PA CPG Needs Assessment Compendium

1996-2010

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Pennsylvania Community Planning Group and Pennsylvania Prevention Project
University of Pittsburgh Graduate School of Public Health

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Introduction: Using the Needs Assessment Compendium

The Needs Assessment Compendium serves as a collection of studies undertaken by the Needs Assessment Committee of the Pennsylvania HIV Prevention Community Planning Group (CPG). The Pennsylvania Prevention Project (PPP) of the Graduate School of Public Health at the University of Pittsburgh collaborates with the CPG, providing research support and expertise throughout the needs assessment process. Studies presented here range from 1996 to present-day research endeavors. Research activities include scientific literature reviews on pertinent HIV prevention topics, focus groups and in-depth interviews with populations of interest in Pennsylvania, as well as small-scale surveys used for descriptive statistical purposes. Focus group and interview data provide a deep understanding of participants' experiences, capturing their attitudes and opinions regarding issues pertinent to HIV prevention. To make use of these data within other contexts consider how your particular situations compare to the studies contained in the compendium and decide what degree of insight these data provide. For example, do you feel that the experiences reported by a series of focus groups of men who have sex with men correspond with what you know about men who have sex with men within your area?

The Needs Assessment Compendium is divided into chapters organized by HIV prevention target populations: intravenous drug users (IDU), men who have sex with men (MSM), heterosexuals at risk for HIV (HRH), youth, and special populations. Chapters contain all needs assessments associated with the particular target population of that chapter. Reports contained here summarize the original reports.

Each report is divided into five parts:

1. Report title and IRB number or report classification
2. Brief description
    - Provides information on research methods and population studied.
3. Relevant findings
    - Provides a list of findings relevant for HIV prevention planning. For larger studies[1], relevant findings are categorized by italicized themes.
4. Limitations
    - Provides details on how these data may be useful in other contexts.
5. Recommendations
    - Provides HIV prevention planning actions resulting from relevant findings.

Some reports address more than one at-risk population, such as MSM who are sex workers and use injecting drugs. At-risk populations are conveyed in each report title, therefore a thorough reading of the table of contents is recommended to find all reports which may illuminate

[1] Larger studies were the 2003 Needs Assessment of Injection Drug Users, Men Who Have Sex with Men, and Heterosexuals at Risk for HIV

understanding of a particular population. There is particular overlap among heterosexuals and MSM who are also IDU, as well as youth across all risk categories.

Contained within reports are new presentations of the data. Success stories that emerged from the data are highlighted and separated from the listed findings. Quotes from participants are highlighted by separating them from the lists of findings as well. For further information on a particular study, please refer to the full report of that study. Report titles contain hyperlinks to the original studies when available.

The data

The process of data collection for needs assessment reports begins with a review of national HIV prevention literature to identify what is known about a particular target population or prevention concern. PPP selects appropriate research methods and tools to gather data to generate a deeper understanding of local contexts. Needs assessment studies reported here use qualitative data (personal interviews and focus groups), as well as quantitative data (small surveys).

The majority of studies within this compendium use focus groups to gather people's opinions or attitudes[2]. A moderator leads the focus group conversations of 5-10 participants through a series of questions meant to illicit discussion on the topic of interest. Participants represent the target population of the assessment, and moderators were selected to closely resemble participants, intending to increase interaction and expression of opinions. Interviews are recorded and transcribed, and all original tapes of the interviews are destroyed upon transcription. Participants receive incentives as compensation.

PPP analyzes the transcriptions of the taped focus group and in-depth interviews and organizes data into themes. Themes are presented to the Needs Assessment Committee and expanded upon based on their input and discussion. Needs Assessment Committee members ask further questions they have of the data for inclusion in the final report. Needs Assessment Committee members then present relevant information to the full CPG for additional input.

Acknowledgements

The actions of the Needs Assessment Committee are to be acknowledged and commended. Members of the Needs Assessment Committee of the Pennsylvania HIV Prevention Community Planning Group have overseen and planned each of the studies contained within the Needs Assessment Compendium. Needs Assessment Committee members choose topics and populations for investigation, develop research questions, provide feedback on research protocols, assist in recruitment of participants, and help with the presentation of the data. The collaborative process between Needs Assessment, the CPG, and PPP allows for studies that investigate the social realities of at-risk populations throughout Pennsylvania.

[2] It is noted when focus group data are collected alongside data using another research method, such as surveys or in-depth interviews in the brief description of the study.

We acknowledge all Needs Assessment Committee members who assisted in the carrying out of these studies over the years.

Planning Year 2011 Needs Assessment Committee members
Brenda Doucette **Dennie Hakanen -- Co-Chair** **Michael Hellman -- Co-Chair** **Melissa Johnson** **Andrea Norris, RN** **Nathaniel Williams** **Tamara Wurst**

The Pennsylvania Department of Health, HIV/AIDS Division, supports the Pennsylvania HIV Prevention Community Planning Group and the Needs Assessment Committee. Their assistance and feedback to the Needs Assessment Committee is to be acknowledged and commended. Also to be acknowledged are the many researchers who have worked with the Needs Assessment Committee and PPP in carrying out the research and reporting the findings.

The Needs Assessment compendium highlights the work done to date while informing future steps for innovative HIV prevention planning in Pennsylvania. The compendium is a reference for what we know about HIV prevention in Pennsylvania and will help determine what we want to know as we enter the fourth decade of the HIV epidemic.

The compendium may be shared with local organizations to help improve HIV prevention planning and programming. This is a living document. As more needs assessment studies are conducted, the compendium will be expanded.

Chapter 1: Needs Assessment Report Summaries 1996-2010, IDU

2003

Report **Needs Assessment Final Report, IDU results**

University of Pittsburgh
IRB Number 960456

Brief description This report describes the committee's recent research findings from 2001-2003, including focus groups with injection drug users (IDU). During this time period the committee analyzed findings from the following subpopulations of IDU: traditional IDU, young IDU between the ages of 18-25, women who are IDU, and rural IDU. Participants were either active IDU or near-active, having recently entered into drug-addiction treatment.

Relevant findings Themes from findings are categorized by:

- drug use patterns,
- barriers to change,
- needle behaviors,
- services, needs,
- and strengths.

Drug use patterns Most participants initiated general drug use at young ages, many beginning before the age of 15. Alcohol and non-injection drugs were typical at initiation, over time leading to use of injection drugs.

Drug and alcohol use at young ages was accompanied with violence and abusive environments.

Most participants reported needle sharing.

Most participants reported a lack of practice with cleaning used needles.

> "You don't care about anything but the drug, you're thinking about getting high, not thinking about tomorrow or an hour from now, not thinking about condoms."
>
> -Participant

Behavior Change Participants reported that drug addiction supersedes ability to change behaviors and reported pessimistic feelings about ability to quit.

Free condoms were not easily attained, especially among rural and young IDU who did not know where to get them for free or were embarrassed to acquire them.

Participants reported disliking condoms due to reduced sexual stimulation and loss of erection when using them.

MSM/IDU and women who are IDU were unsure about asking sexual partners to use condoms, expressing a lack of assertiveness.

MSM/IDU and IDU women involved in sex work/trade receive more money or drugs for services when condoms are not used.

Traditional IDU men reported sex as an unplanned occurrence.

All subgroups of IDU report some level of unprotected sex on a regular basis.

> "When you can get it up, you do it and you don't wait and go get a condom."
>
> -Participant

Services

Participants reported they would use clean needles if they were available.

Participants reported they would use other harm reduction paraphernalia.

Participants reported being accepting of HIV/STI/Hep C prevention messages from knowledgeable providers in needle-exchange programs.

Participants wanted providers who are HIV/AIDS knowledgeable and who honor client confidentiality.

Participants reported that community agencies and the streets where IDU gather are the best places for prevention intervention.

> "We share because needles just aren't available. Period."
>
> -Participant

Community Strengths

Community institutions and services have been sources of HIV information for most participants (detoxification, shelters, jails, and schools).

Information received in these places is good *yet not adequate.*

Peers are important sources of information, especially for young IDU.

IDU showed a very good knowledge about HIV risk behaviors.

Participants knew where to get tested for HIV and had been tested.

Limitations

Focus groups provide insights into opinions, attitudes, and lived experiences of the study population. To use the data for other populations, consider their specific context and decide to what degree these data apply.

Recommendations

Make harm reduction paraphernalia free and accessible.

Increase availability of free condoms.

Include intervention strategies to increase self-efficacy and self-esteem.

Intervene as early as possible once individuals begin to use substances.

Include intensive skills building and behavior change approaches in interventions.

Discuss sexual risks for HIV/STI transmission in interventions.

Assure and maintain confidentiality when working with IDU communities.

Drug and alcohol treatment settings may make a good site for interventions.

A potential pathway to MSM/IDU interventions is through ties with IDU communities.

A potential pathway for interventions with women who are IDUs is relationships with men who are IDU.

Address preparation for unplanned sexual encounters in interventions with IDUs.

Educate IDU on HIV and AIDS (not just risk behaviors).

2005

Report **HIV among People over 50, AA IDU Findings**

University of Pittsburgh
IRB Number 0410088

Brief description For this study, a group of African American IDU was recruited from a local NA Chapter and substance rehabilitation program. This group was conducted in Southwestern PA (n=6). The focus group facilitators and the group recruiters reflected the race, ethnicity, and characteristics of the group participants. Among the older adult African American IDUs there was an even distribution of participants between the ages of 50-54 and 55-59.

Relevant findings Illicit drug use is a risk factor for older adults, which includes alcohol abuse and prescription drug abuse. When combining drug use with sexual behaviors, the risk for contracting HIV increases.

All respondents knew their HIV status, and all of the IDU participants reported HIV-negative serostatus.

