



## PENNSYLVANIA HIV PREVENTION COMMUNITY PLANNING UPDATE

*A quarterly publication of the Pennsylvania Department of Health, Division of HIV/AIDS*

### New Committee Structure

In January 2002 the Committee eliminated existing subcommittees and created four new subcommittees: (1) Needs assessment, (2) Evaluation, (3) Epidemiology, and (4) Interventions. Each subcommittee selects a Chair and Alternate and they are responsible for running meetings and maintaining notes. Subcommittees may recruit appropriate experts (including former members) to fill in gaps of expertise, but such participants would not have voting power. The efforts of subcommittees need to be clearly communicated between each other and share needed information in order to minimize duplication of efforts.

Thus each Subcommittee Chair and Alternate along with the Committee Co-chairs form a Steering Committee. Alternates are encouraged to attend the Steering Committee, but have no vote unless their Chair is absent. Subcommittees meet from 10 AM to Noon and report to the full Committee in the afternoon. The Steering Committee meets at the end of the day to better insure that the individual work of

subcommittees is progressing and specific needs are being met. It was made clear that this was not an Executive Committee and its sole role was to promote and insure communication between subcommittees. Due to their

unique position of knowing the technical assistance needs of the Committee an additional role would be to point out the training or technical assistance needs of the Committee. Health Department staff supports each subcommittee.

### New Committee Members for 2003 Sought

A Membership Work Group has reviewed the needs of the Committee for 2003. There are approximately 40 members on the statewide Committee. In general more representation is needed from the Southwest, South Central and Philadelphia AIDS Consortium (TPAC) Ryan White HIV/AIDS Regional Planning Coalition areas. In particular African-American males, men who have sex with men (MSM) of color, MSM in general, and representation from rural areas is needed.

Those desiring to participate with the Committee can access an application from the <http://www.stophiv.com> web site or by contacting the Co-Chairs (see contact box at the end of this newsletter).

Prospective members would be contacted by the Membership Work Group of the Committee for a brief interview to better insure they understand the work of the Committee as well as the serious commitment to participate fully.

Once members are selected they attend a one-day orientation on Tuesday 14 January and commence the following day with their first full Committee meeting. In addition, each new Committee member is assigned a mentor from the current Committee to assist and facilitate his or her learning curve with the Community HIV prevention planning process.

Future meetings scheduled in 2003:

Tuesday

**14 January**-Orientation for New Members

Wednesday

**15 January**

Wednesday & Thursday

**19-20 March**

Wednesday & Thursday

**21-22 May**

Wednesday & Thursday

**16-17 July**

Wednesday & Thursday

**20-21 August**

Wednesday

**18 September**

Wednesday

**19 November**

Committee meetings are conducted at the:

Best Western Inn & Suites  
Harrisburg/Middletown  
815 Eisenhower Boulevard  
(adjacent to the Harrisburg East  
Interchange 19 of the PA Turnpike)  
717-939-1600.

### **National HIV Prevention Summit 2003**

The Annual Community Planning Leadership Summit for HIV Prevention is scheduled on 12-15 March at the Sheraton New York City.

Health departments, community co-chairs, and community planning leaders involved in this process at the local, state, and national levels will come together for the 11<sup>th</sup> Community Planning Leadership Summit for HIV Prevention.

Although it's the center for the HIV/AIDS epidemic, New York has never been the site for this national conference. The revised community planning guidance will have been issued when the conference convenes in March 2003. The next five-year planning cycle work commences in 2003 and covers the calendar years of 2004 through 2008. Therefore New York was an ideal choice. In addition, the Conference Steering Committee feels it is imperative to convene in New York in the wake of September 11<sup>th</sup>.

The conference will offer 48 workshops as well as institutes and other sessions designed to enhance the HIV prevention planning skills of participants. These sessions will be organized in four tracks: Effective Interventions, Future Trends in Community Planning, Managing the Process and the Steps of Community Planning. Abstracts are available at [www.nmac.org](http://www.nmac.org) and due 11 October.

