DISTRICT OF COLUMBIA HIV PREVENTION PLAN

2011-2012

Developed by the
HIV/AIDS, Hepatitis, STD, and TB Administration
DC Department of Health
and the
DC HIV Prevention Community Planning Group

June 9, 2011

GOVERNMENT OF THE DISTRICT OF COLUMBIA
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DEPARTMENT OF HEALTH
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Introduction

The primary purpose of the District of Columbia HIV Prevention Plan is to identify the HIV prevention needs of District residents, to help the DC HIV Prevention Community Planning Group (HPCPG) identify and prioritize the populations most in need of HIV prevention services and the most effective HIV prevention strategies and interventions for those populations.

The plan is developed by the DC Department of Health's HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) in conjunction with the District's HIV Prevention Community Planning Group (HPCPG), following the requirements of the "*2003-2008 HIV Prevention Community Planning Guidance"* of the Centers for Disease Control and Prevention (CDC).

HIV prevention community planning is a collaborative process by which HAHSTA works in partnership with the community to develop a comprehensive HIV prevention plan that best represents the needs of populations infected with or at risk for HIV.[1]

Together, representatives of affected populations, epidemiologists, behavioral and social scientists, HIV/AIDS prevention service providers, health department staff and others analyze the course of the epidemic in the District, assess and prioritize HIV prevention needs, identify HIV prevention interventions to meet those needs, and develop an HIV prevention plan that is directly responsive to the epidemic. HAHSTA uses the information on prioritized populations and recommended interventions to guide its annual application for federal HIV prevention funds from the Centers for Disease Control and Prevention (CDC), as well as the use of District-appropriated funds for HIV prevention.

The District of Columbia HIV Prevention Plan for 2011-2012 is divided into the following sections:

Community Services Assessment: This section, approved by the HPCPG in June 2011, describes the HIV prevention needs of the populations that were prioritized by the planning group in 2009. Information was obtained from behavioral surveillance studies conducted in DC among men who have sex with men (MSM), heterosexuals and injecting drug users (IDUs); focus groups with several populations, including transgender women, and literature reviews.

HIV Prevention Interventions: This section describes interventions and strategies that can be used to prevent new HIV infections, and identifies which interventions have been shown to reduce HIV risk behavior in different populations.

Prioritization of Populations: This section describes the process used by the HPCPG to prioritize the prevention needs of at-risk populations using information from the *District of Columbia HIV/AIDS Epidemiology Annual Report 2007.*

Recommended Interventions: This section identifies the interventions that the HPCPG determined were most appropriate for each of the prioritized populations.

[1] HIV Prevention Community Planning Guidance, Centers for Disease Control and Prevention, 2003

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Community Services Assessment

June 2011

The purpose of the Community Services Assessment is to demonstrate the HIV prevention needs of different populations in the District of Columbia and factors related to HIV risk behaviors. This chapter brings together epidemiologic data, behavioral data, and ethnographic data to provide a comprehensive description of communities at risk for HIV in the District.

Behavioral and qualitative data show broad behavioral risk factors across all populations. These behaviors affect different populations in their own unique ways with varying levels of impact, yet they are all present in each population. Addressing prevention activities that exist across all populations as well as those designed for specific populations provides a more in-depth portfolio for HIV prevention within the District.

Prioritized Populations

In 2003, the Centers for Disease Control and Prevention launched an initiative to reduce HIV transmission using strategies that focused on people living with HIV (PLWH), including reducing barriers to early diagnosis of HIV infection and increasing access to quality medical care, treatment, and prevention services for those living with HIV. The initiative consists of four key strategies: Making HIV testing a routine part of medical care; implementing new models for diagnosing HIV infections outside medical settings; preventing new infections by working with persons diagnosed with HIV and their partners; and further decreasing perinatal HIV transmission.

The strategies included increasing emphasis on services targeted at prevention for PLWH by requiring that PLWH be the number one priority for prevention services in all jurisdictions.

In July 2009, the HPCPG prioritized populations by risk group based on the data on newly diagnosed HIV cases in 2001-2006.

People living with HIV – Black Heterosexuals of all ages; Black men who have sex with men (MSM) of all ages; Latino MSM, 20-39; White MSM, 20-49; Black injecting drug users (IDUs), 20-59; Latino IDUs, 40-49; and White IDUs, 30-49 – were ranked as Priority 1.

High-risk, HIV-negative individuals from the same risk groups were ranked as Priority 2.

All populations within each of these two groups have the same priority.

The HPCPG also prioritized 10 Special Populations: High-Risk Youth; Transgender Individuals; Individuals Involved in the Sex Trade; the Deaf and Hard of Hearing; individuals who are 50 or older; Latino heterosexuals between 20 and 49 years old; recent immigrants that may face challenges in accessing health services; incarcerated and recently released individuals; individuals with physical, mental or developmental disabilities; and homeless individuals.

Contents

Methodology / Organization

In order to determine the specific prevention needs of the target populations, a literature review was done for all prioritized and special populations, and focus groups and key informant interviews were conducted with MSM, Black and Latino heterosexuals, transgender women and current and former substance users.

The specific questions that guided the CSA were:

- What are the HIV-related risk behaviors of the target populations?
- What are the prevention needs of the target populations?
- What barriers to accessing or using prevention services do members of the target population experience or perceive?

The population sections include the following information, when available:

Description of Population – An overview of knowledge, attitudes and behaviors of the target population as well as an epidemiologic summary of the focus population.

HIV Risk Behaviors

HIV Prevention Needs

The CSA also includes information on drivers of the epidemic – structural and social factors, such as gender inequality, human rights violation, stigma and discrimination, which are not easily measured and increase an individual's vulnerability to HIV infection. This includes individual and structural barriers to the access and utilization of prevention and intervention services.

Priority One
People Living With HIV/AIDS

As of December 31, 2008, a total of 16,513 people 13 or older were living with HIV/AIDS in the District of Columbia, accounting for 3.2% of District residents. MSM continues to be the leading mode of transmission (37.3%) for those living with HIV/AIDS. However, heterosexual sex is the leading mode of transmission among new HIV and new AIDS diagnosis.[2] Black males have the highest burden of disease, with 7.1% (N=8,285) of all black males in the District living with HIV/AIDS. Nearly 5% (N=12,489) of all blacks and 3.4% (N=736) of Hispanic males are diagnosed and living with HIV/AIDS.

Living HIV/AIDS Cases among Adults and Adolescents by Race/Ethnicity and Mode of Transmission in the District of Columbia, data through 2008

	White		Black		Hispanic		Other*		Total	
	N	%	N	%	N	%	N	%	N	%
Mode of Transmission										
MSM	2,051	76.2	3,536	28.3	441	50.0	133	29.6	6,161	37.3
IDU	98	3.6	2,666	21.4	62	7.0	44	9.8	2,870	17.4
MSM/IDU	71	2.6	455	3.6	27	3.1	8	1.8	561	3.4
Heterosexual contact	166	6.2	3,968	31.8	233	26.4	85	18.9	4,452	26.9
Risk not identified	299	11.1	1,838	14.7	116	13.2	180	40.0	2,433	14.7
Other**	7	0.3	26	0.2	3	0.3	<3	--	36	0.2
Total	2,692	100.0	12,489	100.0	882	100.0	450	100.0	16,513	100.0
Male										
MSM	2,051	80.5	3,536	42.7	441	59.9	133	40.9	6,161	51.8
IDU	54	2.1	1,552	18.7	41	5.6	22	6.8	1,669	14.0
MSM/IDU	71	2.8	455	5.5	27	3.7	8	2.5	561	4.7
Heterosexual contact	89	3.5	1,554	18.8	131	17.8	31	9.5	1,805	15.2
Risk not identified	276	10.8	1,177	14.2	94	12.8	131	40.3	1,678	14.1
Other**	7	0.3	11	0.1	<3	--	<3	--	20	0.2
Subtotal	2,548	100.0	8,285	100.0	736	100.0	325	100.0	11,894	100.0

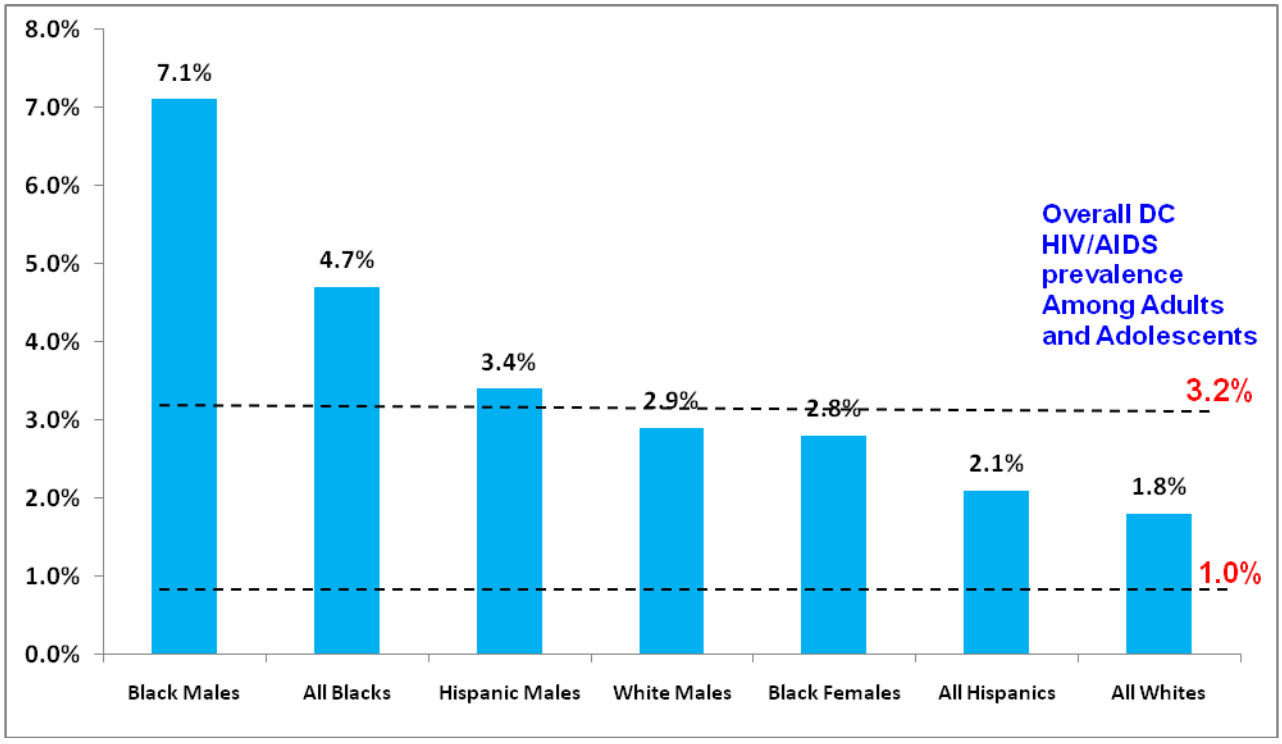
[2] District of Columbia Annual Report, 2007

	White		Black		Hispanic		Other*		Total	
	N	%	N	%	N	%	N	%	N	%
Female										
IDU	44	30.6	1,114	26.5	21	14.4	22	17.6	1,201	26.0
Heterosexual contact	77	53.5	2,414	57.4	102	69.9	54	43.2	2,647	57.3
Risk not identified	23	15.9	661	15.7	22	15.1	49	39.2	755	16.4
Other**	<3	--	15	0.4	<3	--	<3	--	16	0.4
Subtotal	144	100.0	4,204	100.0	146	100.0	125	100.0	4,619	100.0

* Other race includes mixed race individuals, Asians, Alaska Natives, American Indians, Native Hawaiian, Pacific Islanders, and Unknowns.

