



DATE: August 9, 2010

SUBJECT: Policy Guidance on the Implementation of Evidence-Based HIV Prevention Interventions; Priority populations; and Incentives

TO: All Department of Health HIV Prevention Services Grantees/Contractors

FROM: Joseph M. Pease, Director
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In February 2005, the Department of Health (Department) distributed a memo clarifying our position on the implementation of evidence-based HIV prevention interventions. Evidence-based interventions (EBIs) include, but are not limited to, interventions disseminated by the Diffusion of Effective Behavioral Interventions (DEBI) project. Additional guidance was provided in January 2007.

The purpose of this memo is to update the guidance and in some cases, reinforce and/or clarify previous guidance. Additional guidance is also provided on issues that have arisen as a result of our experience in implementing EBIs.

Previous Guidance:

1. Although the Centers for Disease Control and Prevention (CDC) has limited their funding of HIV Prevention Projects for Community-Based Organizations to only interventions contained in the Procedural Guidance/ *Updated Compendium of Evidence-Based Interventions*, the Department had not placed this limitation on its HIV prevention grantees/contractors (HIV Planning Coalitions, county/municipal health departments, and community-based organizations) or subgrantees/subcontractors.
2. The Department's policy was to incrementally redirect prevention efforts to focus on supporting interventions that can demonstrate effectiveness and that are appropriate for the respective target populations and the grantee's/contractors' capacity to conduct them. It is intended that this policy be consistently applied to all contractors and their subcontractors and consistently applied to both state (656) and federal (299) funding sources. The Department believes that a consistent policy is necessary to develop and maintain cohesive and comprehensive HIV prevention services.
3. This redirection required a gradual transition in the services that we fund. We understand that agencies must first receive training on these new interventions. The Department will continue to request training on the additional interventions available through the DEBI Project.

Updated Guidance:

Target Populations:

The following guidance is effective immediately for all future grants/contracts and subgrants/subcontracts.

The following recommendations from previous guidance regarding target populations are repeated again for emphasis:

1. Target populations must be identified by a risk factor. To state that you are targeting racial/ethnic minorities or youth is insufficient. Effective targeting and the matching of interventions require that you identify the risk behaviors (MSM, IDU, high-risk heterosexual). Acceptable target populations for HIV prevention are identified in the 2010 Pennsylvania Community HIV Prevention Plan Update.
2. Prioritization of target populations must be evidence-based (determined by local HIV/AIDS epidemiologic data).

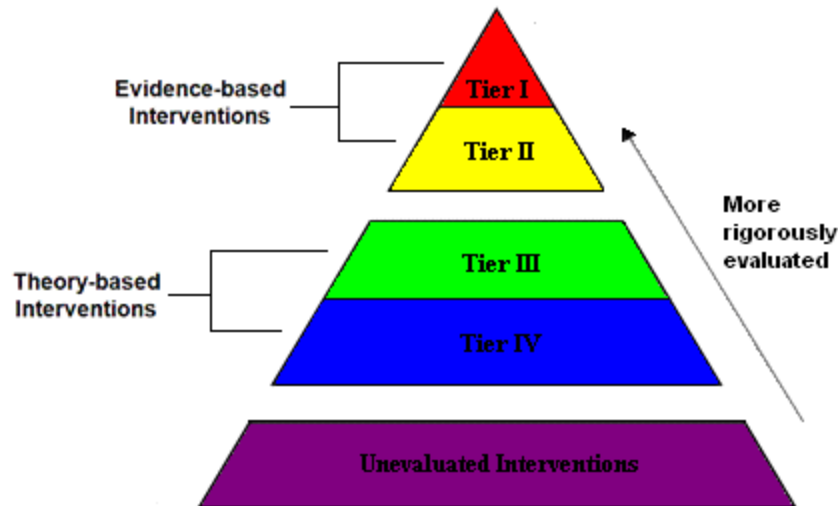
Although not explicitly stated in the previous guidance - *HIV positive individuals remain the number one priority population for HIV prevention services*. Prevention interventions for persons living with HIV/AIDS shall be prioritized for funding by the Department and its grantees/contractors.

Evidence Based Interventions:

The following guidance is effective immediately for all future grants/contracts and subgrants/subcontracts.

1. All interventions supported by Department funding (federal and state) shall be limited to EBIs.

As noted in the 2010 Pennsylvania Community HIV Prevention Plan Update: the Centers for Disease Control and Prevention (CDC) has developed a tiered-framework for classifying HIV behavioral interventions based on their level of scientific evidence in reducing HIV risk. The framework identifies those interventions with the greatest chances of working in practice. The interventions with the strongest evidence are highlighted in the *Updated Compendium of Evidence-Based Interventions*.



The DEBI Project focuses on identifying, packaging, and disseminating Tier I (best-evidence) and Tier II (promising-evidence) interventions. The Department shall limit funding to *any evidence-based intervention* within Tier I and Tier II interventions. Any exemptions to this requirement must be approved in writing by the Department’s Project Officer before implementation.

