



# Reaching Florida's Communities: Guidelines for Traditional and Internet-based HIV Prevention Outreach



Prevention  
Program

FLORIDA DEPARTMENT OF HEALTH  
DIVISION OF DISEASE CONTROL - BUREAU OF HIV/AIDS





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## Section 1: Background

### 1.1 Introduction

For the purposes of this document, outreach is defined as **an HIV prevention intervention designed to meet potential clients in their own communities and in settings where they live, work, and socialize in order to link them to prevention, testing, and treatment services**. Outreach activities are highly adaptable and can be designed to meet a variety of prevention objectives. Outreach can be conducted as a stand-alone program, with measurable objectives and goals, or can be used as a complementary activity with other interventions (e.g., Community PROMISE, Mpowerment, Social Networking Strategy, HIV testing). Frequently, outreach includes the distribution of materials in addition to more interactive activities; however, the distribution of materials alone is NOT considered outreach. In order to be considered an outreach intervention, staff must have some form of interaction (e.g., brief conversation, provide information and potentially probe for questions) with the outreach contact.

The primary goal of outreach is to proactively initiate contact with high-risk target populations that are in need of HIV prevention interventions or treatment in order to provide them with health information and increase their awareness of the availability of HIV services within their community. One objective of outreach is to encourage high-risk individuals to learn their HIV status through testing and to provide information and assistance in accessing prevention services (National HIV Prevention Program Monitoring and Evaluation Guidance, 2009).

Florida continues to be heavily impacted by HIV and AIDS. The population has grown to almost 19 million; despite a recent slow down, we expect growth to continue as the economic recovery continues. The Florida Department of Health (DOH) estimates that approximately 135,000 persons, or roughly 11.7% of the national total, are currently living with HIV infection in Florida as of the end of 2010; and about 20% don't know they are infected. Our incidence data indicate that about 15 people become infected with HIV every day in Florida. Florida ranked first among states in the number of HIV cases *reported* in 2009. That year, a total of 5,755 (13% of total US) HIV cases were *reported* in Florida, followed by 4,886 (11%) in California and 4,291 (10%) in New York. In 2010, eight counties in Florida reported 100 or more cases; the eight counties are Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach, Pinellas, and Polk. They reported a combined total of 3,889 cases, or 75% of Florida's total reported cases in 2010 (N=5,211). The greatest number of HIV cases were reported from Miami-Dade (N=1,242),

Broward (N=882), and Orange (N=485). These three counties reported a combined total of 2,609 cases in 2010, or 50% of the statewide total. As statistics and characteristics of disease change over time, so too do the populations that are hardest hit by diseases and other health disparities.

Florida's HIV prevention program is comprehensive and grounded in several evidence-based models. In previous years, outreach became an activity that everyone did, but was not at the forefront of prevention programming and not recognized as an acceptable or "evidence-based" intervention. Outreach has been and continues to be an effective strategy in reaching large numbers of individuals within high-risk populations that other interventions have failed to reach. With clear guidance, protocols, and measurable outcomes, we feel that outreach can be another valuable component of Florida's robust and comprehensive HIV prevention program. We hope this document can provide the necessary guidance for agencies wishing to conduct outreach as an HIV prevention strategy

### **1.2 Florida's Traditional & Internet-based Outreach Activities: Phase 1 Survey Report**

The purpose of this survey was to get an inventory of 1) Internet-based and 2) traditional HIV prevention activities (e.g., outreach, interventions) being conducted by HIV prevention staff throughout Florida. The survey was conducted using Survey Monkey, and respondents were able to provide feedback from November 17, 2009 to December 17, 2009. In total, there were 71 respondents, representing both county health departments (CHDs) and community-based organizations (CBOs) from the following counties: Alachua, Baker, Bay, Brevard, Broward, Charlotte, Clay, Collier, Columbia, Desoto, Duval, Escambia, Gadsden, Glades, Hardee, Hendry, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Leon, Manatee, Miami-Dade, Monroe, Okaloosa, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Santa Rosa, Sarasota, Seminole, St. Johns, St. Lucie, and Volusia.

#### Phase 1 Survey Results Overview (see **Appendix A** for charts and graphs)

- There were a total of 71 respondents to the survey.
- The service areas of the agencies vary across the state.
- The most commonly targeted population is black/African-American persons, followed by Hispanic persons.
- Based on the following indicators, we can assume that respondents took the survey seriously:
  - Relative stability in skip patterns
  - High participation rate in open-ended questions
  - Number of responses to optional questions (i.e., additional comments)

#### Phase 1 Survey Results Overview: *Internet HIV Prevention Activities (Part A)*

- There were a total of 66 respondents to this section of the survey.
- More than half of respondents indicate they are using the Internet for HIV prevention activities.
- The amount of experience varies significantly among respondents.
- The number one use of the Internet is disseminating educational information, followed by program advertising/marketing, recruitment, and Internet outreach.
- Very little use of Health Education/Risk Reduction (HERR)/chat. If we use content from this survey in future instruments, it may be helpful to list examples/options for HERR/chat to better differentiate.

- The target populations for each Internet activity vary by agency.
- Most agencies use their own website, though Facebook and MySpace are also notable.
- Most agencies provide agency information, general HIV/AIDS info, and testing/event information.
- There's a broad range of experience (in number of years) with Internet-based prevention.
- A total of 39 respondents provided contact information for follow up.

### Phase 1 Survey Results Overview: *HIV Prevention Outreach Activities (Part B)*

- There were a total of 71 respondents to this section of the survey.
- More than half of respondents indicate they are doing traditional HIV prevention outreach activities in their service areas.
- More than 92% have five or more years of experience.
- HIV/AIDS presentations, Counseling/Testing/Linkage, and other education are the most common purposes of outreach activities.
- Some agencies also use traditional outreach for recruitment and mobilization.
- The two most common outreach settings are health fairs and public locations, respectively.
- A large number of agencies also reported facilitating HIV prevention in correctional settings and at special events.
- Fifteen respondents reported that outreach is conducted in settings that were not listed as options.
- Definitions, examples of outreach, and examples of non-outreach activities varied significantly.
- A total of 50 respondents provided contact information for follow-up.

Note: All charts and graphs related to the Phase 1 Survey Report are located in **Appendix A**.

## **Section 2: General Principles of Outreach**

### **2.1 Recommended Core Elements**

In reference to HIV/AIDS/STDs, outreach should include the following core elements:

- Clearly define the population to be served by gender, sexual orientation, age, race/ethnicity, geographic location, and risk behaviors.
- Be conducted where the population is, face-to-face or via the Internet or other means of virtual communication, with individuals or groups at risk for HIV and other STDs.
- Develop and deliver health messages, materials, education, risk reduction counseling, HIV testing (when appropriate), and referrals to testing, treatment, case management, and/or other social services.
- Ensure all educational materials and messages are culturally competent, language/age appropriate, and relevant for the target population being served.
- Identify appropriate methods and strategies to achieve specific objectives and reach the target population.
- Include procedures for providing referrals and tracking clients (when applicable) to appropriate services inside and outside of the agency.

## **2.2 Goals and Objectives**

The primary goal of outreach is to proactively initiate contact with high-risk target populations that are in need of HIV prevention interventions or treatment in order to provide them with health information and increase their awareness of the availability of HIV services within their community. One of the major purposes of outreach is to encourage high-risk individuals to learn their HIV status through testing and to provide information and assistance in accessing prevention services (NHM&EG, 2009).

Some objectives of outreach may be to:

- Increase knowledge and awareness about HIV/AIDS and other STDs
- Dispel myths about HIV/STDs
- Increase knowledge about safer sex practices
- Promote sexual risk reduction techniques and safer sex options such as, condom use, mutual monogamy, and abstinence
- Encourage risk reduction techniques for individuals that use injection drugs
- Create open discussion about sexual health and sexuality
- Reach the community where they are and at times that are convenient to them
- Provide referrals for HIV, STD, and Hepatitis A, B, and C testing
- Provide opportunities for HIV testing and education
- Provide referrals to HIV prevention and other social services
- Recruit individuals into additional HIV prevention interventions

## **2.3 Client Focused**

Counseling should be conducted in an interactive manner, responsive to the individual patient's needs and requiring an understanding of the unique circumstances of the patient including behaviors, culture, knowledge, and social and economic status (CDC Guidelines for Health Education and Risk Reduction Activities, April 1995). Staff conducting outreach are not expected to, nor should they be striving to, change peoples' behaviors when in the field. Staff must accept clients where they are at present, in terms of their specific behaviors, and provide appropriate information and support without judgment or criticism.

## **2.4 Cultural and Linguistic Competency**

Florida's population of almost 19 million people is incredibly varied and diverse. As of 2010, Florida's population was about 60% white, 16% black or African American, 21% Hispanic or Latino, and 3% other (which includes Asian/Pacific Islanders, American Indians, Alaskan Natives, and multiracial). Within all of these cultural and ethnic groups, there are many subcultures. Florida is a cultural melting pot which includes groups such as: African Americans; Haitians; Caribbean Americans (from Jamaica, Cuba, Dominican Republic, Trinidad, Puerto Rico, Bahamas); Hispanics/Latinos from Mexico, South America, Central America and Caribbean nations; Native Americans; Asians; Eastern Europeans; and many other diverse peoples from different ethnic backgrounds.

Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, socio-economics, sexual orientations, and other diversity factors in a manner that recognizes, affirms, protects, and preserves the dignity of each (NASW, 2001).

In a state where so many cultures intermingle, it is important to remember the importance of cultural and linguistic competency. Culture plays a large role in defining the way people receive

and respond to health information, as well as subsequent health behaviors and outcomes. Culture also defines what is considered to be a health problem; how symptoms and concerns about the problem are expressed; when and what type of treatment should be given; who should provide the treatment; and who will incur the cost of treatment. Because health care is largely a cultural construct which arises from beliefs about the nature of disease and the human body, cultural issues are crucial in the delivery of health services and preventive interventions.

Cultural competence refers to an ability to interact with people of different cultures. Cultural competence comprises four components (Cross, Bazron, Dennis, & Isaacs, 1989):

- 1) Awareness of ones' own cultural worldview
- 2) Attitude towards cultural differences
- 3) Knowledge of different cultural practices and worldviews
- 4) Cross-cultural skills

Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures (Martin & Vaughn, 2007). Cultural competence requires that individuals and programs value diversity; have the capacity for cultural self-assessment; be conscious of dynamics when cultures interact; institutionalize cultural knowledge; and develop cultural adaptations for service delivery when appropriate (Cross, Bazron, Dennis, & Isaacs, 1989).

To make outreach successful, outreach workers should have a thorough understanding of the community within which prevention activities take place. It is important to not only understand the beliefs, attitudes, behaviors, norms, and values of a population, but also be able to understand and convey information in their "language" (National Guidelines for Internet-based STD/HIV Prevention-Outreach, March 2008). Outreach workers are expected to be skilled at providing health education messages to their specific target populations in a culturally competent manner. It is necessary for all staff conducting outreach to possess specific knowledge about the population they are serving, including the range of historical experiences, individual and group oppression, socioeconomic backgrounds, learning styles, worldviews and specific cultural practices, their definition of and beliefs about the causation of wellness and illness or normality and abnormality, and how care and service should be delivered (Adapted from NASW, 2001). If staff are working with a population that speaks a language different from their own, we recommend either using an interpreter or pairing up with another staff that speaks the language.

The Bureau of HIV/AIDS strongly recommends that all outreach staffs participate in cultural competency trainings that are specific to the population that is targeted. Quality assurance measures should be implemented to periodically assess outreach staffs' level of cultural competency. This will keep staff up to date and allow managers and supervisors to determine when training updates are necessary.

#### **2.4.1 Internet Culture**

Online communities, similar to offline communities, will each have their own cultural and linguistic identities. Online communities often have their own unique language, filled with acronyms, emoticons, and abbreviations (National Guidelines for Internet-based STD/HIV Prevention- Outreach, March 2008). Even within the Internet, there are a multitude of different cultures and languages. For example, a social networking site targeting young gay men will have a different culture and language than a social networking site for seniors.

Online outreach workers must understand the culture and language of an online community before engaging in any outreach activities.

As with traditional outreach, it may be necessary for staff to conduct a community assessment or spend time on websites that are popular with the target population to better understand the online community with which they are attempting to work. Staff conducting outreach online should possess a comfort level with communication that may be sexually explicit or conform to community standards that could be in conflict with the personal ethics or values of the outreach worker (National Guidelines for Internet-based STD/HIV Prevention-Outreach, March 2008).

Note: For Internet and Cell Phone-based Terminology, Acronyms, and Slang, please see the AIDS Committee of London's Sexual Health Educator Internet Resource (SHEIR) document at the following link, [http://www.aidslondon.com/sites/default/files/PDFs/GMHS-SHEIR-OnlineGuide-ENG-FNL\\_web.pdf](http://www.aidslondon.com/sites/default/files/PDFs/GMHS-SHEIR-OnlineGuide-ENG-FNL_web.pdf)

## **2.5 Ethics and Safety**

Outreach is conducted in settings that are unique and always changing. Outreach can sometimes present certain risks for a worker's health and safety. The following guidelines should be adhered to when conducting outreach:

### **DOs:**

- Notify your immediate supervisor of where you are going and what areas you plan to cover.
- Always be aware of your environment.
- Abide by your agency's standards and policies.
- Dress "down"; wear comfortable clothes and shoes. Do not overdress.
- Be aware of gang areas and gang colors. Avoid wearing known gang colors in areas with high gang activity.
- Carry identification with you at all times; however, be mindful of how you display your identification. Sometimes wearing your badge around your neck makes you look too "official" and some individuals will hesitate to speak with you.
- Inform collaborating agencies of your presence.
- Inform local law enforcement of your presence; establish contacts with police precincts in all areas where you plan to conduct outreach.
- Introduce yourself and inform people of what you are doing and why.
- Behave respectfully to addicts, dealers, pimps, sex workers, and all other clients in order to win personal trust and confidence.
- Develop a contingency plan for worst-case scenarios or dangerous situations with your partner and supervisor.
- Keep your supervisor informed of any unusual developments.
- In case of emergency, call or have another person call 911. Do not separate from your partner unless you feel that staying would increase your danger.
- Maintain confidentiality with all clients you meet.
- Dispel myths and misconceptions about HIV/AIDS, drug abuse, and other social issues.
- Distribute literature that is culturally appropriate.
- Have good listening skills; hear people out.
- Be prepared to direct clients to social services.

- Tell clients when you will be back and where you can be reached; provide a hotline or work number.
- Be aware of weather conditions and plan accordingly.
- Design and adhere to a schedule.

### **DON'Ts:**

- Do not carry valuables or other personal possessions such as jewelry, large amounts of money, radios, laptops, etc. If carrying incentives, make arrangements to hold these in a secure place.
- Do not be critical of your partner in public while conducting outreach; always present yourselves as a team.
- Do not approach people who are giving “signs” or have said they do not want to be bothered.
- Do not remain in a spot where you are privy to a drug deal in process; leave the area immediately without drawing attention to yourself or others.
- Do not interrupt the sale of sex or drugs for money; leave the area immediately without drawing attention to yourself or others.
- Do not counsel or play the role of a social worker on the streets.
- Do not accept gifts, food, or buy any merchandise from clients.
- Do not give or lend money to clients.
- Do not accept or hold any type of controlled substance.
- Never enter any clients’ cars, homes, or any enclosed area.
- Do not pretend to be someone you are not; be honest about your role as an outreach worker.
- Do not come on too strong, pressure clients to change behavior, and/or accept materials.
- Do not play doctor/clinician and try to diagnose infections, any ailment, or mental health issue.
- Do not make promises that you cannot deliver.

Some ethical issues to consider while conducting outreach, both offline and online, are:

- Staff should never use a relationship formed while conducting outreach to pursue any personal, sexual, or illegal activities.
- Staff should never misrepresent themselves or mislead clients; if you are not a doctor/clinician, then do not give out medical or psychological advice. Staff should always identify themselves and their role while conducting outreach. Staff that fail to identify themselves may be accused of lurking, spying, or possibly entrapment, especially when working in online environments. In cases where “characters” are created within certain interventions to deliver health information online, the identity of the individual is kept hidden deliberately. Programs that use “characters,” such as in role model stories, are able to deliver health messaging that may otherwise be less effective if delivered by an outreach worker affiliated with a community-based organization or health department.
- Staff should also be aware and cautious of how much personal information they are disclosing to clients while conducting outreach. Personal information should never be disclosed to outreach clients. This includes personal phone number, home address, Internet screen name, personal email address, or web addresses of personal profiles.

- Staff should be aware of boundaries and know when to disengage a client that may be acting inappropriately (i.e., sexually aggressive, verbally or physically abusive). Any threats of violence must be taken seriously and addressed immediately. If working offline, remove yourself from the location, find a safe space, and notify your supervisor. If online, print out the conversations, notify your supervisor, and contact law enforcement if you think the client knows your location.

## 2.6 Confidentiality and Privacy

Concern over confidentiality is often stated as a barrier to HIV testing, referrals, education, and other social service provisions. In a 2008 study (Ford, Tilson, Smurzynski, Leone, and Miller) of barriers to HIV testing and service provisions, confidentiality concerns were the most salient for most of the groups interviewed. Maintaining confidentiality while conducting outreach (both offline and online) is of critical importance. All staff conducting outreach are expected to adhere to their agency policies regarding confidentiality, as well as the Health Insurance Portability and Accountability Act (HIPAA). For example, if outreach staff are conducting HIV testing while out in the community, they must adhere to their agency's protocols concerning safekeeping of test forms and specimens.

Confidentiality is just as important when working in online communities to conduct outreach. Agencies that conduct Internet outreach should have policies in place that specifically cover Internet-related and electronic client-identifying information. The confidentiality agreement should not only cover the outreach staff, but also include the organization's Internet Technology (IT) staff and any staff that may view or have access to sensitive information (National Guidelines for Internet-based STD/HIV Prevention-Outreach, March 2008).

Florida also has specific laws concerning communications between state/county employees and the public. The "Sunshine" Law reads:

*F.S. 119.01 General state policy on public records-*

*(1) It is the policy of this state that all state, county, and municipal records are open for personal inspection and copying by any person. Providing access to public records is a duty of each agency.*

*(f) Each agency that maintains a public record in an electronic recordkeeping system shall provide to any person, pursuant to this chapter, a copy of any public record in that system which is not exempted by law from public disclosure. An agency must provide a copy of the record in the medium requested if the agency maintains the record in that medium, and the agency may charge a fee in accordance with this chapter. For the purpose of satisfying a public records request, the fee to be charged by an agency if it elects to provide a copy of a public record in a medium not routinely used by the agency, or if it elects to compile information not routinely developed or maintained by the agency or that requires a substantial amount of manipulation or programming, must be in accordance with s. 119.07(4)*

*(3) If public funds are expended by an agency in payment of dues or membership contributions for any person, corporation, foundation, trust, association, group, or other organization, all the financial, business, and membership records of that person, corporation, foundation, trust, association, group, or other organization which pertain to the public agency are public records and subject to the provisions of s. 119.07.*

*Florida Statute, Chapter 119.01*

County health department staff and state health agency staff conducting outreach on the Internet or via text messaging, must make all communications had with clients in the field available for review if requested. The Department recommends that all online/virtual

communications (e.g., chatting, instant messaging, emails, text messages, etc.) be printed out and placed in a secure location. Printed documents containing screen names, email addresses, HIV status, and any other personal or health information are considered highly confidential and must be treated as such. Documents such as logs, transcripts, or online reports that contain screen names and/or email addresses are also considered confidential. All confidential records, communication logs, and any other identifying information must be stored in a locked filing cabinet, within a room that has a locking door.

State/county/municipal staff conducting outreach online may need to use a different computer that is not connected with the Department's network. Staff may choose to work on their personal computers or a Department-issued laptop that is not connected to the Department's network in any way. By using equipment that is not connected to the Department's network, we are ensuring safety from viruses, spam emails, and any other files/websites that may corrupt the statewide network.

Staff conducting outreach on the Internet that are not affiliated with a state/county/municipal agency (i.e., community-based organizations) may not be held to the same standards (i.e., The Sunshine Law), but are still advised to print and keep all communications had between outreach staff and clients in online/virtual communities.

Outreach staff should never share any information about one cyber client to anyone else, whether online or offline. For email groups and ListServes, it is recommended that member email addresses not be shared with any other members (National Guidelines for Internet-based STD/HIV Prevention- Outreach, March 2008).

## **2.7 Training**

Training is essential to ensure staffs have the necessary skill sets to perform the most effective outreach possible. Even the most experienced outreach worker can benefit from additional trainings in areas that may not be his/her strongest skill. Training standards for all outreach staff must be set in place and staff should be updated on a regular basis (e.g., annually or quarterly). Certain trainings will need to be mandatory for all agency staff, with additional trainings required for all staff conducting outreach activities (including peers and volunteers). Trainings can and should be both didactic and interactive, making sure to include role-playing activities to practice handling certain situations that outreach workers may experience while out in the field. Some suggested trainings and topics that all outreach staff should take part in include but are not limited to:

- Basic HIV/AIDS Education (or HIV 101)
- HIV 500/501
- Cultural Competency
- Health Education/Risk Reduction topics from CDC
- Outreach & Recruitment protocol found within the CDC Procedural Guidance document
- Communication skills training (to identify different communication styles and learn how to better interact with individuals with communication styles different from your own)
- How to Read Body Language
- Outreach, Recruitment, and Retention
- Crisis Intervention
- Prevention Case Management
- For staff conducting outreach via the Internet- training on working within online communities, basic Internet etiquette, and safety

- How to handle potential threats and basic safety
- How to deal with law enforcement
- How to handle offers of drugs or sex

An initial assessment of all outreach staff will assist in determining the current skills each worker possesses. From there, it is up to supervisors and program managers to make the determination about what additional trainings each worker must attend and how often they should be updated.

## 2.8 Staffing

In order to conduct outreach as effectively as possible, decisions related to staffing outreach positions must be well thought out. Not everyone has the necessary skills to conduct outreach, either in-person or via a virtual method, such as the Internet or text messaging. In addition to being knowledgeable about HIV/AIDS and STDs, potential outreach staff should: be familiar with the target population and area; have a working knowledge of HIV/AIDS and STDs; be familiar with common language and terminology used in the target population; and be familiar with factors that make the population vulnerable to HIV and/or STDs.

### 2.8.1 Technical Skills & Characteristics of Effective Outreach Staff

#### Technical Skills

Skills to look for when choosing staff to conduct outreach should include:

- Speak the same “language” as the community or group; understand terminology used by target population; if conducting outreach via the Internet or cell phone, staff should be familiar with chat room and/or text messaging language and abbreviations
- Knowledge of HIV/AIDS, STDs, hepatitis
- Familiarity with the population’s cultural nuances
- Knowledge of the area and surroundings
- Good active listening skills
- Ability to establish trust and rapport with the community
- Organizational skills
- Knowledge of local social service agencies and contacts
- Ability to network with different groups
- Ability to maintain and recognize appropriate personal boundaries
- If conducting outreach via the Internet and/or cell phone, staff should be knowledgeable about using the Internet and/or text messaging

#### Characteristics

Personal characteristics can be just as important as skill sets when it comes to choosing appropriate outreach staff. In 2000, the National Institute on Drug Abuse (NIDA) published the *NIDA Community-Based Outreach Model* and included several desirable personal characteristics for effective outreach staff. They are:

- **Empathy-** Understanding what another person is experiencing and communicating that understanding.