** Other mode of transmission includes hemophilia, blood transfusion, occupational exposure (health care workers) and perinatal.

HIV Prevalence by Race/Ethnicity, District of Columbia, 2008



In 2003, the Centers for Disease Control and Prevention began a renewed focus to include individuals diagnosed and living with HIV. Strategies include increasing the number of individuals aware of their HIV status, preventing new infections by working with HIV infected persons and their partners, increasing emphasis on services targeted at prevention for people living with HIV.

In the District identifying HIV risk behaviors and prevention needs of people living with HIV is essential to scaling up facilitators that decrease high risk behaviors and new infections. Studies indicate that HIV-infected individuals have a high level of need for services, including housing, care and mental health services.[3] The chronic nature of the HIV, the stigma and misinformation related to treatment and the stigma associated with having HIV are just some of the factors that complicate the provision and utilization of prevention services, medical and support services to these populations. Quantitative and qualitative data on people living with HIV support focus on three behaviors and prevention needs, 1) Access and utilization of HIV Care and Treatment, 2) Condom Use, 3) Disclosure of HIV status and awareness of partners status.

Risk Behaviors

HIV Risk Behaviors of People Living with HIV, National HIV Behavioral Surveillance System, Men who have sex with Men, Injection Drug Users and Heterosexuals at risk for HIV, District of Columbia (2006-2009)

NHBS Populations	*HET-1, 2006-7*	*MSM-2, 2008*	*IDU-2, 2009*
Total Population=N	750	500	553
Total Positive	5.2%	14.1%	13.0%
New Positive*	47.4%	41.2%	30.3%
HIV Risk Behaviors among Positives			
Unprotected Sex at last sex	70.1%	42.6%	69.1%
Awareness of HIV Status	60.9%	66.4%	67.4%
Aware of Partners HIV Status	50.3%	64.1%	72.3%
Shared needles at last injection	--	--	19.8%

*Unaware of HIV Status prior to study participation

Access

Health and HIV-related services are highly available within the District. There are over 80 non-profit providers directly-funded by HAHSTA to provide HIV-related services. Because of the availability of the local DC Alliance insurance program, it is estimated that nearly 95% of District residents have access to health insurance—private or public. The Districts AIDS Drug Assistance Program (ADAP) enrolls most eligible clients within 24 hours, supports a formulary of more than 100 drugs and covers co-pay and insurance premium options as well. The public transport system includes bus, metro/subway, and Metro Access van service. Routine opt-out testing is being scaled-up in medical settings throughout the District, with approximately 110,000 publicly-supported rapid tests performed in 2010, a 303% increase from 2006. However, despite the availability of these services, utilization and health impact are still sub-

[3] Katz, M. H., Cunningham, W. E., Mor, V., Andersen, R. M., Kellogg, T., Zierler, S., Crystal, S. C., Stein, M. D., Cylar, K., Bozzette, S. A., & Shapiro, M. F. (2000). Prevalence and predictors of unmet need for supportive services among HIV-infected persons: impact of case management. Medical Care., 38, 58-69.

optimal. Examination of structural, provider and individual barriers are critical to increasing utilization of care and prevention services among PLWHA.

Utilization of Care Services

Data from key informant interviews with HIV care providers found cultural and linguistic barriers to care among Latina women; high rates of substance use, domestic violence, and depression among impoverished women at increased risk for HIV and complicated medical co-morbidities unrelated to HIV, such as hypertension, diabetes and obesity. Importantly, providers note that retention in care is not enough—PLWHA remaining in care seem to be less likely to attain viral suppression and positive health benefits, indicating a need for more concerted and effective supports. Focus Interviewing Groups (FIGS) completed in 2007 by the Ryan White Planning Council, documented in the Comprehensive Care Plan, suggest that women as health consumers may be less focused than men on issues related directly to their treatment success and health status. The FIG of African-American MSM stated strongly that "health care workers were not doing a good job of making clients aware of the side effects of medications and discussing the meaning of lab work." By contrast, the FIG of African-American women focused nearly exclusively on clients relationships with case managers, and the breadth of case manager knowledge of supportive services, with no direct attention to skills-building or awareness of treatment or markers of disease status. The women's FIG did explicitly address for more support surrounding disclosure for HIV, and the need to better empower women to identify and secure their own resources and supports.

Utilization of Prevention Services

One of the strategies identified as having a direct impact on the decrease in HIV infection among injection drug users is the expansion of needle exchange services. In December 2007, Congress voted to lift restrictions on District funding for needle exchange programs. In January of 2008, HAHSTA began funding needle exchange programs. Prevention Works, a community based program that utilizes a harm reduction center to reach injection drug users in Washington, DC, that prior to 2007 was funded through private foundations was contracted for NEX services. At the end of 2009, 279,707 needles were removed off the streets through DC NEX programs, serving 1,831 clients in the last 12 months. In an effort to Increase the number of complementary services delivered to DC NEX clients, the following were provided at the end of 2009:

Indicator	Baseline	Year
1a. Number of DC NEX injection drug users who are linked to primary medical care	251	2009
1b.Number of HIV tests done for NEX clients	2,033	2009
1c. Number of DC NEX injection drug users who are linked to Hep C services	50	2009
1d. Number of injection drug users who are linked to detoxification/substance abuse	307	2009
1e. Number of condoms distributed to NEX	370,681	2009

Indicator	Baseline	Year
clients		

Unprotected Sex/Condom Use

The scale up of Highly Active Antiretroviral Therapy (HAART) has improved the quality and extended the lives of those with HIV/AIDS (PLWHA). The use of HAART improves both improves health outcomes among PLWHA, as well as decreases their viral load (VL), reducing the risk of transmitting the virus to uninfected people. Many PWLAs are married, in long term relationships and are leading sexually active lives. The Client Satisfaction Survey (CSS), conducted in 2008, is an assessment of people living with HIV and accessing Ryan White Services in the Washington, DC Eligible Metropolitan Area (EMA).

Though data is not available for DC only, this survey gives insight about PLWHA in the EMA and who may come in to the District to receive prevention and care services.

Of the 1,054 people living with HIV surveyed, the study found 14% reported having had sex (anal or vaginal) without a condom always or most of the time, while 4% reported having had sex (anal or vaginal) without a condom with an HIV-negative person (serodiscordant) always or most of the time. Inconsistent condom use was the most reported HIV risk behavior spanning across all populations throughout behavioral and ethnographic research. Ethnographic data revealed inconsistent condom use across focus and prioritized populations.

Many individuals across populations were aware of the free condoms available throughout the city, but were unaware of what agencies were providing these condoms and the services these agencies provided.

Condom Use among PLWHA, 2008, Washington, DC EMA, N=1,039

Risk Behavior	Always/ Most of the Time	Sometimes/ Not Much of the Time	Never	Missing Data/ Unknown / Not Applicable
Have sex (anal or vaginal) without a condom?	14% (143)	18% (191)	47% (492)	21% (228)
Have sex (anal or vaginal) without condom with an HIV-negative person	4% (45)	18% (193)	52% (546)	26% (270)
Have sex (anal or vaginal) without condom with an HIV-positive person?	6% (64)	18% (190)	54% (572)	22% (228)
Have sex (anal or vaginal) without discussing HIV status?	10% (99)	17% (171)	55% (579)	20% (205)
Have Sex (anal or vaginal) without a condom while drunk or high?	4% (41)	11% (107)	54% (569)	22% (337)

Disclosure

Studies have found that the stigma associated with HIV/AIDS, lack of trust and poor understanding of the health care system, fear of disclosure and discrimination are associated with people not accessing services or anti-retroviral medications. Reducing stigma and increasing PLWHA social supports are critical to ensuring utilization of prevention, care and treatment services. Key informant interviews with HIV clinicians found that many patients only disclose their HIV status to their physician and do not have recommended social supports structures. Many PLWHA find intra- and interpersonal turmoil and shock when confronted with life changes associated with HIV and subsequent need to disclose their HIV status to 1) family and close friends, 2) sexual partners.

Of the 1,054 DC Area Client Satisfaction Survey (CSS) respondents:

- Only 45% discussed their HIV status with their sexual partners
- 33% strongly Agree/Agree with the statement "*I worry that if people knew I have HIV/AIDS, they would think less of me*"
- Only 40% of respondents Strongly Agree/Agree with the statement "*I always discuss my HIV status with my sexual partner*"
- Almost a quarter (24%) of participants Strongly Disagree/Disagree with the statement *"I always tell my sexual partner(s) the truth about my HIV status"*
- Nearly 29% of PLWHA Strongly Agree/Agree with the statement "*I feel that because I have HIV/AIDS it is difficult to form lasting relationships"*

Awareness of Partner's HIV Status

Partner communication is a critical tool in addressing transmission of HIV. Yet the DC Behavior study shows only 64.1% of MSM, 72.3% of IDU and 50.3% of heterosexuals living with HIV knew their last sex partners HIV status. Other complexities such as high rates of partner concurrency and multiple sex partners highlight the need to target initiatives that decrease barriers to target partner communication.

Drivers of the Epidemic

Barriers to engaging and remaining in care exist at the structural level, the provider level and at the individual client level. Major barriers outlined in the literature and qualitative assessment indicates the following barriers as major obstacles to access and utilization of HIV prevention, care and treatment among PLWHA in the District:

Access and utilization of HIV Care and Treatment

Research has identified many barriers and factors that keep PLWH from engaging and remaining in and benefiting from care. Diagnosis of HIV in later advance stages of disease, hindrance to linkages into care immediately after an HIV diagnosis, higher risk for AIDS, and death, while poor retention once in care is related with lower response to treatment and survival (CDC Fact Sheet HIV/AIDS). In the District:

- **Linked to Care:** From 2004-2008, of the 5,946 people newly diagnosed with HIV/AIDS, 57.1 % entered care within 3 months of their HIV diagnosis as evidence by CD4 count or viral load.
- **Median CD4**: Among all new HIV/AIDS diagnosis with at least one CD4 count reported, over the last 5 years, the median CD4 count was 285. The median CD4 count has increased from 211 in 2004 to 339 in 2008.
- **Late Testing:** Of the 3,143 AIDS cases diagnosed between 2004-2008 nearly, 61% were "Late testers" meaning that their initial HIV diagnosis was within 12 months of their AIDS diagnosis. In 2005 the District Department of Corrections implemented routine opt-out HIV screening in the DC Jail. Since that time late testing has decreased from 71.4% in 2005 to 58.5% in 2008.
- **In Care:** Of the 16,513 people living with HIV/AIDS in the District, nearly 60% are in care, evidenced by two CD4 counts and/or viral loads in the last 12 months.

HIV/AIDS remains the leading cause of premature mortality for men and women in the District. HIV is the second leading cause of premature mortality among residents.[4] The District has made strides in elimination of mother to child transmission, however over 80% of women living with HIV/AIDS are of child bearing age (15-45), highlighting a need for services directed at safe conception and maternity. Men have more sub-optimal health outcomes than women.

Though proportion of HIV positive men and women linked to care within 3 months are relatively equal (58.9% vs. 59.2%), HIV positive men have lower median cd4 counts (332 vs. 373 in 2008) and more men are late testers (62.5% vs. 57.8%). This is a definite sign of failure to completely engage men in screening and HIV care. Studies have found that the stigma associated with HIV/AIDS, lack of trust in the health care system, poor understanding of the health system and personal health outcomes, and fear of confidentiality violations are all associated with people not accessing services or using anti-retroviral medications. Numerous studies have documented that co-morbidities such as mental illness and active substance abuse have an important impact on access to medical care in general and HIV medical care in particular.