Participants with histories of injection drug use were most likely to have had an HIV test.

> *"I got my HIV test when I was in rehab."*
>
> -Participant

Participants were most likely to know their status in comparison to other study populations aged over 50.

Participants were more knowledgeable about behavioral risks associated with HIV infection, although self-assessment data of participants indicated a need for education among older adult minority women.

Participants did not use condoms, routinely, despite their high level of prevention knowledge.

Limitations These data provide a glimpse into the lives of AA IDU. To apply these data to other populations, consider their context and decide to what degree these data may apply.

Recommendations HIV/AIDS education for older adults, including AA IDU, is needed.

2009

Report
Literature Review

MSM who engage in sex work and inject drugs

Brief description

A brief review was conducted highlighting recent scientific literature trends for MSM who engage in sex work from 1990s through 2007. The review discusses prevalence of HIV among MSM who engage in sex work, and risk behaviors including drug use.

Relevant findings

Men who have sex with men (MSM) who inject drugs (MSM/IDU) and engage in sex work (MSW) have a high risk of HIV infection:

- as the number of paying sex partners increases so does the risk of HIV infection.
- Canadian MSW who inject drugs have a higher prevalence of HIV than male IDU who aren't sex workers (27% vs. 17%).
- MSM who engage in sex work have a much higher prevalence of HIV infection compared to not only the general population but also other high risk populations such as MSM and IDU.

HIV infection among MSW has been associated with history of IDU and unprotected sex with a casual partner and not necessarily only sex work.

Drug use appears more common among MSM sex workers than the general population of MSM. MSM sex workers also have been shown to have a high prevalence of needle sharing.

MSM who trade sex for money, drugs, and shelter, or food was correlated with use of crack cocaine and IDU, homelessness, childhood maltreatment and self-identified sexual orientation.

MSM/IDU report polydrug behaviors, meaning multiple drugs are taken within the same time period, contributing to high risk behaviors.

Altering peer norms by having opinion leaders endorse safer behaviors to their peers showed some success in New York City, reducing rates of unprotected sexual behavior and needle-sharing among MSW and their patrons. The evaluation reported a small but significant reduction in unprotected anal sex during paid encounters.

In Houston, an intervention utilizing HIV education and harm reduction principles showed a significant decrease in risky behaviors such as drug use, IDU, number of sex partners and an increase in condom use.

Limitations

MSM who engage in sex work are a hard-to-reach and understudied population. Findings reported here provide insight into the lives of MSM who engage in sex work in PA. When applying these findings to other populations, consider their context and to what extent these data may provide insight.

Recommendations

The interventions that have occurred for this population provide some insight into how to decrease risk of HIV infection.

The multiple risks occurring for this population could be addressed by multiple healthcare providers.

2009

Report **Literature Review**	**MSM Injection Drug Users**
Brief description	A brief review was conducted highlighting recent scientific literature trends for MSM who inject drugs (MSM/IDU) from 1990s through 2009. The review discusses HIV prevalence among MSM/IDU, risk behaviors, demographics of MSM/IDU, variances of drug use within the population, and synergistic effects of drug use on other MSM/IDU health concerns.
Relevant findings	Approximately 3-5% of HIV/AIDS new diagnoses/year occur among MSM/IDU. Among IDU-related AIDS cases in the US in 2006, the proportions of AIDS diagnoses attributed to MSM & IDU were generally of the same magnitude across different age groups. MSM/IDU have the highest prevalence of HIV among risk populations, as well as the highest reports of risk behaviors, such as unprotected sexual behavior, needle-sharing, multiple partners, injecting drug use. Multiple risk behaviors also increase the likelihood of hepatitis C and other STIs. Within MSM/IDU populations, those who identify as gay or bisexual have the highest prevalence of HIV compared to MSM/IDU who identify as heterosexual. Drug use among MSM/IDU varies, as some mostly inject amphetamines while others mostly inject heroin and/or cocaine, as well as speedballs (cocaine and heroin mixture).
Limitations	MSM/IDU are a hard-to-reach and understudied population. Findings reported here provide insight into the lives of MSM/IDU in PA. Latino and Black MSM/IDU have been even further understudied. When applying these findings to other populations, consider how the contexts compare and to what degree the findings can be useful.
Recommendations	MSM/IDU are a heterogeneous population which must be considered in HIV prevention education and intervention. Multiple risk behaviors may bring MSM/IDU to a number of healthcare providers who should all be aware of the risk of HIV infection, as well as other co-morbidities, and be able to make appropriate referrals.

2011

Report **HIV prevention in substance abuse and mental health care facilities**

University of Pittsburgh
IRB Number 10030476

Brief description The Needs Assessment committee of the Pennsylvania Community Planning Group wanted to learn about HIV prevention provided by substance abuse and mental health care providers across Pennsylvania. An online survey was distributed to mental health and substance abuse clinics throughout the state. Providers returned 189 completed surveys. Descriptive statistics of the data were provided to the committee.

Relevant findings Addictions counselors constituted 26% of the sample.

57% provide care in drug and alcohol treatment facilities.

66% conduct risk assessments, mainly around substance use behaviors and less around disclosure of HIV status.

53% claimed to have HIV+ clients.

Face-to-face discussion and written materials were most often cited as educational formats used with HIV+ clients to help them in preventing transmission of the virus to their partners.

Respondents sought to build their clients skills most around using condoms/barriers (50%) and negotiating harm reduction (49%), while providing clean needles (2%) or distributed drug/works cleaning kits (6%) the least.

Counseling issues principally concerned the HIV+ client's substance abuse, such as a need for referral and adhering to harm reduction practices. Disclosure of status to partners (42%) was the least cited counseling issue addressed.

Respondents claim to spend between 1-25% of their time giving HIV+ clients information and resources to prevent transmission.

Respondents received information about prevention activities from professional trainings the most, as well as professional publications and Internet resources.

Respondents relied upon friends and colleagues as well as their professional networks to find out about community resources.

Respondents use government websites as reliable sources of information for their clients. The Centers for Disease Control and Prevention as well as the SAMHSA website were cited as often used resources.

Top 5 Needs	Top 5 Barriers
• Education pamphlets for clients • Free condoms • Professional trainings • Receive updated communications about prevention • Funding	• Substance use/Mental health issues • Lack of accurate information regarding safer sex • Silence around disclosure • Complacency about HIV • Policy barriers (ie paraphernalia laws)

Limitations

These data provide a general understanding of how substance use and mental health providers in Pennsylvania do HIV prevention. Qualitative analyses are needed for a more nuanced understanding.

Recommendations

Provide yearly HIV prevention trainings to substance abuse/mental health care providers.

Provide free condoms to mental health/substance abuse clinics.

Provide educational literature for clients of mental health/substance abuse clinics.

Chapter 2: Needs Assessment Summaries, MSM results

2003

Report **Needs Assessment Final Report, MSM results**

University of Pittsburgh
IRB Number 960456

Brief description This report describes the committee's recent research findings from 2001-2003, including focus groups with MSM. Subpopulations in this assessment included: African-American; Latino; Rural; Young (18-25); and Traditional (mostly Caucasian, middle-class, and "out of the closet"). The assessment sought to capture the perceptions, ideas, and experiences of MSM.

Relevant findings Reported findings for MSM are categorized by major themes of the focus group interviews.

Knowledge of HIV Participants had a general but not sophisticated understanding of HIV and AIDS.

Participants had very good knowledge about HIV risk behavior, except for rural MSM, who maintained only a general knowledge of risks.

Participants said that they perceived their peers to have little understanding about HIV risks.

> "Some brothers don't know that grease doesn't cut it."
>
> -African American participant

Communities African-American and Latino participants felt isolated from larger communities, respective minority communities, and visible gay communities.

Participants stated a Latino gay organization was badly needed.

Traditional MSM described community fragmentation as interfering with reaching a full representation of MSM with HIV-prevention or other health-promotion programs.

> "It's like being Anne Frank in Nazi Germany. No joke. You hide out with people you know from the enemy."
>
> -Rural participant

Rural and young MSM expressed isolation from identifiable gay communities.

Rural MSM described their communities as morally and politically conservative, with high levels of HIV stigma and homophobia. Few men are out, even fewer act as advocates.

Rural MSM stated that the structure of their gay communities was a barrier to implementing prevention since it is divided into cliques, often isolating new guys.

> "We can't talk about being gay, we can't even talk about sex in this area."
>
> -Rural participant

Participants perceived a silence about HIV and a retreat from HIV prevention in LGBT communities. Condoms are one example, which were once easily available and free in gay bars and at other gay community events/places in the 1990s, are no longer as accessible.

Participants perceive that all gay men and other MSM infrequently talk about HIV with their peers and not nearly as often as in the 1990s.

> "There was some kind of tradition in the early 1990's when everyone was talking about it—a peer reinforcement type of thing. Not so today."
>
> -African American participant

Mental health

Gay, bisexual, and other MSM face a number of psycho-social conditions including low self-esteem, anxiety, depression, and substance use.

Participants, particularly African American and Latino, reported challenges in coming out to families and communities because of fear of violence, banishment, and isolation.

African-American and Latino MSM perceived lower levels of self-esteem as a contributor to unsafe behavior and less concern about one's health.

Internalized homophobia caused participants to often relate to other gay men sexually without engaging in conversations about health and protection.

Services and Trust

Community institutions and providers were perceived to be homophobic outside of urban areas, including AIDS services organizations (ASOs) that censored activities and messages directed toward MSM.

HIV-prevention and service providers were generally not trusted by MSM outside of urban areas.

African-Americans mistrusted governmental providers, specifically the various Department-of-Health clinics.

Latinos mistrusted ASOs, commenting that confidentiality is often broken.