This annual event is co-sponsored with the Academy for Educational Development (AED), The Centers for Disease Control and Prevention (CDC), National Alliance of State and Territorial AIDS Directors (NASTAD), and the National Minority AIDS Council (NMAC).

In addition, the Summit is presented in partnership with the following national technical assistance organizations: Advocates for Youth (AFY), American Psychological Association's Behavioral and Social Science Volunteer (BSSV) Program, Asian & Pacific Islander American Health Forum (APIAHF), National Association of People with AIDS (NAPWA), National Native American AIDS Prevention Center (NNAAPC), and the United States-Mexico Border Health Association (USMBHA).

### **Pennsylvania Prevention Project Staff**

Mr. Scott Arrowood has joined the Pennsylvania Prevention Project as a research specialist. His primary responsibility is in the research of prevention activities targeting HIV+ individuals: Identifying HIV primary prevention curriculum, models, and other resources relevant to HIV+ individuals and their primary care workers; Assessing the capacity of HIV primary care clinics to implement HIV prevention programs; and developing and disseminating the curriculum statewide. Mr. Arrowood received his Master in Social Work from the University

of Pittsburgh and has over seven years of social work experience in the areas of family and children services; HIV/AIDS service; and HIV prevention. He recently relocated back to Pittsburgh from Philadelphia and is originally from Newport News, VA. He anticipates enrolling in a doctoral program and is interested in sexuality & health, children & youth, and community development & research.

Mrs. Grace Kizzie has joined the Pennsylvania Prevention Project as a research specialist. Her primary responsibility involve managing needs assessments and/or focus groups for African Americans, Hispanics, Injection Drug Users, Men who have Sex with Men, Transgender, Homeless/Severely Mentally Ill & Corrections.

Mrs. Kizzie earned her undergraduate & graduate degrees in Social Work from the University of Pittsburgh. Mrs. Kizzie has over 20 years experience in administration, mental health counseling, community organization, HIV/AIDS and Employee Assistance Programs. She has facilitated educational workshops and seminars in HIV prevention. Mrs. Kizzie maintains a private practice which specialize in the mental health needs of those infected with or affected by HIV/AIDS disease. She anticipates enrolling in a doctoral program and is interested in reducing HIV infections by empowering minority women about responsible health care choices.

### A Snapshot of Pennsylvania

In the 2003 Plan Update recently submitted to the Centers for Disease Control and Prevention a brief picture of Pennsylvania was presented. Pennsylvania has 44,820 square miles with a land/population density of 274 persons per square mile (2000 Census—12,281,084) with a range of 11 persons per square mile in Forrest County to 11,088 in Philadelphia (1,517,506). The next highest density not including Philadelphia is Delaware County with 2,876 persons per square mile.

Pennsylvania's population demographics can fluctuate greatly from region to region. Where feasible this analysis does not include residents of Philadelphia as this Plan Update relates to the remainder of the Commonwealth. There are 10,763,504 persons residing in Pennsylvania outside of Philadelphia of which 4,587,556 (48.5%) are male and 5,538,948 (51.5%) are female.

Outside of Philadelphia, 91% of the population is White, 5.3% Black, 2.5% Hispanic/Latino(a), 1.4% Asian, and .13% American Indian. Further examination of the Hispanic/Latino(a) population indicate that 52% are Puerto Rican, 18% Mexican, 3% Cuban and 37% are classified as other.

Examining Pennsylvania's Asian population 29% Asian Indian, 22% Chinese, 16% Korean, 12% Vietnamese, 7% Filipino and 4% Japanese. Those identifying as Native Hawaiian and other Pacific

Islanders, two-thirds are Guamanian, Chamorro, or Samoan.

The 508,282 persons of foreign birth are from Asia-36%, Europe-35.9%, Latin America-19.6%, and Africa-5%. English only is spoken by 91.6% of the population, Spanish only by 3.1%, and other Indo-European languages by 3.7%. German ancestry accounts for 25.4%, Irish-16.1%, Italian-11.6%, and English-7.9% of the population outside of Philadelphia.