[4] DC Mortality Report, 2006

Stigma/Discrimination

A major barrier for PLWHA in DC is high rates of HIV-related stigma that lead to social isolation, fear and reluctance to disclose to friends or family members. Although this is often considered an individual-level psycho-social barrier, respondents of the needs assessment focus groups indicated there is a need to address this as a community-level/structural barrier as well. With the launch of the first epidemiology report in 2007, public reaction to the high rates was one of shock and surprise, and commonly demonstrated a remaining pervasive belief that HIV was still a 'gay white man's disease, that sort of affects injection drug users and "sex workers as well' (paraphrasing of common responses). In fact, local data demonstrate that increasingly, women are infected heterosexually and do not have traditional individual-level 'high risk' factors—rather they are sexually active in an environment of high HIV rates. In the 2009 BRFSS survey, over 50% of respondents reported that they would want to keep the HIV positive status of a close friend or family a secret and 11% reported that they would be fearful of contracting HIV from an immediate family member in their household. The persistent stereotyping and stigma surrounding HIV in DC seems to impact PLWHA, and reflects a low level of baseline information in the community about the realities and opportunities for living long and healthy lives with the virus.

Disclosure

HIV-positive persons face significant challenges to disclosing their HIV serostatus, and failure to disclose can place their sex partners at risk. Disclosure is very closely related to stigma and discrimination in that people living with HIV/AIDS fail to disclose their status to potential partners in the fear of rejection and discrimination. Among respondents of the 2009 BRFSS, 20% of respondents reported that they would not tell friends, family or sexual partners if they were HIV positive. Though people living with HIV/AIDS are encouraged to disclose their HIV status, the uneasiness of discrimination limits the possibility of even potential important resources of support such as family and friends.

Mental Health

Mental health issues for PLWHA fall upon a large range, from counseling on HIV disclosure issues, maintaining one's health and drug adherence, to addressing chronic psychological and social challenges.[5] An individual's mental health impacts the patient's functioning and ability to adhere and participate in medical care as well as the patient's access to mental health services to address these issues.[6] Since early in the epidemic, literature has reported relatively high rates of depression among HIV-infected populations and that psychiatric disorders interfere with a patient's ability to initiate or continue antiretroviral regimens.[7] This notion is supported by evidence that patients with a history of depression have significant delays in beginning protease inhibitor treatment.[8] Moreover, once therapy is initiated, poor mental health status may interfere with a patient's continued adherence to medication. Literature has also shown that adherence to antiretroviral therapy is worse among those with depression[9] as well as among

[5] Fairfield KM, Libman H, Davis RB, et al. Delays in protease inhibitor use in clinical practice. *J Gen Intern Med* 1999;14:395–401.

[6] Klinkenberg,W. D. AIDS Care, Volume 16, Issue S1 January 2004 , pages 22 - 42

[7] Boland R. HIV and depression. *Am J Psychiatry* 1997;154:1632–3.

[8] Fairfield KM, Libman H, Davis RB, et al. Delays in protease inhibitor use in clinical practice. *J Gen Intern Med* 1999;14:395–401.

[9] Gordillo V, del Amo J, Soriano V, et al. Sociodemographic and psychologic variables influencing adherence to antiretroviral therapy. *AIDS* 1999;13:1763–9.

those with emotional disturbance.[10] PLWHA in the District cited mental health services as the primary support service accessed, however PLWHA, specifically HIV positive black men who have sex with men and heterosexual men and women and Latino/as, reported high levels of stigma was associated with accessing substance abuse and mental health treatment services.

Substance Use

People living with HIV/AIDS who have substance use disorders frequently do not receive adequate treatment for one or more of their illnesses.[11] Poverty, risky behaviors, vacillating motivation, and cognitive impairments are additional problems facing many.[12] In many communities, the service system is inadequately prepared to serve this population. Treatment barriers include stigma associated with the, separate funding streams, and lack of co-ordination between medical, mental health, and substance abuse treatment facilities.

Health Disparities

The Institute of Medicine's Report on Unequal Treatment: Confronting Racial and Ethnic disparities in Health Care clearly describes and documents the racial and ethnic disparities in access to health care services. People of color experience greater delays in entering HIV care plan than whites after a positive HIV test. Several have found that people of color are less likely to receive HIV care and treatment. The racial and ethnic disparities in accessing HIV care are further compounded by age, gender and a host of other barriers. Numerous studies have documented that co-morbidities such as mental illness and active substance abuse have an important impact on access to medical care in general and HIV medical care in particular. Provider attitudes also significantly influence people's care-seeking behavior. If providers hold prejudices or practice differently with people of color, women, sexual minorities, drugs users, people with mental illness or homeless individuals, then these attitudes may be felt by the client who then fail to engage in care.

[10] Singh N, Squier C, Sivek C, et al. Determinants of compliance with antiretroviral therapy in patients with human immunodeficiency virus: prospective assessment with implications for enhancing compliance. *AIDS Care* 1996;8:261–9.

[11] Fairfield KM, Libman H, Davis RB, et al. Delays in protease inhibitor use in clinical practice. *J Gen Intern Med* 1999;14:395–401.

[12] AIDS Care Volume 16, Issue S1 January 2004 , pages 56 - 70

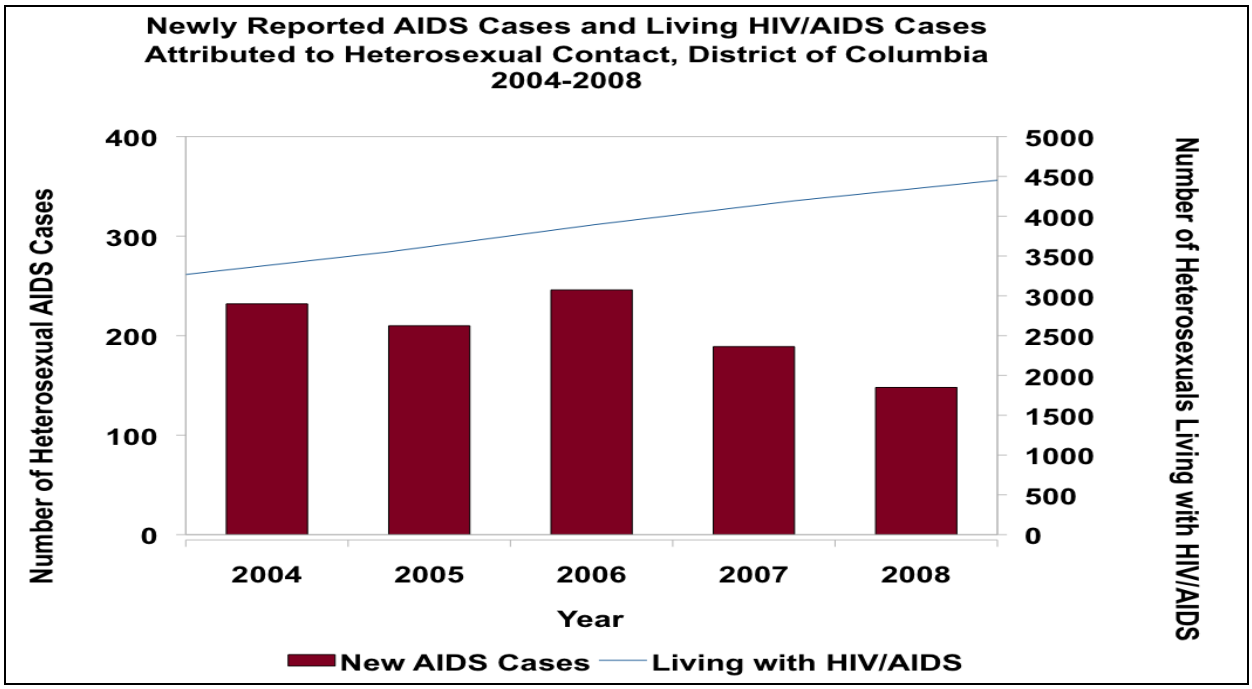
Priority Two
High-risk HIV-Negative Individuals

Black Heterosexual Men and Women

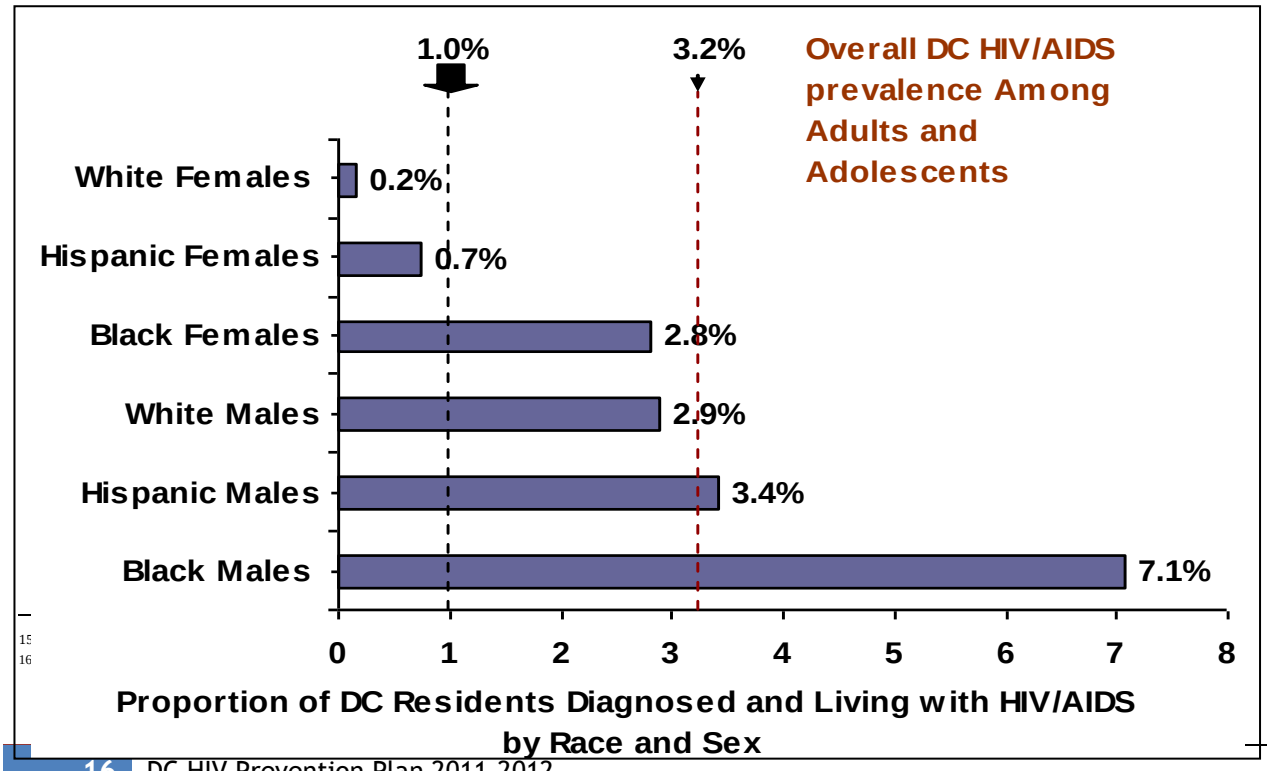
Washington, DC is in the midst of a severe HIV epidemic driven by new HIV diagnosis among heterosexuals and sustained high rates of HIV among injection drug users and men who have sex with men (MSM)[13]. These populations have overlapping social and sexual networks, complicated further by DC's small population size and prevalence rate among blacks. Blacks, men, people who live or are socially or sexually connected to economically depressed areas and people over the age of 40 are severely impacted by the epidemic. Not only are there high rates of disease, but low perception of HIV risk. The DC Behavior study on Heterosexuals[14] found high rates of undiagnosed HIV, with the highest overall rates of HIV in women. Over half of heterosexuals who participated in the study knew their HIV status, only half knew the HIV status of their last sex partner and a third of participants used condoms at last sex.