> "Yes, they'll be all professional at their place, but then you see them in a parking lot and she says 'I saw you at [name of agency] yesterday' and then everyone knows."
>
> -Latino participant

Rural MSM questioned the ability of providers to maintain confidentiality.

African-American and Latino MSM reported mistrust of providers and others in authoritative positions. One Latino MSM stated, "We've been burned and so we're very distrustful." An African-American MSM said, "Easy access to testing kits is needed so you don't have to deal with the government."

In particular, these individuals stated that ASOs often did not employ appropriate individuals.

> "I was in a group, the word 'trade' came up, and he didn't understand this. You can't live in our culture and not know what this term means."
>
> -African American participant

African-American MSM hoped to have gay men, preferably gay African-American men, provide prevention services.

Latino MSM expressed concern that many providers do not respect them as Latino individuals, and separately, as Latino MSM.

Rural MSM also expressed a sense that providers do not respect them and concerns regarding confidentiality.

> "Many rural gay men won't get tested because of this [perceived lack of confidentiality]. I'm not just talking about at the Department of Health but also hospitals and private doctors."
>
> - Rural participant

Condoms

MSM reported seldom using condoms for oral sex and some of the time for anal sex.

Reasons for lack of condom use included:

- effects of drug and alcohol; loss of sexual sensation and erection when using condoms;
- lack of access to free condoms especially among rural and young MSM;
- cultural and relationship issues, such as a strong sense of "machismo" among Latinos that interfere with condom use;
- and lack of proper training in using condoms.

Bareback/Raw sex

Participants believed barebacking (intentionally not using a condom during anal sex) occurred for the following reasons:

- increased sexual pleasure,
- having a main partner,
- the thrill involved with danger,
- lack of self-esteem or assertiveness skills to demand condom use,
- and decreased danger in the face of advanced treatments.

Prevention needs

Participants expressed HIV prevention should include a combination of prevention strategies to address the HIV epidemic among MSM.

- education,
- access to free prevention materials,
- attention to attitude change related to risks,
- skill-building activities,
- activities to develop self-esteem,
- activities stressing intimacy and mutual-caring in their communities,
- and affirm gay sexuality.

Participants stated that knowing someone with AIDS was important in changing their attitudes and behaviors related to risk.

Use HIV statistics to present the reality of the HIV epidemic in local communities.

According to youth participants who take part in LGBT support and social organizations, important aspects of participation in such organizations that foster HIV prevention included:

- exposure to at least one well-respected, adult role mode;
- discussions on self-esteem and being gay;
- exercises on use of condoms and communicating with sexual partners;
- presentation of HIV-related information; and,
- peer support unrelated to HIV.

> "A billboard, a few condoms here or there isn't going to do much to change anyone's behavior."
>
> -Participant

African American MSM participants spoke of the need for more effective African American leaders to actually deliver HIV prevention messages and advocate for HIV prevention.

Participants expressed the need for LGBT community leaders to reinvigorate prevention efforts that seemed to have been abandoned in LGBT communities.

The following strategies were recommended to reach MSM who are heterosexually involved:

- fliers and other information should be -distributed where people cruise for sex;
- focus on non-gay venues (e.g., condoms could be distributed or otherwise made available in "straight" bars that are frequented predominantly by African Americans);
- the Internet must be utilized; and
- prevention-related articles and advertisements should be placed in publications read by heterosexuals.

Agencies targeting subpopulations of MSM need to show respective symbols of their minority status within their organizations, in agency-leadership positions, as well as performing the roles of counselors and prevention outreach staff.

Rural MSM spoke of the need to decrease HIV stigma and homophobia in rural communities so that HIV prevention activities could be developed in these areas.

Participants perceived churches to be closed to MSM and conversations about HIV.

Participants suggested that activities such as lectures, occasional bar-related or health department activities did not have impact on attitudes or behaviors.

Suggested venues for prevention services include:

- Young MSM stressed the importance of providing clear, targeted, and non-judgmental HIV-prevention information in schools.
- Participants believed a hotline or central information source should be available for MSM providing details about HIV and other issues of interest.
- Traditional MSM claimed a number of missed opportunities for including HIV-prevention services with community events sponsored by and attracting gay, bisexual and other MSM.

Peers & Support

A key theme among all subpopulations of MSM was the development of peers and community leaders to address HIV prevention:

- A sense of mutual support was especially important to young MSM.
- African-American and Latino MSM described a need for intimacy and social support that extended beyond sex because, as stated above.
- Participants viewed peer outreach as a vital part of prevention.
- MSM spoke of the need to develop and use existing friendship/peer networks to implement HIV prevention.
- Latino, African-American, and rural MSM talked about their need to advocate for and develop HIV prevention.

Limitations

Focus groups provide insights into opinions, attitudes, and lived experiences of the study population. To use these data for other populations, consider how the contexts compare and to what degree the findings can be useful.

Recommendations

Build self-esteem, peer support, community caring and reduce social isolation. Recommendations for interventions directed to MSM include approaches that focus on self-esteem and fostering community connections.

Local gay and other community leaders need to be re-invigorated to play a role in HIV prevention targeting MSM in a way that was identifiable in the late 1980s to mid-1990s**.**

Gay community events (e.g., drag shows, gay bingo, and no-alcohol events) could be infused with HIV-prevention materials.

HIV-prevention interventions targeting MSM should include messages for the diversely identified men and delivered in appropriate settings for the target population.

Prevention interventions directed to MSM should discuss real-life challenges people living with HIV face.

Diminish institutional homophobia in agencies receiving public HIV prevention funding and in schools.

Success Story: Pitt Men's Study

Participants who had experienced prevention through the Pitt Men's Study (PMS), a research project focusing on HIV and prevention, tended to be conscious about the need to protect themselves and reported that they were more likely to use condoms than men who had not participated in prevention activities.

Several participants said their experiences as volunteers for this research study changed their HIV-related attitudes and behaviors. PMS was viewed as effective because:

1) The experience caused participants to reflect on themselves and their behaviors;
2) individuals felt very trusting of the PMS staff

"I felt like I could really connect and trust [the staff member")

3) individuals had regular interactions with the study over time; and,
4) the study involved HIV testing and counseling.

2005

Report **HIV Prevention needs of at-risk Asian & Pacific Islander (API) MSM in Pennsylvania**

University of Pittsburgh
IRB Number 010495 and 0404081

Brief description This study was a needs assessment among API MSM in Pennsylvania. The process included an extensive literature review and data collection through focus groups.

Facilitators and recorders conducted one API/MSM focus group in the Pittsburgh area. A total of 10 API MSMs participated in the focus group after first answering a short intake form describing themselves. The focus group was recorded.

Relevant findings

Cultural factors APIs are a culturally diverse population, with multiple language barriers with marked differences in educational level, income, and degree of adaptation to the dominant US culture.

A lack of peer and community support for sexual and racial diversity often creates barriers to self-esteem and positive self-identity for API MSM.

Cultural taboos and sanctions discourage open discussion of sexual topics, substance use, and illness; resulting in discomfort or inhibition for the API population when discussing HIV risk behaviors and care.

Risk behaviors Many gay API men do not perceive themselves to be at risk for HIV yet API MSM are as likely to engage in HIV-risk behaviors as other racial/ethnic groups of MSM.

Services API MSM rarely use the services provided by HIV prevention programs due to the stigma associated with HIV and homosexuality in API communities.

API MSM report having few or zero API providers of HIV prevention programming.

60% of participants reported having had an HIV test.

HIV diagnoses are often made late in the progression of the disease.

API MSM reported an unwillingness to discuss HIV prevention with medical providers.

Faith-based ministries would not be effective for reaching this population due to the stigma associated with HIV and homosexuality.

Limitations

Few data exist on the experiences of API MSM in Pennsylvania. These data provide an initial glimpse into their experiences. When applying these findings to other populations, consider their context and to what extent these data may provide insight.

Recommendations

LGBT community-based centers should establish confidential peer support and HIV education/prevention programs employing API trained providers.

Print and distribute literature in API's native languages to ensure the prevention messages are communicated and share across agencies, with AIDS Services in Asian Communities (ASIAC) in Philadelphia as a potential leader.

Develop media promotions using API celebrities and community leaders that highlight HIV testing, counseling, and harm reduction techniques to assist with reducing HIV-related stigma.

Make prevention media available in private exam rooms instead of the reception area.

Programs should attempt to increase the API community's comfort with talking about sex, and provide training to increase skills about safer sex techniques, addressing sexuality without discomfort.

Prevention strategies directed at the individual, the family, the general API community, and the mainstream gay community should be implemented to reduce HIV risk among API.

Programs promoting the importance of counseling and HIV/STI prevention should target API health providers because health professionals can have great influence on API populations.

2005

Report **African American Men who have Sex with Men (16 & 17 years old)**

University of Pittsburgh
IRB Number 020646

Brief description Confidential interviews were conducted in two sites in Pittsburgh. Participants were recruited from high schools and community based LGBT organizations providing youth programming. Ten young men who have sex with men (MSM) were interviewed after answering a short intake form describing themselves.

Relevant findings 20% of participants reported having had an HIV test.

Participants reported that HIV stigma is a barrier to testing.

Participants, regardless of their sexual orientation, expressed that youth view themselves at low-risk for HIV infection.

Limited dialogue exists about HIV & STIs with family or peers.

Limited access to free condoms is a barrier to practicing safer sex.

Limitations This study provides details of the opinions, attitudes, and experience of young African American MSM in Pittsburgh. When applying these findings to other populations, consider their context and to what extent these data may provide insight.

Recommendations Market confidential HIV testing and counseling as an essential component for self-empowerment within HIV prevention programs.

Develop and implement a “Knowledge is Power” campaign promoting young MSM to know their HIV status and to gain skills for making informed choices about intimacy, condom negotiation and self-worth.