Educational, health and social services account for 21.9% of employment, manufacturing-16%, and retail trade-12.1%. Private wage and salary workers account for 82.4% of the work force and 11.3% are government workers. Civilian veterans, 18 years of age or older, account for 13.7% (1,280,788) of the population.

In 1999 7.8% (250,296) of families were in poverty with 188,366 in families with children under 18 years of age and 88,081 with children under 5 years of age. There were 134,560 families with a female householder and no husband present. Median (50% above & below) household income for Pennsylvania is \$31,044 with a median range of \$21,286 in Forrest County to \$47,728 in Chester County. There was a 4.9% overall increase of Pennsylvania's population from 1990 to 2000 with a range of an 11.2% decrease in Philadelphia to a 61.1% increase in Pike County.

### Priority Interventions

Lisa Manly, the Centers for Disease Control and Prevention Federal Project Office to both Pennsylvania and Philadelphia, attended the July Committee meeting. In addition, Denise Raybon of the Academy for Educational Development provided a half-day technical assistance session on prioritizing HIV prevention interventions. Denise had several conversations and email communication with the Committee Co-Chairs about the needs for this technical assistance as well as personnel at the Pennsylvania Prevention Project (PPP) concerning the history of priority setting with the Committee.

At the end of the session, with Denise's facilitation, the Committee discussed the next steps to setting priority interventions. Two options emerged, one in which the larger Committee would make some determinations and the Interventions Subcommittee would develop the specific details. The second model would have the Interventions Subcommittee develop the process and present to the larger Committee for full approval.

The Committee selected the second model. The entire process would involve the Interventions Subcommittee gathering or accessing data, setting goals, getting feedback from the Needs Assessment Subcommittee, identifying interventions, gathering information from other subcommittees, and an education process throughout the process.

The full Committee would review the proposed model, vote to adopt or not adopt, provide necessary information to the Subcommittee, provide suggestions and/or tweaks, and must trust the work of the Subcommittee. That is, the Committee is not to provide major revisions to the work that they have entrusted to the subcommittee to accomplish.

In addition, the Steering Committee would have to insure information exchange and two-way communication would have to be maintained throughout the process.

### Recent Publications

Two recent peer-reviewed articles based upon some efforts of the Committee have been published:

Silvestre, A.J., Arrowood, S., Ivery J., and Barksdale, S. (2002). HIV-prevention capacity building in gay, racial, and ethnic minority communities in small cities and towns. *Health and Social Work, 27*, 1, 61-66.

Silvestre, A.J., Faber, J.F., Shankle, M.D., and Kopelman, J.P. (2002). A model for involving youth in health planning: HIV prevention in Pennsylvania. *Perspectives on Sexual and Reproductive Health, 34*, 2, 91-97.

### Needs Assessment

Some of the most important findings of our recent assessment are described here. The most profound finding was that IDUs were generally very pessimistic

about their ability to change behaviors that put them at risk of HIV, explaining that their addiction to drugs was “so strong” so that they would continually and indefinitely put themselves at risk of HIV and other related dangers. This negative effect of addiction was perceived to be “less strong” among young IDUs and adult MSM/IDUs. The negative effect of addiction was explained to be most strong among (1) rural IDUs, who described themselves as isolated and with less access to free condoms and free needles; and, (2) women in relationships with male IDUs who controlled drugs, sex, and consequently, prevention materials if they were available at all.

Whether socially open or not open about having sex with men, African-American and Latino MSM felt isolated from larger communities, respective minority communities, and a visible gay community. Both rural and young MSM expressed isolation from an identifiable gay community. Because of the above psychosocial issues, African-American, Latino, rural, and young MSM suggested that most of their peers did not identify as being “gay,” and did not attend gay events/institutions. They also described other peers who were gay-identified, but who did not use these resources. Therefore, the majority of MSM is hard-to-reach and would need to be reached with HIV-prevention services in mainly non-gay identified venues. Another finding concerned an “increasing silence” about HIV/AIDS among MSM and a “retreat from HIV prevention” in communities.