Heterosexuals accounted for 37% of new HIV infections among adults and adolescents in the District i9n 2001-2006. In 2006 alone, 43% of newly reported HIV cases among adults and adolescents were attributed to heterosexual contact. Since 2004, the number of people living with HIV/AIDS whose diagnosis was attributed to heterosexual contact increased by 29% (figure. XX). Heterosexuals living with HIV/AIDS are more likely to be over the age of 30 at the time of their HIV diagnosis and currently over the age of 40.

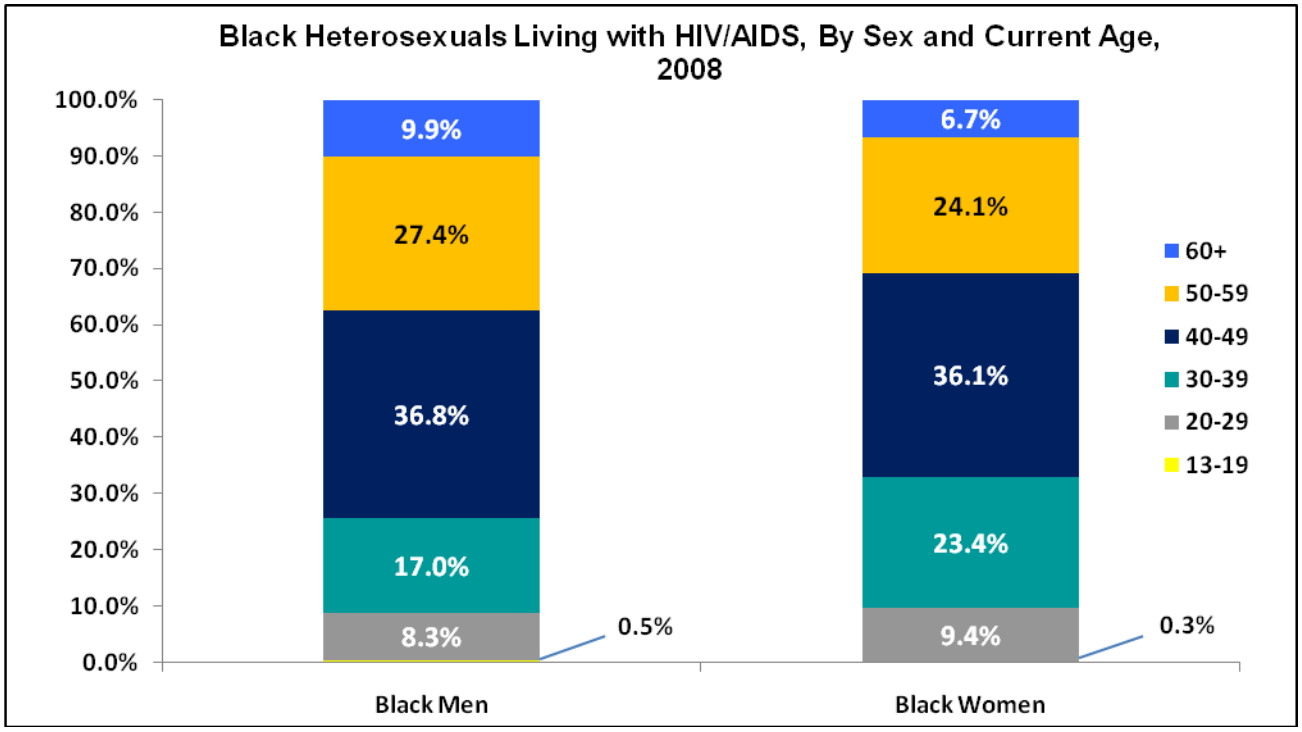
[13] Greenberg, 2010
[14] NHBS



Blacks are disproportionately impacted by HIV in the District, with heterosexual sex as the leading mode of transmission for new HIV (41.8%) from 2001-2006[15] and new AIDS (32.6%) diagnoses from 2004-2008.[16] Nearly 90% of heterosexuals living with HIV/AIDS in the District are among blacks. Black heterosexual women have the highest burden of disease among women, accounting for 91% of heterosexual female residents living with HIV/AIDS. Although prevalence rates among blacks by mode of transmission cannot be calculated, nearly 7.1% of black men and 2.8% of black women residents of the District are diagnosed and living with HIV/AIDS.



Among those living with HIV/AIDS by age, the highest burden of disease is among black men and women aged 40 and above, with 74.1% of Black men and 66.9% of Black women over the age of 40 living with HIV/AIDS.



Black heterosexual community needs assessment (2010) participants described their own community as diverse based on racial identity, age, and as one female participant described, has a higher ratio of women to men, *"so it can be pretty competitive."* Participants also described their community as mobile, with a specific emphasis by black heterosexual participants that their population extends outside the DC borders into neighboring Maryland and Virginia. Participants indicated many people enter the District for work, as well as for socializing. [17]

Themes within Literature and Data

HIV and Relationships

Research has highlighted that many people have difficulty accurately assessing HIV risks in their relationships. Nationally, several studies found heterosexual women contract HIV through their

[17] 2009 CSA Needs Assessment

main partners[18]. Several studies have provided insight into how personal circumstances and social networks play a role in increased risk of HIV. Finding detailed reasons for high risk behaviors, like concurrent relationships or "serial monogamy," which in many situations, is due to high rates of incarceration among men in minority communities[19] and low marriage rates among Blacks.[20] The DC Heterosexual Behavior Study has broadened DC's understanding of the cross sections between relationships and the HIV epidemic. Although 75% of participants indicated they were in a main, or monogamous relationship, approximately half of both men and women surveyed had sex outside their relationship and believed their partners had sex outside of the relationship, 49% surveyed did not know their last sex partner's HIV status, and only 30% surveyed used condoms at last sex.

Condoms

Condom use is considered to be an effective prevention method for reducing the risk of HIV transmission, yet many men and women are still not engaging in the condom use. Nationally, an estimated 25% of men and women reported condom use at last sex. In the District, over 30% of participants in the DC Heterosexual Behavior Study reported condom use the last time they had sex.[21] According to the DC 2009 BRFSS survey, over half of participants (53.7%) reported using a condom at last sex.[22] Several possible reasons for the low prevalence of condom use are noted in the literature. Several studies with heterosexuals [23] found men are more likely to purchase and carry condoms; however, they tend to rely on the woman to negotiate condom use.[24] Several factors were shown to affect the likelihood of women negotiating condom use with main partners. Exposure to partner violence, accusations of infidelity, age and race are factors that indicate influence lower rates on condom use in women.[25]

HIV Testing Behavior

Knowing your HIV status and that of your sexual partners is the cornerstone of fighting the HIV epidemic. In the District, among those living with AIDS over the last 5 years, 61% received their AIDS diagnosis less than 12 months after an initial HIV diagnosis[26], highlighting a failure of the medical system in addressing the HIV epidemic. Although the District is moving toward annual routine-opt out testing, in 2007 only 61% of the DC Heterosexual Behavior study participants had been tested for HIV in the past year, while 40% of participants reported they were offered an HIV test during their last medical visit. Of the 5.2% of people who tested positive in the study, nearly half of the participants were previously unaware of their status. A separate examination of the District's 2006 HIV scale up campaign indicated that out of the **38,586** persons tested during campaign, nearly a third (31.7%) indicated ***never*** being tested for HIV, with blacks being more likely to never have been tested (34.6%). According to DC 2009 BRFSS, 51% of DC residents reported having an HIV test in the last 12 months.[27]

Social-structure:

[18] SHAS
[19] El-Sadr et al., 2010
[20] Adimora, 2005
[21] NHBS
[22] BRFSS 2009
[23] Carter and colleagues (1999)
[24] Perrino and colleagues (2006),
[25] Perrino et al., 2006; Williams & Semanchuk, 1999; Margillo & Imahori, 1998
[26] 2009 Epi Annual Update Report
[27] BRFSS 2009

Nationally, CDC found that social-structural variables – particularly measures of individual socio-economic status – were the most effective means of identifying heterosexuals at increased risk of HIV infection[28]. Research[29] suggests that social factors such as poverty, racial segregation and chronic unemployment shape sexual networks and access to health services which are, in turn, thought to contribute significantly to the increased risk of HIV infection in disadvantaged communities. Mental health and domestic violence also impact HIV transmission. In a study conducted in Baltimore, MD, investigators found that depressed patients were more likely to engage in exchange sex, have sex with an injecting drug user, have a greater number of lifetime partners, and abuse alcohol and drugs. [30] Several other studies have concluded that women who have experienced physical, sexual or emotional abuse, or who suffer from symptoms of depression are also more likely to engage in high risk behaviors[31]. Women in low-income communities were also more likely to engage in unwanted sex due to threatened force, were less likely to negotiate condom use, and were more likely to have substance abuse problems. In a separate study, domestic violence was shown to reduce the likelihood of condom use, specifically among black women. [32] In the recent DC heterosexual study, 49% of women reported having depressive symptoms in the past week, while 36% of men reported symptoms of depression. In addition, 48% of women reported ever being emotionally or physically abused compared to 26% of men.

Risk Behaviors

Condom use

Though studies have shown that people living with HIV/AIDS engage in safer-sex practices, a considerable percentage of seropositive persons (range 10% to 60% depending on the specific sexual activity)[33,34] continue to engage in unprotected sexual behaviors that place others at risk for infection and place themselves at risk for contracting secondary infections (e.g., Chlamydia, syphilis, gonorrhea, herpes, etc.) that may accelerate their HIV disease.[35] In an analysis of sexual behaviors among PLWHA, seropositive subjects who had high viral loads were just as likely as those with undetectable viral loads to have had unprotected sex in the past 6 months.[36] As more and more people with HIV live longer and healthier lives because of antiretroviral therapy, an increasing number of sexual transmissions of HIV may stem from those who know they are infected and engage in unprotected sexual activities.[37,38]

The DC Heterosexual HIV Behavior study showed that only 30% of participants used condoms at last sex, however only 50% of participants knew their partners HIV status. [39] CSA needs assessment participants (both men and women) agreed condom use is not common among primary partners, but is more likely to be used with other sexual partners. Condom use generally stops soon after sexual relationships begin (e.g., one month into the relationship). *"I've seen*

[28] NHBS Protocol
[29] Adimora, 2005; Adimora, 2009; Holtgrave 2003
[30] Hutton et al., 2004
[31] Brown et al., 2006; Laughon et al., 2007
[32] Wingood & Diclemente, 1997
[33] Kalichman SC.. Clin Psychol: Sci Pract 2000,7:32±47.
[34] Marks G, Burris S, Peterman TA. AIDS 1999, 13:297-306.
[35] Balzquez MV, Madueno JA, Jurado R, Fernandez-Arcas N, Munoz E. J Acquir Immune Deficiency Syndr Hum Retrovirol 1995, 9:389-394.
[36] van der Straten, Ariane et al. AIDS 2000, 14:F47-F54.
[37] Kalichman SC.. Clin Psychol: Sci Pract 2000,7:32±47.
[38] Schiltz MA, Sandfort TG.. Soc Sci Med 2000, 50:1571-1588.
[39] DC HIV Heterosexual Behavior Study

myself sometimes asking them, ok well if you are going out there are you using condoms still? And some of them say no, I'm not, I have a girlfriend I don't use condoms with her but I use condoms with the one I have a one-night stand with." Nonetheless, some participants made it clear that condom use outside the main relationship is not always practiced. Many men agree that it is the woman's responsibility to make her partner use condoms because she has most at stake by becoming pregnant if she does not use them. In several focus groups, women also indicated participants said the primary reason for using condoms was to prevent pregnancy. The women participants further said many times the behavior was specifically for pregnancy prevention, not to prevent HIV or other sexually transmitted infections (STI).[40]

Partner Concurrency

In conjunction with low rates of condom use, concurrent sexual partners among people living with HIV/AIDS place others at risk for infection. In a study of sexual behaviors among Black PLWHA, 17% of participants had four or more partners in the 18 months.[41] The DC HIV Heterosexual Behavioral study found a significant number of participants reporting partner concurrency. The study showed that while 78% of female participants and 68% of male participants reported being in a committed relationship, 45 % of participants disclosed having concurrent sexual partners, while 46% believed their partner was having sex outside the relationship.[42] Over half (52.6%) of participants knew about their HIV + status, but only 30% reported condom use the last time they engaged in sexual activity. Together, these data suggest that the frequency of partner concurrency may be especially salient risk behaviors for HIV transmission in the Black community.