Make trained peer educators accessible at local community/recreation centers, AIDS service organizations, and school-based prevention programs.

Create and support community-based safe-spaces within the LGBT communities.

These spaces should provide this population with opportunities to increase self-esteem and self-worth, promote dialogues about relationships, foster effective communication and listening skills, and provide harm reduction information and testing and counseling.

2008

Report **Literature Review**	**MSM prevention with positives**
Brief description	This study reviewed recent literature in order to examine MSM prevention issues for MSM currently living with HIV.
Relevant findings	Men know about condoms and HIV and seek to find alternatives that do not involve condoms but are perceived to be less risky (e.g. sero-sorting). Substance use among gay, bisexual, and other MSM is still an issue. The Internet is an important resource for finding partners and for providing prevention messages. Structural issues continue to limit prevention resources. A few interventions exist; however, barriers exist that prevent larger populations of MSM benefitting from these interventions. Racism, socioeconomic status (SES) issues, geographic issues, and homophobia isolate people.
Limitations	Studies cited here provide a glimpse of what may be occurring in Pennsylvania. These data may guide future inquiry into this population or other populations with similar contexts.
Recommendations	Prevention messages must become more sophisticated in order to target people who have already been exposed to previous HIV messages. Prevention services need to move more into other arenas (hospitals, health care facilities, etc.) Studies are needed to examine MSM populations in more detail to see how prevention resources are being utilized.

2009

Report **Literature Review**	**MSM Injection Drug Users**
Brief description	A brief review was conducted highlighting recent scientific literature trends for MSM who inject drugs (MSM/IDU) from 1990s through 2009. The review discusses HIV prevalence among MSM/IDU, risk behaviors, demographics of MSM/IDU, variances of drug use within the population, and synergistic effects of drug use on other MSM/IDU health concerns.
Relevant findings	Approximately 4% of HIV/AIDS new diagnoses in the US in 2007 were among MSM/IDU. This trend continues over the years of approximately 3-5% of HIV/AIDS new diagnoses/year occurring among MSM/IDU. Among IDU-related AIDS cases in the US in 2006, the proportions of AIDS diagnoses attributed to MSM & IDU were generally of the same magnitude across different age groups among adults and adolescents. MSM/IDU have the highest prevalence of HIV among risk populations, as well as the highest reports of risk behaviors, such as unprotected sexual behavior, needle-sharing, multiple partners, injecting drug use. Within MSM/IDU populations, those who identify as gay or bisexual have the highest prevalence of HIV compared to MSM/IDU who identify as heterosexual. MSM/IDU who identify as heterosexual have higher rates of trading sex for drugs or money. Drug use among MSM/IDU varies from amphetamines to mostly heroin and/or cocaine, as well as speedballs (cocaine and heroin mixture). Racial/ethnic differences among MSM/IDU have not been well documented. MSM/IDU have multiple risk factors for HIV infection and transmission: needle sharing, a high number of unprotected sexual partners, sex work, and methamphetamine use, interact to increase the likelihood of HIV infection, hepatitis C and other STIs.
Limitations	MSM/IDU are a hard-to-reach and understudied population. Latino and Black MSM/IDU have been even further understudied. Findings reported here provide insight into the lives of MSM/IDU and can inform future inquiry into MSM/IDU in Pennsylvania.

Recommendations

MSM/IDU are a heterogeneous population which must be considered in HIV prevention education and intervention. Multiple risk behaviors may bring MSM/IDU to a number of healthcare providers who should all be aware of the risk of HIV infection, as well as other co-morbidities, and be able to make appropriate referrals.

MSM/IDU need to be aware of the various resources beyond HIV prevention that exist to assist them in their healthcare.

2010

Report **Differences between MSM in virtual & physical settings**

University of Pittsburgh
IRB Number 08120139

Brief description

This study examined the sexual activity of men who have sex with men (MSM) and the impact of location on partner selection. PPP staff facilitated four focus groups over a two week period in 2009. Recruitment divided participants into two categories:

- Physical group, who primarily used bathhouses, straight and gay bars to find sexual partners.
- Virtual group, who primarily used virtual locations such as chat groups, Craigslist/message boards, and other Internet sites/apps to find sexual partners.

Two groups of each type with 20 total participants were conducted. Researchers recruited participants from an existing participant population within the Pitt Men's Study. Researchers used Grounded Theory in the analysis of focus group transcripts and dialogue.

Relevant findings

Men participating in the physical locations focus group reported:

- less opportunity to define sexual preferences and expectations in advance.
- the pool of partners was limited to the venue at a specific time.
- there was an increased fear of rejection in a physical space; this fear increased with the aspect of public rejection and scrutiny.

Men participating in the virtual locations focus group reported:

- perceiving an unlimited number of potential partners.
- using information from personal profiles and the type of website they are on to screen partners for sexual compatibility before initiating conversation.
- it was easier to discuss sex and that it was more private than in physical locations.

Participants felt that Internet partners had more opportunities to falsify both physical and emotional attributes.

Participants sub-divided physical locations into venues that are either heterosexual or gay. Physical spaces can offer increased risk for physical violence. Further, participants might consider themselves limited by their appearance and reputation in a public space.

MSM who participated in the virtual space groups felt that physical locations took too much time to meet and obtain a partner, offered only a limited partner pool, and were inconvenient.

Participants who used physical locations to find sexual partners perceived virtual spaces as being unsafe. This group felt that the Internet was "only for hooking up" and allowed people to be duplicitous in their description and profile.

MSM virtual group participants felt the Internet allowed for a deeper personal connection. These participants did note that people should follow specific online rules and that many people lie.

Virtual and physical spaces have different emotions/feelings attached to them that influence both choice of space and behavior within space.

MSM use multiple spaces over their life course. Spaces are used together.

As one space becomes old (or the novelty wears off) MSM will move to another space, but sometimes returning to the space in which they began. The implication of this is that bars can be a venue to reach internet users and vice versa.

Limitations

Focus group discussions yield insights into the experiences of these men. When applying these findings to other populations, consider their context and to what extent these data may provide insight.

Recommendations

Internet interventions need to consider the diversity of men present in virtual spaces and respect their motives for being on a particular site.

Internet interventionists need to remain aware of the sites virtual space users are accessing.

Physical spaces are also diverse, and interventions need to remain aware of the needs of the men present in each space.

Space matters. Interventions need to recognize the influence a virtual or physical space has on the behaviors and social norms that exist within that space.

"The bathhouse is about more than just sex."

-Participant

"It's (gay social space) just not my scene anymore."

-Participant

Chapter 3: Heterosexuals

2003

Report **Needs Assessment Final Report, Heterosexual Results**

University of Pittsburgh
IRB Number 960456

Brief description This report describes the committee's recent research findings from 2001-2003, including focus groups with at-risk heterosexuals. During this time period the committee analyzed findings from the following subpopulation of heterosexuals: Women who have sex with MSM, Latina Females, Sex Workers, Non-Injecting Drug-Using Females, Young African-American Females (18-25), Young African-American Males (18-25), and Other At-Risk Females.

Relevant findings

Testing Most young African-American participants had been tested for HIV.

Both African-American men and women at heterosexual risk reported under-access to HIV counseling and testing.

HIV Education Heterosexual participants were less knowledgeable about HIV/AIDS compared to IDU and MSM populations.

Women of childbearing age did not know about the role of ART for pregnant women living with HIV to help prevent mother-to-child transmission.

Participants reported obtaining information about HIV through community agencies and services they had accessed. Clients typically needed to ask for HIV-related information.

All sub-populations possessed a reasonably specific and accurate understanding of risky and less risky behaviors.

Significant gaps in knowledge were found to exist. For example some sex workers and several of the young African-American males and females did not know the difference between HIV and AIDS.

Prevention Barriers Participants claimed that HIV is simply not talked about much. Young African Americans and Latinas described an extensive amount of HIV stigma existing in their communities.

Participants reported being less likely to use condoms when using substances.

Substance use was prominent for sex workers, who used a variety of substances.

Sex workers expressed desire to use condoms even when using substances, however less likely to do so.

Participants reported that they and many of their peers sometimes or never used condoms.

Reasons given for lack of condom use included:

- denial of HIV as a threat,
- low self-esteem,
- some women and men like barebacking,
- the cost of condoms,
- substance use, and
- men resisting condom use.

Female sex workers "sometimes" used condoms with johns, they almost never used condoms with their partners who were not johns.

Participants reported that condoms were accessible when individuals made it a point to acquire them. (e.g., in stores, clinics, health departments, AIDS service organizations, family planning clinics, health clinics). Female participants did not make it a point to get condoms.

Heterosexual women and men perceived low self-esteem as a barrier to consistent condom use in sexual encounters. Young African-American females repeatedly mentioned self-esteem as a barrier.

> "If you don't feel good about yourself, what do you care?"
>
> -Participant

> "Men see us as a container to deposit their sugar, and we allow them to do that."
>
> -Participant

Prevention needs

Latinas expressed that they lacked basic knowledge about HIV, the need for Latina-affirming resources and "a place that would bring something positive to Latino communities." Latinas stated a need for more culturally and linguistically relevant HIV information.

Knowing or being exposed to someone living with HIV was viewed by participants as an important determinant of behavioral change.

Participants, especially young African Americans, spoke of the need for services to be confidential.

Participants in one group said that physical isolation from the nearest AIDS service organization reduces the likelihood of participating in HIV-related activities.

> "You feel like you'll insult them by asking them to use condoms, and you feel insulted when they ask you."
>
> -Participant

Service experiences

Participants could not identify brochures, billboards, speakers, or outreach activities directed to their respective subpopulations with the exception of a women's group at a Williamsport hospital.

Interactions with service providers were positive. Several at-risk females trusted the local service providers but did not trust larger systems (i.e., research organizations and pharmaceutical companies).