- **Respect-** Showing appreciation for the dignity and worth of others and accepting the fact that individuals have a right to make their own decisions and manage their own lives.
- **Genuineness-** Being oneself without pretense, role-playing, or defensiveness.
- **Concreteness-** Specific communications that relate to the what, why, when, where, and how of something. Concreteness keeps the participant from avoiding or escaping the issues at hand.
- **Self-Disclosure-** Revealing one's personal feelings, attitudes, opinions, and experiences; sharing about yourself when showing support.
- **Immediacy-** Dealing with the feelings between the participant and the community-based outreach worker in the present.
- **Charisma-** The dynamic force and magnetic quality of community-based outreach workers who are in command of themselves and able to communicate their competence and trustworthiness; this characteristic could also be conveyed as self-confidence.
- **Commitment-** A personal acceptance of responsibility to one's community and to working to produce changes and improvements in the lives of community members.
- **Discipline-** The ability to adhere to guidelines or a program.
- **Conviction-** Knowing one's purpose and the correctness of one's efforts despite opposition or attempted manipulation.

In addition to the personal characteristics listed above, other characteristics of effective outreach staff can include:

- Non-judgment regarding community norms, values, and beliefs
- Shared identity with the target population
- Similar age as the target population or group
- Open-mind and willingness to learn about cultures different from their own

### 2.8.2 Working in Teams

When conducting outreach, it is always important to work in pairs or teams. Staff should *never* conduct outreach alone unless they have received prior approval from a supervisor. It is ideal if staffs are reflective of the racial, ethnic, and linguistic make-up of the target population, but it is not essential. When putting together your outreach team, consider the target population you will be trying to reach. For example, if you are conducting street outreach to Hispanic migrant/rural female sex workers, then you might decide to have a team of all females so the sex workers feel more comfortable speaking with you. On the other hand, if you are a group of only-female staff, you might decide to bring one male outreach worker along if you are going into an especially rough neighborhood in the middle of the night and feel threatened by other males that may be in the area.

### 2.8.3 Hours of Operation

When it comes to conducting outreach, non-traditional hours are essential. Because conducting outreach means reaching people where they are, it is crucial to know when your target population will be available. Conducting outreach on a weekday, during the middle of the day, in a neighborhood where most people work traditional hours will probably not yield a positive outcome. For example, if you are planning on conducting venue-based outreach to a gay bar in an urban area, your staff will most likely be at the venue whenever the bar opens and remain there until the bar closes (normally 2:00 am). If you have already figured out more individuals are likely to speak with you after leaving the bar (as opposed to entering), you may decide to have staff arrive at 12:00 am or 1:00 am and stay until the last of the patrons leave the bar. Another example would be reaching out to migrant workers in a rural area. Most often, migrant workers work all week and have one day off (normally Sunday). It would be most effective to conduct outreach on Sunday with this population, when you know you won't be interfering with their work schedules and their livelihood.

### 2.8.4 Coping with Burnout

Burnout is a prolonged response to chronic emotional and interpersonal stressors on the job, and is defined by the three dimensions of exhaustion, cynicism, and inefficacy (Maslach, Schaufeli, & Leiter, 2001).

Below is a table taken from Jackson & Schuler's publication (1983), *Preventing Employee Burnout*, regarding some of the causes and consequences of employee burnout.

Causes and Consequences of Employee Burnout		
<i>Causes</i>	<i>Psychological Reactions</i>	<i>Consequences</i>
<i>Organizational Conditions:</i> Lack of rewards. Lack of control. Lack of clarity. Lack of support.	Emotional exhaustion.  Depersonalization.	Withdrawal.  Interpersonal friction.  Declining Performance.
<i>Personal Conditions:</i> Idealistic expectations. Personal responsibility.	Low personal accomplishment.	Family problems. Health suffers.

Staff can potentially suffer from burnout as a result of conducting outreach. Not only is mental and physical fatigue possible (e.g., from looking at a computer screen too long without breaks, or standing in the hot sun contacting people), but emotional stress can also cause burnout to occur. Nurses and others who enter human services professions are often strongly motivated by a concern for humanity and a desire to help people (Jackson & Schuler, 1983). Outreach staff sometimes feel they have not done enough or it is possibly their fault that a client did not get what they needed or follow through as planned. Clients' behaviors can change from one day to the next and outreach staff should understand that they cannot force clients to change their behaviors, nor can they be everything to everyone, all the time.

With regards to Internet outreach, not every website user outreach staff come into contact with will appreciate the message or materials. Internet outreach staff should focus their attention on those that are actively engaged in the conversation and/or seeking health

information. In situations where outreach staff must constantly explain and/or defend the purpose behind their outreach messages/activities, online productivity starts to decline.

Agency and management support is also crucial to reducing staff burnout. It has been shown that inadequate support from management, combined with lack of recognition and lack of clear-cut expectations can all be factors leading to employee burnout. In order to avoid staff burnout, it is important that management strive to always keep lines of communication open, allow staff to participate in decision-making processes, clearly define job duties and expectations, and provide feedback on staff performance whenever possible.

## **2.9 Peers and Volunteers**

In addition to dedicated outreach staff, it may be useful to recruit peers and/or volunteers to assist with either traditional or virtual (i.e., Internet or cell phone) outreach and education activities. As defined by CDC's Health Education/Risk Reduction guidelines, peer education refers to a role-model method of education in which trained, self-identified members of the client population provide HIV/STD education to their behavioral peers. All peers and volunteers must receive the same training as all other outreach staff and be monitored on a regular basis by a program supervisor and/or coordinator. Peers and volunteers must sign confidentiality agreements if they will be working with confidential information in any way (via the Internet or in-person).

## **Section 3: Traditional Outreach**

### **3.1 Types of Traditional Outreach**

Although there are many varieties of outreach activities, each having their own specialized components, most traditional outreach activities can be categorized into the following three categories: active street outreach, fixed-site or venue-based outreach, and drop-off site outreach (Valentine, 1994).

#### **3.1.1 Active Street Outreach**

This type of outreach consists of outreach staff moving down a street or canvassing a certain area, screening and engaging prospective clients for the purposes of delivering risk reduction information, materials, and/or referrals (Valentine, 1994). Active street outreach is usually conducted within a specified area, taking place within a few blocks or in a certain neighborhood or community.

#### **3.1.2 Fixed-Site or Venue-based Outreach**

This type of outreach consists of activities which are conducted at a specific place within a given location (Valentine, 1994). Fixed-site or venue-based outreach activities usually involve setting up a table on a street in front of a frequented corner store, in a well-known bar or hangout, or even working out of a mobile HIV testing unit or storefront. During these activities, outreach staff can invite people they have engaged in the street to come to the site or venue for more in-depth assessment discussions and/or service delivery, based upon client needs and interests (Valentine, 1994). This type of outreach usually requires one staff person to remain at the fixed site and the other to participate in more of an active street outreach capacity. While activities associated with active street outreach may be part of the fixed-site or venue-based outreach, the primary focus of the intervention is at the fixed site (Valentine, 1994).

### **3.1.3 Drop-Off Site Outreach**

This type of outreach consists of providing risk reduction supplies to volunteer distributors who may then distribute these items to persons involved in high-risk behaviors (Valentine, 1994). Drop-off site outreach usually involves leaving condoms and educational materials with the volunteer distributor. In cases where syringe exchange programs are allowed, bleach kits are often left or distributed at “shooting galleries.” Many outreach workers leave condoms and educational materials with store owners that are partners in HIV prevention; some examples include, barber shops, beauty salons, student organizations on college campuses, corner markets, bookstores, tattoo/piercing parlors, churches, youth recreation centers, gyms, and after-school programs.

## **3.2 Community Assessment**

One of the most important first steps in conducting outreach is the community assessment. The most effective outreach programs and activities are those that are based on the target populations’ needs. During community assessment activities, it is critical to assess what services are currently available in the community that is being targeted. Communities vary greatly in terms of HIV/STD risk behaviors, socio-economic factors (e.g., education and poverty levels), drug use, access to healthcare, and availability of other social service resources. Therefore, the needs assessment process should be one that is data driven and uses information gathered from the community to make determinations about the kinds of activities and approaches that will work best. There are many different assessment activities that can be used to learn about a specific population’s attitudes, behaviors, language, community norms, and values. Some of these activities include:

- Focus groups
- Direct observation
- Anecdotal observations of certain venues
- Interviews with local agency staff
- Canvassing the neighborhood on foot, by car
- Visiting venues during peak hours
- Interviews with venue owners, patrons, bartenders
- Use of epidemiologic/surveillance data from health departments/clinics
- Demographic data
- Risk assessment data for other STDs and drug use
- Prevailing attitudes and policies of local law enforcement agencies
- Interviews with key informants, community gatekeepers, client advisory boards
- Community forums, town halls
- Surveys (online and in-person)

Community assessment is not something that is only conducted once, but rather, is an ongoing process that helps guide outreach activities and programs. Quality assurance and periodic assessment should be conducted to ensure that all outreach activities are meeting community needs and that the target population is involved and engaged throughout the process.

Another key component to any successful outreach program is building rapport (pronounced RAH-pore) with your target population. Rapport, or trust, is an essential element to conduct effective outreach. One of the main reasons outreach efforts fail is due to a lack of rapport with the target population. Building rapport with your community, like assessment, is an on-going process. Some of the key things to remember when trying to build rapport with a community are:

- Remain consistent- if you consistently visit the area, people will see you are serious about reaching out; you will begin to earn their trust
- Be sensible- do not say things that will push people away; avoid discussing politics, religion, etc.
- Be visible- the more they see you, the more they will remember and recognize you
- Be sincere- if you are insincere, people will pick up on it *immediately* and you will have lost their trust
- Be respectful- everyone wants to be treated with respect and if you respect them, they might respect you and your efforts
- Be genuine- if you truly don't believe in what you are doing and the feeling isn't there, people will pick up on it immediately; be honest with yourself.
- Be nonjudgmental- you are not there to judge anyone; the more non-judgmental you are, the more people will open up to you.

Even after rapport is established within a specified community, barriers may still exist for one reason or another. Some community barriers include:

- Stigmas, myths, misconceptions
- Drugs and sex for profit
- Politics
- Lack of support
- Lack of funds

It is important to coordinate with other agencies that may also be conducting outreach in certain areas and neighborhoods. When multiple agencies are conducting outreach in a certain area for a specific population, over-saturation is a possibility. Over-saturation can lead to prevention message burn-out or fatigue. In order to avoid this situation, coordination and collaboration is extremely important among agencies serving the same target population. Ideally, contact persons from each agency should coordinate with each other in order to prevent duplication and come up with best practices.

### **3.3 Identifying Target Populations**

Outreach is most effective when targeted to populations at high risk for HIV/STDs. There are several resources to consider when identifying your target population for outreach efforts. An essential resource in identifying your target population for outreach is the Prevention Planning Group's (PPG) statewide and area-specific priority populations. The current priority setting methodology was designed and implemented by the PPG in 2008 to ensure the selection of target populations and the allocation of resources were done in a fair and uniform manner across the state. The purpose of the guidelines was to assist each partnership in assessing the local population's need for prevention efforts. In an effort to maximize the efficiency, effectiveness and allocation of limited HIV prevention resources throughout the state, the PPG decided to focus on seven priority populations, HIV-infected persons and the top six categories prioritized by local communities (*see below*). Florida's priority populations (statewide and by area) can be found in the *2010-2011 HIV/AIDS Prevention Plan*, located on the Bureau of HIV/AIDS, Prevention Section web page at this link: [http://www.preventhivflorida.org/2010\\_Prevention\\_Plan.pdf](http://www.preventhivflorida.org/2010_Prevention_Plan.pdf).

#### **State of Florida, Top Seven Target Populations**

- 1) HIV-Infected Persons
- 2) Black Heterosexual

- 3) Black MSM
- 4) White MSM
- 5) Hispanic MSM
- 6) Hispanic Heterosexual
- 7) White Heterosexual

Another key resource for identifying your target population is local health department surveillance data. Disease intervention specialists (DIS) ask STD patients about sex partners and in doing so, find out about current locations of partners (either online venues or venues within a specific area of a community). STDs have been shown to increase risk for and/or be an indicator of HIV infection; diagnosis of an STD can be considered a “sentinel event” reflecting unprotected sexual activity. Patients with one STD are at high risk for having others. Examining data by zip code is one way to pinpoint specific communities and neighborhoods with high disease prevalence and risk factors. GIS (Geographic Information System) mapping can also be a useful tool in determining high prevalence areas and the need for additional outreach and/or other prevention services.

In identifying your target population, geographic location and socio-economic factors are important to consider. Geographic location often plays a critical role in determining the prevalence of certain diseases, such as HIV/STDs. In counties with metropolitan areas (e.g., large urban areas, major cities), diseases tend to cluster heavily in more urban areas, due to higher population densities and more disease prevalence in general. While rural areas may not have the disease prevalence urban areas possess, individuals in these areas are still at risk for acquiring or transmitting HIV/STDs. People in rural areas are more likely to use the Internet and/or travel to more populated areas when seeking partners.

Socio-economic factors to consider when identifying your target population include things such as, poverty levels, access to healthcare, and racial/ethnic make-up of the area. The US HIV/AIDS epidemic largely impacts lower-income populations (LaLota, Beck, Metsch, Brewer, Forrest, Cardenas, & Liberti, 2010), as well as racial and ethnic minorities.

### **3.4 Identifying Potential Outreach Venues**

When choosing locations for conducting outreach activities, thorough knowledge of the community is essential. Before initiating outreach, workers should identify areas where and when the target population congregates, such as bars, clubs, recreation centers, liquor stores, corner markets, public housing projects, check-cashing centers, lounges, pool halls, prostitution “strolls”, crack houses, shooting galleries, homeless shelters, public parks, and other local businesses.

If your outreach staff consists of members of the target population and community, they can be essential in helping to identify potential outreach venues. In addition to outreach staff, local agencies can also be a valuable resource in determining the most effective locations and times to conduct outreach to your target population. Some of the techniques and strategies considered useful during this process are listed below:

- Enlist the help of community gatekeepers
- Talk with local police departments to determine areas used as hangouts or high traffic areas for drug users and/or prostitutes
- Use knowledge from friends or relatives, if appropriate

- Talk to community members on the street (e.g., asking them where they hang out, which bar or club is preferred in the community)
- Ask local business owners where their customers prefer to go for certain activities
- Talk to community-based organizations and other social service providers (e.g., drug treatment centers about which areas are most effective to reach the target population)
- Visit public housing projects and talking to residents
- Canvass certain areas of a community at different times of day and night to determine the most effective time to reach the most people

Once outreach venues have been established, it is important to introduce outreach and program staff to local business owners and residents, if appropriate. The more outreach staff are able to garner community support and increase visibility, the more productive the outreach activities will be. This is also a good time for outreach staff to establish credibility and create rapport with the community. Outreach staff should always explain why they will be conducting outreach in a certain area to avoid speculation and anxiety on the part of community members as to why they are being targeted. Ultimately, this is the stage when outreach workers can demonstrate their sincere concern for community members that may be affected by or infected with HIV/AIDS.

### **3.5 Recruitment and Referrals**

One of the core elements of outreach is to provide referrals and recruitment for other programs and services. Agencies and outreach staff should always maintain up-to-date resource guides for local social service agencies and programs. Outreach staff will need to ask certain key questions in order to assess the needs of and make the most informed decision about which referrals are needed. Some questions outreach staff should attempt to answer are:

- What is the client's current HIV status?
- Have they ever tested for HIV? If so, when was the last time they tested?
- Are they currently receiving medical care? If so, where do they go for care?
- Does the client have health insurance?
- Does the client have a substance abuse problem? Have they ever been in treatment for the substance abuse?
- Has the client been vaccinated against hepatitis?
- Is the client currently experiencing a crisis?
- Does the client feel more comfortable going to a county health department or non-profit agency?

Agencies and services in a referral/recruitment resource guide should include, but are not limited to: AIDS service organizations (ASOs); community-based organizations (CBOs); support groups; other HIV/STD prevention providers; health department clinics; community healthcare centers; family planning clinics; mental health providers; substance abuse treatment centers; youth services; homeless/emergency shelters; food pantries; housing/financial services; domestic violence shelters; various hotlines (suicide, rape, crisis, HIV/AIDS, domestic violence, etc.); and child protective services.

Collaborating with other local agencies is essential when providing referrals and recruiting clients into programs and services. One example would be for an outreach worker to refer a client to another prevention agency for STD testing because their agency does not offer this service. Often times, the relationship between agencies is symbiotic, wherein one agency has expertise in one area (e.g., outreach to the community) and the other agency does not; however, the agency (that is not skilled at conducting outreach) might have an HIV/STD clinic

where they can conduct testing of clients that are referred through outreach. Partnerships such as this are always encouraged and can be extremely useful in times of dwindling resources and funding.

Recruitment into local prevention programs and services is often an indirect goal of outreach. Outreach staff should be familiar with local area HIV/AIDS programs and services in order to provide the most information when recruiting clients. Services and programs that clients can be recruited into include: HIV support groups, HIV care and treatment, prevention interventions (e.g., SISTA, VOICES, Healthy Relationships, LIFE), peer mentoring programs, basic HIV/STD education classes, HIV/STD testing, advisory groups, and hepatitis screening and vaccination.

### **3.6 Making Contact**

Once the target population has been identified and appropriate sites established, outreach workers can begin to conduct outreach on a regular basis. The interaction between the client and the outreach worker is the fundamental element of any street outreach activity (Valentine & Wright-De Agüero, 1996). Depending on which type of outreach is being conducted, staff may choose to approach individuals that appear to members of the target population, set up a table at a local venue (e.g., Laundromat, corner market, bar), or drop materials off at certain sites that have agreed to be drop-off outreach sites. Usually, outreach workers make contact with one or two individuals at a time, but can also make contact with groups if it is appropriate to do so. Outreach staff should approach individuals or groups by introducing themselves, explaining what they are doing in the community, and with which agency they are affiliated.

Initial encounters with the target population may be brief and may only consist of handing out a brochure or condoms. However, despite the limited amount of communication and/or education that is occurring, these initial encounters serve a very important purpose. These first contacts help outreach workers to create a presence in the community and build credibility among target population members (Valentine & Wright-De Agüero, 1996). Over time, these brief interactions will lead to more lengthy encounters where outreach workers can assess an individual's needs and provide information, materials, and/or referrals accordingly.

During the AESOP (AIDS Evaluation of Street Outreach Projects) Study conducted in 1991 through the CDC, elements of contacts and encounters were identified (Valentine & Wright-De Agüero, 1996). The elements of the outreach encounter can be a useful guide if they are appropriate for your particular outreach program. The five elements of the AESOP encounter were: screening, engagement, assessment, service delivery, and follow-up.

- Screening- Outreach workers can determine this via sensory cues and/or body language; can determine whether someone is open to being approached or is avoiding the contact; sometimes instinct will direct whether or not an outreach worker engages a client on the street or at a specific venue.
- Engagement- Outreach workers establish rapport and gain trust; can often be done by explaining what they are there for (e.g., "We're here in the community passing out information about HIV prevention").
- Assessment- Outreach workers conduct quick assessments of client needs to determine appropriate service/material delivery; can use open-ended questions to gauge the client's current knowledge, attitudes, and beliefs regarding HIV/STDs.

- **Service Delivery-** Outreach workers provide direct or indirect services to the client based on the assessment of clients' needs; services can include HIV/AIDS/STD information, information for local agencies and/or clinics, HIV testing, condoms, and referrals for other social services.
- **Follow-Up-** If possible, outreach workers should attempt to follow-up with clients met during street outreach; if condoms or referrals were given to individuals, workers can ask basic questions like, "How did those condoms work out?"; "Were you able to make that appointment?"; "Were you able to get into the shelter?"; "What did your partner say about the condoms?" to demonstrate their commitment and interest in the client's health and well-being. Follow-up is crucial, in part, because word on the street can travel quickly if clients are being turned away from certain organizations to which they have been referred.

These elements do not have to be performed in the order in which they are presented. Sometimes service delivery (e.g., giving out a condom) can facilitate engagement (e.g., begin a conversation with a client). These elements require flexibility but the primary focus is always the outreach encounter be client-centered.

In order to conduct outreach to the best of their abilities, it is recommended that staff receive training in communication skills and ways to engage clients on the street. Training should also include information about what social services are available in the area and creating a resource guide is always an easy way to quickly reference what services may be appropriate for clients in the target community. More information about staff training will be discussed in Section 5.2.

### **3.7 Follow-Up**

Referrals to resources should always be appropriate to the clients' needs and should be tracked when possible. Sometimes agencies collaborate with one another to track referrals that are provided between agencies. Following up on a referral can be as simple as asking an outreach contact whether or not they followed through with the information and/or materials you provided to them. Follow-up is crucial, in part, because word on the street can travel quickly if clients are being turned away from certain organizations to which they have been referred. As with any other client activity, outreach workers should always ask the client's permission to follow-up with them via phone or email.

## **Section 4: Traditional Outreach- Monitoring & Evaluation**

### **4.1 Evaluating Outreach Programs and Activities**

Quality assurance and evaluation are vital components needed to create the most effective and successful outreach program. Monitoring and evaluation (M&E) not only assess whether or not outreach is being conducted effectively, but also provide information on whether or not outreach activities are meeting agency goals and objectives, reaching individuals within the target population, and the need for continued funding of such activities. To thoroughly evaluate an outreach program, staff should submit activity logs, referral logs, contact sheets, and any other data collection deemed necessary to adequately evaluate and monitor outreach activities. In addition to various activity logs, other tools to gather information should include: client-level data (demographics), activity times, referrals, referral follow-up information, staff and client interviews, satisfaction surveys, and advisory boards. All data collected should be analyzed on a regular basis in order to make appropriate adjustments to outreach activities to ensure success.

Using a logic model can assist in planning evaluation and monitoring activities for your outreach program. Logic models help to describe the main elements of an intervention and how they work together to prevent HIV/STDs in a targeted population. For an example of a logic model for an HIV prevention outreach program, please see **Appendix F**. Additional resources can also be found at the following Centers for Disease Control and Prevention (CDC) evaluation resources link <http://www.cdc.gov/eval/resources.htm#logic%20model>.

For the purposes of outreach process monitoring, it is recommended that outreach staff collect the following information. These are items that can be obtained through staff observation and are meant to be basic and brief. Some items can be completed before outreach staff head into the field.