Community needs assessment participants discussed a high level of concurrent partners among Black heterosexuals in the District. Concurrency was discussed as an issue that affects both men and women. Women discussed monogamy in a relationship with their partners and the need to not "step out" and have sexual relationships with someone else. However, they were very concerned that their partners would not tell the truth about their past or current sexual activities, increasing their risk of contracting HIV/AIDS.[43]

Low rates of Routine HIV Screening

The DC Heterosexual HIV Behavioral study showed 87.9% of participants having ever been tested for HIV, but the number of individuals who had been tested within the last year dropped to 60.9%. Among those who tested positive in the study, close to half (47.4%) were unaware of their HIV status.[44] Community needs assessment results showed participant's experiences with HIV testing to be infrequent or not occurring at all, unless specific reasons were given to believe they were at risk of exposure. Participants discussed they would get tested if they found out their previous partner had many sexual partners in the past, if they did not look very healthy after running into them, and women said they would get tested if they suspected their partner was having sex with men on the side.

CSA focus group participants discussed a reason for not testing frequently was because individuals do not have primary care physicians. Lack of preventive health care plays an important role in testing, care and treatment. Participants expressed only going to the doctor

[40] 2009 CSA Needs Assessment
[41] Smith et al. AIDS 2000, 14:1237-1248
[42] NHBS HET Study
[43] DC Community Needs Assessment
[44] DC HIV Heterosexual Behavior Study

when they felt sick. A few CSA focus group participants expressed concern for those individuals who know they probably are infected with HIV due to personal risk factors but don't get tested because there are no signs or symptoms. Because going to any clinic is rare, there was a fear that other people would take notice and would assume the reason that the person is frequenting the clinic is because they are HIV positive: *"There's a lot of older people that's HIV positive but they don't want to admit it, or they don't want to be caught going to the clinic. A lot of people don't go to the clinic."*

Risk Perception

Perception of HIV risk is an ongoing issue among Black heterosexuals in the District. Female Needs Assessment participants have developed their own criteria to determine risk which informed their decision to use a condom, discuss the status of their relationship or bring up HIV status with a sexual partner. Women relied on a series of "signs" from their partners to determine their risk. Examples include history of incarceration of their partner, as an indication of possible MSM/W behavior, hairstyles, whether their partner requests anal sex, and degree of masculinity and outward visible clues. The same conclusions apply if their partner lived a lifestyle that made him more liable to cheat, ("street life, drug dealer.) *"I think the difference is that more brothers today are not telling their spouses what's going on. It is different when you think you're in a monogamous, heterosexual relationship with a man, then you find out that he is confused about his sexuality for different reasons than jail or being molested, or whatever and he goes to the other side*. Needs Assessment Participants expressed strong perception that the high rate of HIV in the District was due to the large population of MSM in the city. The perception among Black men in several focus groups was that HIV is still a "gay man's" disease where the infection rate is typically only found in that population. Black women primarily identified at-risk populations in terms of their risk behaviors (e.g. IV drug use, or unprotected sex) rather than using labels (e.g. gay men) men interviewed.[45]

Barriers to Accessing or Using Prevention Services:

Stigma and Discrimination

The nature and intensity of HIV/AIDS stigma and discrimination are shaped by the social construction of the epidemic in different locales. Stigma therefore needs to be discussed in its cultural context. Stigma has interfered with effective societal response to HIV/AIDS and has imposed hardships on people living with HIV as well as their loved ones, caregivers, and communities.[46] Stigmatized attitudes are strongly correlated with misunderstanding the mechanisms of HIV transmission and overestimating the risks of casual contact and with negative attitudes toward social groups disproportionately affected by the epidemic.[47] Of the 1,054 CSS respondents, 33% "Strongly Agree/Agreed with the statement "*I worry that if people knew I have HIV/AIDS, they would think less of me*." Nearly 29% of those surveyed Strongly Agree/Agree with the statement "*I feel that because I have HIV/AIDS, it is difficult to form lasting relationships."*

Various CSA focus group participants described the persistent belief among some individuals that HIV infection is a moral consequence of MSM behavior. Still others said that there is a widespread belief that HIV primarily affects the transgender community, and some believed

[45] CSA Needs Assessment
[46] Herek GM, et al. AIDS and Stigma: a conceptual framework and research agenda. *AIDS Public Policy J.* 1998;13:36–47.
[47] Ibid.

that men who have sex with men and women (MSMW)-(who participants referred to these men as "on the down low") are the driving force behind the District's high HIV rates. Several of the women identified MSMW as one of the main reasons for the increased HIV rate among Black females. Several women had personal accounts with men who were secretly in sexual relationships with other men while still in relationships with women. For one Black woman, contracting HIV from a MSMW was her first and foremost fear when asked about her HIV concerns. *"Because there's a lot of like I said men on the DL who do practice sex with other men and may not be protected all the time and come back and sleep with their girlfriends."*

Another barrier mentioned with regard to seeking HIV prevention, testing, care and treatment from service organizations was the stigma that certain agencies had from being associated with HIV. Participants mentioned Walker Jones (a Unity healthcare clinic) as being a comfortable place to go because, *"they usually have other patients that don't have HIV. And yes, usually that clinic has other patients that don't have, it's like a regular clinic so that's the reason you feel comfortable going there. It's not necessary to have HIV and you are a patient so I think they do that because you see some people are like 'I don't want anyone to know I have HIV.'"* Stigma associated with agencies that target specific populations, such as MSM or IDU, was also mentioned as a reason why individuals do not utilize the services at those agencies.[48]

Mistrust within Government and the Medical Community

Common misconceptions surrounding HIV have been previously stated in this report. When follow up questions were asked regarding these misconceptions, there was an overall lack of trust in government reports and statistics with CSA focus group participants saying, *"I don't believe that, I don't believe anything…We don't know, don't know, we just going by what they say on the news or whatever…[R2]: Just by the numbers they put out. [Interviewer]: You don't believe it though? [Respondents]: no, no (many voices saying 'no, I don't believe that')."* One participant discussed his belief about HIV explaining that he does not *"think sex causes HIV. [He] learned that HIV didn't come around until the 60s…if it was produced by sex, [he's] quite sure that throughout the centuries you'd have heard a whole lot about it. The percentage of people having HIV would be much higher."* [49]

Testing: Fear and Lack of Confidentiality

When asked about HIV testing, with CSA focus group participants gave various reasons why people do not test. Fear was the most common barrier to getting tested: *"A lot of people don't get tested 'cause they scared, and um, they want to go but they're scared because they probably even know they…or probably really sense they have it. They scared to go and get tested 'cause they gotta think about who they got to go back and let know this."* Many participants said a positive diagnosis was scary because it meant a lifestyle change and others possibly finding out about their HIV diagnosis. Others finding out meant possibly being outcast by friends and family, but it also involved a fear of safety. Participants shared stories about friends who had previous partners find out the friend's HIV status and it lead to violence: *"…but they find out some kinda way or another and they know that, they know who the people they been with and they go through there's a block of women on that street they deal with and they know who they done been with, and if her name come up, they know this is the one that you know…probably gave it to me and she gotta go, or he gotta go, or he gonna put the word out that they got AIDS.* [Respondent 2]: *They got it, know the next man that deal with her or*

[48] CSA Needs Assessment
[49] CSA Needs Assessment

whatever might deal with her, hurt her or him or whatever. They find out somehow, someway they find out."

An overall distrust regarding confidentiality surrounding HIV testing pervaded discussions by CSA focus group participants. Participants felt confidentiality could be violated two main ways: 1) by knowing someone at the clinic who tells family and friends they saw him/her; and, 2) by the Health Department during partner notification. *"Another reason is because when you do go get tested and you pop up positive, they start asking you…how many sexual relationships and partners you done had and who are they, and what's their info, you know what I'm saying, so we can contact them and let them know. They don't tell them, 'Oh, we not gonna call them and mention your name', you know what I'm saying, so they like, 'if I give them this number, they gonna call and be like, well yeah '(name deleted), she just came down here and got tested and she HIV positive,' you know what I'm saying? And the next thing you know he might see (name deleted) on the street and start shooting at her…"*

Participants believed the breach of confidentiality within service organizations or clinics was due to staff discussing work with friends and family: *"I think the organizations…are discreet, but you know the people that is in there that, I'm not saying that they tell on you, but there's some people in there that you know that work in the clinics and they see you in there and they somewhere talking about it right, and it gets out like that."*

According of to the DC Heterosexual Study, among those who had not have an HIV test in the last 12 months, nearly 30% of participants reported that they were worried that someone would find out about the test result.[50]

Lack of Health Insurance

Another barrier for not receiving care and treatment was that individuals lacked health insurance and that HIV is expensive to treat: *"You got to have money to treat this disease…You got to have money, doctors are not gonna work on you for free…and you got Magic Johnson, he had this HIV for years and nothin's going on…and he ain't got it cus of the medication, and they don't take none of that medicine, none of those drugs, ain't bring them down here to the hood…."* Some CSA focus group participants also expressed a misguided belief that without health insurance, one could not get an HIV test.

Partner Violence Abuse

Nearly half of female participants in the DC Heterosexual HIV Behavior study reported ever being emotionally of physically abused by a partner (47.6%).[51] CSA needs assessment participants, specifically black women, discussed domestic violence as a somewhat common occurrence. Women participants described HIV as the cause for domestic violence, as well as the reason it continues. One participant described a couple where the husband is a cocaine addict and frequently buys sex from commercial sex workers. She reported that he is physically abusive to his wife and assumes it escalates to sexual violence. *"Because I told you he hits his wife and after he takes her to her room. And after, I hear her screaming but we didn't hear him hitting her."*[52]

Predictors/Drivers of HIV in Black Heterosexual Population

[50] NHBS Heterosexual Study
[51] DC Heterosexual HIV Behavior Study
[52] CSA Needs Assessment

Substance Use

The DC Heterosexual HIV Behavioral Study shows marijuana and crack/cocaine as the two most commonly used non-injection drugs among participants (49% and 21.5% respectively), with 60.2% of all participants reporting non-injection drug use within the past year.[53] CSA focus group participants agreed that cocaine, marijuana and alcohol were commonly used substances within the Black heterosexual community in the District. They also agreed that illegal substances were very easy to obtain. The overall consensus among CSA focus group participants was that condom use while under the influence was inconsistent and in most cases, not practiced due to the mind-altering effects of the substance.[54]

For additional information on non-injection drug use and HIV, please see page 70.