2. The following recommendations from previous guidance remain pertinent in regards to implementing EBIs:
 - a. Go through a careful process of selecting the EBI that most meets/matches the capacity of your staff and agency, and which also addresses similar HIV risk determinants of the target population.
 - b. After selection of an EBI, agencies should undergo a careful and thoughtful process of adapting the EBI to their resources and risk population.
 - c. Adhere to the principles of fidelity and adaptation.
 - i. **Fidelity** is conducting an intervention by exactly following the core elements, procedures, and content that determined its effectiveness.
 - ii. **Adaptation** is the change(s) to the *who (target population) and where* in the original intervention.
 - d. The *core elements* are those aspects of the intervention that the researchers believed made the difference within the target populations. Therefore, in order to assert that the intervention is effective, it is imperative that core elements not be altered. When the core elements of an intervention are dropped or added, reinvention has occurred.
 - e. An agency should feel encouraged to adapt an intervention to reach populations, settings and risk behaviors for which there is not an appropriate EBI/DEBI to fill in the gap. However, the adaptation process needs to be evidence-based, that is, based on real information collected by the agency to help in the adaptation process.
 - f. We suggest conducting an evidence-based adaptation rather than opinion-based adaptation. The distinction is that the agency needs to conduct focus groups with

- their target population on the intervention activities and processes to see if the target population will participate and to seek suggestions for adaptation.
- g. The agency will need to pilot some of the intervention activities to see how they might be adapted to better reach the target population. This careful and thoughtful process is informed by data and is far superior to those adaptations made without listening to the target population because those making the adaptations assume they know everything there is to know about the population they serve.
 - h. Adaptation issues should be taken on a case by case basis and a dialogue must occur between the funding agency and the grantee/contractor. The agency must document: 1) the adaptation and the justifications for the adaptation; and 2) the evidence-based process of adaptation that was conducted (including focus groups and piloting of activities).

Incentives:

The following guidance is effective immediately for all grants/contracts and subgrants/subcontracts.

As demonstrated locally and nationally with counseling and testing efforts and EBI interventions, incentives are a crucial component of client recruitment and retention.

State and federal funds may be used for incentives only with prior written approval from your Department Project Officer. If the incentives are documented in detail in the agency's funding application work statement and budget, approval of the application (through a signed grant agreement/contract) will constitute written approval of the incentive(s). The use of incentives not explicitly detailed in the agency's funding application/grant agreement shall require the submission of a written request to the Department Project Officer for review and written approval. (This approval process may require a budget revision or amendment to the grant agreement.)

Grantees/contractors shall document a written incentive approval process for their subgrantees/subcontractors.

Use of incentives:

1. Incentives may be provided on a one-time or periodic basis to encourage individuals to participate in prevention activities/interventions (counseling and testing and health education/risk reduction interventions); to encourage them to return for test results or return for multi-session interventions.
2. Incentives are also important for retaining the assistance of peer volunteers and for HIV prevention planning needs assessment activities among target populations (focus groups, interviews and surveys).
3. The use of incentives must be carefully considered because of the possibility that they may be, or are viewed as, coercive.

4. The message that we relay to clients in using incentives is that we are thanking them for coming back for their test results and their time. We need to relay the message that we are not buying anyone.
5. Agencies shall develop protocols that indicate:
 - a. Whether or not incentives will be used, and if so, what they will be, and how they will be obtained, when and under what conditions they will be provided.
 - b. The method for tracking disbursement of incentives and security/accountability assurances.
6. The use of state or federal funds to purchase alcohol is prohibited.
7. The use of incentives that violate state or federal law is prohibited.
8. Although cash incentives are not recommended, the Department recognizes that monetary incentives may be useful or necessary in maintaining peer volunteers, volunteer HIV prevention community planning committee members, and for conducting HIV prevention community planning needs assessment activities. Direct cash payments to recipients of services are prohibited.
9. Examples of acceptable incentives may include, but are not limited to: gift cards; bus tokens; certificates of appreciation; food and refreshments; clothing; and small gifts such as hygiene kits and toiletries. To be an effective incentive, it must be of value to the target population. This value is dependent upon the needs and circumstances of the target population.

The use of incentives by grantees/contractors is bound by all the terms of their agreement with the Department, which may be both, state and federal, as applicable.

Technical Assistance/Capacity Building:

The process of selecting, adapting and successfully implementing DEBIs/EBIs is dependent upon the service provider possessing an extensive knowledge of the complexities and scientific requirements of the specific behavioral intervention (prior to requesting funding). In addition to the training of facilitators' (TOF) course specific to each DEBI, please consider that some basic courses such as Group Facilitation, HIV/AIDS 101, DEBI Overviews, Implementation Basics, Adaptation, and Cultural Competency are also a critical foundation for the successful implementation of any intervention.

As the Department transitions the state-funded HE/RR providers (Consortia and their sub-grantees/sub-contractors) to the Program Evaluation and Monitoring System (PEMS), this training/technical assistance will also be made available.

The Department's RFA process for prevention funding to the CMHDs required attendance of a DEBI TOF as a prerequisite for funding. However, the ability to absorb this up-front cost may not be feasible for many community-based organizations. Funding application budgets should include the travel and lodging expenses needed to attend the required training and the costs of the implementation kit. Training shall be completed prior to implementation of the intervention.

The Department is committed to providing service providers with the necessary knowledge-base to facilitate the successful implementation of DEBIs/EBIs. Please direct all requests for technical assistance/capacity building assistance to the Division of HIV/AIDS Training Coordinator, Julia Montgomery. She can provide you with information on currently scheduled events, available topics and the process and requirements for requesting on-site technical assistance. She can be reached by calling 717-783-0572 or at jmontgomer@state.pa.us.

Please understand that if we can not directly meet your technical assistance/capacity building needs, we have the ability to request technical assistance thru the CDC. Please do not hesitate to ask for assistance.

Thank you for supporting the changes we are making in Pennsylvania's HIV prevention system. If you have questions regarding this guidance please direct them to your Project Officer.