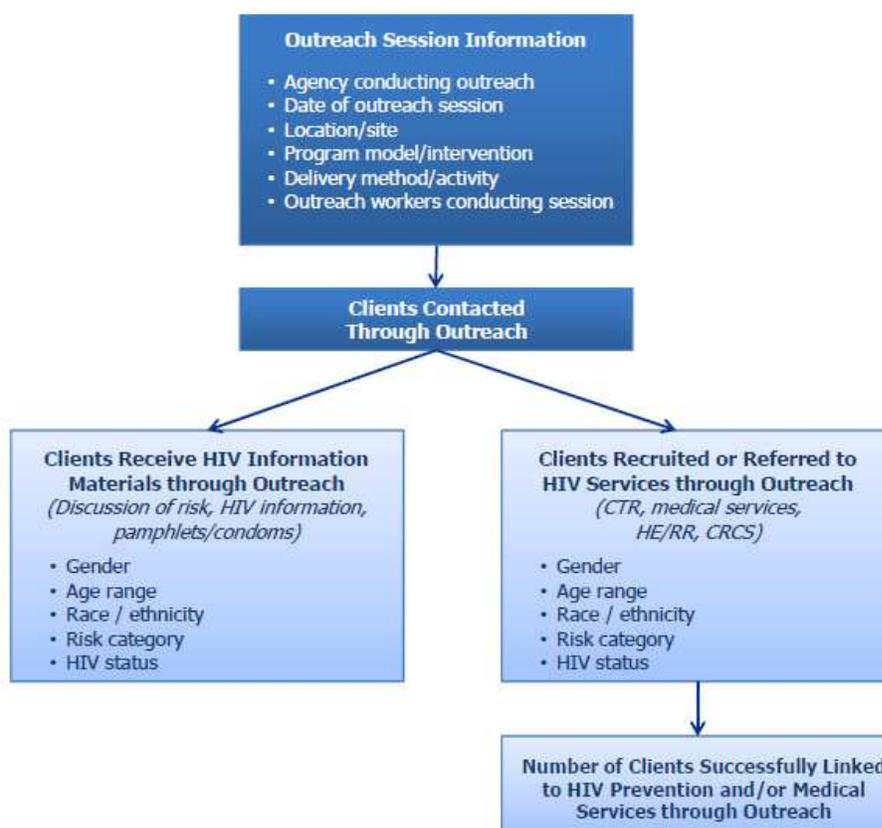
#### Outreach Process Monitoring Items

- **Date**- the date of the outreach activity
- **Period of Outreach**- period of time during which outreach activity occurs
- **Outreach Location**- specific location where outreach activity occurs (e.g., unique identifier such as Holden Heights neighborhood or corner of SW 25<sup>th</sup> Ave. and Sunshine Blvd.)
- **Target Population**- the specific population to be targeted for outreach
- **Outreach Team**- a list of outreach staff or a special “team name” to identify the team conducting the outreach activity
- **Team Size**- number of outreach staff comprising the outreach team
- **Type of Outreach**- description of the outreach activity (e.g., active street, fixed-site or venue-based, and/or drop-off site)
- **Volunteer/Business Contacts**- total number of volunteer or business distributors (e.g., Laundromats, convenience stores, hotel managers, etc.) contacted by the outreach team to distribute information or prevention materials
- **Participant Contacts**- total number of participant contacts resulting in delivery of service (information, materials, referrals) during outreach activity, including relevant demographics (e.g., race/ethnicity, age, gender, etc.)
- **Service Delivered**- any service (information, materials, referrals) provided by outreach staff to a participant during the outreach activity
- **Print Materials Distributed**- number and type/title of brochures, pamphlets, or fliers distributed during the outreach activity

The diagram on the following page is taken directly from the CDC’s National HIV Prevention Program Monitoring and Evaluation Guidance (NHM&EG) and illustrates each of the general steps included in the outreach process and includes National HIV Prevention Program Monitoring and Evaluation Data Set (NHM&E DS) variables that are associated with each step. Answering these monitoring questions can be incredibly useful, as agencies can compare the information to prevention plan objectives, which will help in setting future outreach program objectives. These data can also be compared across time to assist in evaluating your program’s geographic and community coverage and recruitment success. Agencies can choose how they wish to collect these data variables, but at a minimum, will need to collect the data variables mentioned above.

## Outreach Data Flowchart

(CDC, National HIV Prevention Program Monitoring and Evaluation Guidance, 2009)



### *Brief Review: Types of Monitoring and Evaluation*

**Process Monitoring** is the routine documentation and review of program activities, populations served, or resources used in order to inform program improvement and process evaluation.

**Process Evaluation** assesses planned versus actual program performance over a period of time for the purpose of program improvement and future planning.

**Outcome monitoring** involves the routine documentation and review of program-associated outcomes (e.g., individual-level knowledge, attitudes, and behaviors or access to services; service delivery; community or structural factors) in order to determine the extent to which program goals and objectives are being met.

### Using CDC's NHM&E DS Variables to Monitor Outreach Efforts

Documenting information about outreach sessions is an important first step in beginning to understand how well different community-based activities are working toward achieving your program's HIV prevention goals. Below are some examples (NHM&EG, 2009) of specific *process monitoring* questions about outreach sessions that your agency might consider.

 <b>Process Monitoring Questions</b>	<ul style="list-style-type: none"><li>• What was the total number of clients who were contacted in the community through outreach efforts during the most recent reporting period?</li></ul>
	<ul style="list-style-type: none"><li>• What was the average number of clients contacted at each of the outreach sessions?</li></ul>
	<ul style="list-style-type: none"><li>• What time of day were more contacts made with potential clients in community settings?</li></ul>
	<ul style="list-style-type: none"><li>• What was the best time of year to conduct outreach?</li></ul>
	<ul style="list-style-type: none"><li>• Which outreach staff seem to have the most contacts with clients?</li></ul>

Reviewing outreach activities can help an agency determine whether changes are needed in their outreach approach, location, or staff.

Descriptive information provided by process monitoring can also lead to other questions about why the activities were or were not successful. *Process evaluation* questions might include some of the examples below:

 <b>Process Evaluation Questions</b>	<ul style="list-style-type: none"><li>• Was this number of clients greater or fewer than the number we planned to contact?</li></ul>
	<ul style="list-style-type: none"><li>• Was the number of clients to be contacted through outreach activities realistic, based on what we know about the community and the target population?</li></ul>
	<ul style="list-style-type: none"><li>• What were the challenges that prevented our program from reaching our outreach targets?</li></ul>
	<ul style="list-style-type: none"><li>• How does this impact program planning projections and recruitment resources for upcoming months?</li></ul>

### Collecting Client-Level or Aggregate-Level Data

Agencies can decide whether to collect outreach data in one of two ways: at the *client level* or by *aggregate level*. Client-level data are specific to an individual, for example, client #1 was a 25-year old Hispanic female who lived in zip code 33355. This information would typically be collected on a self-administered data collection form, in a client's chart, or through some other data collection method implemented within an agency.

With aggregate-level data, information is collected about each of these characteristics separately and staff do not necessarily keep a record of information about each specific client (NHM&EG, 2009). The table below shows an example of aggregate data collected by an outreach worker who saw 13 clients: seven males and six females. However, because these data were collected and presented in aggregate form, it is not possible to determine whether any particular man was Hispanic and between the ages of 25 and 34.

Example of Aggregate Outreach Data (n=13)

Age	13–18	19–24	25–34	35–44	45+
Number of Clients Seen	4	7	2	0	0
Race	American Indian/Alaska Native	Asian	Black/African American	Native Hawaiian/Pacific Islander	White
Number of Clients Seen	0	2	5	0	6
Gender	Male	Female	Male-to-Female	Female-to-Male	
Number of Clients Seen	7	6	0	0	

Client information entered as aggregate (or combined counts or proportions) can be used to determine if there are potential gaps in outreach efforts and to identify locations where an agency’s outreach efforts are most effective at accessing individuals in need of services (NHM&EG, 2009).

**Note:** Aggregate Level Data collection is not the same as Aggregate data. **Aggregate Level Data Collection** is the process by which data are collected and reported from all clients as a whole. For example, an agency conducted an outreach intervention for MSM. They know from provider observation that 100% of the participants are male and that 65% of participants are white and 45% are African American.

**Aggregate data** is defined as data combined from several sources and reported as a whole. For example, individual records (client-level data) are recorded but when the data are reported the records are combined and reported as a whole representation.

(CDC, NHM&EG, 2009)

Using the NHM&E DS assists with the collection of important data about the general demographic and risk characteristics of the target population, including gender, race/ethnicity, age range, risk category, HIV test history, and HIV status. Some specific outreach process monitoring questions about client characteristics include the following examples:

 <b>Process Monitoring Questions</b>	<ul style="list-style-type: none"> <li>• What are the demographic characteristics of clients who are contacted through outreach services (e.g., age, race, ethnicity)? (AG09–AG13)</li> </ul>
	<ul style="list-style-type: none"> <li>• How do these characteristics vary by the location of the outreach setting or type of outreach activity?</li> </ul>
	<ul style="list-style-type: none"> <li>• What are the risk categories of clients who were contacted in outreach activities? (AG08)</li> </ul>
	<ul style="list-style-type: none"> <li>• How many outreach contacts are HIV positive? (AG13)</li> </ul>

Some agencies may choose to extend their understanding of their agency’s needs and accomplishments by examining more in-depth evaluation questions over an extended period of time. To accomplish this, an agency should answer additional process evaluation questions based on a review of the process monitoring data. The questions below are examples that can be answered with a combination of the NHM&E DS and other data sources:

 <b>Process Evaluation Questions</b>	<ul style="list-style-type: none"> <li>• Why are there so few high-risk outreach contacts in certain locations and so many in others?</li> </ul>
	<ul style="list-style-type: none"> <li>• What additional activities are workers providing to clients with higher recruitment rates for recruiting high-risk outreach clients for HIV prevention and treatment services?</li> </ul>

Keeping Count while Conducting Outreach

To conduct high quality process monitoring and evaluation of outreach activities, accurate information collection is critical. While most outreach workers would agree that collecting information while conducting outreach is time consuming and takes away from the valuable service they are providing, certain evaluation standards must be upheld to determine the reach and scope of the outreach activities being conducted. Process evaluation during outreach should never take away from the actual outreach activities. Process evaluation is intended to measure, inform, and improve outreach, not hinder or supplant it (Valentine, 1994). Two methods of keeping count are recommended to count the number of participants reached and to track the types of services being provided. These methods are the Indirect Method and the Direct Method (Valentine, 1994).

Indirect Method

This method relies on the number of materials that are being distributed during outreach activities. If staff use this method, they will need to create a standard materials distribution pattern and stick to it. This method provides an approximate number of participant contacts based on the number of materials given away (e.g., condoms, brochures, pamphlets). One limitation to using this method to estimate the number of participants reached is that not all participants will be satisfied with the standard number of condoms or brochures and may ask for more. On the other hand, there may be some people that do not want condoms altogether. Another limitation of this measurement is it does not provide demographic information about the people contacted through outreach. This method only provides a

stand-in measure of participant contacts and will not allow outreach staff to get an exact number of participant contacts.

Direct Method

The direct method of keeping count will take more effort on the part of the outreach worker, but in the end, a more accurate assessment of who and how many were contacted through outreach will result. This method does not rely on the number of materials distributed as a replacement measure for the number of people actually contacted. In this case, small note cards are used to record basic information about people contacted during outreach activities using hatch marks (IIII). Outreach staff can carry small index cards (3 x 5) or pocket-size notebooks to record encounters while in the field. Staff can record encounters after they happen (if the activity is slower) or designate a certain time interval (e.g., every 30 or 60 minutes) to stop and record the people they have encountered thus far. Boxes on the index cards can be organized in whichever way is more logical for the outreach staff and the type of outreach being conducted. Demographic information on the card should be determined by the agency according to their outreach objectives. Boxes could be organized around age, risk behavior, or race/ethnicity. Outreach workers should be able to determine the information needed by observation, or at least make their best estimate. Ultimately, the card should be very basic and brief. Below is an image of a sample index card for keeping count during outreach.

*Example:* Index card (3 x 5) used during an outreach activity in a primarily African American/black community (some Latinos also reside in this community) to target African American/black men and women with safer sex information and materials.

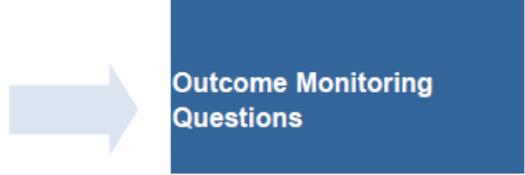
<b>Date:</b>	<b>Location:</b>				<b>Staff Initials:</b>
<b>African American- M</b>					
<b>Ages 13-19</b>	<b>20-29</b>	<b>30-39</b>	<b>40-49</b>	<b>50+</b>	
IIII	III	IIII	II	I	
<b>African American- F</b>					
<b>Ages 13-19</b>	<b>20-29</b>	<b>30-39</b>	<b>40-49</b>	<b>50+</b>	
III	IIII	II	IIII		
<b>Hispanic/Latino- M</b>					
<b>Ages 13-19</b>	<b>20-29</b>	<b>30-39</b>	<b>40-49</b>	<b>50+</b>	
<b>Hispanic/Latino- F</b>					
<b>Ages 13-19</b>	<b>20-29</b>	<b>30-39</b>	<b>40-49</b>	<b>50+</b>	

Please see **Appendix B** for sample Outreach Data Collection Tools and the CDC NHM&E Data Variable Set.

Outcome Monitoring and Outreach

The primary goal of outreach is to proactively initiate contact with high-risk target populations that are in need of HIV prevention interventions or treatment in order to provide them with health information and increase their awareness of the availability of HIV services within their community. One of the major purposes of outreach is to encourage high-risk individuals to learn their HIV status through testing and to provide information and assistance in accessing

prevention services (NHM&EG, 2009). Outcome monitoring involves the process of answering questions about the results of your outreach services. Examining outcome monitoring data can provide an agency with information that can be used in many different ways, such as agency improvement, community initiatives, and planning. Outcome monitoring data can also help agencies determine the need for additional resources for clients. For example, by monitoring the number of successful outreach contacts with HIV-positive individuals or those at high risk for HIV infection, program managers can determine if this particular intervention goal, or outcome, is being reached. Some examples of specific outcome monitoring questions include the following:

	<ul style="list-style-type: none"> <li>• How many outreach contacts were made aware of important information about HIV infection, the availability of CTR services in the community, or HIV care and treatment services?</li> </ul>
	<ul style="list-style-type: none"> <li>• Of those clients who were contacted through outreach activities, what proportion of clients were successfully referred and linked to services?</li> </ul>

Agencies can monitor their outreach programs in many different ways to suit their needs. Both process and outcome monitoring are essential in determining the reach and scope of any prevention activity or outreach program. The ultimate question will always be, “How is your agency reaching the community that it is serving?”

#### 4.2 Supervision

To ensure accountability, outreach staff should be monitored on a regular basis. Outreach staff should be monitored to assess whether protocols are being followed and if they are performing their duties as expected. Consistency is key to protecting both the outreach workers and clients they come into contact with while conducting outreach. Supervisors should attempt to accompany outreach staff on a regular basis to conduct their own on-site monitoring and evaluate the quality of outreach their staffs are conducting.

Ideally, all new outreach staff should first be paired with or “shadow” experienced staff or supervisors during their first few outreach excursions. This will help to get a feel for the area in which they will be conducting outreach and certain nuances they should be aware of when heading out into the community.

Communication between outreach staff and supervisors is essential to quality assurance. Program staff should meet on a regular basis to discuss outreach activities, any challenges or successes experienced, and any improvements or changes that could make the outreach activities more effective. Staff should be ready to discuss their most recent outreach activities and clearly describe how they approached clients in the field, how they were received by the clients, what they did while they were out (e.g., conducted HIV testing, handed out information and condoms, went into a venue to pass out literature), and any barriers they encountered while out in the field.

#### 4.3 Ongoing Training

While training is an essential component to ensure staffs are prepared to conduct outreach and represent your agency, ongoing training is just as important. Supervisors and program managers should assess staff at regular intervals and provide necessary ongoing training to ensure staff skills remain sharp and focused. The skills needed to conduct effective outreach

are ever-changing and staff can always benefit from additional training updates even if they are “veterans” with years of experience. Characteristics of populations change over time and staff need to be prepared to change with them, which means having the most up-to-date information regarding influencing factors for risk behaviors and characteristics of their target population.

Agencies should have a regular schedule for training updates and make all trainings mandatory for outreach staff. Training updates can be conducted from within (in-house) or outsourced to other local social service agencies and/or health departments. It can be beneficial to have outside agencies come in and train all staff regarding issues that may be affecting a target population. For example, if outreach staff have noticed many women in the community affected by domestic violence, it may be helpful to get staff from a local women’s shelter to come in and talk about issues surrounding domestic violence in that community. Not only will the staff at your agency be more knowledgeable about domestic violence in their community, they will also have a better understanding of what services are available for women who are experiencing domestic violence.

### **Section 5: Internet and Cell Phone Outreach**

This section of the Outreach Guidance document contains recommendations for conducting outreach through the Internet via settings such as social networking sites, chat rooms, e-mail groups, cell phone text messaging, and other virtual communities. Internet outreach is defined in the NCSD’s *National Guidelines for Internet Outreach* as, “A virtual interaction between an STD/HIV prevention professional, such as an outreach worker, and a person or persons at risk for STDs or HIV, for the purposes of providing STD/HIV related: health information and education, referrals and access to services, recruitment for testing and treatment, and support for reducing risk behaviors.”

As more and more individuals turn to the Internet for information, socialization, and dating, the need for Internet prevention and outreach becomes more evident. An estimated 79% of all American adults (ages 18 and over) go online, a number that has remained relatively steady since early 2006 (Generations 2010, Pew Research Center). While most generations have Internet adoption rates of at least 70%, Internet use drops off significantly for adults over age 65: only 58% of adults ages 65-73 (the Silent Generation) and 30% of adults age 74 and older (the G.I. Generation) go online. On the other hand, 93% of teens ages 12-17, 95% of adults ages 18-33 (Millennials), 86% of adults ages 34-45 (Gen X), and 81% of adults ages 46-55 (Young Boomers) go online (Generations 2010, Pew Research Center). Teens (ages 12-17) and Millennials (ages 18-33) were more likely to engage in activities such as using social networks sites, watching a video, or sending instant messages; 73% of teens and 83% of Millennials engaged in using a social network site (Generations 2010, Pew Research Center). Additionally, searching for health information, an activity that was once the primary domain of older adults, is now the third most popular online activity for all Internet users 18 and older (Generations 2010, Pew Research Center).

Internet/phone outreach possesses many of the same qualities as traditional outreach and in many cases, online or virtual venues share characteristics of more traditional venues. Online venues such as chat rooms, forums, blogs, and social networking sites can be compared to bars, clubs, campuses, and other venues where social interaction takes place. These venues can be used for risk reduction conversations, health education, and/or one-on-one counseling with the added benefit of anonymity in many cases.

Internet- and cell phone-based [outreach] programs can overcome barriers to traditional interventions including facilitator issues (e.g., discomfort with topics, incomplete implementation)

and individual obstacles (e.g., transportation, insurance, physical limitations, the need for child care) (Ybarra & Bull, 2007). When discussing HIV and STDs, the Internet is widely utilized and has created a new “risk environment.” Men who have sex with other men (MSM) and other adults use the Internet to find sex partners and negotiate both risky and safe sex (Horvath, Rosser, & Remafedi, 2008; Al-Tayyib, McFarlane, Kachur, et al., 2009). Adolescents display risk behaviors on MySpace [or Facebook] profiles, potentially linking them to risky social networks (Moreno, Parks, Zimmerman, et al., 2009). With the introduction of smartphones [e.g., iPhone (Apple, Cupertino, California, USA) and Google Android phones (Google, Mountain View, California, USA)], the reach of this new risk environment has been significantly extended by enabling Internet access that is always on, always worn, and context aware through global positioning satellite (GPS) radios in phones and geographic information systems (GIS) (Honan, 2009).

Outreach conducted via the Internet or phone can reach a much larger and geographically diverse audience, which in turn, increases the impact of health education and risk reduction messages. In addition to a wider reach, Internet and phone outreach have the potential to save costs associated with hiring staff. For example, traditional outreach requires at least two staff to go out at the same time to one particular area, one staff working via the Internet or phone can visit three social networking sites at the same time, and still answer sexual health questions in another chat room or through text messages.

### **5.1 Identifying Virtual Target Populations/Community Assessment**

Similar to traditional outreach, identifying target populations and assessing communities are just as essential with Internet outreach. The most notable difference in this case will be that community assessment will be conducted with online, or *virtual* communities. In addition to the resources listed in **Section 3.2**, several additional questions must be addressed when considering target populations within online communities. They include:

- Are those at greatest risk using the Internet in your local area?
- If your target population is using the Internet, what are they using the Internet for? (e.g., social networking, finding sex partners, chat rooms, seeking health information).
- Which high-risk populations are currently underserved online?
- Does your target population use text messaging via cell phone as a common method of communication and/or information sharing?

Assessing your virtual communities is essential prior to developing any type of Internet outreach initiative. It is recommended that agencies and outreach staff spend time assessing potential online or virtual communities by venturing onto the Internet to learn more about attitudes, behaviors, language, norms, and values. Many of the activities used to assess in-person communities (**Section 3.1**) can also be used to assess online communities. For example, instead of conducting focus groups in-person, staff can try conducting focus groups in various chat rooms to get a feel for the people that use that particular web site. Another example would be to login to different social networking or dating sites, such as Adam4Adam.com or GayBlackChat.com and see what the users are primarily talking about or looking for.

### **5.2 Working in Online/Virtual Venues**

County health departments (CHD) are advised to consult with their health department director and information technology (IT) staff before engaging in any form of online or virtual prevention activities. Because DOH operates on a very large computer network, any outside computer activity that is not approved poses a serious threat to the network.

The Bureau of HIV/AIDS strongly recommends that all agencies (CHD or CBO) develop formal guidelines and trainings on how to conduct Internet and/or cell-phone based outreach that is specific to their program. In many cases, it may be easier for CBOs to implement an Internet or text messaging outreach program because they are not working from the same computer network as DOH staffs. The National Coalition of STD Directors (NCSDD) recommends that agencies wishing to implement an Internet outreach program contact organizations that have experience conducting prevention activities via the Internet at this website [www.ncsddc.org](http://www.ncsddc.org).

Each agency (CBO or CHD) should have organizational-level Internet and cell-phone policies and be reviewed prior to engaging in any type of online prevention activity. Use of the Internet or work cell phone for personal use and work should be clearly defined and staff should be made aware of all policies concerning Internet and cell phone use.

Not all Internet venues will allow outreach staff to create online profiles or chat with other users. Remember, people are not on the site to hear prevention messages, they are there for other reasons. In certain cases, an outreach worker providing HIV or STD prevention messages might be seen as harassing other users and might be asked to leave the site and may not be allowed to come back. Many online entities prohibit public health agencies or staff from providing any kind of prevention service on their sites. Due to the nature of Internet outreach, it is possible to be disconnected abruptly or blocked by a user. Websites can ban users without notice or warning and it is their right to do so. This is why it is crucial to make contact with website management first and see what is and is not allowable. If contact with the website is not possible, then it is up to the outreach staffs' supervisor or program manager whether or not to continue to pursue that particular venue for outreach.