[53] DC Heterosexual HIV Behavioral Study
[54] 2009 CSA Needs Assessment

Knowledge of HIV Status

Among AIDS cases in the District between 2003 and 2007, 63% of Black heterosexuals with HIV received an AIDS diagnosis less than 12 months after an HIV diagnosis.[55] The DC Behavioral heterosexual study reported that 61% of participants had been tested for HIV in the past year; meanwhile, nearly half of the participants who tested positive in the study were not previously aware of their status.[56] Additionally, the monitoring and evaluation of the DC HIV screening campaign showed that among the 26,356 persons reporting a history of prior HIV testing, 43.6% had been tested within the last 12 months. Sixty eight percent of respondents reported ever being tested for HIV prior to the test that was conducted through the campaign. Among those who had previously tested, 1% self reported that they were already aware of their HIV positive status.[57]

Knowledge of Partner's HIV Status

While routine screening has made much of an impact within the past few years during implementation and many individuals know their status who would have not known otherwise, there are still people who do not know their partner's HIV status. The heterosexual behavioral study reported that 49% of the individuals surveyed did not know their last sexual partner's HIV status and only 30% surveyed used condoms at last sex[58,59]. CSA focus group participants described requesting to see formal medical documentation of their most current HIV test results or their "papers" prior to engaging in sexual activity. However participants did state that this may not be common practice among people District wide.[60]

HIV Prevention Needs

HIV Myths

Even though HIV is a generalized epidemic in DC, CSA focus group participants primarily believed that only gay men or intravenous drug users are at risk for HIV infection, and a number of the participants were surprised to learn that African Americans are the most affected population. I

Some participants believed that the Dupont Circle area was the only area in the District with high infection rates and several participants did not know that Wards 7 and 8 had high infection rates as well.

Some participants also assumed that if a person looks clean they probably are "clean," meaning s/he is not infected with HIV or any other STI. When asked whether a discussion about using condoms is necessary, a participant answered: *"Is she clean? Is her nails clean?*

Some participants still believe d that HIV is a death sentence. *"He disclosed he was HIV. And for him to have a happy heart lets me know, even though he was handed a death sentence, he ain't going out like that."*

[55] 2009 Epidemiology Report Update
[56] DC Heterosexual HIV Behavioral Study
[57] Castel, et al, 2010
[58] 2008 Epi Report
[59] DC Heterosexual HIV Behavioral Technical Report
[60] CSA Needs Assessment

Participants repeatedly expressed concern about HIV, but there was an overall perception of low risk, especially among the male participants;

Men Who Have Sex with Men (MSM)

Sexual contact between men is the leading mode of transmission (37.3%) among persons living with HIV/AIDS in the District. More than half (51.8%) of living adult and adolescent males living with HIV/AIDS were infected through MSM sexual contact.[61] This number reflects the national estimates, which the CDC reports are as high as 60% of living adult and adolescent male AIDS cases.[62] Certain ethnic and cultural subgroups identified among the MSM community present additional areas to be assessed and addressed. Among all populations living with HIV/AIDS in the District, 21.4% are Black MSM. The leading mode of transmission among Hispanics living with HIV/AIDS is MSM contact (50%). More specifically, among men living with HIV/AIDS, 80.5% of white males reported MSM contact, 42.7% of Black males reported MSM contact and 59.9% of Hispanic males reported MSM contact, making MSM contact the leading mode of transmission among men living with HIV/AIDS in the District.[63]

Themes within Literature and Data

Culturally Specific Risk Behaviors

Information regarding risk behaviors among MSM residing specifically in the District has recently been investigated. Reports from the National HIV Behavioral Surveillance - MSM study (DC MSM Behavior Study) conducted in 2009 in DC reveal some similar and some very different behavioral risk factors within the MSM population when compared to the heterosexual population. Participants in the DC MSM Behavior Study were more likely to have had an HIV test in the past 12 months (79.7%) compared to heterosexuals (60.9%) and were more likely to know their last sexual partner's HIV status (64.1% vs. 50.3%).[64]

Gay/Bisexual Self Identity

Literature supports the perception that Black MSM are less likely to identify as gay than other MSM.[65] However, neither literature nor NHBS-MSM data support the belief that MSM identifying as non-gay increases an individual's HIV risk behavior.[66] Millett and colleagues found that "having a non-gay identity does not increase HIV risk-taking behavior with male sexual partners" among African American MSM.[67] Throughout a review of the literature, Millett found that sexuality nondisclosure was correlated with lower sexual risk taking among male sexual partners.[68] El-Sadr and colleagues conclude that increased risk among African American MSM is due to the high prevalence of HIV among their sexual networks and the increased probability of choosing partners within their same race.[69]

Risk Behaviors

[61] 2009 Epi Annual Report Update
[62] CDC, 2007
[63] 2009 Epi Annual Report Update
[64] DC MSM Behavior Study, 2008, DC Heterosexual Study, 2007
[65] Millett et al., 2006
[66] Magnus et al., 2009, Millett et al. 2006
[67] Millett et al. 2006
[68] Millett et al. 2006
[69] El-Sadr et a.l, 2010

MSM of Color (including Black, Hispanic and other) make up 66.7% of MSM living with HIV/AIDS.[70] The DC MSM Behavior study reported similar findings: MSM of Color were more likely to be HIV-positive than White MSM (19.8% and 7.6%, respectively).[71] The DC MSM Behavior study also found some differences in risk behaviors between White and non-White participants:

- White MSM were more likely to have unprotected anal intercourse, both receptive and insertive (56.2% and 51.0%) than MSM of Color (30.5% and 30.2%, respectively)
- MSM of Color were more likely to have an older partner than White participants (48.6% vs. 32.5%, respectively)
- MSM of Color participants were less likely to identify as homosexual (76.4% vs. 94.2%, respectively) but were more likely to identify as bisexual (23.3% vs. 5.4%, respectively)[72]

Condom Use

Along with partner concurrency, participants in the DC MSM Behavior Study reported 57.4% used a condom at last anal sex, where 65.7% of MSM of Color and 46.6%of White MSM used a condom at last anal sex.[73] Unprotected anal sex places MSM at great risk for becoming infected with HIV. Also, for those men already infected with HIV, unprotected sex poses an increased risk for re-infection and opportunistic infections.[74]

Elford et al. found that MSM whop do not use condoms for anal intercourse (sometimes known as barebackers), were more likely than other MSM to have "looked for sex (of any kind, not just unprotected anal intercourse) both online and offline and more likely to have had sex (of any kind) with someone they met online or offline."[75] The previous study also found that men who bareback were more likely to have a sexually transmitted infection within the last year.[76] Berg's review of literature on condom use found that even though unprotected sex contributes greatly to HIV transmission risk, three quarters of high risk sex among HIV positive MSM is unintentional, meaning that those who engage in unprotected sex did not specifically seek a partner who preferred unprotected anal intercourse.[77] Further research found that the decision to bareback was positively associated with number of partners and the number of unprotected receptive anal intercourse (URAI) episodes.[78]

Partner Concurrency

According to the MSM Behavior study, 44% of men reported they had a concurrent relationship in the past 12 months, while 53% believed that their partner has had a current relationship in the past 12 months. An overwhelming majority of CSA focus group participants indicated that monogamy and fidelity were not typical characteristics of the MSM population in the District. "*We're always cheating. I have not; I have not met a gay guy that was faithful to his partner. And I know a lot of gay guys.*" The interviews with key informants in the MSM community

[70] DC MSM Behavior Study, 2009
[71] Ibid.
[72] Ibid.
[73] Ibid.
[74] Halkitis, 2003
[75] Elford et al., 2007
[76] Ibid.
[77] Berg, 2009
[78] Bauermeister et al., 2009

revealed a common theme that concurrent relationships and infidelity are the sexual norm among this community. A common response when asked why there is such a high level of concurrent relationships among MSM was, "*We are men and men like sex.*" Many focus group participants described the widespread practice of having "open relationships," where a couple will be accepting of each other having sexual relationships with others and even agree to bring in other individuals into their sexual encounters. Overall, condom use among couples was inconsistent at best. Some participants said that condoms may be used in the early stages of the relationship but eventually the use of condoms diminishes, even though they acknowledged high levels of concurrency among MSM.

Relationships/Sex Partners

There were a high number of DC MSM Behavior study participants that believed their partner had sex outside of the relationship, regardless of whether the relationship was short-term or long term (54.3% and 52.3% respectively). Of those participants in short term relationships, 39.5% reported self-concurrency while 60.5% of those in long term relationships reported self concurrency.[79]

Another common theme when CSA focus group participants spoke of MSM relationships was the frequency of younger MSM becoming involved with a much older man. The younger individual was described as being in his mid- to late-teens or early twenties, while the older partner is typically ten to fifteen years older. The reasons for such age gaps among relationships were similar when described by both younger and older MSM participants who had personal experiences in this situation. Most participants defined the relationship as a type of exchange relationship. That is, the older partner usually provides certain material needs or wants for the younger partner and the younger partner satisfies certain physical needs for the older partner. The needs that the younger partner will receive may include housing, food, or even monetary gifts or other material possessions. *"The youth may or may not actually be romantically interested in this person, but they see this person giving 'em a need that they may not be getting from somewhere else, either from home or wherever it may be. So, it's a support mechanism, um, for some of the young people."* According to the DC MSM Behavior Study, 40.9% of participants reported that their last sex partner was older.

When stratified by age, 54.1% of MSM said that their last sex partner was older, compared to 27.9% among MSM aged 30 and older. Many key informants who work directly with MSM youth expressed concern about this type of relationship because they suspect this is one of the leading causes for the high rate of HIV among young MSM. The concern is that young MSM may not demonstrate the self-efficacy needed to initiate or negotiate condom use. The youth may believe that in exchange for the gifts and or support they receive, they are expected to passively accept the terms of the sexual relationship.

Focus group participants thought that young men could become exposed to HIV more readily when they engaged in sex with older men than they were engaging in sexual relationships with their peers. Some MSM said that the younger partner holds a certain degree of power in the relationship because the older partner wants to feel youthful and sexually desirable. The young MSM/older MSM dichotomy was just one of the high risk sexual situations described by the participants.

Engaging in relationships with non-gay identified men was another theme that emerged when CSA focus group participants spoke of MSM relationships. According to focus group participants, this situation is a common occurrence in the District; several participants admitted

[79] DC MSM Behavior Study, 2009

they had at least one personal experience with a non-gay identified male partner. Participants said that these relationships usually begin with the non-gay identified man approaching the visibly gay man for sex. Usually, it is not until after this encounter that the man admits to leading a straight life, although some participants did provide examples of men who do not admit to their straight life. *"I'll take one guy, for example, that was coming to see me, knew nothing about it, he had a girlfriend and everything and never mentioned nothing to me about it. And then, one day, I happened to be downtown, and he was with his woman and they had this little baby girl in a stroller. And, then, he looked at me and was so scared that I was gonna open my mouth and say something."*

Other focus group participants said that those men who do admit to their straight lifestyle will set ground rules for the relationship that will purportedly prevent them from getting caught. In exchange for this sex-based relationship, non-gay identified men may also provide material goods, money, and even housing for their male sex partner. In general, participants agreed that condom use among non-gay identified men was inconsistent even though they understood that the non-gay identified man was also having unprotected sex with his female partner(s).