Because of a growing perception that HIV/AIDS is no longer a significant concern and false idea that AIDS is no longer fatal (especially among young MSM), participants reported less information-sharing about HIV among peers. Further, HIV prevention targeted specifically toward MSM is perceived to be waning in communities where it had once existed. For instance, free condoms, which were once easily available in places like gay bars in the 1990s, were no longer as accessible.

Except for Latina heterosexuals who had received little HIV/AIDS information, participants reported having obtained a fair amount of general information about HIV/AIDS through community agencies and services that they had accessed. They felt, however, that this information was not targeted to specific demographic groups (e.g., African-American women or pregnant women); and that clients typically needed to ask for information they received, rather than having had it routinely provided. The majority of heterosexual participants had received HIV counseling and testing; however, a noticeable minority of African-American men and women had not been tested. More intensive types of HIV-prevention interventions, such as targeted, community outreach and attitude-change and skills-building activities, were rarely provided for any of the sub-populations.

Heterosexual participants described a large number of barriers to HIV prevention, including: stigma related to HIV/AIDS (especially

among African-American women and Latinas); lack of provider recognition that clients may have diverse expressions of sexuality (e.g., women who have sex with MSM, bisexuality among women); low self-esteem that interferes with the ability or desire to attend to issues of one's health and risk-reduction activities (among all subpopulations, including African-American men); male-dominated relationships, including sexual relationships, in which women have little voice or control (e.g., women cannot ask their male sexual partners to use condoms without negative and potentially dangerous repercussions); alcohol and drug addiction which interferes with the ability to practice less risky behaviors; physical isolation that makes prevention activities difficult if not impossible to access; and language barriers for Latinas. Condom use ranged from sporadic to non-existent among all subpopulations.

### Young Adult Roundtable Mentors

Young Adult Roundtables began in 1995 with four groups (Allentown, Erie, Pittsburgh, and York). Subsequently the nationally recognized Young Adult Roundtable has been created in nine communities in 2002 (Camp Hill, Erie, Harrisburg, Lehigh Valley, Norristown, Pittsburgh, Reading, Williamsport, and York). This is the eighth year of facilitating the participation of at-risk young people in HIV prevention community planning. Incorporating recommendations

from Roundtable members, from Committee members and from Department of Health staff, the Roundtables change from year to year to accommodate planning needs and project capacities. They continue to struggle finding recruiters and high risk young people (those who engage in high-risk behaviors) for young people living with HIV and young people living in rural settings.

Each group is composed of a select demographic group of young people (gay, African American or Latino, for example) who are at the greatest risk for HIV infection/re-infection. As such, these individuals can convey both a clearer understanding of risk behaviors and the HIV prevention needs of young people. Convenience-sampling methods are used to recruit new project members. Because Roundtable members are not randomly selected from the general population, the opinions and recommendations of Roundtable member are not representative of all high-risk young people. However, the input and ideas of Roundtable members certainly help us to understand more clearly the perceptions of young people at risk of HIV infection/re-infection.

Recruiting efforts were moderately successful in 2002 due largely to the leadership of Roundtable representatives, who, together with local gatekeepers worked hard to identify new members. The goal was to have an average of 15 young people in each group. This year, the Roundtables are composed of 110 young adults, an average of 14 members per group.

Committee members who reside within a community where a Young Adult Roundtable exists volunteer to act as the adult mentor for the group. They attend the meetings to help resolve any logistical concerns with the location and participation as well as provide a link to the HIV prevention community efforts. Many thanks to Committee members Gloria Banks, Anna Claudio, Ronnie Colcher, Sonny Concepcion, Rafael Canizares and Elsa Vasquez who served as mentors in 2002.

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This Newsletter Is Now Available Online At <http://www.stophiv.com>

*[This newsletter is produced at the Graduate School of Public Health, University of Pittsburgh, Pennsylvania Prevention Project for the Pennsylvania Department of Health's Division of HIV/AIDS Pennsylvania HIV Prevention Community Planning Committee. In addition, this quarterly newsletter is intended to keep the traditionally non HIV Prevention community posted of the activities of the Pennsylvania HIV Prevention Community Planning Committee and is distributed by the Division of HIV/AIDS]*