Participants stated that more intensive types of HIV-prevention interventions, such as targeted, community outreach and attitude-change and skill-building activities, were needed.

Outreach

Sex workers said that outreach should target them and not the Johns.

Young African-American males said that outreach should target guys where they hang out (e.g., basketball courts, people's homes, street corners, clubs, African-American organizations, YMCA, social functions in the black community).

Limitations

Focus groups yield insights into lived experiences. When applying these findings to other populations, consider their context and to what extent these data may provide insight.

Recommendations

A comprehensive range of HIV-prevention services that are culturally appropriate, language-specific, and targeted HIV information, education, and outreach are needed for at-risk heterosexuals.

Interventions need to address self-esteem, self-efficacy, apathy, HIV and sexuality stigma, and skills affecting behavior change. Women especially liked the idea of skill-building groups in which mutual support would be fostered.

Interventions need to be specific about heterosexual risks of HIV, countering community and individual denial that heterosexuals are at risk.

Increase availability of free condoms and condom outreach to promote their use.

Participants encouraged increased and quality-controlled HIV-prevention through existing institutions, such as drug-treatment centers and schools.

All subpopulations stated that HIV-related information would be an important component to effective prevention campaigns.

Provide information on mother-to-infant HIV transmission and treatment at locations where pregnant women receive services as well as in target community locations.

Create social marketing campaigns to address HIV apathy and HIV stigma.

Target heterosexual couples to address gender norms that affect decision-making and couple's counseling in HIV counseling and testing.

Increase drug treatment availability.

Many participants were aware of family and community members who would benefit from needle distribution.

Provide spaces for people to dialogue with those living with HIV.

"You have to go get the information yourself." Another said, "AIDS-related information] is not visible in the community unless you go to the health centers."

-Participant

"Seeing someone go through it, that's prevention to me. That changed me."

-Participant

Table 1. Sources of information for HIV/AIDS for at-risk heterosexuals in Pennsylvania

Frequently Cited Sources of Information by Participants
AIDS Service Organizations
Local health departments
Health clinics
Hospitals
Shelters
Rehab/treatment facilities
Churches (Williamsport)
Markets (Chester)

Success Story: Shout Outreach

Prevention activities sponsored by the *Shout Outreach* program in Erie were described as the impetus for some women to be tested and counseled for HIV. *Shout Outreach* was described as performing outreach in bars and in areas where teens frequent and regularly abuse drugs, passing out literature and condoms in the streets, and providing a multiple session workshop on using condoms and other topics.

2005

Report **HIV among women of color over 50 (non-IDU)**

University of Pittsburgh
IRB Number 0410088

Brief description Three focus groups were conducted throughout Pennsylvania targeting heterosexual women of color 50 years of age or older. Faith-based participants (n=8) were recruited for one specific group, another was African American women only (n=9), while another was Hispanic women only (n=6). The focus group facilitators and the group recruiters reflected the race, ethnicity, and characteristics of the group participants.

All participants also completed a risk-assessment survey.

Relevant findings Physicians and other healthcare professionals do not routinely assess adults over the age of 50 for risk of HIV infection.

Physicians and other healthcare providers may mistake HIV-related symptoms with other illnesses that are common to the aging process.

The majority of participants had not been tested for HIV despite being sexually active.

Participants associated condoms with pregnancy prevention and reported using condoms infrequently.

Participants assumed being in monogamous and/or marital relationships kept them safe from acquiring HIV.

Participants displayed some difficulty discussing issues involving intimacy and behaviors that could put them at risk for contracting HIV.

Participants from the faith-based group reported not knowing anyone who was living with HIV.

Participants did not feel they received messages about HIV prevention and believed HIV messages go only to younger people.

Participants perceive in-home healthcare and social services as trusted and valued providers.

Limitations Focus groups provide a glimpse of what is occurring around a particular topic and community and the study population's experience. When applying these findings to other populations, consider their context and to what extent these data may provide insight.

Recommendations

Increase HIV prevention education for minority women over the age of 50.

Physicians and other healthcare providers need to talk to their patients over the age of 50 about sexual health

In-home healthcare providers could be trained to provide confidential HIV testing and counseling.

Age-specific and culturally sensitive HIV prevention efforts developed for minority women over the age of 50 could be placed in communities where a need exists.

Faith-based spaces could benefit from inviting people living with HIV to talk to them about living with the virus and decrease fears of testing for HIV. HIV prevention resources could be provided to congregations.

> "Really, this is the first I had anybody sit down and even talk about it (HIV prevention)."
>
> -Participant

2005

Report **Young Heterosexual African Americans (16 & 17 year olds)**

University of Pittsburgh
IRB Number 020646

Brief description Confidential interviews were conducted at two sites in the Pittsburgh area. Participants were recruited from high school parenting programs and from community-based organizations that provide health promotion to at-risk teens. Ten heterosexual males and ten heterosexual females participated in the confidential (taped) interviews after first completing a short intake form describing themselves. Race and gender matched professionals conducted each interview.

Major findings 20% of those surveyed reported having taken an HIV test.
Fears and stigmas associated with HIV were identified as barriers for HIV testing.

Adolescents have limited discussions about HIV prevention with family or peers.

For high school participants, exposure to HIV prevention information, free condoms, and skills building appear to be limited to school-based health classes.

Male respondents reported having discussions with parents about condom use for the prevention of unwanted pregnancies, but not about HIV prevention.

Males shared that condom use was learned on a “trial & error” basis.

Female respondents reported being offered HIV testing during routine gynecological appointments, but offered little or no prevention counseling or skills building.

Female respondents further reported that they lacked the skills to negotiate the use of condoms more effectively.

Limitations Interviews tell us about individual’s experiences around a particular topic. When applying these findings to other populations, consider their context and to what extent these data may provide insight.

Recommendations

Provide in-home HIV/STI prevention programming for peer/family groups of diverse ages.

In-home programming could foster positive (group) dialogue about HIV, STIs, and pregnancy prevention.

In-home programming could increase opportunities for on-site HIV testing and counseling, within the confines and safety of one's own home—or those of their friends/peers.

Participants thought that older adults do not perceive of themselves as being at risk. In-home programming could also be a means to educate family members over the age of 50 about their risk for HIV/STI infections and to increase awareness of harm reduction techniques.

Design programs that encourage youth to get tested for HIV, to make healthy and informed decisions, and to decrease fears/stigmas associated with HIV/AIDS.

Make free condoms more available, with an emphasis on youth in rural areas.

Develop and implement billboard ads that list HIV prevention facts, promote testing and counseling, and identify local AIDS service organizations.

Include skills-building and negotiating skills for males and females within youth prevention programming.

Have trained peer educators be accessible at local community/recreation centers, AIDS service organizations, and school-based prevention programs.

Chapter 4: Youth
1996

Report **Process Evaluation**	**Public High School Students Focus Groups**
Brief description	Students were selected to participate in focus groups regarding their experience of HIV education in PA public schools. Eight students agreed to participate. Participants discussed their opinions on the amount of HIV education they received and its usefulness for their personal lives. They rated their high school's education on a scale of 1-10 and then justified their answers through discussion with other students. Discussion was not limited to their high school experience since participants included recollections of elementary and junior high school HIV education.
Relevant findings	Participants rated their public schools across the range of 1-10 for the amount of information and usefulness of the HIV education they received. Participants rated the amount of HIV education received on the lower end of the 10-point scale, with most responding in the 1-5 range. They desired more HIV education. Information was generally presented once with no future reinforcement in later grades. Participants who rated their schools with better "usefulness" scores claimed they received information about specific risk behaviors. Participants who rated their schools with worse "usefulness" scores claimed that teachers were uncomfortable with adolescent sexuality, the HIV education message was abstinence-only, and the information was only targeted to heterosexual students. Quality and amount of information generally depended on a teacher's ability and willingness to talk about HIV and risk behaviors. HIV prevention messages were not specific as the information did not address risk activities and ways to prevent HIV. Schools portrayed homosexuality as something dangerous and something you should not "do". Some participants in the groups noted that they were told not to use injection drugs or use other people's needles. Specific information about

the risks of needle sharing was not being addressed in public school HIV education.

Information available through the schools was dependent upon the students' initiative to ask for information, the teachers' willingness to provide information, and the principal's leadership in arranging for information and activities.

Information received had little impact since the information was too general, the abstinence message was not realistic and students did not think the information pertained to them.

Participants emphasized the need for specific information about sexual health issues to make informed decisions.

Students need negotiation skills to know how to deal with pressures that place them in at-risk situations.

Participants noted a preference for small group discussions with someone living with HIV instead of large assemblies.

Participants said that they would like the schools to address HIV with the same intensity that they address other adolescent health issues, such as alcohol, drugs, car accidents, and date rape.

Participants noted media as a principal source for relevant information.

Limitations

These data provide a glimpse of what was occurring in PA public schools at the time of the investigation. These data may inform future data collection tools used to investigate schools and youth.

Recommendations

Consider media as a potential outlet to reach youth, especially Internet.

Collaborate with schools, AIDS-service organizations, local media outlets, religious organizations, and parent groups to raise the likelihood of reaching youth with the information they need.

1998

Report Process Evaluation	**1998 Young Adult Roundtable Personal Statements**
Brief description	Personal statements collected on day two from Young Adult Roundtable Summit participants across Pennsylvania. Some participants provided oral statements to the group while others submitted written statements. These statements generally tell the story of the youth's perception and experience of HIV and how they think HIV prevention and education can move forward.
Relevant themes	Youth expressed the need for more HIV education and adult support. Youth identified parents, schools, and other adults at home as obstacles to HIV prevention and education. Youth noted the importance of adult champions in their communities, such as the Department of Health and other adults who have empowered them to get needed information. Youth noted the importance of self-esteem and getting youth to care enough for their own lives so they will take precautions, such as using a condom. Youth participating in roundtables expressed frustration with doing HIV education outreach and that friends were still not taking precautions such as using condoms. Youth stressed the importance of beginning HIV education and peer leadership when they are in elementary school and continue the messaging throughout high school and college.