Internet/Partners/Condom Use

The literature has found that the internet is a strong venue to not only find casual sex partners, but also a place to find individuals specifically wanting to bareback.[80] Seeking sex partners on the internet has also been shown to put MSM at a higher risk for other sexually transmitted diseases (STD) by facilitating group sex, high-risk sexual practices such as rimming (oral-anal stimulation), and increased numbers of partners.[81] Thirty-five percent of participants in the DC MSM Behavior study sought out sexual partners on the internet within the last three months.[82]

Although some focus group participants said that connecting with a non-gay identified man can readily occur in public, most participants agreed that the way these men seek sex with other men is through the internet. They said that several online sites are frequently used by non-gay identified men because they can remain anonymous and can more easily find men for sex than in person. Aside from non-gay identified men, MSM in general reported frequent use of the internet to search for and make connections with sex partners, regardless of race. One Latino participant said that even low-income MSM who cannot afford a computer might readily afford a cell phone with internet access. Almost all CSA focus group participants said that MSM in the District use technological methods to seek sex as much as, if not more than traditional sex partner seeking methods at venues such as bars or clubs.

Data from focus group participants described a new software application called "Grindr" for the iPhone, which enables MSM to determine and locate how many feet away from them there is another MSM looking for sex. There were also several common websites described by participants that are used for the purpose of seeking sex (e.g., Manhunt, Adam4Adam, AdultFinder). Focus group participants said that these websites allow users to create a profile that may include HIV status, though many agreed that users generally are not truthful in disclosing their status. In addition to HIV status, a user's profile can include a list of characteristics that make it easy for others to filter out undesirable partners. *"Well, if you think about it this way, you're on the website, primarily there for the hookup with sex. You know what the person wants. You know what you want. You can look at their stats, what they're into … It's like, uh, uh, you know, like a grocery store. "No, that's not what I want. Um, that's not what I want." You can filter people out based on all sorts of things."* Moreover, several

[80] Berg, 2009; Grov, 2006; Slayers-Bull et al., 2004
[81] Mettey et al., 2003; McFarlane et al., 2000
[82] DC MSM Behavior Study, 2009

participants described the use of websites to plan for sexual encounters when traveling by setting up a sex date with a partner in their destination city ahead of time.

Another way technology is being used for finding sex among MSM in the District is through targeted e-mail lists. These lists are created using word of mouth and are used to organize sex parties. *"Um, I have friends who are on the email list and you have to submit their picture, your picture, and if they like what they see, they say, 'You know, here's the address. Come on by.'"* Sex parties were described as common occurrences in the District, which are frequently advertized in gay newspapers or online. The majority of these sex parties occur in private residences that may build a reputation for holding these events. CSA focus group participants stated that condom use was variable depending on the rules of the sex party. For instance, a host may make it clear that condom use is welcomed by giving away condoms and lubrication at the door, whereas others may advertise that the event is for "bare-backing" only, where condoms are not welcomed.

Substance Use

Substance use is an important HIV risk factor among MSM individuals. Multiple studies have reported high substance abuse rates among MSM across the United States.[83] Drug use is associated with high-risk sexual behaviors and injection drug use contributes to increased HIV risk. The DC MSM Behavior study found that non-injection drug use in the past 12 months was popular among MSM participants, with over half of the participants reporting using non-injection drugs. Of those who reported non-injection drug use, marijuana, poppers, powdered cocaine and ecstasy were the most popular (77.2%, 46.3%, 39%, and 20.9%, respectively). When distributed by ethnicity/race, White MSM were more likely to use poppers compared to MSM of Color (53.1% vs. 39.5%) and downers (27.1% vs. 14.6%). MSM of Color were more likely to use ecstasy (27.1% vs. 14.6).[84]

Another type of sex party described by focus group participants is referred to as "party and play." These sex parties include libido-enhancing drugs, such as ecstasy or crystal meth. While these events may also be organized online, they can also be organized while at a bar or club by inviting other men at the venue. Condom use may or may not occur at these events, though participants admit that the likelihood of using condoms is diminished at these types of sex parties.

Although crystal meth was frequently discussed, all focus group participants emphasized that it was predominately used only by White MSM. Ecstasy, on the other hand, was more common among younger MSM of all races and among those who mixed sex with drugs. Cocaine was also mentioned as a common drug among MSM, as was marijuana. One Latino participant described non-gay identified Latino men as the highest marijuana users because they perceive marijuana use to be common among heterosexual men and therefore prefer to adopt those behaviors that can be classified as heterosexual. Overall, most CSA focus group participants agreed that alcohol was the most common substance used by MSM. One participant even described alcohol as a cultural characteristic of the gay community. *"I think, again, because [pause] alcohol has been a part of the social universe for the gay community more so than in the straight community, because for such a long time we were excluded from society that the one of the few places in the world we could socialize with people like ourselves were in the bar. So, it became a part of our culture."* Participants admitted that drug use, especially alcohol use, has a negative effect on condom use, reducing the chance of using them. One key informant phrased

[83] Thiede et al., 2003
[84] DC MSM Behavior Study, 2009

this problem in this way, *"We don't say 'don't drink and fuck,' we say 'don't drink and drive,' but it is, it's dangerous to drink and then have sex, because you're less likely to use a condom. If you do use a condom, you're less likely to do it properly, right, there's all these things."*

Substance Use/Commercial Sex Work

Among CSA focus members, drug use was also discussed in connection with commercial sex work. Some focus group participants said that commercial sex workers use drugs while engaging in exchange sex in order to cope with the lifestyle. Others said that drug addiction drives commercial sex work and the risky sexual behaviors associated with it. *"So what I'm saying is, that date might pull up and not want to use a condom, but I want that money so I can get high, so, okay, the hell with the condom."* In addition to substance addiction, financial instability was also described as driving risky sex behaviors in commercial sex work, especially among youth who do not have the resources to obtain other sources of income. Condom use also varied among ethnicities, according to participants. On one hand, condom use among Black commercial sex workers was characterized as inconsistent and was frequently based on the customer's willingness to pay more if they desired not to use condoms. *"Condom use is a secondary negotiation to how much money I am going to get out of this exchange."* On the other hand, a Latino participant described condom use as the standard practice among Latino commercial sex workers.

Sex work among Latinos was reported as mostly advertized on the internet via Craigslist because many sex workers are undocumented (illegal) immigrants, and thereby believe they are at less risk of being arrested than if they were on the streets, while African American sex workers, meanwhile, reported they do most of their recruitment of clients from the streets. Although there is some sex exchange that occurs at P Street Beach, a large proportion of participants discussed that anonymous sex is even more common than exchange sex in that area. Other areas where anonymous sex is common among MSM, according to participants, were the bathrooms at Union Station, Macy's, Library of Congress and the Martin Luther King library. CSA focus group participants admitted that condom use in these areas is sparsely practiced either because they believe they do not have the time to put one on or because it will reduce the stimulation that is sought from an anonymous sexual encounter.

Barriers to Accessing or Using Prevention Services

Cultural Competency

Overall, the largest reported barrier for MSM seeking services in the District was attending service agencies. CSA focus group participants said that when service agency staff members are not culturally competent in serving MSM, they may be visibly uncomfortable engaging with them or may make assumptions about their risk behaviors. This barrier was described as having the largest impact on youth because they are more easily deterred by any incidents that may occur as a result of what they perceive as being culturally violated. Participants expressed the importance of providing a safe space where youth can open up about their risk behaviors and thereby receive appropriate prevention measures. According to participants, building safe spaces begins with hiring culturally competent, MSM-sensitive staff and by providing targeted services to this population.

Agency Stigma

Focus group participants agreed that a common barrier for MSM seeking services is stigma associated with specific agencies. For instance, although Whitman Walker has broadened its services to a wide variety of populations, several participants admitted that they themselves or their friends have had apprehension entering the clinic for fear that someone they know may see them and assume they are HIV positive. This concern with entering an agency is amplified when the individual is not openly gay, especially if the agency is known to primarily serve gay clients. Thus, several participants blamed targeting services to "MSM" as the primary reason those who do not identify as gay avoid such services. They maintain that men who do not identify as gay will not identify as MSM and therefore will not seek services targeting MSM. Participants insist prevention measures should focus on behaviors as a strategy to reach all men who engage in risky sexual behaviors regardless of how they identify themselves.

Competing Priorities

Another barrier to seeking services is the lack of health prioritization. As previously mentioned, many MSM are struggling to meet their basic needs including food and housing, and thus make HIV prevention less of a priority. As one CSA focus group participant said, *"And what you find is that a lot of people who may be HIV-positive or may be at risk for HIV-positive, don't see HIV as being a right-now thing… people are like, "Okay, so, if I get HIV, I'm, okay, so what? I'll die within fifteen years. Okay. But, right now, I'm hungry. Right now I don't have a place to stay. I'll deal with my HIV later and I will take care of what I need to do to survive through the night."* Competing priorities can give a sense of indifference toward becoming HIV-positive and this was also blamed for the low prioritization of HIV prevention. Also, many CSA focus group participants said that a common attitude toward becoming infected with HIV is that of lack of concern due to the availability of ARVs. *"I had that conversation with some of my friends before and I was like 'Don't you think HIV would be a bad thing to get?' they're like, 'There are medicines, there are pills I can take.'"* Key informants also described prevention fatigue among their clients, especially among younger MSM. They explain that these clients frequently become frustrated with consistent HIV-related prevention messages and may even avoid agencies that provide these services. As one key informant said, his clients frequently protest *"My life isn't HIV"* when he tries to broach the topic of HIV prevention.

HIV Prevention Needs

Targeted Services

CSA focus group participants expressed the need for additional HIV services targeting the MSM community. Interestingly, among the organizations and agencies providing HIV prevention services in DC, Whitman Walker, Us Helping Us and HIPS were mentioned as providing the services that the MSM who participants found the most favorable. However, they also mentioned that other than these providers, there were limited services that addressed the specific MSM HIV prevention needs. One participant said that there are no services or even health-related messages targeting the MSM community in or near the Trinidad neighborhood.

Several participants said that there is a dearth of available services targeting Latino MSM. They acknowledged that the Latino MSM population has a high HIV infection rate and they, too, need targeted HIV prevention services, especially for undocumented immigrant MSM.

Another area of need, as reported by CSA focus group participants, is more mental health services targeting MSM, particularly youth. Most participants described the high prevalence of diminished self-esteem among MSM due to rejection from family and societal stigma. They said

that low self-esteem was a significant cause for infrequent condom use, especially among youth. *"I think the biggest challenge around HIV and I have come to believe this more recently than in my past, is that until we work on the self-esteem of gay men, we will not address H… we will not have an impact on HIV like we want to."*

Post-test Counseling:

Although CSA focus group participants promoted increasing testing opportunities by integrating them into all clinic visits, they were concerned with post-test services. Several key informants worried that appropriate post-test counseling or even adequate referrals to HIV care are not happening for MSM that test positive. They were concerned that options for MSM specific HIV care are limited for MSM in the District, with Whitman Walker being the only clinic in DC that offers an array of clinical services specifically for MSM. Another concern for key informants was the over-emphasis on testing large numbers of people, which distracts agencies from providing quality post-test services. *"I think there's a lot of, what I perceive, is a lot of focus on testing this many people, 'Let's get this many people tested.' Well if I'm focusing on I gotta test five people a day to meet my quota, then I'm, that's what I'm focusing on. I'm not focusing on providing a holistic service, right? Where are the numbers for linkages to care? Are we seeing folks getting linked to care? Are we seeing where they're getting linked to care, are we following them through the system, to see how the system is working?"*

Education

Focus group participants also discussed the need for more HIV-related education. Participants gave several examples of how MSM in the District are still misled about safe sex practices (e.g., HIV cannot be transmitted through oral sex); testing (e.g., you have to wait six months before you can be tested); and how they lack the skill to properly use condoms (e.g., using two condoms at a time). *"But how many people you think actually know how to use a condom? I didn't know what I was doing before until I came to HIPS. Thought I knew what I was doing, I didn't know."* Some participants emphasized the need to educate the men who buy sex and men who do not identify as gay. They said that while agencies are able to reach commercial sex workers and gay-identified men to educate them about risk reduction, their customers and non-gay identified men are not receiving the message because they are not accessing services. As a result, they frequently incentivize sex workers with either extra money or drugs to have unprotected sex with them. Furthermore, key informants emphasized the need to focus prevention efforts on behaviors (e.g., anal sex), rather than on labels (e.g., MSM); this way, they can better target those who do not identify as gay.