#### Text Messaging (via cell phone) for Outreach Purposes

In the case of using an agency-issued cell phone for a text messaging outreach program, it is recommended staff clearly develop guidelines for the program and obtain approval from their immediate supervisor(s), as well as other management staff. Submitting a proposal for a text messaging outreach program ahead of time will alleviate any unforeseen roadblocks that might occur as a result of insufficient information. If conducting a text messaging outreach program from an agency-issued cell phone, it is critically important to ensure all supervisors, billing personnel, and IT staff are well-informed and understand the purpose of the program. They will also need to know exactly which staff are conducting the texting program, the exact phone that will be used, and the user will need to keep detailed records of all incoming and outgoing text messages. If the cell phone is enabled to send and receive text messages, there will already be a record of all incoming and outgoing texts, but staff conducting outreach via text messages are required to keep a log of all incoming and outgoing texts. Each agency will need to approach their IT/phone staff and supervisor about implementing a text messaging outreach program.

In the case of using a Department-issued cell phone for a text messaging outreach program, health department staff will first need to approach their immediate supervisor about whether the use of a Department-issued cell phone would be allowable for this purpose. Health Department staff should reference the Information and Security Privacy Policy 4: Acceptable Use and Confidentiality Agreement at the following link <http://dohiws.doh.ad.state.fl.us/Divisions/IRM/Policy/InfraSupportPolicies/InfoSecurityPrivacyPolicies/Policy4.pdf>.

Please see **Appendix C** for the *Internet Outreach Program Checklist*; this checklist is taken from the National Guidelines for Internet-based STD/HIV Prevention (March 2008) and can be used to develop agency guidelines for an Internet-based outreach program.

### **5.3 Accessing Questionable Web Sites**

In the world of HIV and STD prevention, access to adult web sites and web sites that contain sexually explicit material is often a necessity. It can be assumed that high-risk sexual behavior will and does take place on sex-positive web sites. If outreach staff are expected to reach high-risk populations and meet them where they are, then access to these types of sites will need to be granted. Granting access to these sites may be somewhat sensitive and policies should be in place that clearly outline which staff are allowed to visit these sites, for what purpose, and any interactions had on the sites need to be recorded.

Agencies such as CBOs, ASOs, and other social service agencies conducting HIV or STD prevention activities via the Internet, should have specific computer-use policies in place for all staff that have access to and use the Internet for work purposes.

Within DOH, specific forms must be completed by all staffs that have a need to access these sites for work purposes. Upon hire, all DOH staff are required to read and sign all forms related to the Information Security and Privacy Policy (DOHP 50-10-10) ([http://dohiws.doh.state.fl.us/Divisions/IRM/Policies/Security/table\\_of\\_contents.htm](http://dohiws.doh.state.fl.us/Divisions/IRM/Policies/Security/table_of_contents.htm)). Policy 4: Acceptable Use and Confidentiality Agreement specifically speaks to using the Internet at work and can be found at the following web address <http://dohiws.doh.state.fl.us/Divisions/IRM/Policies/Security/NewPolicy/Policy4.pdf>. It is critical that all staff understand the terms and conditions of this policy, especially as it relates to using the Internet for work purposes. This training is available through the DOH Trak-It system and all DOH staff are required to have annual updates (i.e., they must take the training course and pass the test every year).

We have provided an example *Computer Use & Confidentiality Agreement* form in **Appendix D**.

### **5.4 Website Terms of Service**

Most, if not all, websites will have specific Terms of Service that include things like: code of conduct, regulations, privacy policy, etc. Before conducting any prevention activities online, it's important to read and understand the Terms of Service entirely. By creating a profile on a certain website, you are agreeing to their Terms of Service.

At a minimum, agencies wishing to conduct outreach in online venues should make contact with website management. Outreach staff should be mindful that they are invited guests on these websites and that they are owned by private companies. An example of guidelines to work on Manhunt.com are available at the NCSD's website [www.ncsddc.org](http://www.ncsddc.org).

### **5.5 Potential Venues for Internet and Phone Outreach**

#### **5.5.1 Social Networking Sites**

Social networking sites (SNSs), such as Facebook and MySpace, support the established social networks (e.g., friends, relatives), but also allow strangers to connect based on their personal or career interests, political views, or hobbies. Most sites cater to a varying array of members, and others ("niche" websites) attract people based on shared sexual, racial, or religious identities. Within this virtual community, people can share daily activities, thoughts,

pictures, blogs, and/or videos. There are friendship and dating sites, as well as sites for career-minded individuals.

#### **5.5.1.a. Dating Websites**

Dating websites are a web-based service that allows individuals, groups, couples, and groups to create a public or semi-public profile with the objective of developing a personal romantic or sexual relationship. Online dating services generally provide un-moderated matchmaking over the Internet through the use of personal computers and smart phones (e.g., iPhone or Android) (New York State Department of Health, Guidelines for Internet Outreach).

#### **5.5.1.b. Niche Websites**

Some websites refer to all dating websites with adult content created to facilitate sexual hookups as “Niche Internet Dating Sites.” These niche dating sites are used to match people with similar interests (New York State Department of Health, Guidelines for Internet Outreach). For example, there are sites for single parents, tall persons and gay Latino men, the list goes on and on. An example of these sites can be found here: [http://www.onlinepersonalswatch.com/news/niche\\_Internet\\_dating\\_rankings.html](http://www.onlinepersonalswatch.com/news/niche_Internet_dating_rankings.html). Examples of “niche” dating websites include: SeniorPeopleMeet.com, ManHunt.com, Adam4Adam.com, GayBlackChat.com, ChristianMingle.com, and AdultFriendFinder.com.

#### **5.5.2 Bulletin/Message Boards and Forums**

Electronic bulletin/message boards and forums allow users to post and read messages that have been posted on a website. A variety of websites offer bulletin boards which means that agencies will have to research which boards are most effective in reaching their specific target population. Similar to social networking sites, the information-sharing bulletin boards can be used to promote agency services, events, up-to-date information, articles, or statistics on HIV/STDs. Posted messages are public information and available to anyone who visits the bulletin board. Bulletin boards (e.g., Craigslist.org) may be useful for posting health-related messages, promoting events, recruiting participants in surveys, and/or advertising programs and agencies (NCSD, 2008).

Organizations can have a set list of bulletins to post or have outreach staff create their own. All bulletins posted by an agency should be approved by a supervisor or manager prior to posting. Examples of bulletins are as follows:

- Men can be infected by women and vice versa.
- Condoms break more often when water-based lube is not used.
- HIV can be present in pre-ejaculatory fluid.

#### **5.5.3 Chat Rooms**

Chat rooms are online venues where Internet outreach can be conducted. Like bars and clubs, chat rooms serve a similar purpose, only on the Internet. Chat room members and group norms, behaviors, and/or attitudes may change from day-to-day, by the hour, and depending on which room is used. Every chat room is different, some may be very active with a steady flow of conversation and some may be very slow, with hardly any conversation exchanges. The personality and attitudes within a chat room are a direct result of the members within, which indirectly, is a reflection of that particular community. Sometimes chatters will enter a chat room to “listen” to the conversation but not participate. This is referred to as “lurking” and it’s possible they are engaging in private chats with other members.

Because each chat room is different, varying approaches are necessary to effectively engage in a chat with people in the room. Open-ended questions are a must when trying to engage someone in a brief discussion via a chat room. Questions should be timed appropriately so as not to bombard chatters with questions every five minutes (this behavior will most likely get you kicked out of their chat rooms or the chatters will find another place to chat). Open-ended questions posed upon initial entry into the chat room and in increments (no more than four times in an hour) during the outreach timeframe may help to initiate some conversations with people in private chats (NCSD, 2008). For an example of a chat session, please see **Appendix H**.

#### **5.5.4 Instant Messaging**

Instant messaging (IM) is a real-time interaction that may require software to be downloaded and/or a profile to be created. IM provides a more private interaction and provides an opportunity for the outreach staff and another individual to engage in a conversation that is very specific to that individual's health education needs (NCSD, 2008).

Like text messaging, IM can be used to answer questions, discuss safer sex and risk reduction techniques, help improve communication and negotiation skills, refer to online and local social service resources, and recruit into other prevention and/or care services. As with the chat room, outreach staff are encouraged to use open-ended questions (NCSD, 2008).

#### **5.5.5 E-mail**

Similar to IM, e-mail can be used to communicate with an individual in a private conversation. The differences between IM and e-mail are that 1) e-mail is not instant which means a delay in responses, and 2) e-mail may not be as private as an IM because sometimes people share e-mail addresses. Outreach staff should always ask clients which method of communication they prefer (whether it be IM, e-mail, or text message) (NCSD, 2008).

#### **5.5.6 Text Messaging by Phone**

As the number of Americans who own cell or mobile phones increases, text messaging has become an increasingly common method for communication. The Early Release of Estimates from the National Health Interview Survey (July-December 2010) showed that three of every ten American homes (29.7%) had only wireless telephones (also known as cellular telephones, cell phones, or mobile phones) during the last half of 2010, an increase of 3.1 percentage points since the first half of 2010. More than half of adults aged 25-29 (53.5%) lived in households with only wireless telephones. This rate is greater than the rates for adults aged 18-24 (45.5%) or 30-34 (43.8%). A statistic of particular interest was that adults living in poverty (42.8%) and adults living near poverty (35.2%) were more likely than higher income adults (24.1%) to be living in households with only wireless telephones. As we begin to explore the correlations between disease incidence and poverty, new avenues such as text messaging may be increasingly effective. Another important statistic related to health behaviors was that wireless-only adults (48.1%) were more likely than adults living in landline households (35.5%) to have ever been tested for HIV.

Currently, text messaging has become a viable means of partner notification or partner services (PS). In many cases, disease intervention specialists (DIS) may only be able to reach a client by text message. Conducting outreach through text messaging may be more attractive to individuals who communicate primarily via cell phone and text messaging. For

a sampling of questions received via text messages through a local text messaging program, please see **Appendix G**.

## **5.6 Internet and Cell Phone Etiquette**

While using the Internet or a mobile phone to conduct outreach, staff may encounter individuals that want to talk about something other than the topic at-hand. Creating rapport with an outreach contact is still essential; however, boundaries are just as important in the virtual world as out in a community. Outreach staff should always remain professional and use standard health education techniques while keeping the conversation centered on HIV/STD prevention and sexual health.

The following are examples of basic guidelines to follow when conducting Internet or cell phone-based outreach (NCSO, 2008):

- Make no assumptions
- Ask open-ended questions as often as possible to gain more information
- Do not give personal advice or tell clients what they should or shouldn't do
- Include risk and harm-reduction messages
- Use third-person techniques (e.g., "Most people consider unprotected oral sex safe.")
- Answer questions with facts as often as possible (e.g., "We know that unprotected oral sex puts people at higher risk for STDs like syphilis or gonorrhea.")
- Try to keep responses on an impersonal level and try not to make statements that are, or might seem to be, a personal opinion
- Provide relevant and up-to-date referrals for services
- Never entertain personal or inappropriate questions (e.g., "How do I get my girlfriend to have anal sex with me?"); stay professional and state that you are there to answer questions related to sexual health and disease prevention

Proper etiquette when using the Internet or cell phone is extremely important. It is very difficult to detect tone, body language, vocal inflection, or gestures via a chat or text message. Some basic courtesy tips are below:

- Do not type in all caps; in the virtual world it is the equivalent of shouting
- If staff have to step away from the computer for a moment or are involved in another chat session in another room, they should tell clients they will 'be right back' (brb)
- Staff should always be respectful and courteous
- Staff should not ignore IMs unless they are from potentially abusive chatters
- Staff should respond to all e-mails and texts in a timely manner, even if it is brief enough to let the client know they will send a more in-depth response at a later time

## **5.7 Recruitment and Referrals**

One of the primary objectives of Internet and cell phone-based outreach is to refer clients to web-based informational and educational resources, in addition to other service providers. It is important to maintain up-to-date resource guides for online resources and local service providers, such as, health care providers/clinics, HIV/STD prevention/treatment providers, support groups, food pantries, and pharmacies. Agencies should maintain a list of referral sources, such as: the FL AIDS Hotline, suicide or crisis hotlines, child protective services, shelter or housing assistance, and domestic violence agencies. Outreach staff should actively track referrals that are given to anyone they interact with via the Internet or cell phone. An example of a recruitment/referral log can be found in **Appendix E**.

Conducting Internet or cell phone-based outreach can be a useful tool for recruiting clients into other prevention interventions, HIV/STD testing, and treatment (Fernandez, Varga, Perrino, 2004). It can also be used to recruit individuals for focus groups, community/behavioral surveys, advisory boards, or to complete quality assurance surveys.

### **5.8 Follow-Up**

As with traditional outreach, following up with clients encountered via the Internet or cell phone may improve the chances they will follow through with services they need or obtain information. By documenting follow up, outreach staff can demonstrate the effectiveness of the services they are providing. Staff should always ask permission to follow-up with a client and ask which method of follow-up the client prefers: IM, e-mail, or text message. Following-up with a client quickly is always preferred, however, for individuals that do not log in frequently, change screen names or phone numbers, it may be difficult to follow-up in a timely manner.

## **Section 6: Internet Outreach- Monitoring & Evaluation**

### **6.1 Evaluating Internet Outreach Programs and Activities**

As with traditional outreach, monitoring and evaluation is equally essential for Internet and phone outreach. Agencies and organizations should have monitoring and evaluation standards in place to determine whether programs are meeting goals and objectives. Many of the process monitoring/evaluation and outcome monitoring questions identified in **Section 4.1** are applicable to Internet and phone outreach but may need to be adjusted due to the difference in delivery method (i.e., virtual vs. in-person).

Process monitoring tools for Internet/phone outreach can include:

- Internet contact log/database (e.g., chat room, IM, e-mail, forum, text message logs)
- Referral log/database
- Activity report form (e.g., chat room, IM, e-mail, text message, forum)
- Online survey/questionnaire
- Transcripts (e.g., chat room transcripts, text message transcripts, email transcripts)

As with all client interactions, confidentiality is of the utmost importance and should be maintained at all times. Usually, dialogue that occurs between a client and outreach worker in the field does not get recorded in its entirety. On the other hand, dialogue between an outreach worker and client via a virtual medium may be recorded for quality assurance/evaluation purposes. It is important to remember why so many people use the Internet and text messaging service for information- anonymity. Because conversations and interactions may be recorded, it is important to protect your client's privacy. This can be done in several ways:

- Clearly state your agency's policy regarding recording virtual interactions (e.g., via chat rooms, e-mail, text messaging, IM) on the agency website or in your user profile; one example could be similar to this, *"Dialogues and/or transcripts may be copied and stored for quality assurance and evaluation purposes. In order to maintain anonymity, please avoid providing identifying information."*
- During chats, e-mails, IM exchanges, or text messages, it may be necessary to remind the client not to provide any identifying information
- If identifying or confidential information is still provided by a client, delete it. If possible, substitute non-identifiable information before saving transcripts.

Confidentiality for DOH employees is discussed in more detail in *Section 2.6: Confidentiality and Privacy*. Florida’s “Sunshine” Law should be adhered to at all times and a copy of all virtual transcripts kept for public records purposes. Please refer to **Section 2.6** for the “Sunshine” law.

Below is a list of some of the ways in which an Internet or text messaging outreach program can be evaluated:

- Develop a process monitoring and evaluation plan
- Ensure consistent and accurate data collection methods and tools
- Supervisors/managers should periodically evaluate outreach staff by directly observing them in the field and providing written feedback on job performance
- Develop a tool that allows clients to provide feedback or complaints
- Designate specific staff for evaluation and quality assurance activities, as well as data collection and analysis
- Create benchmarks or indicators for assessing progress towards meeting program process objectives
- Create tools to assess the referral and recruitment processes

## **6.2 Supervision**

In addition to the information provided in **Section 4.2**, it is important supervisors and managers regularly review chat room conversations, IMs, e-mails, and/or text messages had between outreach staff and clients via the Internet or cell phone. Consistent review of dialogues and conversations will ensure both the client and staff are protected and that Internet/phone policies are adhered to. In some cases, supervisors may wish to conduct random monitorings of Internet/text messaging staff or observe them while they work. The Internet or phone-based outreach supervisor should check all documentation required from staff to include: chat room, IM, e-mail, text message logs, Internet activity report forms, and referral/recruitment logs.

## **6.3 Ongoing Training**

In addition to the information provided in **Section 4.3**, it is important to note that not all staff will have the necessary skills to conduct Internet or cell phone-based outreach activities. All staff that conduct outreach via the Internet or cell phone should be thoroughly screened to ensure they are well suited for an online or cell phone-based outreach program. It is recommended all staff conducting outreach via the Internet or cell phones go through the same training as staff conducting traditional outreach activities in the field, but emphasis should be placed on Internet etiquette, profile development/text messaging, and safety/security.

## **Section 7: Outreach- Best Practices for Populations**

When conducting any type of outreach, it is critical to remember that not all outreach approaches will work with every population. Florida is home to a wide variety of racial/ethnic communities with even more variation in lifestyles. Within most cultures, there exist sub-cultures, and in some cases, sub- sub- cultures. Sometimes it will not be possible to create inroads to every sub-culture and unless you are a part of that particular community, it may be difficult to gain insight into cultural nuances specific to that population. The most important piece of advice is to “know the community you are working with”; even the simplest things like knowing what to wear, what to say, and how to say it will help to open up communication with your target population.

For example, communication methods may not be the same for all Hispanics or African Americans. It is important to remember that socio-economic status and education levels will

also have an impact on what outreach approach you decide to use. A single mother with several children will have different priorities than a homeless person, and needs to be considered when choosing outreach methods, times, and materials.

The best practices below were solicited from HIV prevention providers (both community and state/county) across Florida. The Bureau of HIV/AIDS, Prevention Section wishes to thank all the respondents for sharing their best practices for outreach with their target populations. Special thanks to: Center for Multicultural Wellness and Prevention (CMWP), Metropolitan Charities, In the Image of Christ, AIDS Help, Hispanic Unity of FL, Big Bend Cares, Care Resource, Outreach Community Care Network, Jacksonville Area Sexual Minority Youth Network (JASMYN), BASIC NWFL, Empower-U, Alachua County Health Department (CHD), Jackson CHD, Leon CHD, Hernando CHD, Pinellas CHD, Duval CHD, Volusia CHD, Broward CHD, Miami-Dade County Public Schools, Clay County Victim Services Center, and the University of Miami Comprehensive AIDS Program.

### **7.1 General High-Risk**

A common best practice element for general high-risk populations was how to approach the public; be open, a good listener, non-judgmental, patient, do not assume or generalize, and be culturally sensitive. “Give the facts about the consequences of their high-risk behaviors.” Other respondents mentioned techniques such as public forums and presentations, standing outside on the street using placards; “conduct outreach at locations in which the high-risk populations frequent to eat, sleep/live, work, party, shop, and hang out.” Messaging was also an important factor with agencies stating that [messages] they should be “short, simple messages that have a frame of reference in the world in which they exist.” Another best practice mentioned was that outreach staff should be comfortable with the job before heading out in the community; they should also partner with STD staff whenever possible. Other agencies stated that hiring staff that are indigenous to the target population is beneficial because the staff understand the community better and are more familiar with gatekeepers and leaders.

Another agency mentioned using mobile units to canvass areas with a high prevalence of HIV/STDs and to offer other health screenings with the HIV tests (e.g., blood pressure, blood glucose, cholesterol, and STD). Others stated that the “shoe leather express” or going door-to-door and face-to-face, was the best means of conducting outreach to general high-risk populations; other effective venues were health fairs, church groups, street fairs, college campus events, and prison/jail outreach. Another agency mentioned using local media as a best practice; “...we are lucky to live in a community where there is serious networking and coordination in getting the message out to the general community on how important it is to know one’s status....the [local radio station] has dedicated time specifically to talk on the air about HIV prevention and locations for being tested.” Another agency provided the example of BRTA/LRTA (Business Responds to AIDS/Labor Responds to AIDS) initiatives to get local businesses and organizations involved in condom and educational materials distribution to the general population.

The use of incentives, when possible, was also listed as a best practice; “we have used incentives creatively, like ‘drawings’ (maximizing use of scarce resources) or ‘packaging’ services that provide incentives (like CDC’s Partnership for Health risk survey) with other services that don’t incentivize (HIV, STI, blood pressure, glucose screenings) to maximize the use of the incentive.” Agencies also reported that by packaging HIV testing with other screenings, it helps to broaden the appeal of the HIV test and results in people being more willing to get tested.

Lastly, an agency listed their best practice steps to conducting outreach in their area as the following:

- 1) Identify the high-risk areas where the target population congregates to provide general HIV awareness
- 2) Establish a level of comfort and trust with the population
- 3) Provide information on the types of prevention services available
- 4) Determine high-risk activities and behaviors occurring within the target population
- 5) Offer free, confidential HIV testing at that time and/or provide target population with dates, locations, and times they may get a test
- 6) Provide condoms and/or other materials that are pertinent to the target population and their stage of readiness
- 7) Provide contact information so the target population may reach a specialist at another time

## **7.2 HIV Positive**

A common best practice listed for HIV-positive individuals was support groups. Although support groups can't be done in the field, they are a great way to get HIV-positive individuals together and provide education and materials in a safe, confidential environment. One respondent made the statement that, "...you can't just put up a sign that says all individuals with HIV please come to this table; outreach must be conducted in places that individuals with HIV frequent such as medical clinics, ASOs, CBOs, pharmacies, health awareness events, and support groups." Another agency discussed using the Internet to reach HIV-positive individuals with the Community PROMISE intervention. He mentions that, "his interaction with POZ individuals is mostly to make them aware that they can be re-infected with a different strain of HIV and that what is working now for them medically may not in the future if they don't use precaution while engaging in sexual activity." Other places noted as good locations to reach HIV-positive individuals included HIV clinics, STD clinics, ADAP offices, Ryan White eligibility offices, and CHD pharmacies.

Agencies also responded they frequently link HIV-positive individuals encountered through outreach to interventions such as ARTAS (Antiretroviral Treatment Access Study) and CRCS (Comprehensive Risk Counseling Services); these interventions use an individualized approach to help reduce risk behaviors and promote adherence to treatment for persons living with HIV and/or AIDS. Another agency said it is important to "be consistent, reinforce testing options for partners, reinforce safe sex messages/condom usage...reiterate that intimacy and sex are not off-limits, if safely practiced...offer assistance with disclosure if appropriate, and lastly, reinforce the benefits of going to regular doctor visits and creating/maintaining an emotional support system." Other staff cited examples of using materials and posters in waiting and exam rooms of medical providers "so that HIV-positive individuals are exposed to what services an agency can offer without actually having to ask someone....this allows them to maintain their dignity and yet know where they may go [for services] when they are ready."