"…we need to change legislation because how can you talk about issues if you aren't allowed to talk about certain subjects…."

- Norristown participant

"I'm glad to see people my age and younger are actually involved and care."

- Pittsburgh participant

"So what do you do when you can't get your own patches from (the AIDS) Quilt? You make your own quilt."

- Pittsburgh participant

"Go to your school board and tell them you want condoms in your schools. That's the only way it's gonna happen because nobody's gonna do it for you."

- Williamsport participant

Limitations

The youth participants are already involved in HIV prevention and education and do not reflect the viewpoints of those youth who are not involved.

Identified themes may give insights as to what continues to occur among adolescents today while considering current context.

Recommendations

Involve youth in HIV education at young ages.

Incorporate self-esteem and self-efficacy building in HIV prevention with youth.

Incorporate adults into HIV education for youth and foster a community of support for the youth to rely on.

A Success Story: Get the Job Done

Our student council decided that school education isn't working and we need more education about AIDS. We decided to have an AIDS awareness week. We got the approval of the school. We got approval of the principal who was very supportive. We got approval of the teachers. We thought that would be enough.

There was a lot of info from outside agencies because it was a big city. But the question was bringing it all to the school. We knew we couldn't bring in condoms. We couldn't pass them out even on the sidewalks next to the building because it was still school property. Next was getting the money for it. We wanted to bring in some patches for the Quilt. We wanted to bring in speakers. There was a supplemental school grant, $500 that was given out by the Alumni Association and by the Parent Teacher Association. There were usually eight available that year. We applied. They gave out six. We were people who didn't get it.

Our Principal managed to allocate $50 for us. So what do you do when you can't get your own patches from Quilt? You make your own quilt. We bought material. We made Clubs make their own little patches with their messages. Right now there's four quilts hanging in high school.

My first year we wanted to raise some money for the Pittsburgh AIDS Task Force and also our first year coincided with the first AIDS walk in Pittsburgh. So we went as a unit and our Principal went with us. Every news camera that was there, every channel, shot us. Every newspaper shot us. Only one paper published it.

Our school newspaper the next month's issue had three positive responses to cap the week off with a candlewalk through the school. We stopped all the classes. We actually stopped turned out all the lights in the rooms and we had the school choir follow the group of people who were involved with the project. And every news crew showed it.

When we went to the AIDS Walk we didn't have the money for the T-shirts so we actually just went to K-Mart and bought white T-shirts and stenciled our school name on them. Second year, we had all the money we wanted. Third year, we had all the money we wanted. Fourth year, which is coming up right now, they're having a kick-ass program. Don't give up cause that's the only way you're gonna get the funding and you're gonna get the job done.

- Pittsburgh participant

2004

Report **Youth Empowerment Project (YEP) Survey: An analysis on youth and HIV testing**

University of Pittsburgh
IRB Number 021145

Brief description Data were collected over a 6-month period (in 2003) from various events and venues (bars, clubs, college dormitories, streets and social settings) in the Pittsburgh area, YEP outreach staff informed young people about the study using signs and conversation. The survey was a 4-page, anonymous questionnaire and took approximately 10-20 minutes to complete. Participants returned the questionnaire to the staff person, and received a five ($5) dollar incentive.

580 youth between the ages of 14-24 participated in the study. The mean age was 18.5 years. The information gathered from these surveys provide the basis for future data-gathering and will give HIV prevention programs information about why youth do not seek HIV counseling and testing and what behaviors place them at risk for HIV infection or re-infection.

Relevant findings Overall, 17% of youth were found to be at high or some risk for HIV infection, while many of them agreed they were not at-risk for HIV. A large majority of young people didn't know anyone living with HIV/AIDS.

Respondents who identified as gay or bisexual had ever tested for an STI and tested for HIV in the last year more than their straight and lesbian identified peers.

Respondents identifying as transgender did not feel they were at risk for HIV and therefore did not seek an HIV test.

Young gay men who engaged in the highest risk behaviors reported being afraid of testing HIV positive and therefore did not seek an HIV test.

Gay, lesbian, and bisexual youth reported smoking more than their straight peers.

Young gay men reported getting information about HIV/AIDS mostly from friends and the Internet.

Straight, lesbian, and bisexual youth reported getting information about HIV/AIDS mostly from school.

Young people continue to engage in high-risk behaviors and avoid HIV testing, and efforts are needed to identify these youth and equip them with the resources they need to avoid infection.

Limitations

This study focuses on youth and HIV/STD testing in Pittsburgh. To apply to other areas of Pennsylvania consider how each context differs and to what extent insights can be drawn.

Recommendations

Innovative prevention interventions are needed encouraging HIV and STI testing among youth at-risk.

Many young people don't know anyone living with HIV/AIDS. They did not personally witness the devastation of the disease in the 1980s and early 1990s. New prevention programs are needed to address their misconceptions and erroneous understanding of their risk of being infected.

We need additional research to better understand what interventions will work to increase HIV testing among high-risk youth.

Programs need to be more vocal in reporting recent data that point to increases in HIV diagnoses.

Programs are needed for middle and high school students, since 70% of all high school youth report sexual exploration.

In order to counter young people's fears regarding needles used to draw blood for testing, *OraSure* and *OraQuick* tests should be made widely available.

People living with HIV should be engaged in educational programs targeting young people, especially young people themselves infected. This gives young people an opportunity to meet someone living with HIV/AIDS and also someone to whom they can relate.

Programs can effectively reach youth with HIV prevention information and knowledge regarding HIV testing centers by making testing readily available, having information on what the test results mean, the different types of tests available, where to go for testing, clinic hours and cost.

2010

Report **Parent Focus Groups and Interviews**

University of Pittsburgh
IRB Number 07110177

Brief description PPP gathered preliminary data regarding the HIV prevention needs of parents of adolescents less than 18 years of age. Both state and national data show increasing rates of STI and HIV transmission among adolescents, especially among racial and ethnic minorities.

This study consisted of in-depth qualitative interviews with 11 parents of adolescents (seven individual interviews and 1 focus group with four people). The purpose was to understand the types of information that parents of racial and ethnic minority adolescents need in order to improve HIV education and prevention.

Relevant findings Parents want training on sexuality and HIV, and skills to communicate with their children about these topics. Parents lack preparation and planning when talking to youth about HIV education.

Parents believed having multiple venues for HIV education is important to reinforce messages. Parents identified home, schools, medical providers, churches, and community-based agencies as potential venues.

Parents want to address how sexuality is communicated through media. Media messages are very sexual but are devoid of any discussion of HIV.

Participants discussed how young women are being targeted by older men for sexual relationships who use gifts as a way to manipulate young women.

Parents mentioned stigma regarding sexuality translates into a lack of public education available to LGBT youth.

Parents acknowledged HIV stigma prevents many people from even talking about HIV, and will prevent people with HIV from talking about it to others. Stigma prevents people from accessing care and testing.

Parents felt relevant HIV education for adolescents could be created from HIV education curriculums currently available.

Limitations

These data provide a glimpse into parental views on HIV prevention and education. When applying these findings to other populations, consider their context and to what extent these data may provide insight.

Recommendations

Parents need specific HIV prevention and education tools and guidelines, such as talking points and timelines.

Tailor HIV prevention and education tools for specific populations including single parents and co-parents.

Education should be hands on, age appropriate, and consistent and complementary from all sources including teachers, doctors, and other child care professionals, reinforcing the health messages that adolescents receive.

HIV prevention and education should include strategies for safety and empowerment.

Parents recommend using puberty and body changes to initiate conversations.

Parents all made note that the emotional environment is crucial to the receptivity of the health message; the information presented can be embarrassing for children, which could hinder learning.

Parents specifically requested curricula s that were tailored for earlier age groups such as preadolescent children. They feel pre and early adolescent children require educational models very different from what parents are seeing as being currently available. They wish to have the tools to provide sex and HIV education at an age appropriate level and include training/tips for adults on how to perform such education.

> "Parent education is just as important as education for young adults and adolescents."
>
> -Participant

Chapter 5 Special Populations

2005

Report **HIV Prevention needs of at-risk African American Homeless Adult Men and Women**

University of Pittsburgh
IRB Number 0406090

Brief description The specific aim of this study is to develop an understanding of the needs and barriers of African American homeless adults. A literature review was conducted as well as interviews of homeless African American adults. Confidential interviews were conducted in homeless shelter sites in and around the Greater Pittsburgh area. Fifteen homeless males and females participated in the confidential (taped) interviews after a short intake describing themselves. Shelter staff were trained to recruit and facilitate the confidential (taped) interviews.

Relevant findings In the United States HIV seroprevalence is higher among populations of homeless adults compared to the general population.

The day-to-day survival needs of homeless adults take precedence over preventing HIV and planning for the future.

Homeless adults have more sexual partners compared to adults who are not homeless, and report using condoms infrequently with sex partners.

Homeless adults often present more than one risk factor for HIV.

10% of participants reported having had an HIV test.

Some homeless adults reported histories of substance use and/or histories of incarceration.

Homeless adults identified limited opportunities for learning harm reduction techniques.

Homeless adults identified limited access to free condoms.

Homeless adults have limited negotiation skills and active coping strategies.

Homeless adults have a mistrust of community services.

