, the CSA Committee and DPH developed and implemented a resource inventory survey tool for HIV prevention contractors and non-DPH service providers for implementation in the fall/winter of 2003 and 2004. The results of the resource inventory survey were presented to the CPG by DPH staff person Susan Major at the August 18 CPG meeting (**see Chapter 3 for a description of this process).** CSA Committee is also arranging focus groups with the transgender male to female and female to male populations. These focus groups will take place in the fall of 2004.

- **Objective F: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome**

effectiveness, and/or have been adequately tested with the intended target populations for cultural appropriateness, relevance and acceptability.

Descriptions of the evidenced based interventions recommended by the CPG can be found in Chapter 4 – *What Works in HIV Prevention?* DPH asked that potential contractors use these evidence-based interventions in the development of their request for proposals for HIV prevention funds during 2002. In addition, DPH also sponsored several trainings for potential contractors during the winter of 2001 and spring of 2002 to better acquaint them with cognitive theories and models of health-related behaviors. During the 2004 planning cycle, presentations were provided for the CPG that addressed some of the topics listed above including a clinical intervention for HIV positive individuals, syringe exchange, migrant farm workers, injection drug users and updates on the status of current DPH HIV prevention programming.

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

- **Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.**

- **Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.**

In the spring of 2002, many CPG members and advisors participated in the request for proposals (RFP) review process of HIV prevention agencies for federal and state HIV prevention funds. The review, which was based on the information contained in Connecticut's Comprehensive HIV Prevention Plan for 2002-2004, consisted of separate review committees for each CPG region. At least one CPG member served on each committee. In addition, a committee charged to review statewide level interventions was also developed, and that group also included one CPG member. DPH is expected to ask for RFPs for prevention activities in the fall of 2004 and CPG members will again be asked to sit on review panels.

As the plan enters its update stage, CPG members review and provide feedback and comments for revisions. As this evaluation chapter is being updated (August 2004), members of the CPG reviewed individual draft chapters of the 2005-2008 Comprehensive HIV Prevention Plan. The CPG voted to approve the new plan at the July 21, 2004 meeting. CPG members will be send draft copies of the 2005 Cooperative Agreement for federal HIV prevention funding before the August 18 CPG meeting. The department will present the draft application at the August 18 and review the revised application based on feedback from CPG members and advisors at the September 1 CPG meeting. The CPG will vote on concurrence at meeting the September 1, 2004 meeting.

Summary and Recommendations

Although the CPG encountered many obstacles during this year's planning process, this evaluation update has highlighted the many positive things, which are also happening within the CPG, as well as the improvements to be made during the 2005 planning cycle. While there was a wide range of opinions among the individuals who completed the mid-year, end-of-the year and CDC evaluation tools, these comments were invaluable in identifying the following recommendations to improve Connecticut's community planning process during the next planning cycle:

- **Clearer roles of CPG members and advisors:** Parity was brought up as a concern and some members felt like their voices were not equal and/or heard. Perceptions of power and influence were also seen as issues. In 2003 it was suggested that the more vocal members try to refrain from being the first to share opinions in order to allow/encourage the more quiet members to speak and provide input. The new committee structure instituted in July 2003 also appears to have addressed many of the inclusion issues addressed in last year's mid-year and end of the year surveys. The CPG will continue to focus on improvement of PIR during the upcoming planning year. Based on the results of the End-of-the Year Evaluation of Community Planning (August 2004) compared to the Mid-Year survey (April 2004), the percentage of members and advisors who felt members and advisors didn't have equal status decreased from 43% to 38%. The percentage of members and advisors who felt there were differences in perceptions of power increased 24% from 11% from 35%) and members who were more influential stayed the same (35%) in the end-of-the year survey compared to mid-year.

- **Orientation:** The orientation agenda seems to be a bit overwhelming and causes participants to go into information overload. The orientation process, rather than attempting to cover every community planning issue, should instead cover more of the basics and only go into detail in those areas needing clarification and explanation. In addition, it was recommended that the mentorship program be initiated at orientation, to help assist new members to feel more welcome during their orientation period. The CPG will revisit the orientation process in the upcoming planning cycle to make it more "user friendly" for new members (e.g. mailing orientation materials to new members prior to the orientation training, focusing on roles and responsibilities and committee structure during training, highlighting the goals of community planning and editing the orientation training PowerPoint to reflect new changes to the CPG structure as well as the new CDC *Guidance on Community Planning*). Based on the results of the End-of-the Year Evaluation of Community Planning (August 2004), members also suggested the inclusion of the following in the orientation process: mentoring of new members, increased focus on the community planning process, and more information about committees.

- **CPG structure:** A better distribution of work among committee members will balance the load of committee tasks and responsibilities. Rather than one or two people being solely responsible for accomplishing the work, it is the CPG's goal that all committee members will equally share tasks. With the restructuring of the CPG committees in July 2003, a better distribution of work has been and will be effected. The CPG will continue to define group and committee processes during the upcoming planning year to assure better adherence to timelines and work plans, as well as accomplishment of tasks in a timely fashion. Based on the results of the End-of-the Year Evaluation of Community Planning (August 2004), 78% (compared to 89% mid-year) of the members and advisors indicated they were satisfied with the current meeting structure of two committee focused and one full CPG meeting per quarter.

- **CPG timeline and workplan:** A better distribution of work and reduction of major agenda items on committee and full CPG timelines will assist in reducing "crunch" periods in the planning process. Committees reviewed and updated respective timelines and work plans for 2004 at the annual CPG Retreat in November 2003. During the 2003-2004 planning process review of the timeline was a standing agenda item on

standing and ad-hoc committee agendas and the agenda of the full CPG meeting. The co-chairs also made efforts to start CPG meetings on time in order to allow for completion of CPG and committee tasks in a timely fashion.

Additional End of Year (EY) Member Evaluation results compared to Mid-Year (MY) Member Evaluation results:

- **Member Understanding of Community Planning Process:** Eight-five percent (EY) of members stated they understood mostly everything or everything about the community planning process compared to 89% (MY). To further enhance their understanding of the community planning process, 35% (EY) indicated they had contacted and received feedback from other CPG members and advisors compared to 21% (MY).

- **Co-Chair Effectiveness:** The CPG has three co-chairs, one appointed by the DPH and two community representatives elected by the CPG**.** 89% of the members and advisors in the end- of the year survey felt the co-chairs run the monthly meetings smoothly and efficiently and conduct orderly meetings compared to 84% in the mid-year survey. Eighty-nine percent (EY) felt that the co-chairs provide adequate leadership compared to 84% (MY). Eighty-nine percent (EY) indicated that the co-chairs allow opportunities for group discussion (84% MY), and 89% (EY) felt that the co-chairs shared the responsibilities for facilitating the CPG meetings compared to 84% (MY).