## **7.3 Black/African-American**

A common best practice among black/African American populations was to conduct church outreach. As faith is an integral part of many black/African American's lives, the church can be an important venue to reach many individuals. Careful attention must be paid to how one approaches a congregation and the initial conversation with the clergy should be well thought-out. As with any population, it is important to gain the trust of the church first before presenting any information or materials to members.

Other agency staff stated, “you must first gain their trust; you must first present the benefits prior to informing them about the need for health services that you are providing...if not, you will lose them.” Best practices also included street outreach, going door-to-door, having a presence at community events consistently, and being respectful and understanding of all individuals. Another agency discussed the use of SOS (Sistas Organizing to Survive) in conjunction with health fairs to reach out to black/African American women. The SOS/health fair combination “provides a venue to reach members that would not otherwise be tested and/or receive health services.”

Respondents also cited credibility within the community as being of utmost importance when conducting outreach to this population. “Having credibility allows me to attend club events, social gatherings, etc.” Rapport also goes hand-in-hand with credibility and the more consistent you are with this population, the better you will be received. Also mentioned was the use of culturally-specific messages that inspire African Americans; “use role models to reinforce the messages; be sensitive and realize that this population has ongoing fears and mistrust of the majority population, especially in the South where discrimination is still prevalent and very institutionalized.” Respondents also mentioned, “identifying what the immediate needs are and assisting to address them is a main component of outreach. HIV is not their main priority and until we can address housing, child care, food, or another need they perceive as priority, we will not be effective in educating them on HIV. A level of trust has to be established and you must be sensitive to the culture of this population.”

Other venues listed as best practices for conducting outreach for black/African American communities included, social events (concerts, festivals, etc.), faith-based organizations, bars, night clubs, community centers, local businesses, Historically Black Colleges and Universities (HCBUs), beauty/barber shops, urban league centers, corner stores, store fronts, public housing neighborhoods, community block parties, and community hang-outs.

#### **7.4 Hispanic/Latino**

As with other racial/ethnic populations, it is always important to remember to be culturally sensitive and to not take a generalized approach for everyone. Within the Hispanic/Latino community there are many sub-populations, based on country of origin and in some cases, immigration status. It is important to assess current needs before providing education and awareness messages and information. Respondents cited venues such as small bodegas, tiendas/taquerias, Laundromats, faith-based organizations, clubs, bars, and other businesses or areas where the community normally hangs out. Another best practice mentioned to reach out to Hispanic/Latino populations was the use of Latin radio and television channels (e.g., Telemundo, Univision) in combination with attendance at Hispanic health fairs, festivals, and other social gatherings.

Fotonovelas (similar to a soap opera but in the form of a comic book with pictures of real characters) have proved to be very effective in educating Hispanic/Latino communities. Whether using a fotonovela or other types of educational materials, it is always important to tailor materials to include everyday (or common) language of the population and ensure that the language is developed with country of origin (e.g., Cuba vs. Mexico vs. Puerto Rico) and educational level in mind.

It is also important to have bilingual staff available to perform outreach; in cases where bilingual staff are not available, a best practice would include recruiting a gatekeeper (e.g., a community leader or elder) within the Hispanic/Latino community in your area to assist with gaining access to venues where Hispanics/Latinos frequent. In these cases, it is also helpful to collaborate with

other organizations and businesses that are frequented by the Hispanic/Latino population and already have established relationships within the community. If conducting conversations with individuals in the field is not possible (e.g., due to language barriers), then materials and information (in Spanish language and tailored to country of origin) can be left at high-traffic venues.

### **7.5 Women**

When conducting outreach to women, it is best to have another woman go into the field. Some women may not be comfortable speaking to men, especially if their specific culture dictates a clear separation between genders and gender roles. One respondent uses a practice called HOT (Home Outreach Testing) Parties to reach groups of women at a time. This practice works in her area because the women feel more comfortable to share experiences, learn about HIV/STDs, and get tested for HIV in a safe space, such as a friend's home.

Other respondents noted that creating special events that cater only to women is a good way to draw in community members. Emphasizing empowerment, caring, and health (e.g., sexual health, family health, etc.) can help to get women to the event and then educate them on preventing/treating HIV and other STDs. Because women tend to be caregivers for their family, “women tend to neglect their own well-being for the health of others, thus, health fairs which address family health, education, and SOS (Sistas Organizing to Survive) tend to be the best strategies to address women’s issues.” It is also important to note any signs of verbal, physical, or emotional abuse past or present and refer the client to appropriate services if necessary. By determining the role of the woman within her family, you will be able to better frame HIV/STD prevention messages to her specific life situation. “When in the field, we emphasize the importance of empowering women to take responsibility for themselves; being a good listener and identifying risk behaviors and having open dialogue in their comfort zone has been successful.”

Venues listed as best practices to reach women include: WIC (Women, Infants, and Children) offices/waiting rooms, OB/GYN offices/waiting rooms, Medicaid offices/clinics, faith-based organizations, churches, clubs, beauty shops, hair/nail salons, Laundromats, government assistance locations, domestic violence shelters, women’s correctional facilities, victim services centers, girl scout troops, shopping centers, grocery stores/markets, and other social functions that women attend.

### **7.6 Youth**

Many times, outreach staff feel that reaching youth outside of school settings is difficult but there are other avenues to explore besides school settings. In some cases, outreach staff are not allowed in schools, especially if the school does not teach comprehensive sex education, but rather, focuses on abstinence-based education. A common best practice mentioned from respondents included making the outreach fun; “include small prizes, giveaways, interactive activities, food, open discussions with peers, having the ability to ask questions that they would normally be too shy to ask in public.” Staff also responded, “Listening, listening, listening; youth need to feel that they are heard, understood, and respected; in outreach, if you are older, you may slide into a ‘parental’ role, which may not be helpful; it is important to create a relationship where you are a sounding board and facilitator to help them uncover and discover the changes they want to make.” Since college-aged students are also considered youth, college campuses and classrooms can serve as another venue to conduct outreach.

Many youth are not receiving the HIV/STD education they so desperately need and as a result, many are becoming infected with STDs and HIV at younger and younger ages. Condoms are

rarely distributed at junior high and high schools and as a result, many youth do not use protection. Cost and embarrassment can also be barriers to youth purchasing condoms, which is why it is important to provide condoms, if appropriate, to youth receiving HIV/STD testing or education.

Another agency cited peer education as being a best practice - “peer education is most effective; however, peer education must be monitored and youth need to be educated with HIV/STD basics before speaking to other youth.” In addition to using peers to educate, recruiting mentors or coaches can also be effective in reaching youth where they are. One agency discussed a best practice of recruiting local sports coaches from the community to act as “lay” health educators and to provide youth with information and materials when appropriate. The “Positively Negative” project was also referenced as a national best practice for reaching teens by NACCHO; “Positively Negative” is an education and testing program geared to African-American youth who are at risk for acquiring or transmitting HIV/STDs with the purpose of increasing knowledge and the proportion of youth that are tested.

An agency that works primarily with LGBTQ (lesbian, gay, bisexual, transgender, queer and/or questioning) youth, listed specific examples that assist in reaching out to this vulnerable population, “ [we] apply a multi-faceted approach to outreach...[we] offer support groups, Youth Council, HIV/STD clinic/testing, HIV prevention interventions, case management, food pantry, social events (e.g., movie nights, prom, drop-in), skills building groups (career support/training), artistic expression groups, community education, and a Gay/Straight Alliance support network.” Social media is also important in reaching youth as most youth have a cell phone/computer or access to a cell phone or the Internet. Best practices to reach youth include: Facebook, Twitter, printed calendars, e-mail to other social service agencies that serve youth, text messages, word-of-mouth, community event announcements, areas/venues known to be popular with youth (malls, coffee shops, bookstores, recreation centers), sports teams/clubs, skating rinks, fast food restaurants during school lunch hours, game rooms, video game stores, and after-school clubs/organizations if appropriate.

## **7.7 Migrant/Rural**

For many migrant/rural populations, the costs of treatment, medication, doctor visits, and hospitalization are barriers to accessing health services. Geographic isolation and lack of transportation further limits their access to health care; in addition, many undocumented workers fear that seeking mental health services may cause them to get fired from their job. In Florida, the majority (over 80%) of migrant/rural populations are of Hispanic/Latino ethnicity, although migrants of different racial/ethnic backgrounds (e.g., Vietnamese, Haitian) do exist within our state. Other barriers include lack of power and increased vulnerability due to an uncertain legal status, substandard physical living conditions, and separation/isolation from family members that may be in another country. There is also increased prevalence of domestic violence experienced by low-income, predominantly Latina farm-worker women. Florida is commonly known amongst law enforcement personnel to have one of the highest incidences of human trafficking in the country. Labor trafficking victims are typically utilized in areas where there is a demand for unskilled labor, which is present in sectors such as seasonal agriculture, garment manufacturing, construction, and domestic servitude.

When working with the Hispanic migrant/rural community, it is critical to gain trust and acceptance before presenting information and/or materials through outreach. Many members of this community fear that by accessing HIV prevention and outreach services, they will be reported to the U.S. ICE (United States Immigration and Customs Enforcement) and risk being deported to their country of origin or face jail/prison time.

Often times, migrant camps are well-hidden and outreach staff will not be able to find them or reach them without enlisting the help of a community gatekeeper or the camp “landlord”. One best practice noted from the field comes from Alachua County where Hispanic migrants are brought in to harvest blueberries every year. Staff obtained permission from management that oversees the harvest, and outreach (HIV testing, education, materials) is conducted in the blueberry fields at a certain time of day when the workers have been granted a break. Because transportation is often a barrier to this population, staff travel to the fields to offer migrant workers prevention education, materials, and linkage to other services.

Location, date, and time of day is also an important consideration when conducting outreach to migrant/rural populations. The migrant population work in the fields from early morning (dawn) until late afternoon (dusk) during the picking or crop seasons, so the day and time must be adjusted to reach them while they are not working. One best practice is to conduct outreach on Sundays or on a weekday (after dusk when the workers return to their homes). Also, during the day, small children who are not in school are left with a few women that act as a day care for many members of the migrant camp; this would be an opportunity to reach the women of the migrant camp.

When considering what materials to use, it is important to remember that because materials are in Spanish language it does not mean that it is appropriate for every Hispanic/Latino population. Materials need to be sensitive to the specific culture or country of origin and should also address gender roles when possible. Fotonovelas have proven to be very effective in educating Hispanic/Latino communities. Whether using a fotonovela or another type of educational material, it is always important to tailor materials to include everyday (or common) language of the population and ensure that materials are appropriate for the educational levels. In certain agencies, geographic distance and lack of bilingual staff can present challenges with distributing materials and conducting outreach to rural/migrant populations. In these cases, it is helpful to collaborate with other organizations and businesses that are frequented by the rural/migrant population and already have established relationships within the community.

Other venues and events where migrant/rural populations can be reached include: Laundromats, Consulate events (e.g., Mexican Consulate event), Hispanic churches or faith-based organizations, migrant or work camps, crop fields during picking season, migrant education centers, tiendas/taquerias, fairs/carnivals, bars, and certain clubs.

### **7.8 Gay, Bisexual, and other MSM**

A common best practice listed among respondents was to tailor the prevention message to meet specific needs of gay, bisexual, and other MSM. “Most MSM know their risk, so continuing to preach that message is not always effective. You must be able to tailor the outreach to somehow convey the message that the program or service will help them to lead healthy lives which will allow them to maintain or reach their goals.” Another agency listed a new approach called “NW FL Manreach” which involves a retreat-style camping trip for gay men of all backgrounds; men come together and participate in prevention education, skills building activities, and sharing experiences (in a similar format to the Mpowerment intervention).

Many agencies listed using the Internet as a best practice to reach gay, bisexual and other MSM. “I work online with the PROMISE intervention. I have to say...it is absolutely amazing. I am so encouraged with the results, and I have several identifications from different role model stories I have written.” One respondent stated, “MSM need competent staff who are able to answer their questions; they frequently don’t have others in their lives who either know their situations or are knowledgeable enough to answer their questions. Also, when we’ve had

motivated staff working on social networking sites, they have been able to answer questions and recruit participants in services like CRCS, but the staff have to be motivated and competent to maneuver through these sites.”

Others responded, “Be sensitive, be direct. Remember that there are many subpopulations within this population. Remember that differences in age can be reflected in individuals’ response to being positive or at-risk. Be patient because this population will challenge you like no other.”

Venues and events listed as best practices include: gay bars/clubs, bath houses, adult bookstores, gay resorts, social networking sites (“niche” websites that cater to MSM), sex clubs, sex parties, gay/bi events (Pride, Gay Days, Bear Run/weekends, White Party, Gay Rodeo, gay softball/bowling leagues), gay/straight alliances, LGBTQ student unions, CBOs, faith-based organizations, PFLAG (Parents, Families, & Friends of Lesbians and Gays) meetings, MSM-friendly medical practices or clinics, STD clinics, LGBT community centers, gay/bi-friendly businesses/associations, and gay newspapers/magazines.

## **7.9 Transgender**

Transgender (‘trans’) is an umbrella term for people whose gender identity and expression do not conform to norms and expectations traditionally associated with their sex assigned at birth (UCSF Fact Sheet 67, 2010). Transgender people, including transsexual and intersex people, exist in every race, class, and culture. Some factors that drive HIV transmission among trans populations include social stigma (discrimination, violence, unemployment, poverty, homelessness, incarceration), gender identity validation through sex (multiple sex partners, unprotected sex), survival sex work (unprotected sex, substance use), lack of appropriate medical care (lack of screenings, including HIV/STDs), culturally incompetent prevention methods, multiple injection risks (drugs, silicone, hormones), self-medication through street hormones, and reluctance by MSM-serving agencies to include trans people.

Despite the evidence of extremely high levels of HIV prevalence among trans women in the US, there are no interventions in CDC’s EBI portfolio specifically developed for use with trans people. However, there are several agencies across the country adapting EBIs or creating “homegrown” interventions for trans people. Because the trans population is so diverse, it is almost impossible to develop one universal intervention that addresses all trans people’s needs.

In order to effectively reach out to trans populations, staff should follow some basic guidelines below (AETC, 2009):

- Be aware of possible negative histories with other providers and/or prevention staff
- When asking about sexual behavior, use gender neutral language like, “I need to know what body parts you use for sexual activity.”
- Do not assume a transgender person’s sexual orientation
- Mirror the language that the clients use to describe their body parts
- Be familiar with different types of body modifications trans people may choose (e.g., binding and tucking of body parts, hormone therapy, silicone injections, various gender confirming surgeries [chest, genital, internal], etc.)

Other important points to remember are (AETC, 2009):

- Transgender women of color are at highest risk for HIV
- Young trans women of color often have a “hierarchy of needs” that may take priority over other messages and information

- It is important to involve partners or at least mention that partners should be using protection and getting testing for HIV/STDs
- Trans communities are diverse in terms of gender identity and expression, race/ethnicity, age, socioeconomic status, substance use, etc.

Another best practice, from Broward County, comes in the form of T-House: a digital drop-in center serving the transgender community ([www.T-Houseonline.com](http://www.T-Houseonline.com)). This initiative provides relevant links and materials to assist both providers and members of the transgender community. It provides important information and resources addressing HIV/AIDS, STDs, hepatitis, and other health issues pertinent to trans communities.

Venues listed as best practices to reach transgender populations include: gay bars, night clubs, hormone and silicone parties, clinics known to provide services to trans, ASOs, CBOs, drag shows, and drag balls (e.g., those that participate in ball culture, the house system, and/or ballroom community). It may also be useful if there is a known “house mother” to connect with that person to gain acceptance in the trans community ([http://en.wikipedia.org/wiki/Ball\\_culture](http://en.wikipedia.org/wiki/Ball_culture)).

### **7.10 Injection Drug Users (IDU)**

Currently, Florida law prohibits syringe exchange programs. Outreach to IDUs has been among one of the most successful approaches in preventing HIV and hepatitis C transmission and acquisition. Before making contact with drug users in the field, it is important that outreach staff identify potential sites where drugs are used, purchased, or traded. In addition to ‘where’, it is also important to identify what time of day or night is most effective in reaching drug users.

Indigenous outreach staff can draw on personal experiences to help identify areas in the community where there is high drug activity. Outreach staff who are in drug recovery may also be an asset to the program, as they are likely to know specific sites where drug use occurs. Working with drug treatment agencies may also be beneficial for identifying when and where to reach high-risk individuals. The drug treatment centers may also have regularly scheduled support groups for recovering drug users that can be tapped into for HIV/STD, and hepatitis C education, screening, and linkage to care.

Several agencies also take HIV education and testing to jails where they have been successful in reaching current or former IDUs. Respondents also noted that drug courts can be an effective venue for reaching IDUs; drug court is mandatory and therefore, a captive audience is available for HIV and hepatitis C education and testing. Using a mobile unit to perform HIV testing in areas where drug use and acquisition is high has also been effective in educating and linking IDUs to care and treatment services.

Identifying the major prostitution ‘strolls’ is a good place to start when targeting IDU in the streets; as are shooting galleries, crack houses, bars, liquor stores, public housing projects, soup kitchens/homeless shelters, check-cashing centers, lounges, pool halls, storefronts, and public parks.

### **7.11 American Indian/Alaskan Native**

The long history of oppression within American Indian/Alaskan Native (AI/AN) populations (e.g., colonization, outlawing of Native languages and spiritual practices, and centuries of forced relocations) has created a mistrust of U.S. government programs and health institutions. Like in many other tight-knit communities, confidentiality can be difficult to maintain in AI/AN communities, especially in rural areas. This, coupled with geographic isolation, can be a barrier

to important prevention activities such as testing for HIV, discussing sexual practices with health care providers, obtaining drug treatment, or buying condoms in local stores.

When considering best practices to reach AI/AN populations, it is important to note that Florida has over 500 different tribes, bands, and clans, with the majority of them not being Federally recognized. The only two tribes within Florida with Federal recognition are the Seminole Tribe of Florida and the Miccosukee Tribe of Indians of Florida. It has been established that HIV/STD prevention can work with this population, but what works *must* come from the community itself. The most effective strategies are programs that are “for, of, and by” the population being targeted- in this case, Florida’s American Indian population. One best practice comes in the form of the Shawl Circle- the first project developed specifically for Florida’s American Indian women. The Shawl Circle is a community level, HIV prevention and cervical and breast cancer early detection intervention that uses community health advocates (CHAs) or “peer educators” to go back into their respective communities and educate other community members about HIV/STDs and cervical and breast cancer. By using a peer educator approach, women have the freedom to conduct education sessions when and where they choose, in a format that is culturally appropriate for their tribe, band, or clan.

It has also been a best practice to include other screenings with HIV, when taking prevention services into the field. Screenings such as blood pressure, blood glucose, cholesterol, eye exams, etc. are a way to decrease the stigma associated with HIV testing, and still get AI/AN populations to engage in health screenings. In many cases, AI/AN populations live in rural areas and therefore, it is a best practice to take outreach and services into their communities if at all possible. One particular venue that has been established as being effective is the Native American Pow-Wow or tribal gathering. Many different tribes, bands, and clans come together for these events which typically last three to four days, and are usually held over a weekend; pow-wows tend to follow a spring/fall pattern. Many attendees bring their crafts and goods to sell and/or trade, while others come to visit with family, enjoy dancing, culture, music, food, and special ceremonies.

One important thing to remember before attempting to work with AI/AN populations is that you must always gain permission before attending a tribal event for work purposes. In all instances, proper protocol must be followed and elders must be spoken with (usually in-person) before anything can be agreed upon. This population is extremely wary of outsiders and gaining acceptance is not something that can be accomplished overnight. You will most likely have to meet several times with the elders of the tribe before they will give you an answer on whether or not they will allow you to perform outreach or testing at one of their events. Most importantly- be patient. It can be frustrating to not receive an answer about an event right away, but know that by respecting tribal customs, you are more likely to be welcomed at future events and your relationship with AI/AN populations will be off to a good start.

### **7.12 Internet/Phone**

With more and more Americans using the Internet and cell phones, these forms of communication are proving to be effective in reaching many populations for HIV/STD prevention and outreach. Several agencies are currently using the Internet and/or text messaging to conduct HIV/STD prevention outreach with successful results.

One provider uses the Internet to distribute role model stories in conjunction with the Community PROMISE intervention. Their particular focus is with MSM and they use online profiles (role model stories) to engage gay, bisexual, and other MSM in HIV prevention discussions and provide information on HIV testing and related resources. They place role

model stories on various social networking and “niche” sites that cater to MSM. Staff stated, “I am so encouraged with the results...I am shocked sometimes at the number of responses I get during the course of the day. I know I am reaching huge numbers of MSM, and for the most part, I feel that they have read my profile, and they usually let me know that they do PLAY SAFE.” He also says, “I am always amazed at how many are HIV positive and are willing to admit it, and talk about it.” Virtual media outlets (Internet, cell phone/“smart” phone, texting) have far surpassed the reach of print media, TV, and radio, and as a result, are becoming effective tools to reach large numbers of people at risk for acquiring or transmitting HIV/STDs.

Another agency in Alachua County recently began providing HIV/STD outreach via a text messaging program. This particular program focuses on reaching teens and young adults (college-aged) to provide accurate education and resources about HIV and STDs. In many cases, young people rely solely on their cell phones for communication and information; some only pay for a texting plan to reduce the cost of their phone bill. The program itself is advertised via a web page on the Internet and regular educational presentations conducted in-character with youth. Youth get the hands-on education from the provider, but then they are told that if they have other questions or ever need an answer to an HIV- or STD-related question, they should text their question to a particular number. Since the beginning of the program, the provider has received hundreds of text message questions from youth all over the county and done their best to answer all of them. Many questions received are very basic, from “Is testing free at the health department?” to “Do I need to show my mom’s health insurance to get services?” to “Is there a way to get tested without a parent finding out I got tested?”. The answers are always very professional and based on Florida law. For instance, the answers to the above questions usually look something like this, *Go to [www.313hiv.com](http://www.313hiv.com) for times and locations to get tested in your county. Persons over the age of 13 do not need parental consent to test for HIV or STDs (F.S. 384.30) at any local county health department in the State of Florida. You do not have to show insurance information if you are under the age of 18. We encourage you to communicate with your parent if you are having sex; there may be consequences they should know about. If they do not know you are having sex, and something happens, have you thought about what you will do? Keep this in mind. [www.faceitflorida.com](http://www.faceitflorida.com) and [www.teentruth.org](http://www.teentruth.org) are 2 great websites to help you in communicating with your parents. Thanks for your question and be safe.*

### **7.13 Gatekeepers**

Gatekeepers consist of businesses, organizations, community leaders, politicians, clergy members, and anyone else in a community that has close connections with the population you are trying to reach. Gatekeepers are people that will help to educate and provide materials to community members; they will also help to create norms surrounding HIV testing, education, and prevention. Gatekeepers can range from county commissioners to school principals, and pastors at local churches to leaders in the LGBTQ community. Working with gatekeepers can be effective in reaching populations that are difficult to establish rapport with. Gatekeepers usually know where and when the population congregates and for example, if they own a business that the population frequents, they can provide condoms, prevention messages, and information on where and when HIV testing is available in the community. They may even be open to having HIV testing performed at their business on certain dates and times.