	Homeless adults perceive health care facilities as unable to meet their physical and emotional needs.
	Homeless adults with mental illness may have impaired judgment and lack negotiation skills.
Women	In urban areas across the US, single women and their children account for approximately 1/3 of the homeless population.
	Homeless women may engage in survival and coerced sex and have partners who inject drugs.
	Very few homeless women have received needed mental health care.
Limitations	These data provide a glimpse into the lives of homeless African American adults in Pittsburgh. These data do not represent all communities therefore when applying these findings to other populations, consider their context and to what extent these data may provide insight.
Recommendations	Provide consistent, ongoing HIV prevention programs for this population in homeless and runaway shelter facilities.
	Make timely and age-appropriate prevention literature easily accessible.
	Make free condoms more available and distribute information about their location widely.
	Make confidential HIV testing and counseling programs available at shelter facilities, in addition to ongoing HIV harm reduction information.
	Use mobile prevention programming to educate people about harm reduction techniques and to provide a referral service for those seeking additional information, support, and/or treatment.
	Ask the Department of Health to work with homeless shelters and other homeless services programs to discuss how to provide HIV prevention and education more effectively.

2006

Report
Literature Review

HIV Prevention Needs Among the Severely Mentally Ill (SMI)

Brief description

This study involved a review of the most current literature regarding HIV prevention for SMI individuals. The study was also an update on an earlier University of Pittsburgh study regarding the acceptability of providing HIV prevention among case managers across the state who serve SMI individuals.

Relevant findings

Several studies find alarmingly high rates of HIV infection among convenience samples of individuals with severe mental illness (SMI). Studies estimate higher prevalence rates of HIV infection in the SMI population (4%-22%) than in the general population (0.3%- 0.8%).

HIV prevalence rates vary by institution: in admissions to inpatient psychiatric facilities, 5-8%; in homeless shelters, 19%; in municipal hospitals, 23%; and in not for-profit hospitals, 16.3%.

These high rates are largely a function of lower socio-economic status, higher rates of substance use, homelessness, and risky sexual behavior including unprotected sex and sex work.

Individuals with SMI and substance-use disorder combined have been found to be at greater risk of HIV infection than are persons with SMI alone.

Which mental illness someone is diagnosed with influences risk. Schizophrenics reported lower levels of HIV risk behaviors than individuals living with depression or bi-polar disorder. Living with severe illnesses such as schizophrenia influences the ability to be sexually active more than mild/moderate illnesses like depression.

Individuals with high levels of depression were more likely to report high-risk sexual behaviors in comparison to schizophrenics and individuals with bi-polar disorder.

Maintaining Medicaid coverage is a challenge for individuals living with SMI, often losing eligibility as a result of an institutional stay—either in an Institution for Mental Disease or a correctional institution resulting in lengthy delays in re-establishing Medicaid eligibility. Both mental health problems and other health issues go untreated.

Limitations

This literature review provides a glimpse into what is occurring nationally for individuals living with SMI. Applying findings to Pennsylvania should be done with consideration of local contexts.

Recommendations

Standard education, attitude-change, skills-building, and behavior-change interventions to prevent HIV must be accompanied by routine human support for people who are SMI such as peer advocates and mental health case managers.

Peer advocates need to be provided ample HIV-prevention materials, guidance, and encouragement as part of interventions designed for people with SMI.

In urban areas, especially, peer advocates and case managers may be more transient, and interventions should take this into consideration so that SMI clients are not without help when their prevention support system is dismantled.

Rapid HIV testing assists in assuring that SMI clients get test results, preferably delivered by a mental health professional to ensure the emotional support particularly needed by this population.

Most effective HIV prevention for individuals with SMI consider the range of barriers confronting this population, e.g., acute health problems, and housing and food needs take precedence over HIV prevention.

Provide solutions to gaps in Medicaid coverage, as during these times individuals with untreated SMI become more susceptible to HIV infection due to the inability to maintain safe behaviors.

2006

Report **Prevention with Positives Needs Assessment (Clients)**

University of Pittsburgh
IRB Number 0212102

Brief Description Eight focus groups were conducted across the state comprising three groups each of MSM and women (including IDUs), and two groups of IDUs (all male). Group members were also individually surveyed with a self-administered questionnaire.

A survey was conducted resulting in 203 respondents living with HIV between the ages of 18-68. African Americans comprised 39% of the sample, whites 55%, Latino 3%, and Native American 3%. Males made up 79% of respondents. Sixty-one percent of respondents identified as gay/lesbian, 28% straight, and 12% bisexual/queer. Thirty-nine percent of respondents had an annual income of $10,000 or less, while 13% had an annual income surpassing $40,000. All other participants had incomes within the $10-40,000 range. Sixty percent received an HIV+ diagnosis in 1995 or earlier.

Relevant findings Denial and apathy about acting to prevent further infection exists, particularly among the newly diagnosed.

Newer treatments may have led to increased risk taking because of improved health.

20 to 40% of HIV-positive individuals-in-care engaged in unprotected intercourse.

> "I am infected and on meds and take care of myself… now if I have sex with someone that's HIV+ and they aren't real sick, I don't think they are going to infect me with anything new. Now if they're very sick, I either wouldn't want to be with them or I'd have safe sex."
>
> – MSM Participant

Sexually transmitted infections occur at higher rates than among the general population. 35% of survey respondents reported STI since testing positive.

55% of survey respondents reported intercourse within the past six months, 67% of whom reported a primary partner and 55% of whom reported casual partner(s).

> "I've had sex since I was positive…I've had unprotected sex but only with men who were also HIV positive."
>
> - MSM Participant

Possible factors associated with high-risk behavior include recent treatment advances, a sense of physical well-being, living with a monogamous or primary partner, substance use prior to sex, having a poor relationship with physician, disclosing status, and prevention burnout.

Survey respondents with primary partners in the past six months reported intercourse without a condom always or most of the time (28%), disclosing status to their partner (95%), and primary partner's status as HIV negative or unknown (74%).

> "My husband is HIV negative, but he only wants to use protection when he is feeling scared at the moment."
>
> – Female participant

Survey respondents with casual partners in the past six months reported intercourse without a condom always or most of the time (33%), disclosing their status sometimes or never (67%), and asking about partner's status sometimes or never (75%).

Doctors, nurses, and other providers in general, do not talk about prevention. Some participants also noted that their providers do not provide condoms.

Survey respondents had visited a medical provider 3 times or more during the year (80%) and reported they were extremely satisfied with their provider (80%).

A small percentage claimed to have never talked with their medical provider about safe sex (17%) or disclosing with partners (38%).

Pre HART/1995 respondents were less likely to have talked with any provider about safe sex.

Lower income African Americans were the most likely to report talking with providers about safe sex.
Focus group participants reported that physicians do not talk to patients about prevention.

Focus group participants reported that CBOs were their primary source of prevention education.

Focus group participants were confused about the difference between prevention and education.

Focus group participants reported that prevention interventions are rarely available.

Focus group participants were knowledgeable about HIV transmission and risk-taking behaviors.

Limitations

These data provide insights into HIV-positive clients' experiences regarding HIV prevention. The findings may be applied to the development of larger quantifiable studies, the prioritization of prevention activities with HIV+ individuals, and the development of behavior change interventions.

Recommendations

HIV+ individuals and service providers be included in all future needs assessment planning. Additional training and resources are needed in medical clinics to provide prevention services.

More research is needed on successful interventions with HIV+ individuals.

Physicians need to be more involved in prevention.

2006

Report **Prevention with Positives Needs Assessment (Providers)**

University of Pittsburgh
IRB Number 0508095

Brief Description During a statewide conference on secondary prevention, self-administered survey questionnaires were conducted with 78 providers, including physicians, nurses, physician assistants, and social workers. Most were from either a community-based social service/health organization or a hospital-based/Ryan White clinic.

Relevant findings The majority of respondents conducted risk assessment interviews with HIV+ clients.

60% of providers did not address preventing the spread of HIV to partners as focus of risk assessment interview.

Skills building topics and activities providers discussed in risk assessment interviews with clients:

- How to use a condom, 64%;
- Condom distribution 64%;
- How to disclose status, 33%;
- How to clean works, 32%;
- Distribution of works cleaning kits, 5%.

Counseling topics providers discussed in interviews with clients:

- Personal barriers to risk reduction, 77%;
- Need for drug and alcohol referral, 52%;
- Committing to a risk reduction plan, 45%;
- Disclosure of status to partners, 41%.

41% said their clinic/agency/practice had a written policy to provide STI/HIV prevention services to the patients/clients.

Most providers said they discussed prevention with their patients/clients, for a few minutes on the average visit, and 71% believed they had enough time to spend on STI/HIV prevention with their patients/clients.

Most respondents conducted risk assessments, mostly through face-to-face interviews, although 1/3 did not assess risk of transmitting HIV to partners.

60% said they had not discussed prevention of transmission to partners with (75-100%) of their patients/clients.

Denial and apathy about acting to prevent further infection exists, particularly among the newly diagnosed.

Newer treatments may have led to increased risk taking because of improved health.

Providers in general do not talk about prevention and do not provide condoms.

Active addiction is a major barrier to prevention.

Many participants perceived that HIV+ patients in rural areas received poor quality of care.

Providers reported the following needs:

- 47% additional training on prevention
- 40% current literature and educational resources
- 28% additional time with patients/clients
- 22% resources for additional STI screening
- 19% more staff for counseling those at high risk
- 17% more staff for assessing risk behavior

Limitations

These data provide insights into providers' experiences with HIV prevention. The findings of this study may be applied to the development of larger quantifiable studies, the prioritization of prevention activities with HIV+ individuals, and the development of behavior change interventions.

Recommendations

HIV+ individuals and service providers be included in all future needs assessment planning.

Train physicians to use a brief research-based intervention proven to be effective during regularly scheduled exams and check-ups.

Recommend physicians be given a referral resource, such as prevention case management, for patients requiring further support.