When working with gatekeepers, it is important to recognize them in some way, to let them know their role in the community is appreciated. Sometimes, it can be as simple as presenting them with a certificate of recognition they can hang on their wall (in their business or office), or perhaps have a special lunch or dinner for all community gatekeepers to show them the work they are doing is important to your agency and community. By gathering all the gatekeepers

together to show appreciation, it provides an opportunity to solicit feedback from them on the work being done in the community. It also provides an opportunity for them to bring new players to the table and potentially recruit more gatekeepers.

To recruit gatekeepers, consider having an initial meeting and give each potential gatekeeper a packet of information about what you are trying to do in the community. The more information they have about the outreach program and initiatives, the more information they can pass on to community members. If your gatekeeper owns a business or has an office, ask them if they would be open to making it a drop-off site for outreach. If they are willing, outreach staff could provide them with condoms, educational materials, and resource information, which they can hand out to community members.

Some other examples of gatekeepers include: barbers, beauticians, dry cleaners, convenience store/grocery store owners, local retailers/businesses, pastors, tattoo/piercing shop owners, security guards, police officers, school principals, coaches, teachers, local radio personalities, restaurant owners, county commissioners/representatives, local media members (e.g., TV news anchors), local entertainers (e.g., drag queens, DJs), bartenders, bar/club owners, nurses, doctors, school counselors, girl scout/boy scout troop leaders, LGBT community center directors, domestic violence shelter staff, homeless shelter staff, and food pantry staff.

### **Section 8: Summary**

We hope this document will be a useful guide in the development and implementation of outreach programs, protocols, policies, training and evaluation. When implemented correctly, outreach can be an effective intervention for HIV and STD prevention. As new technologies become apparent, this document will be updated to include these new avenues for outreach and other HIV/STD disease prevention activities.

### **Glossary (General terms, definitions, acronyms)**

**AIDS-** Acquired Immune Deficiency Syndrome

**ASO-** AIDS Service Organization

**CBO-** Community-based Organization

**CDC-** Centers for Disease Control and Prevention

**CRCS-** Comprehensive Risk Counseling Services (formerly Prevention Case Management); individual-level behavioral intervention

**DOH-** Department of Health

**DIS-** Disease Intervention Specialist

**DJ-** Disc Jockey

**Fotonovela-** small pamphlet akin to comic-book format, with photographs instead of illustrations, combined with small dialogue bubbles. Originally developed in Latin American countries, they typically depict a simple story enveloped in a dramatic plot that contains a moral, or in this case, a health message.

**GIS-** Geographic Information Systems

**HIV-** Human Immunodeficiency Virus

**HIV 500/501-** HIV education course required by DOH for all persons wishing to become certified HIV counselors and testers.

**HOT Party-** Home Outreach Testing Party

**ICE-** Immigration and Customs Enforcement

**IM-** Instant Message

**Intervention-** A set of activities designed to reduce the risk for HIV infection or transmission with a common set of objectives and delivery methods; may be one or more sessions; and may be delivered to an individual, to a group, or to a community.

**LGBTQ-** Lesbian, Gay, Bisexual, Transgender, Queer/Questioning

**LIFE-** Learning Immune Function Enhancement; group-level behavioral intervention

**MAC-** Minority AIDS Coordinator

**MSM-** Men who have sex with men

**NACCHO-** National Association of County and City Health Officials

**Niche website-** A term used to describe a website (primarily dating websites) that is used to match people with similar interests.

**OB/GYN-** Obstetrician/Gynecologist

**Outcome Monitoring-** Involves the routine documentation and review of program-associated outcomes (e.g., individual-level knowledge, attitudes, and behaviors, or access to services; service delivery; community or structural factors) in order to determine the extent to which program goals and objectives are being met.

**Outreach-** HIV prevention intervention designed to meet potential clients in their own communities and in settings where they live, work, and socialize in order to link them to prevention, testing, and treatment services.

**PFLAG-** Parents, Families, and Friends of Lesbians and Gays

**PPG-** Prevention Planning Group

**Process Evaluation-** Assesses planned versus actual program performance over a period of time for the purpose of program improvement and future planning.

**Process Monitoring-** The routine documentation and review of program activities, populations served, or resources used in order to inform program improvement and process evaluation.

**PROMISE-** Peers Reaching Out and Modeling Intervention Strategies; community-level behavioral intervention

**PS-** Partner Services

**Quality Assurance-** The systemic monitoring and evaluation of the various aspects of a project, service or facility to maximize the probability that minimum standards of quality are being met by the production process.

**SISTA-** Sisters Informing Sisters on Topics about AIDS; group-level behavioral intervention

**SNS- Social Networking Sites** (*can also be used as an acronym for Social Networking Strategy*)

**SOS-** Sistas Organizing to Survive

**STD-** Sexually Transmitted Disease

**Taqueria-** A restaurant or stand specializing in Mexican dishes, as tacos and burritos.

**Tienda-** In Cuba, Mexico, etc., a booth, stall, or shop where merchandise is sold.

**VOICES-** Video Opportunities for Innovative Condom Education and Safer Sex; group-level behavioral intervention

**WIC-** Women, Infants, and Children

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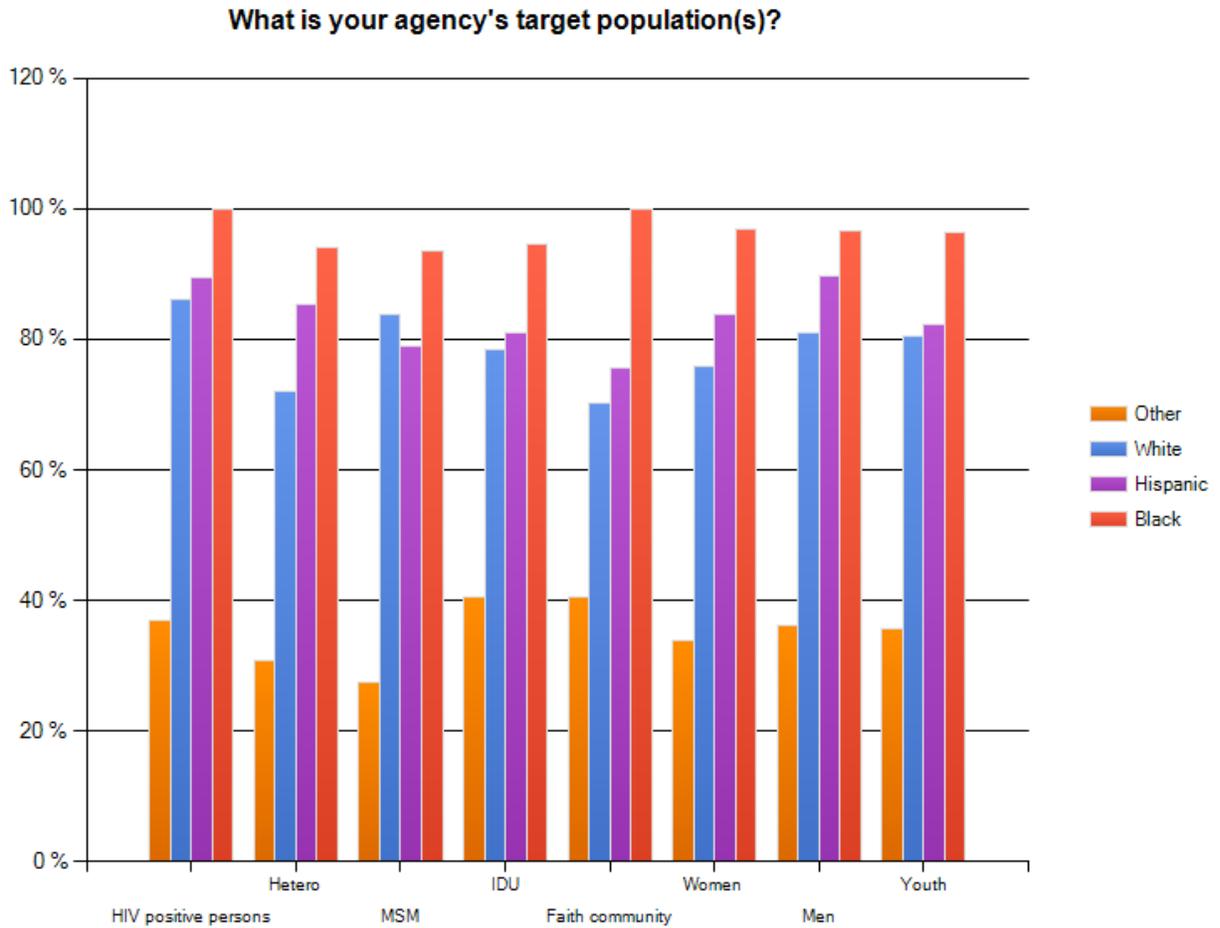
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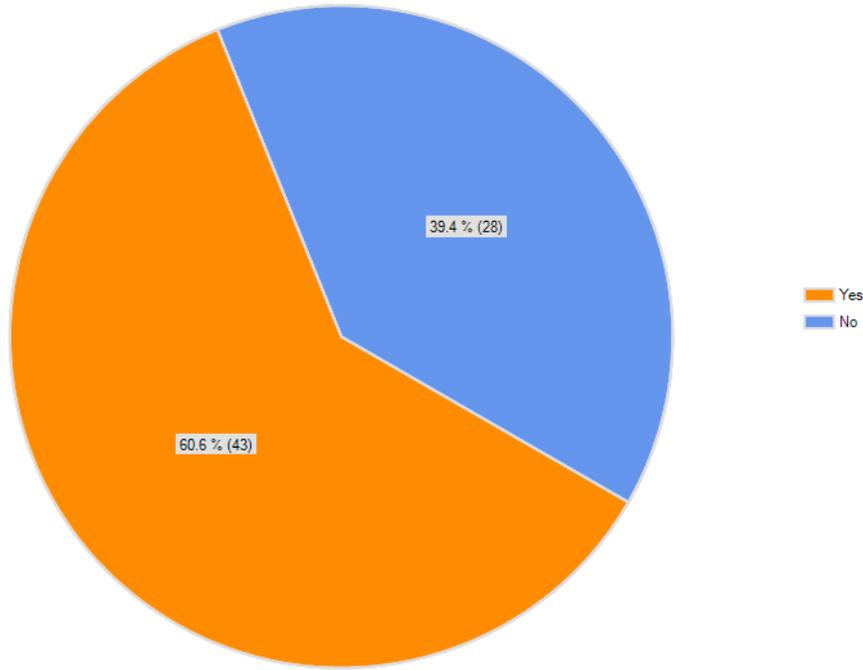
**Appendix A**  
**Florida's Traditional & Internet-based Outreach Activities: Phase 1 Survey Report**  
**Charts and Graphs**

**Phase 1 Survey Results Overview**  
**III. Target Population(s) Served**



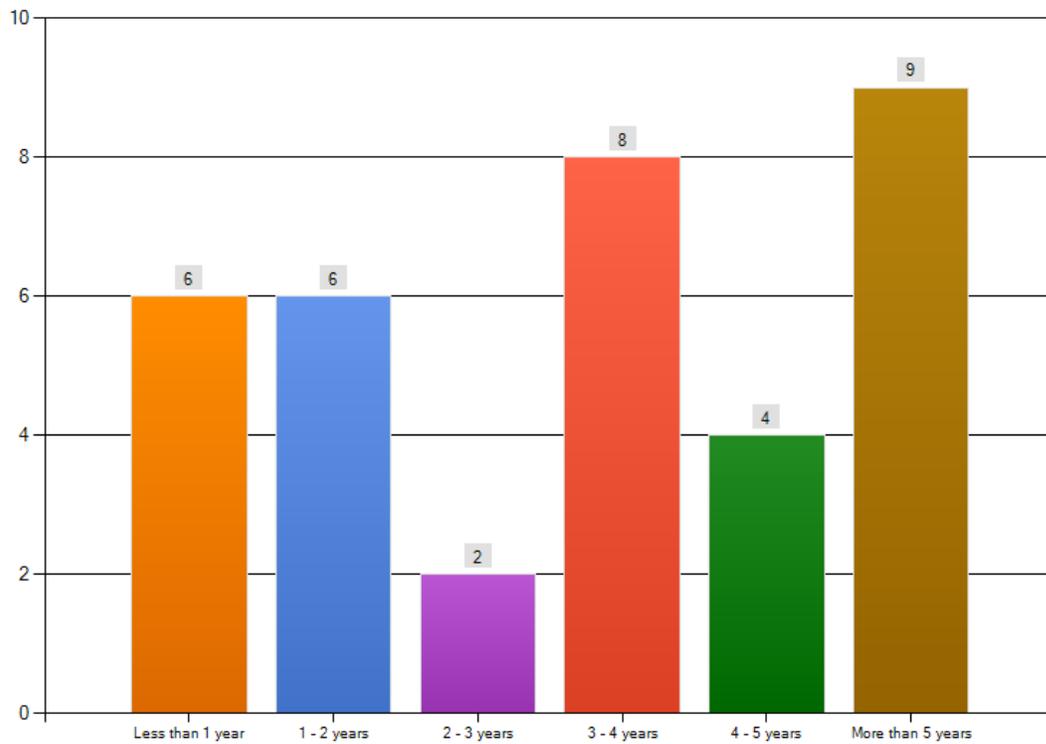
**Part A- Internet HIV Prevention Activities**  
**I. Agency Internet Use**

Does your agency currently use the internet for HIV prevention activities?



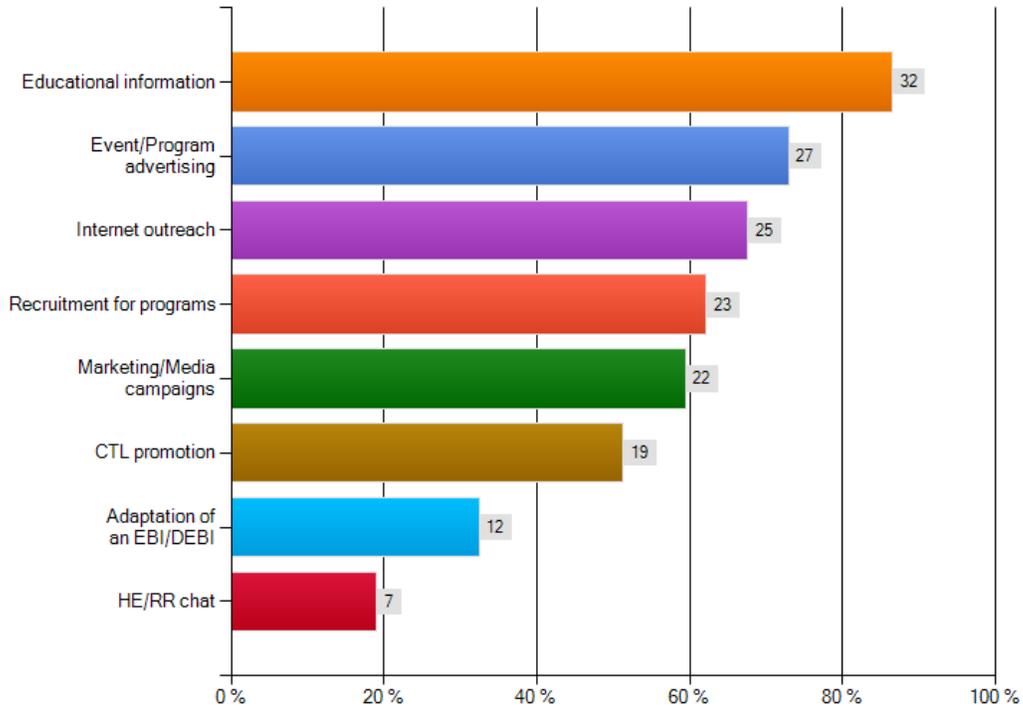
**II. Experience with Internet-based HIV Prevention**

How long has your agency been using the web for Internet-based HIV prevention?



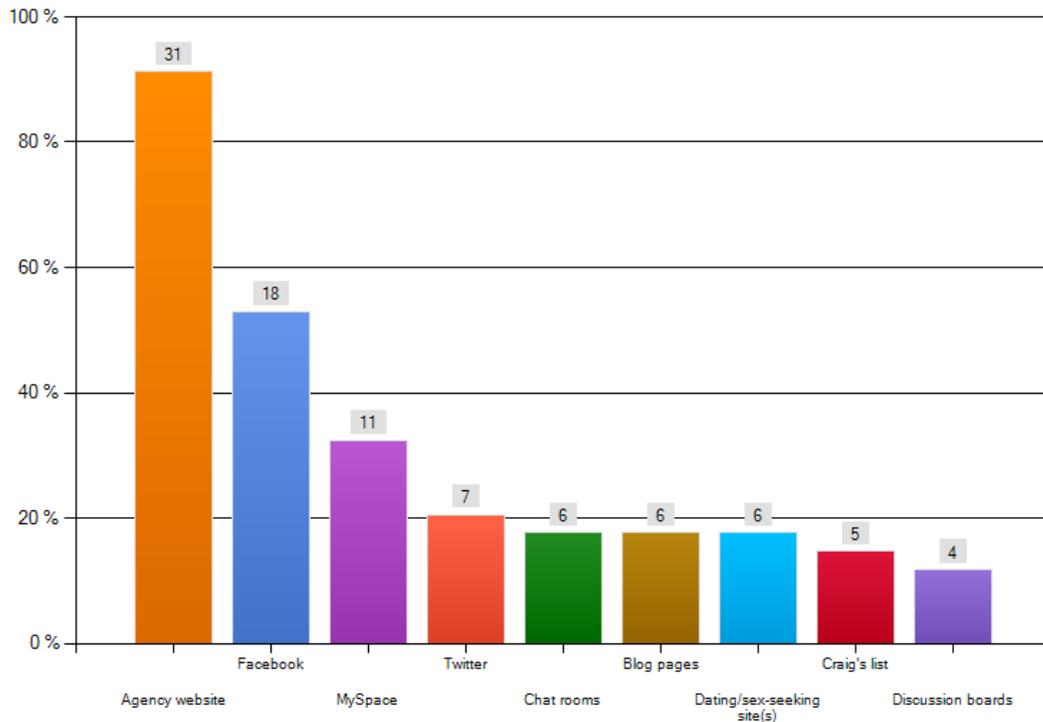
### III. Utility of Internet for HIV Prevention

Check the box(es) that best describe your agency's use of the Internet for HIV prevention activities.



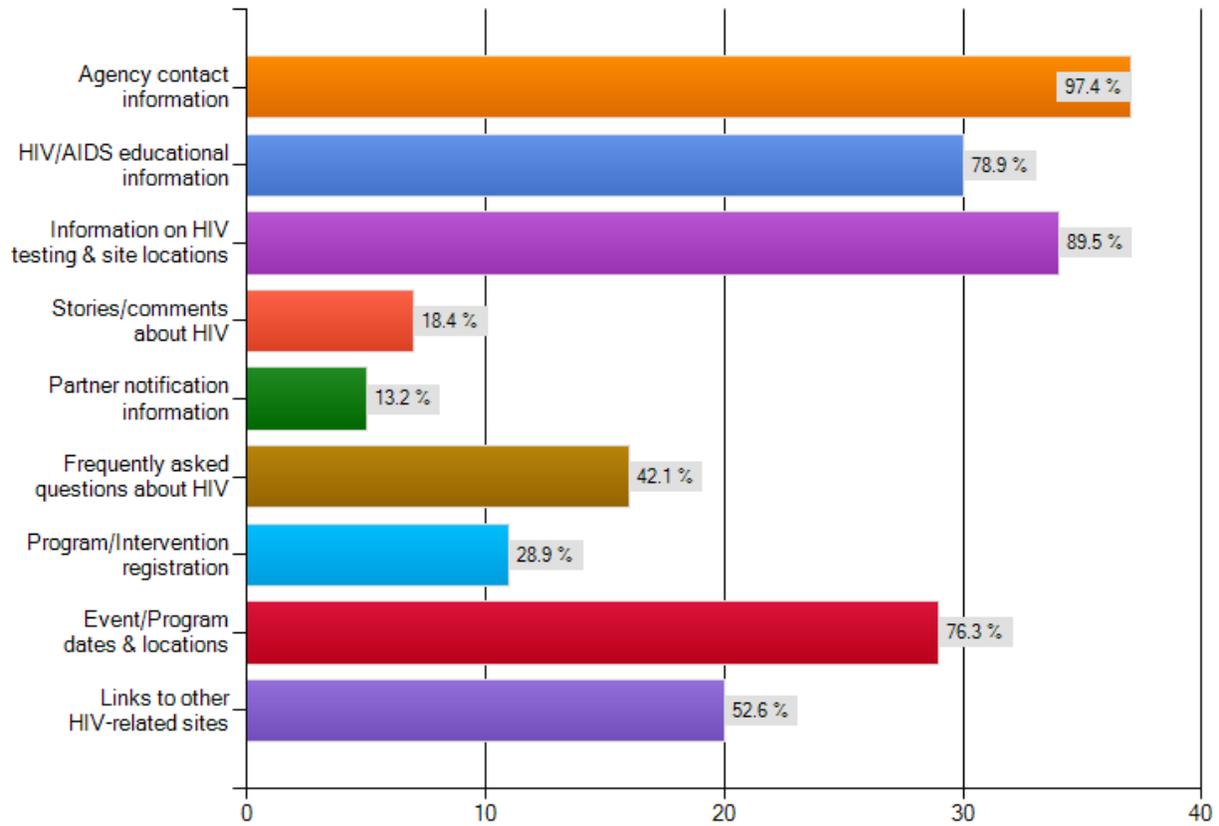
### IV. Internet Sites Used

Which Internet site(s) does your agency use for the Internet-based HIV prevention activities?  
Please check all that apply.



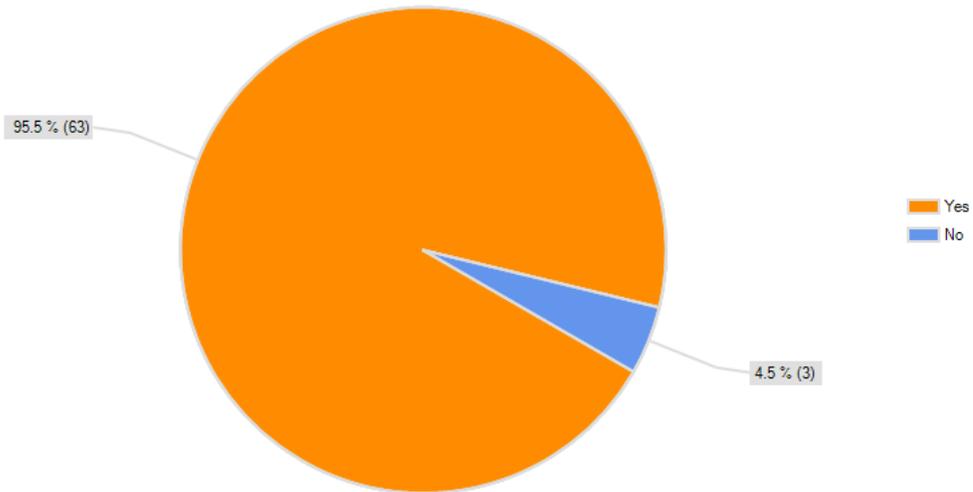
## V. Information Provided to Viewers (via Internet)

What information can the viewer obtain from your agency's Internet resources? Please check all that apply.



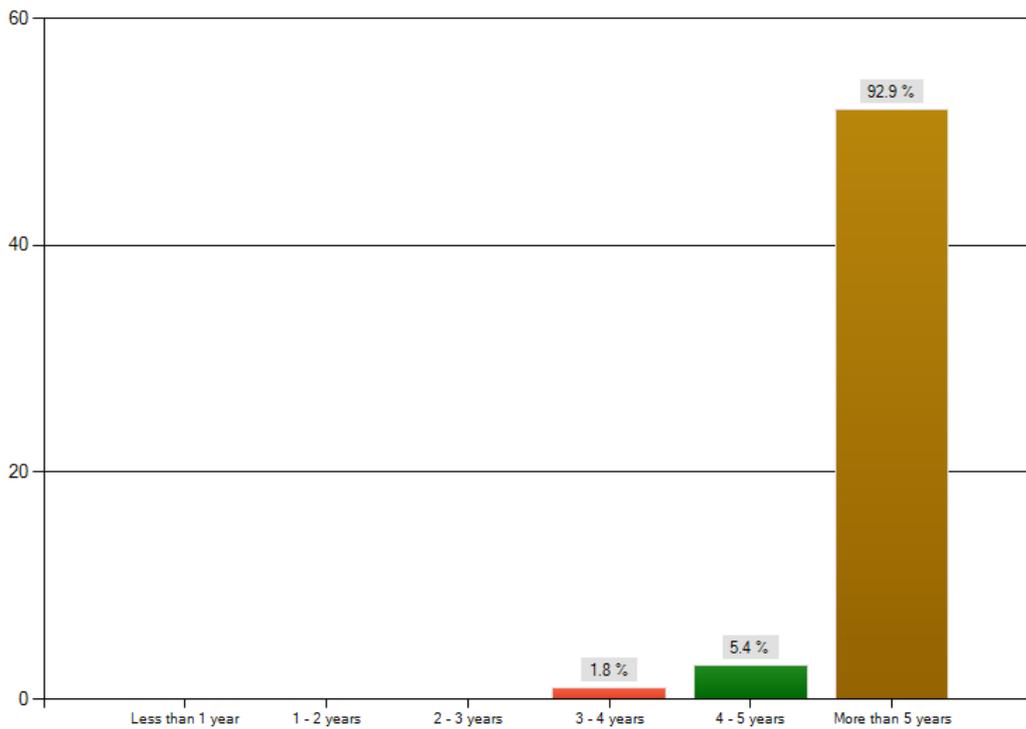
**Part B- HIV Prevention Outreach Activities (Traditional)**  
**I. Agencies currently conducting outreach**

Does your agency currently conduct HIV prevention outreach activities?



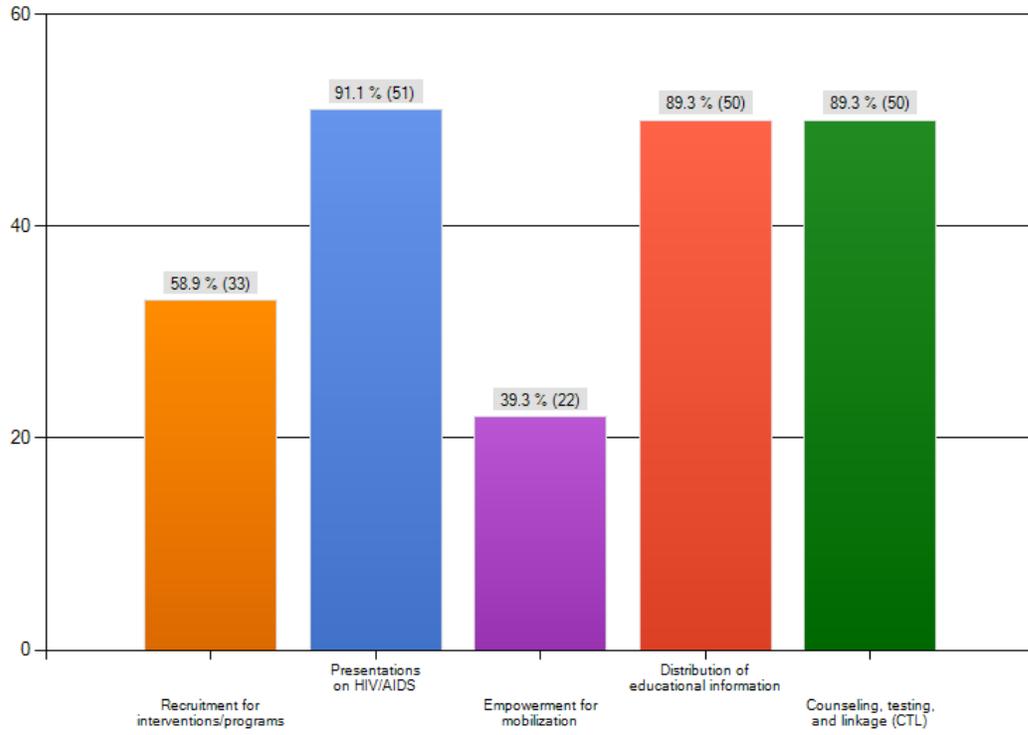
**II. Experience with HIV prevention outreach**

How long has your agency been conducting HIV prevention outreach activities?



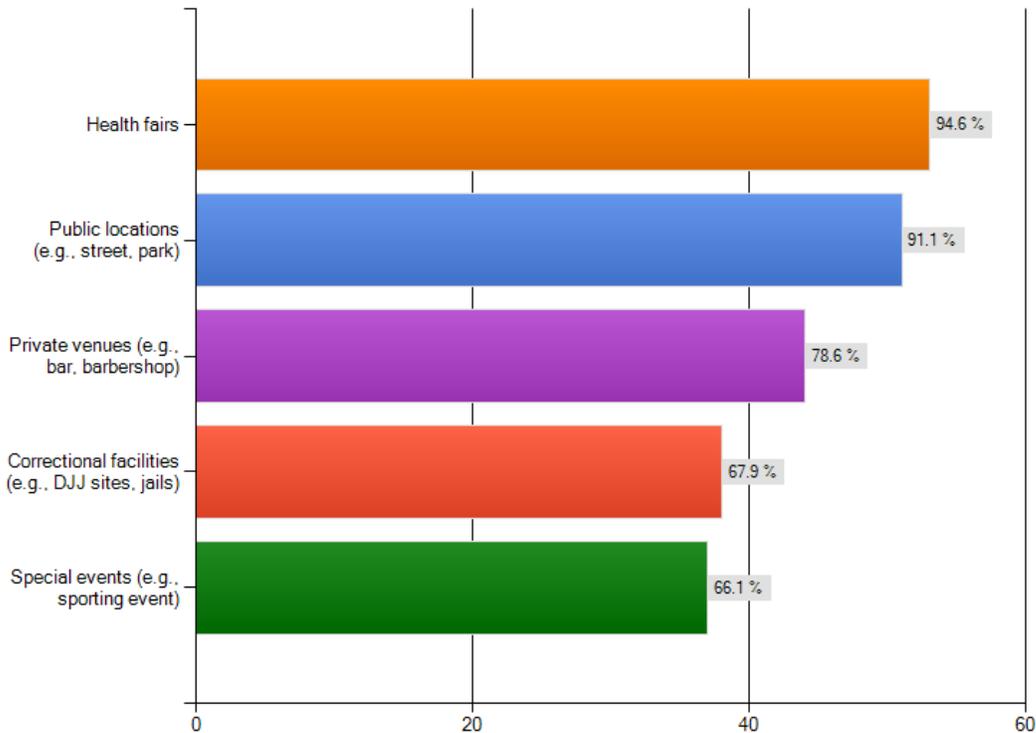
### III. Purpose of Outreach Activities

Check the box(es) that best describe your agency's outreach activities by purpose.



### IV. Settings of Outreach Activities

Check the box(es) that best describe your agency's outreach activities by setting.



**Appendix B**  
**Sample Data Collection Tools- Traditional Outreach**

Sample Format of Outreach Activity Report  
 Note: All items can be tailored to an agency's specific outreach program.

<b>Outreach Activity Report</b>					
<b>Date:</b>		<b>Outreach Team/Size:</b>			
<b>Period of Outreach:</b>		<b>Outreach Location:</b>			
<b>Target Population:</b>					
<b>Type of Outreach: (circle one)</b>					
<b>Active Street</b>	<b>Venue-Based/Fixed-Site</b>			<b>Drop-Off Site</b>	
<b>Volunteer/Business Contacts: (list site types)</b>					
_____ Total					
<b>Participant Contacts:</b>					
_____ African American (M)	Ages 13-19	20-29	30-39	40-49	50+
_____ African American (F)	Ages 13-19	20-29	30-39	40-49	50+
_____ Hispanic/Latino (M)	Ages 13-19	20-29	30-39	40-49	50+
_____ Hispanic/Latino (F)	Ages 13-19	20-29	30-39	40-49	50+
_____ White (M)	Ages 13-19	20-29	30-39	40-49	50+
_____ White (F)	Ages 13-19	20-29	30-39	40-49	50+
_____ Other (M)	Ages 13-19	20-29	30-39	40-49	50+
_____ Other (F)	Ages 13-19	20-29	30-39	40-49	50+
_____ TOTAL					
<b>Service(s) Delivered: (check all that apply)</b>					
_____ Condom Packets (3 condoms in each, with lube)					
_____ Educational Brochures/Pamphlets					
_____ Other Materials					
_____ Referrals (specify) _____					
<b>Print Materials Distributed:</b>					
<b>(Title)</b>					<b>(Number)</b>
_____					_____
_____					_____
_____					_____
<b>Other information to be captured:</b>					

### Sample Data Collection Form (Females)

Epidemiologic and Demographic Information - Outreach Data Collection															
<b>FEMALES</b>	Injecting Drug User (IDU)				Total Female IDU	Heterosexual Sex				Total Female Hetero Sex	Mother with or at Risk for HIV				Total Mother with or at Risk for HIV
	Race	0-19	20-29	30-49		50+	0-19	20-29	30-49		50+	0-19	20-29	30-49	
American Indian / Alaskan Native															
Asian / Pacific Islander															
Black							100	50	50	200					
White															
Multiracial															
Unknown															
<b>Total Age/Risk/Beh:</b>							100	50	50	200					

Ethnicity															
Race	0-19	20-29	30-49	50+	Total Female IDU	0-19	20-29	30-49	50+	Total Female Hetero Sex	0-19	20-29	30-49	50+	Total Mother with or at Risk for HIV
Hispanic-Caribbean															
Hispanic-Central															
Hispanic-South															
Hispanic – origin unknown/other															
Haitian															
All other ethnicities															

<b>FEMALES</b>	General Population				Total Female General Population	Total Female by Ethnicity / Behavior
	Race	0-19	20-29	30-49		
American Indian / Alaskan Native						
Asian / Pacific Islander						
Black						200
White						
Multiracial						
Unknown						
<b>Total Age/Risk/Beh:</b>						200

Ethnicity						
Race	0-19	20-29	30-49	50+	Total Female General Population	Total Female by Ethnicity / Behavior
Hispanic-Caribbean						
Hispanic-Central						
Hispanic-South						
Hispanic – origin unknown/other						
Haitian						
All other ethnicities						

### Sample Data Collection Form (Males)

<b>Epidemiologic and Demographic Information - Outreach Data Collection</b>															
<b>MALES</b>	Male Sex with Male (MSM)				Total MSM	Injecting Drug User (IDU)				Total Male IDU	MSM/IDU				Total MSM/IDU
	0-19	20-29	30-49	50+		0-19	20-29	30-49	50+		0-19	20-29	30-49	50+	
<b>Race</b>															
American Indian / Alaskan Native															
Asian / Pacific Islander															
Black															
White															
Multiracial															
Unknown															
<b>Total Age/Risk/Beh:</b>															

**Ethnicity**

Hispanic-Caribbean														
Hispanic-Central														
Hispanic-South														
Hispanic - origin unknown/other														
Haitian														
All other ethnicities														

<b>MALES</b>	Heterosexual Sex				Total Heterosexual Sex	General Population				Total Male General Population	Total Male by Ethnicity / Behavior
	0-19	20-29	30-49	50+		0-19	20-29	30-49	50+		
<b>Race</b>											
American Indian / Alaskan Native											
Asian / Pacific Islander											
Black		50	50		100						100
White											
Multiracial											
Unknown											
<b>Total Age/Risk/Beh:</b>		50	50		100						100

**Ethnicity**

Hispanic-Caribbean											
Hispanic-Central											
Hispanic-South											
Hispanic - origin unknown/other											
Haitian											
All other ethnicities											

**Appendix C**  
**Internet-based Outreach Program Checklist**

*Check list for creating guidelines for Internet-based outreach*

- Determine who will need to be involved with the creation of the guidelines
  - \_\_\_ Health Department Medical Director/Administrator
  - \_\_\_ Health Department Security Coordinator
  - \_\_\_ Health Department Information Technology (IT) Director
  - \_\_\_ Legal Department
  - \_\_\_ Management Information Systems (MIS) Director
  - \_\_\_ STD Epidemiologist
  - \_\_\_ STD Area Managers
  - \_\_\_ STD Program Managers
  - \_\_\_ STD DIS representative
  
- Determine who will be covered by the guidelines
  - \_\_\_ A specific department
  - \_\_\_ A city or county health department
  - \_\_\_ The entire state department of health
  
- Determine technological and staffing needs
  - \_\_\_ Do you need to hire someone new or are there existing staff members who can work on Internet/online projects such as online outreach?
  - \_\_\_ How much of this staff member's time will be dedicated to online projects (5–100%)?
  - \_\_\_ Does this staff member come to the position with the necessary knowledge or can they be trained on the job?
  - \_\_\_ Is there someone who has the time to supervise this staff member?
  - \_\_\_ Is there at least one computer that can be dedicated to this purpose?
  - \_\_\_ Creation of a dedicated e-mail account
  - \_\_\_ Approval will be needed to obtain unrestricted access to the Internet
  - \_\_\_ There should be at least one IT contact working with staff member
  
- Sections of guidelines
  - \_\_\_ Introduction/Purpose
  - \_\_\_ Involved personnel
  - \_\_\_ Description of responsibilities of all involved personnel
  - \_\_\_ Competencies required of personnel conducting Internet outreach
  - \_\_\_ Training
  - \_\_\_ Confidentiality & Ethics
  - \_\_\_ Standard Operating Procedures of conducting Internet outreach including templates and examples
  - \_\_\_ Adverse Events or Emergencies
  - \_\_\_ Documents and Documentation
  - \_\_\_ Evaluation

### Details within each Guideline section

- Introduction/Purpose
  - \_\_\_ Statement of purpose, i.e., who, what, when, where, why
  - \_\_\_ Description of chat rooms, instant messaging, list serves, websites, etc. as well as passive vs. active outreach
  
- Personnel intimately involved with the Internet outreach
  - \_\_\_ Number of employees that will conduct Internet outreach
  - \_\_\_ Supervisor
  - \_\_\_ IT employee for guidance and technical support
  
- Description of responsibilities of all involved personnel
  
- Competencies required of personnel conducting Internet outreach
  - \_\_\_ Demonstration of good judgment and performance of responsibilities
  
- Training (some examples/suggestions)
  - \_\_\_ Introduction to STD Intervention (ISTDI)
  - \_\_\_ Information Security Training
  - \_\_\_ Ethics Training
  - \_\_\_ Internet Partner Notification and Referral Services Training
  - \_\_\_ Motivational Interviewing Training
  
- Confidentiality
  - \_\_\_ Description of how confidentiality will be handled and maintained
  - \_\_\_ Confidentiality agreement signed by all involved parties including IT and front-desk staff
  
- Standard Operating Procedures for conducting Internet outreach including templates and examples
  - \_\_\_ Creation of step-by-step procedures on how to conduct Internet outreach including what websites to visit
    - \_\_\_ creating online profiles
    - \_\_\_ active vs. passive outreach
    - \_\_\_ client follow-up
    - \_\_\_ chat room vs. instant messaging vs. e-mail
  - \_\_\_ Creation of documentation forms and logs
  - \_\_\_ Creation of online handles/names
  - \_\_\_ Creation of referral resources
  - \_\_\_ FAQ
  - \_\_\_ Templates of forms, logs, etc.
  
- Adverse Events or Emergencies
  - \_\_\_ Description of how adverse events or emergencies will be handled
  - \_\_\_ Who will handle adverse events or emergencies?

Documents and Documentation

- \_\_\_ List of all documents to be used including copies
- \_\_\_ Where documents will be stored
- \_\_\_ When and who will review documents
- \_\_\_ Documents should include, at minimum, the following:
  - \_\_\_ websites visited
  - \_\_\_ handle names used
  - \_\_\_ copies of online messages and conversations
  - \_\_\_ dates & times that Internet outreach was conducted
  - \_\_\_ record of referrals made (to where, for what)

Evaluation

- \_\_\_ **Process Evaluation** (ongoing evaluation while program is being developed and implemented)
  - \_\_\_ During development and implementation, meet on a regular basis with the team involved and ask the following questions:
    - ⌚ What is working?
    - ⌚ What should be improved?
    - ⌚ How should it be changed?
  
- \_\_\_ **Outcome Evaluation** (assessing the degree to which the program has met the objectives, or the degree to which the program has been of use to the target population)
  - \_\_\_ Outcome evaluation should be conducted at least yearly to gauge the impact of the program. Ask the following questions:
    - ⌚ What has happened?
    - ⌚ Who was affected?
    - ⌚ What was the most effective aspect of the program?
    - ⌚ Was it cost-effective?

**Appendix D**  
**DOH Information Security and Privacy Policy and**  
**Sample Computer Use and Confidentiality Agreement**



## Computer Use and Confidentiality Agreement

**SECTION A** The Department of Health (DOH) worker and the appropriate supervisor or designee must address each item and initial.

### Security and Confidentiality Supportive Data

**W S**

- I have been advised of the location of and have access to the Florida Statutes and Administrative Rules.
- I have been advised of the location of and have access to the core Department of Health Policies, Protocols and Procedures and local operating procedures.

### Position-Related Security and Confidentiality Responsibilities

I understand that the Department of Health is a unit of government and generally all its programs and related activities are referenced in Florida Statutes and Administrative Code Rules. I further understand that the listing of specific statutes and rules in this paragraph may not be comprehensive and at times those laws may be subject to amendment or repeal. Notwithstanding these facts, I understand that I am responsible for complying with the provisions of this policy. I further understand that I have the opportunity and responsibility to inquire of my supervisor if there are statutes and rules which I do not understand.

- I have been given copies or been advised of the location of the following specific Florida Statutes and Administrative Rules that pertain to my position responsibilities:  
\_\_\_\_\_

- I have been given copies or been advised of the location of the following specific core DOH Policies, Protocols and Procedures that pertain to my position responsibilities:  
\_\_\_\_\_

- I have been given copies or been advised of the location of the following specific supplemental operating procedures that pertain to my position responsibilities:  
\_\_\_\_\_

- I have received instructions for maintaining the physical security and protection of confidential information, which are in place in my immediate work environment.

I have been given access to the following sets of confidential information:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### Penalties for Non Compliance

- I have been advised of the location of and have access to the DOH Personnel Handbook and understand the disciplinary actions associated with a breach of confidentiality.
- I understand that a security violation may result in criminal prosecution and disciplinary action ranging from reprimand to dismissal.
- I understand my professional responsibility and the procedures to report suspected or known security breaches.

The purpose of this acceptable use and confidentiality agreement is to emphasize that access to all confidential information regarding a member of the workforce or held in client health records is limited and governed by federal and state laws. Information, which is confidential, includes the client's name, social security number, address, medical, social and financial data and services received. Data collection by interview, observation, or review of documents must be in a setting that protects the client's privacy. Information discussed by health team members

must be held in strict confidence, must be limited to information related to the provision of care to the client, and must not be discussed outside the department.

\_\_\_\_\_  
**DOH Worker's Signature**                      **Date**                      **Supervisor or Designee Signature**

**SECTION B** Information Resource Management (Initial each item, which applies)

The member of the workforce has access to computer-related media.

- Yes                      Have each member of the workforce read and sign section B
- No                      It is not necessary to complete section B

**Understanding of Computer-Related Crimes Act, if applicable**

The Department of Health has authorized you to have access to sensitive data through the use of computer-related media (e.g., printed reports, microfiche, system inquiry, on-line update, or any magnetic media).

Computer crimes are a violation of the department's disciplinary standards and in addition to departmental discipline; the commission of computer crimes may result in felony criminal charges. The Florida Computer Crimes Act, Ch. 815, F.S., addresses the unauthorized modification, destruction, disclosure or taking of information resources.

I have read the above statements and by my signature acknowledge that I have read and been given a copy of, or been advised of, the location of the Computer-Related Crimes Act, Ch. 815, F.S. I understand that a security violation may result in criminal prosecution according to the provisions of Ch. 815, F.S., and may also result in disciplinary action against me according to Department of Health Policy.

The minimum information resource management requirements are:

- Personal passwords are not to be disclosed. There may be supplemental operating procedures that permit shared access to electronic mail for the purpose of ensuring day-to-day operations of the department.
- Information, both paper-based and electronic-based, is not to be obtained for my own or another person's personal use.
- Department of Health data, information, and technology resources shall be used for official state business, except as allowed by the department's policy, protocols, and procedures.
- Only approved software shall be installed on Department of Health computers (IRM Policy NO.50-7).
- Access to and use of the Internet and email from a Department of Health computer shall be limited to official state business, except as allowed by the Department's policy, protocols, and procedures.
- Copyright law prohibits the unauthorized use or duplication of software.

\_\_\_\_\_  
**DOH Worker's Signature**                      **Date**                      **Supervisor or Designee Signature**

\_\_\_\_\_  
**Print Name**                      **Date**                      **Print Name**

W=Worker                      S=Supervisor

**I. Policy**

Members of the Department of Health (DOH) workforce shall be held accountable for protecting information from unauthorized modification, destruction, use or disclosure, and for safeguarding confidential information. All DOH data, information, and technology resources shall only be used for official state business, except as allowed by the department’s policies, protocols, and procedures. This includes information in any format.

The department shall respect the legitimate proprietary interests of intellectual property holders and obey the copyright law prohibiting the unauthorized use or duplication of software. Only authorized IT members of the workforce shall install DOH approved software and hardware.

Members of the DOH workforce having access to computer-related media are expected to know the department’s information security and privacy policies, protocols, and procedures. They are to conduct their activities accordingly. An “Acceptable Use and Confidentiality Agreement (Agreement)” must be signed by each DOH worker and filed at the local level. This document confirms that the worker understands the requirements and penalties for failure to comply with the department’s information security and privacy policies, protocols, and procedures.