Recommend that prevention activities be integrated along with ongoing Ryan White funded care services, such as case management, peer intervention, and group services.

2006

Report **Transgender Report**

University of Pittsburgh
IRB Number 0505085

Brief description A review of recent scientific literature and qualitative study was completed. Facilitators and recorders conducted two focus groups in Eastern and Western PA. A total of sixteen transgender/transsexual men and women participated in the focus groups after first answering a short intake form describing themselves. Focus groups were tape recorded.

Eight interviews were conducted within PA with transgender/transsexual women (transwomen) who have sex with men. Interviews were conducted either face to face or over the phone. Participants were located within the South-Eastern and South-Western portions of PA.

Relevant findings Many TG/TS women (i.e. male-to-female [MtF]) are at risk primarily because of risky sex, but the sharing needles in the injection of hormones or intravenous drugs is also seen as a possibility.

Transgender/transsexual people are not homogenous. They are diverse in identity, behaviors, and presentations.

81% of focus group participants reported having had an HIV test. That percentage dropped to 70% when those who identified as gay males were excluded.

Trans Discrimination Many transgender/transsexual people experience multiple forms of discrimination and violence.

Discrimination and oppression of transgender people fosters isolation, reduces self-esteem, and limits access to HIV prevention and health promotion resources.

Many religious institutions do not accept any form of gender nonconformity.

Many transgender people have limited access to employment in the private and public sectors due to the prejudice and discrimination they face.

Lack of economic opportunities will lead transwomen into sex work where more money is available for those who forgo condoms. The sex industry is a major income source for those unable to find jobs and a

	source of pleasure for some related to the thrill and attention they receive. Sex without condoms leads to increased earnings.
	Organizations limit the services that transwomen can get for themselves (e.g., homeless shelters) by having strict gender requirements to access services.
	A lack of knowledge and respect on the part of staff regarding transgender experiences exist at service organizaitons.
	Fear of discrimination and prejudice prevents transwomen from seeking health care and other services.
	Prison places transwomen at risk for sexual assault, and prison staff do nothing to reduce this risk.
	Transgender people have limited opportunities for transgender/transsexual specific HIV prevention programs, literature, and/or prevention programs including those facilitated by peer educators.
Educational Issues	A few of the transwomen interviewed had poor knowledge of HIV/AIDS. They believed that the virus being spread through saliva or describing it as part of a conspiracy was mentioned.
Fear	There is a fear of being seen as having HIV if seen utilizing HIV testing/educational services.
	Those who are HIV positive fear disclosing that fact even to their partners because of the impact that may have on their lives.
Trans Sexuality	People's sexuality goes through changes with transition, and wanting to have sex within one's new gender role. They are willing to take risks because of the fear of losing partners for demanding condoms. They tend to be overly trusting of partners.
Limitations	Focus groups data provide a glimpse into the attitudes, opinions, and lives of participants. When applying these findings to other populations, consider their context and to what extent these data may provide insight.
Recommendations	Gather data on transgender/transsexual men and women, have literature available that is oriented toward transgender/transsexual people, and conduct outreach to transgender/transsexual populations (stated with regard to State funded HIV testing programs).
	Include providing HIV prevention materials in sex work areas.

Make HIV prevention messages/literature and confidential HIV testing and counseling accessible to transgender/transsexual people who are involved in the sex industry.

Develop and implement mobile prevention and education units (strongly recommended).

Keep interventions brief and involve creative incentives to promote participation and follow-up.

Make prevention literature/materials for transgender/transsexual people available that identify risks associated with unprotected sex and sharing needles. These should also identify safe-spaces for transgender people.

Hire transgender/transsexual people to act as peer educators.

Develop and implement more research to investigate the HIV/AIDS issues of transgender/transsexual people. It will be important that research projects utilize HIV testing to gather information about HIV prevalence among transgender/transsexual people in addition to collecting information about their risk factors.

Make forms used by health department staff inclusive of transgender/transsexual individuals thus helping these individuals to identify themselves. It is important to communicate to transgender people that it is safe for them to identify themselves.

2007

Report	**HIV infection among incarcerated men and women**
Key Informant	
Brief description	This study involved a review of the most current literature regarding HIV prevention for incarcerated men and women.
Relevant findings	Incarcerated individuals in Pennsylvania are more likely to be living with HIV than the general population, especially incarcerated individuals of color. Risks for infection exist both within and outside prison/jail settings. Incarcerated women have reported infrequent use of condoms with both long-term and short-term partners and do not express an immediate concern of becoming infected with HIV. Pennsylvania's prison and jail systems do not offer free condoms, with the exception of Philadelphia. Drug use and sexual activity occurs within jails and prisons yet prisoners report that harm reduction would be difficult to implement. Prisons and jail systems limit the HIV prevention and education activities that community agencies could perform with highly vulnerable populations. Prisons and jail systems do not facilitate change in individual risk behaviors. Programs to help reduce the risk of infection exist but are not evenly offered to inmates
Limitations	Literature reviews provide insights from various contexts and can guide inquiry into the lives of local populations.
Recommendations	Programs targeting incarcerated women may be more effective by considering both individual behaviors and the participant's intimate relationships. HIV prevention and education within prison and jail systems is a cost-savings measure. Post incarceration HIV prevention and education could assist individuals and their partners in returning to society.

Corrections staff need greater education and support in order for them to be able to provide HIV prevention/testing resources to incarcerated people.

Project Start and Beyond Fear are HIV prevention interventions that have been successfully implemented for incarcerated or post-incarcerated individuals.

Post incarceration programs may be more feasible for incarcerated individuals.

2007

Report	**Undocumented Persons in the United States**
Key Informant	
Brief description	At the request of the PA CPG, key informant interviews were conducted to identify gaps of information concerning the needs and barriers to HIV prevention among undocumented persons[3] living in Pennsylvania. The data collection process includes literature reviews as well as the identification and construction of a key informant panel throughout Pennsylvania.
Relevant findings	Migrant farm workers often lack basic knowledge about HIV prevention and therefore may have a greater risk once the virus enters their sexual networks. HIV positive undocumented immigrants living in the US are less likely to access care because of their legal status. African immigrants seem to experience HIV stigma to a great degree and report that stigma makes them reticent about obtaining treatment. Language barriers impact the quality of services offered. Program implementers report that even when people take HIV tests, it is often difficult to get them to come back for the results. Stigma of homosexuality in their communities of origin encourages men to not disclose behaviors/identity at home and in the US. Limited resources are available for HIV prevention targeting undocumented persons living in the United States. HIV prevention skills building techniques needed for undocumented persons.
Limitations	This study provides insight into the lives of undocumented persons and their experience of HIV prevention and education. To apply these data to another population, consider the population's context and decide to what degree these data provide insights.
Recommendations	HIV surveillance could benefit from a seroprevalence study among migrant workers.

[3] Undocumented persons include migrant workers, farm workers, and other immigrants who have not obtained legal documentation to reside in the United States.

Develop and implement culturally sensitive HIV/AIDS education interventions regarding transmission of HIV for migrant farm workers.

Develop and implement culturally sensitive HIV/AIDS education interventions aimed at HIV testing--dispelling myths regarding the HIV disease process.

Counsel HIV+ migrant clients about safe sexual practices to help stem the spread of HIV infection.

Develop and implement culturally sensitive interventions (education and outreach interventions) aimed at undocumented MSM.

Provide confidential HIV care and medicine at no cost to migrant program participants.

Develop training for undocumented persons to assist with navigating healthcare systems within the US.

Help clients find culturally competent programs in their communities.

Conclusion

Since the inception of the Community Planning Group (CPG) community needs assessments have been a useful tool in identifying risk behaviors among specific populations, barriers in accessing HIV testing and other related services, and aiding in the prioritization of target populations. Needs assessments have been identified as an important companion to the epidemiologic and counseling and testing data collected by the Dept. of Health. While the Dept of Health data serves the committee by identifying overall trends in HIV prevalence and usage of testing services, needs assessment activities are important in identifying reasons why populations at risk for infections are not using condoms or being tested for HIV.

Over the years, needs assessments conducted by PPP have focused on prevention with positives and populations of HIV-negative men who have sex with men, intravenous drug users, and heterosexual people at high risk of infection. Groups have focused on the experiences of race/ethnic groups, gender (including transgender), age, disability, and factors like HIV status and internet usage. Commonalities between needs assessment studies emerged. Many studies identified the need for greater education, skills training, and condoms. Material that is culturally appropriate for specific groups was also a common outcome. Stigma (HIV, homophobia, racism) have been identified as important factors in HIV prevention.

The needs assessments have been helpful not only in developing the Commonwealth's HIV prevention plan but they have led toward the development of resources to aid support in HIV prevention. With the Department of Health, The Pennsylvania Prevention Project has created capacity building programs to aid agencies in working with diverse communities in a culturally appropriate manner (e.g. working with MSM communities). Programs and intervention utilizing internet based resources arose with the findings that more MSM are using the internet to find sexual partners.

The compendium provides coalitions and community based organizations information that they can use in their activities. Since many CBOs and coalitions do not have the ability to conduct needs assessments, the needs assessment committee can be an important resource for them by conducting needs assessments that they can use to help with their prevention activities. The compendium will be an easily accessed resource to help with their programs.

As we move forward, this compendium will serve as the basis of future needs assessments. This document will allow the Needs Assessment Committee to know who has been the focus of previous activities and what has been previously identified regarding HIV prevention within Pennsylvania. Future activities will include a focus of specific groups under the three main risk categories. The future needs assessments will focus upon those already infected along with an emphasis on testing and accessing care. The role of communities and social relationships will also be an important area of investigation as current literature state these are significant factors in people's behaviors, especially those of men of color who have sex with men.

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