**II. Authority**

See Appendix B, *Acceptable Use and Confidentiality Agreement*.

**III. Supportive Data**

Federal and state laws, rules, and regulations referenced in Appendix C, Confidentiality Statutes, Rules and Federal Regulations.

**IV. Signature Block with Effective Date**

<i>Signature on File</i>	<i>11/4/2010</i>
Ana M. Viamonte Ros, M.D., M.P.H. State Surgeon General	Date

**V. Definitions**

See Appendix A, Definitions and Glossary.

**VI. Protocol**

**A. Outcomes**

1. The Acceptable Use and Confidentiality Agreement, DOH form DH1120 provided in Appendix B, will be completed by a DOH worker prior to providing services to patients, accessing confidential information,

accessing information technology resources, or within 30 days of the employment start date; whichever is earliest. A new Agreement must be completed by users if there is a change in policy or a change in users' roles and responsibilities.

2. Completed Acceptable Use and Confidentiality Agreements are maintained locally.
3. Appropriate security controls are in place to mitigate risks of using mobile devices.
4. Members of the DOH workforce utilize IT resources in a manner that safeguards those resources.

**B. Personnel**

All members of the DOH workforce including volunteers and contractors accessing our data and information resources.

**C. Competencies**

1. Knowledge and skills to reasonably safeguard confidential information from any intentional or unintentional use or disclosure.
2. Knowledge of DOH policies, protocols, and procedures related to information security and privacy.
3. Knowledge of information classified as confidential or exempt from public record disclosure in federal regulations and state laws and rules, requiring specific actions to safeguard.
4. Knowledge of information technology resources security and practices.

**D. Areas of Responsibility**

1. All members of the DOH workforce with access to confidential information must sign Section A of the Acceptable Use and Confidentiality Agreement.
2. All members of the DOH workforce having access to DOH information technology resources must sign Section B of the Acceptable Use and Confidentiality Agreement.
3. The signed Acceptable Use and Confidentiality Agreement must be maintained at the local level. This document shall be signed by the DOH worker and witnessed by the employee's supervisor or designee.

4. All members of the DOH workforce will have access to the respective *Florida Statutes (F.S.)*, administrative rules, and the DOH policies, protocols, and procedures.

## VII. Procedure

### A. General

1. The Florida Computer Crimes Act, Chapter 815, *F.S.*, prohibits the introduction of fraudulent records into a computer system, the unauthorized use of computer facilities, the alteration or destruction of computerized information, and the stealing of data from computer files. Computer crimes violate the department's policies and may also result in criminal charges. Members of the workforce who work with computers or have access to computer information are to be familiar with Chapter 815, *F.S.*; the DOH Information Security and Privacy policies, protocols, procedures; in addition to the Health Insurance Portability and Accountability Act (HIPAA) legislation. Members of the workforce should ask their supervisor for any needed clarification. DOH workforce found to have violated these policies, laws, regulations, etc., may be subject to disciplinary action, up to and including termination of employment.
2. Supervisors may monitor computer use by direct observation, review computer history files through the systems administrator, or review work productivity and quality.
  - a. The local system administrator, with management approval (director, administrator or local human resource director), can look at an employee's computer cookies, Internet history, and event logs for evidence of what the supervisor has observed, suspects, and/or was notified occurred and supply the manager with information; screen shots, printouts of files, a written report.
  - b. If additional information is needed, the supervisor must have the Office of the Inspector General or the Headquarters Office of Human Resources contact the Bureau of Strategic Information Technologies, Security Administration Team and request the information be released.
3. Use of streaming media technologies can only be used with prior written approval of the user's supervisor and the Information Security Manager (ISM) or delegate.
4. Access to the Internet, telephony, or email service is a privilege, not a right. The workforce must adhere to state policies, department policies and procedures, federal regulations, and state and local laws.

November 4, 2010

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5. The workforce shall have no expectation of privacy when using DOH resources.
6. The Security Operations and Response Team and Root Administrator staff will have the capability to monitor all devices on the DOH network.
7. The department may inspect any and all files stored on any network or local computer system, including removable media.
8. Use of state resources constitutes consent to monitoring activities with or without a warning.
9. Only DOH-owned or managed devices may be connected to the DOH network. Exceptions must be granted in writing by the Information Security Manager (ISM).
10. Only department-approved software shall be installed on department-owned or department-managed computers.
11. DOH devices (including computers, mobile devices, printers, etc) will be configured according to IT-approved standards and guidelines.
12. Illegal duplication of software is prohibited.
13. Each computer user must report suspected computer malware (viruses, etc.) occurrences to the local system administrator or designee immediately.
14. The workforce may use the department's Internet email access link for department email access while away from the office with their supervisors' approval.
  - a. Included members of the workforce, (eligible for overtime pay) must obtain prior approval for each use outside of their normal working hours and are required to account for all hours worked and must record any additional hours as required by department policy.
  - b. The workforce must ensure that the computer used for Internet email access has up-to-date anti-malware software and current operating system security patches.
  - c. Approval to use Internet email access in no way eliminates the requirement for prior approval for telecommuting in accordance with the Telecommuting Policy and Procedures, DOHP 60-24-06.

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**B. Computer Use**

1. Members of the workforce will be given a user account to access DOH information technology resources. This access will be based on the documented need as provided by the appropriate hiring authority. The DOH ISM or delegate has final authority regarding access to the DOH network and IT resources. Supervisors will regularly review the access privileges of staff and ensure access is appropriate to job responsibilities. Members of the workforce who have or are responsible for a user account within the department's network are responsible for taking the appropriate steps to select and secure their passwords, see Appendix E, Password Construction.
  - a. Access to DOH information technology resources is reserved for department approved users.
  - b. DOH workforce shall have unique user accounts.
  - c. DOH workforce shall be held accountable for their account activities.
  - d. User accounts must be authenticated at a minimum by a password.
  - e. DOH workforce is responsible for safeguarding their passwords and other authentication methods.
  - f. DOH workforce must not share their department account passwords, personal identification numbers, security tokens, smart cards, identification badges, or other devices used for identification and authentication purposes.
  - g. DOH workforce shall immediately report suspected account compromises according to department incident reporting procedures.
  - h. DOH workforce shall immediately report lost security tokens, smart cards, identification badges, or other devices used for identification and authentication purposes according to department incident reporting procedures.
  - i. All user-level passwords must be changed every 30 days. User password management shall only be performed in accordance with the DOH approved user password management procedures and using only the user password management tool.
  - j. Passwords should not be inserted into e-mail messages or other forms of clear text (plain text) messaging. Passwords should be

encrypted or secured by other means when delivered by the system administrator to the users.

- k. Passwords should be at least eight alphabetic and numeric characters in length.
2. DOH workforce must not disable, alter, or circumvent department workstation security measures.
  3. DOH workforce must logoff or lock their workstations prior to leaving the work area.
  4. Workstations must be secured with a password-protected screensaver with the automatic activation feature set at no more than 10 minutes.
  5. Access to department information technology resources is reserved for business purposes.
  6. DOH workforce are permitted to briefly visit non-prohibited Internet sites or use e-mail and/or telephony for personal reasons during non-work hours (lunch period or before/after work) subject to the limitations contained within this policy.
    - a. Usage must not interfere with the worker's job duties.
    - b. Usage must not consume significant amounts of DOH IT resources or compromise the normal functionality of the department's systems.
    - c. Personal use must not result in any additional cost to the department.
    - d. Personal use may be monitored and subject the employee to disciplinary action.
    - e. DOH workforce may access non-DOH browser based email accounts such as AOL, Yahoo, Hotmail, etc. This privilege applies only to browser based email capabilities; users may not use Outlook, Outlook Express, or other PC-based software or plug-ins to access non-DOH email.
    - f. Examples of non-prohibited Internet/Intranet sites are those dealing with health matters, weather, news, business or work-related topics, community activities, career advancement, and personal enrichment.

**C. Mobile Computing**

1. Only DOH approved mobile devices may be used for or with DOH data systems and networks.
2. Mobile computing devices will be issued to and used by only DOH-authorized users.
3. Mobile computing devices will require user authentication.
4. Mobile computing devices shall be secured with a password-protected screensaver with the automatic activation feature set at no more than 15 minutes.
5. Mobile computing devices must use current and up-to-date anti-malware software where possible.
6. Mobile computing devices must activate a DOH-approved personal firewall (where technology permits) when connected to a non-DOH network.
7. When connecting a DOH laptop to a non-DOH network, the DOH worker must immediately activate an approved DOH Virtual Private Network (VPN) connection.
8. Members of the workforce must take reasonable precautions to protect mobile computing devices in their possession from loss, theft, tampering, unauthorized access, and damage.
9. Mobile device users must report theft of mobile devices immediately to appropriate personnel per the Policy and Procedures on Incident Reporting, DOHP 5-6-08. In addition the DOH Information Security Manager must notify the State Office of Information Security.
10. Only DOH mobile storage devices may store department data or be connected to DOH devices, networks, or systems.
11. All data residing on DOH mobile computing devices and mobile storage devices is the property of the department and subject to monitoring and public records law.
12. Mobile computing devices used with confidential information require whole drive encryption.
13. Mobile storage devices with confidential data must have encryption technology enabled such that all content resides encrypted.

14. To prevent loss of data, DOH data stored on mobile devices must be backed up.
15. Data, including e-mail, on mobile devices that is no longer needed must be purged as often as possible.

**D. Unacceptable Uses**

1. The prohibited activities listed below are examples and are not all inclusive. DOH workforce performing any of these activities as part of their assigned job responsibilities must have written supervisor approval or these tasks must be identified in their position description.
2. DOH workforce must not use DOH IT resources for any purpose which violates state or federal laws or rules.
3. DOH IT resources must not be used for personal profit, benefit, or gain.
4. DOH IT resources must not be used for political campaigning.
5. DOH workforce must not install, introduce, download, access, or distribute:
  - a. Software not approved by the DOH Information Technology Standards Workgroup (ITSW).
  - b. Software not licensed to the department or its affiliates.
  - c. Viruses, worms, Trojan horses, e-mail bombs, etc., through willful intent or negligence. Note: files downloaded from the Internet should be scanned for viruses before use and/or distribution; no file received from an unknown source should be downloaded even if attached to an e-mail message or downloaded from the Internet.
  - d. Harassing, intimidating, threatening, complaining, or otherwise annoying materials including chain letters (chain letters may include any emails, Intranet or Internet that ask or advise the recipient to forward the e-mail to more than one other person).
  - e. Sexually explicit, pornographic, or vulgar material.
  - f. Inappropriate language or profanity, including, but not limited to obscene or inappropriate language, racial, ethnic, or other discriminatory content.
  - g. Non-work related material relating to gambling, weapons, illegal drugs, illegal drug paraphernalia, or violence.

- h. Non-work related chat rooms, news groups, political groups, singles clubs, dating services, computer hacker websites, or software.
  - i. Solicitations for non-state-sponsored activities. This includes, but is not limited to, advertising the sale of a vehicle or other personal property; announcing the sale of cookies, candy, magazines, etc., on behalf of a school or organization; or announcing personal events (weddings, showers, or events not related to work). Recognition of employment or retirement and ceremonies for employee award programs are state business related functions.
6. DOH workforce must not respond directly to the originator of offensive electronic messages. DOH workforce should report the communications to their supervisor, the Information Security Coordinator and, if necessary, to the DOH Office of Inspector General.
7. DOH workforce must not program DOH email to automatically forward messages to a non-DOH email address.
8. DOH workforce must not create security breaches or otherwise disrupt network communication. Security breaches include, but are not limited to, unauthorized access of data not intended for the employee or logging into a server or account that the employee is not expressly authorized to access.
9. DOH workforce must not utilize port scanning, security scanning, and unauthorized executing any form of network monitoring which will intercept data not intended for the employee.
10. Non-DOH devices (including personal MP3 players, thumb drives, printers, CDs, smart phones) shall not be connected to DOH systems.
11. DOH workforce must not attempt to access information or resources without authorization.
12. DOH workforce must not use DOH IT resources for any activity which adversely affects the availability, confidentiality, or integrity of DOH or state information technology resources.

### VIII. Distribution List

Chief of Staff  
Deputies  
Executive Office Directors  
Division Directors  
Bureau Chiefs  
County Health Department Directors and Administrators

Children's Medical Services Medical Directors  
Children's Medical Services Nursing Directors  
Children's Medical Services Program Administrators  
Web Managers

**IX. History Notes**

Original effective date of the Information Security policy was signed November 1999. The April 2005 Information Security and Privacy policy supersedes the original. This policy was revised in August 2007 and in April 2010. The Division of Information Technology, Bureau of Strategic Information Technologies is responsible for this policy.

**Appendix E**  
**Sample Data Collection Tools- Internet Outreach**

Sample Chat Room Activity Report Form  
(Fill out one form per each chat room visited)

<b>Date:</b>	
<b>Outreach Staff:</b>	
<b>Chat Room Visited:</b>	
<b>Number of Bulletins Posted:</b>	
<b>Screen names that commented:</b>	
<b>Time Spent in Room:</b>	
<b>Referrals Given:</b> (please list links)	
<b>Chat Room Transcript? Y/N</b> (please attach)	
<b>Recruitment for Testing?</b>	
<b>Additional Information:</b>	

Sample Instant Message (IM) Activity Report Form  
 (One form per IM contact- client-level information; this could also be modified for texting programs)

<b>Date:</b>	
<b>Outreach Staff:</b>	
<b>Website Visited:</b>	
<b>Sexual Orientation:</b>	
<b>Ethnicity:</b>	
<b>Gender:</b>	
<b>Age:</b>	
<b>Risks Stated:</b>	
<b>Information Given:</b>	
<b>Referrals Given:</b> (please list links)	
<b>Participant added to Buddy List?</b>	
<b>IM Transcript? Y/N</b> (please attach)	
<b>Recruitment for Testing?</b>	
<b>Additional Information:</b>	



Sample E-mail/Text Message Report Form

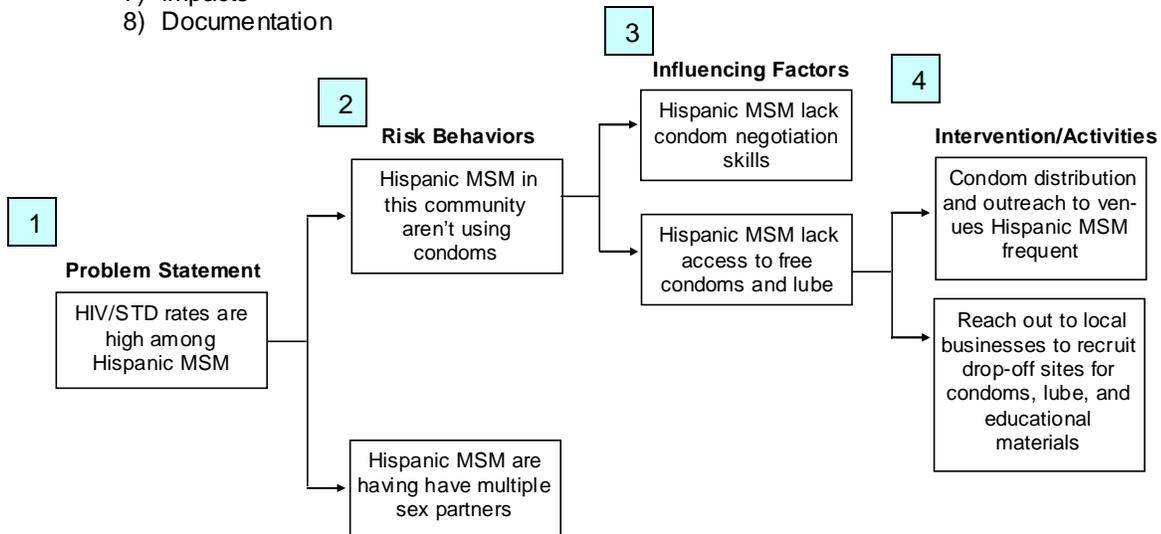
<b>From:</b>
<b>To:</b>
<b>Date:</b>
<b>Original Email/Text Message:</b>
<b>Email/Text Message Response:</b>

**Appendix F**  
**Sample HIV Prevention Outreach Logic Model**

## Sample Outreach Logic Model

### Eight components of logic models:

- 1) Problem Statement
- 2) Inputs/Risk Behaviors
- 3) Influencing Factors
- 4) Intervention/Activities
- 5) Short-term (Immediate) Outcomes
- 6) Intermediate-Term Outcomes
- 7) Impacts
- 8) Documentation



- 5 **Immediate Outcomes:** Immediate results of the intervention, such as changes in knowledge. In this examples, the immediate outcome is that more condoms are available in multiple venues within the target area.
- 6 **Intermediate Outcomes:** Intervention results that occur some time after the intervention is completed, such as changes in behaviors, skills, access, policies, and environmental conditions. An intermediate outcome would be increased condom use due to higher availability of free condoms in the community.
- 7 **Impacts:** Long-term results of one or more interventions over time, such as changes in HIV infection, morbidity, and mortality. An example of an impact would be decreased HIV infection due to more MSM using condoms on a regular basis.
- 8 **Documentation:** Any documentation that helps support your outcomes and impacts (e.g., data collection forms, evaluations, etc.).

**Appendix G**  
**Sample Text Messages**  
**Alachua County Text Messaging Campaign**

**HIV/STD Outreach Texting Campaign**  
**Alachua County Health Department, Minority AIDS Coordinator (MAC)**

After receiving approval from the state to use the state cell phone to start a texting campaign we started receiving questions. We started receiving the following questions after a Condom Miranda Show or community presentation. The questions are from middle school age to college age youth. The questions are written exactly as they are received.

The MAC also promotes the county health department's condom mail order program and local HIV website through the texting campaign. The website is [www.313hiv.com](http://www.313hiv.com) and provides information on how people in the community can volunteer, all HIV testing locations for Alachua and other surrounding counties. The website is a one-stop shop and provides resource links for additional information. The condom mail-order program has helped to solve the problem of condom access and availability. The website also has a listing of BRTA/LRTA businesses that have condoms available.

1. *Hey Mrs. Teresa I have a question to ask if a boy is mad n he say dat he gave me AIDS were do I get tested for free*
2. *Where do I get tested?*
3. *How will I know I am ready to have sex/ I am gay male*
4. *Sometimes when I have sex with my boyfriend, I will dry out and it will start to hurt. Is it a personal problem or do I have the wrong guy?*
5. *Is there somewhere to get immediate STD testing?*
6. *How do I get the 20 min test?*
7. *What if my parents try to find out if I have been tested for HIV or std's*
8. *I want to come in and get tested but do not want to go to the health dept*
9. *Can I get tested at the health dept for free if I am a student?*
10. *Me and my boyfriend broke up and I told him I did not to get back together with him. He then told me infected with me with AIDS, what do I do and I might be pregnant*
11. *How do I get my girlfriend to try butt sex?*
12. *I was kind of curious to try the female condom but I did not get any at the Miranda show, could you mail me some..?*
13. *Just saw your Miranda show and loved it, I will be at Jennings to see you Tuesday maybe I can get some more condoms at the show..*
14. *How is the KY intensity lube?*
15. *Where can I get tested for Chlamydia even if have no symptoms.*
16. *Mrs. Miranda, I had to leave your show early, when is your next show?*
17. *Mrs. Miranda, me and my girlfriend have been running out of lubricant so we started using her shower body wash instead. Is this bad?*
18. *Condom Miranda! Thank you so much for your presentation last night. I had a blast partaking in your sex quiz and beating the boys! I wanted to know what the name of that condom was that you said was made of non latex, the one for females, where can I get them. Thanks!*
19. *Loved your show yesterday! Very informative and entertaining...*
20. *Where can I get tested for all std's*
21. *My boyfriend and I were curious about having anal sex. What can I do to make sure the experience is clean and comfortable for the both of us? We have been tested for HIV and STDs.*

**Appendix H**  
**Sample Chat Conversation from Online Chat Room**

## Sample Chat Script

**Outreach1:** Hello, I'm a <agency/project name> outreach worker/health educator and am available to answer questions about sexual health and HIV prevention. Check out my profile if you get a chance and IM/email me if you have any questions. Thanks!

**Chatter1:** Hey guys, 25, sub, Blu/Blnd, 420,

**Chatter2:** Anybody want to hookup? 34, DDF, Vers, VGL, Papi, Koala bear

**Chatter3:** Anyone wanna IM?

**Chatter4:** 21, 5'10" 160lbs brn/brn, Hispanic boi, Btm

**Chatter5:** 19, 6'2" 185lbs midtown, PNP, uncut- have pics

**Outreach1:** Men who use crystal meth during sex are more likely to have condoms break. If you want more information, please IM/email me.

**Chatter3:** Why is that?

**Outreach1:** Because crystal dries up the natural fluid in the rectum.

**Chatter1:** More lube=more fun!!!

**Outreach1:** That's right- using lube with condoms helps reduce breakage. The more lube the better!

**Chatter4:** Northside, but can travel- wanna BB?

**Chatter5:** WOOF!

**Chatter2:** that's hot but don't mess around wit dat anymore

**Chatter4:** Aw, c'mon, u know u want it

**Chatter5:** I want it...gimme some- WTGP?

**Outreach1:** Not using protection increases your chances of getting HIV or STDs; do you know your status?

**Chatter5:** MYOB

**Chatter3:** this is everyone's business- u should listen up

**Chatter2:** hell yes, I get tested every 6 months- I know I'm clean

**Chatter4:** haven't gotten THE test in over a year- not sure I want to

**Outreach1:** HIV testing is free, fast, confidential and some don't even use needles anymore; the rapid HIV test gives you results in as little as 20 min. For testing locations, visit this website [www.HIVtestingwebsite.com](http://www.HIVtestingwebsite.com)

**Chatter1:** Kinda quiet in here....I need some action. Don't wanna be preached at- that's what parents are for. AMF

**Outreach1:** PLAY SAFE, BFN. IM/email if u have more questions.

### Ways to explain your role as an online outreach worker:

- "I'm not here to find a hook-up. I'm here as a representative of \_\_\_\_\_. I provide information to guys/girls looking for answers to questions regarding sex, HIV transmission/prevention, etc."
- "Thanks for sending me a message. You may have noticed from my profile that I'm in this room as part of an online outreach program with \_\_\_\_\_. I'll do my best to answer questions about HIV/STDs or related topics."

### Tips for ending conversations that don't seem to be going anywhere:

- "So, you said you were concerned about \_\_\_\_\_. Are you concerned about prevention?"
- "You bring up some really good points. Can you pick one of those to expand on?"

- “Let me see if I can better understand your point. Can you please repeat your question?”
- “I think you should visit this website \_\_\_\_\_. They have a lot of great information and may be able to answer your question better than I can.”

**Conversation starters:**

- “A lot of people have questions about \_\_\_\_\_.”
- “I’m here to answer difficult questions about \_\_\_\_\_. Please ask anything you want!”
- “Would you like to know more about \_\_\_\_\_.”
- “That’s really interesting. Some guys/girls really want to know about \_\_\_\_\_.”