Non-Gay-Identified MSM Outreach

Reaching non-gay identified men, according to focus group participants, can be very difficult to do via the traditional avenues including venue-based methods, yet many men who do not identify as gay utilize the internet to seek sex. Therefore, participants emphasized the importance of the need to target these men, and the overwhelming amount of the MSM population who find sex partners via the internet. Although traditional venue-based outreach efforts may not reach all MSM, the majority of CSA focus group participants expressed the need for more street and venue based outreach. They claim that by doing on-foot outreach to their target population, they are able to reach far more people that would otherwise not enter a clinic or approach a mobile unit.

Comprehensive Care

Several CSA focus group participants agreed that the MSM community needs holistic care that addresses their unique circumstances that ultimately put them at risk for HIV acquisition. Many MSM are homeless and are on waiting lists for shelters which may or may not be gay-friendly. Additionally, participants mentioned that some of these men do not have the skills to obtain employment that will allow them to become financially stable and are forced into sex work in order to survive. Also noted were many MSM in DC who suffer from mental health disorders or drug addiction. Participants agree that with all of these compounding issues, an individual cannot prioritize their HIV prevention above basic needs.

Injecting Drug Users (IDUs)

According to the DC HIV/AIDS Epidemiology Update (2009), IDU is the third most prevalent mode of HIV transmission, accounting for 17.4% of transmissions in the District.[85] Thirteen percent of new HIV infections from 2001-2006 were attributed to IDU. Among newly diagnosed HIV infections attributed to IDU, 93.5% were black.[86]

From 2004-2008, IDUs accounted for 21.4% of newly reported AIDS cases, while MSM/IDU accounted for 4% of newly reported AIDS cases. IDU was the second leading mode of transmission for newly reported AIDS cases among women, and the third among men from 2004-2008. [87] However, from 2001-2006 IDUs only showed a 2% decrease in the number of newly reported AIDS cases. IDUs also accounted for over one third of all adults and adolescents who died in 2006, the highest proportion overall.[88]

Themes within Literature and Data

Factors HIV-positive substance users face not only pose a greater risk to themselves for re-exposure to HIV infection, but pose a risk to their sexual partners as well. Risk to partners, as well as to themselves, include inconsistently following their HIV/AIDS treatment, HAART, if they have access to treatment at all. Celentano et al. report that drug-using HAART receivers are likely to actually increase their risky sexual practice as a result of a false feeling of safety or reduced perception of transmission likelihood.[89] The literature also found particular population-specific data regarding substance abuse and HAART adherence; poorer adherence to anti-retrovirals was connected to excessive drinking and cocaine use.[90,91,92] Nationally, 53% of surveyed HIV-positive adults reported drinking in the previous 30 days; this rate is approximately double that of the general population. Adherence is the primary predictor of treatment success, and is therefore of paramount concern given how many HAART patients are drinkers. Alcohol use is the most significant predictor of non-adherence. Having one of more

[85] 2009 Annual Report Update
[86] 2007 Annual Report Update
[87] 2009 Annual Report Update
[88] DC Department of Health IDU Fact Sheet, 2007
[89] Celentano et al., 2008
[90] Adirmora and Schoenbach, 2002
[91] Tucker et al., 2003
[92] Parsons et al., 2008

drinks increased the odds of non-adherence by 8.78 times.[93] Given that many HIV-positive members of sexual communities have HIV-negative partners, interventions must address the substance abusing HIV-positive community, as their non-adherence may directly be responsible for transmission.

Tucker et al.'s study also presented five critical findings regarding the association of substance use and HIV treatment adherence: any drug use and more severe use were both associated with non adherence, particularly marijuana/hashish, cocaine/crack, freebase, sedatives, and amphetamines; the use of heroin, analgesics, inhalants and hallucinogens did not differentiate those who adhered to treatment from those who did not; drinkers tended to have worse adherence than non-drinkers, with non-adherence increasing with the level of drinking severity; adherence was worse among those with probable diagnoses of depression, generalized anxiety disorder, or panic disorder; and moderate drinking was also an important risk factor for non-adherence, despite previous research suggestions that heavy drinking is only of concern.[94]

Risk Behaviors

Low Condom Use

Condom use is often not the priority when people are under the influence of drugs. Condom use is not considered when the individual has a desire for sex. All substance user behaviors occur with infrequent condom use. Also exchange partners will incentivize, providing more drugs or money if the person agrees to have sex without a condom. According to data from the DC IDU Behavior study, only 30% of participants reported condom use at last sex.

Enhanced Desire for Sex

Some drugs exaggerate people's desire for sex. Although not all drugs affect everyone the same way, PCP and crack cocaine more commonly result in a hyper-sexual drive than heroin. Furthermore, when male substance users engage in heroin use, they are sometimes able to maintain prolonged erections and delayed ejaculations. Among participants in the DC IDU Behavior Study, 5.5% reported alcohol use at last sex, 41.8% reported drugs use, and 37.2% reported using both drugs and alcohol at last sex

When under the influence of drugs, people engage in activities that they would not otherwise do; they would do anything to "get a fix," including exchange sex, low condom use, concurrent partners, and other high risk behaviors. Drugs are often used to enhance people's libido and to improve their sexual experiences.

Men who have Sex with Men and Women (MSMW)

Individuals sometimes would even step outside of their primary sexual orientation in order to exchange sex for drugs, such as heterosexual men or lesbian women who have sex with men in order to obtain drugs. Men who are married or engaged with women to cover up their sexual orientation often engage in sexual intercourse with other men or transgender male-to-females without condoms and then have sex with their primary partners, also without condoms.

Predictors/Drivers

[93] Tucker et al., 2003
[94] Tucker et al., 2003

Risk factors that commonly lead to substance use are low levels and standards of education, lack of employment, lack of role models and prominent community leaders to guide youth, and high rates of incarceration. Mental health issues are also one of the root causes of substance abuse, where low self esteem and depression are often the leading modes. Substance use is often a coping mechanism for dealing with personal and environmental issue - the more mental health issues people experience, the more potent the drug they must use to ease the pain.

Delays in linkage into care have been shown to result in more advanced disease, higher risk of AIDS, and death, while poorer retention once in care is associated with lower rates of response to treatment and survival.

Barriers to Accessing/Using Prevention Services:

Due to various individual- (demographic, stigma), provider- (communication, experience), and structural-level (accessibility, lack of coordinated services) barriers, substance users frequently do not engage or stay engaged in care, resulting in the lack of routinely monitoring and evaluating patient outcomes, including CD4 counts, viral loads, and co-morbidities. In terms of barriers to accessing and utilizing health services, there is a lack of services in areas "hardest hit" by HIV/AIDS, such as housing, medications, and mental health counseling. People often fear that there is a lack of confidentiality among staff at community based organizations and local clinics, which is a major deterrent in seeking health services.

There was concern among CSA focus group participants with health professionals who have conflicts treating clients who are still active users, which leads to perceived diminished quality of care. These IDU believe that healthcare workers "look down" on them due to their drug habits, resulting in the individual leaving care and treatment. Participants also have concerns over volunteer outreach workers not sharing the same cultural backgrounds or coming from communities that they are serving, leading to the lack of culturally sensitive services, causing the substance user to distance themselves from these programs.

Facilitators

Structural-level facilitators of low-risk behavior include coordination, integration of services, cultural competence, community empowerment, engagement and education, flexibility, quality measures, and timely availability and accessibility of information for referrals, laboratory tests, appointments, eligibility certifications, and medications.

Provider-level facilitators include communication, cultural competency, persistence, commitment (e.g., appropriate attitudes and strong commitment of providers and staff), acknowledgement of competing needs, ongoing training, reminders, multidisciplinary care teams, and consistency and trust.

Individual-level facilitators include: willingness to engage and remain in care, and resources for addressing competing needs (e.g., stable housing, child care).

HIV Prevention Needs

In addition to offering accurate and up-to-date information on risky behaviors, effective HIV/AIDS prevention programs focus on enhancing individuals' motivation to change their

behavioral patterns, teaching concrete strategies and behavioral skills to reduce risk, providing tools for risk reduction, and reinforcing positive behavior change.

Access to sterile injection equipment

Individuals who inject drugs are at high risk for HIV and other infections if they share or reuse someone else's syringe and other injection equipment, including cookers, cottons, and rinse water. Access to sterile syringes effectively reduces syringe sharing and prevents the spread of HIV. Though there has been extensive work in needle exchange in the District, there are still instances of sharing needles, injecting works (including the cooker, cotton, or water) and using drugs divided by the same syringe. According to the DC IDU Behavior Study, overall, 19.8% of participants shared needles with last injecting partner, 74.4% shared works, and 50.5% used drugs divided with the same syringe. With only 47.2% of participants knowing the HIV status of their last injecting partner, it is imperative to provide sterile injecting equipment to this population.

Targeting HIV-positive drug users, their sex partners, and other social networks

Risky behaviors typically occur in the context of social groups. Community-based outreach interventions that engage these groups can be highly effective in reducing risks and preventing the spread of infection. People with HIV disease need help gaining access to services and adhering to treatments that can prevent HIV from progressing to AIDS. HIV-positive drug users are able to make major behavioral changes to protect their injecting and sex partners from contracting the infection.

Drug abuse treatment

Drug abusers in treatment stop or reduce their drug use and related risk behaviors, including risky injection practices and unsafe sex. Drug treatment programs also serve an important role in providing current information on HIV/AIDS and related diseases, counseling and testing services, and referrals for medical and social services.

Routine HIV Screening

Early detection of HIV is another approach for preventing HIV transmission. Research indicates that routine HIV screening in healthcare settings among populations with a prevalence rate as low as 1 percent is as cost effective as screening for other conditions such as breast cancer and high blood pressure. These findings suggest that HIV screening can lower healthcare costs by preventing high-risk practices and decreasing virus transmission.

Special Populations

The HPCPG prioritized 10 Special Populations, including populations that may not be captured by surveillance data but that research suggests are at high risk for contracting HIV and populations that have specific needs associated with their HIV risk behaviors that may not be adequately addressed in traditional HIV prevention projects.

This section includes the available information on these populations.

- High-Risk Youth
- Transgender Individuals
- Individuals Involved in the Sex Trade
- The Deaf and Hard of Hearing.
- Individuals who are 50 or older
- Latino heterosexuals between 20 and 49 years old
- Recent immigrants that may face challenges in accessing health services
- Incarcerated and recently released individuals
- Individuals with physical, mental or developmental disabilities
- Homeless individuals

High-Risk Youth

Though HIV/AIDS prevalence among youth, aged 13-24, is still low at 0.4%, youth in the District have the leading rates of sexually transmitted diseases, including gonorrhea and Chlamydia. Youth accounted for 68.3% of Chlamydia cases and 55.2% of gonorrhea cases reported in the District through 2008. Since the introduction of the school-based and community-based screening for sexually transmitted diseases in 2006, there has been an increase in the number of Chlamydia and gonorrhea cases diagnosed. Between 2006 and 2007, the number of Chlamydia cases among youth increased by nearly 80% while the number of gonorrhea cases increased by 32.1%. This increase is particularly apparent among those between the ages of 15 and 19. For both Chlamydia and gonorrhea cases, the numbers are higher among blacks than other racial groups, and higher among young women than young men.

Risk Behaviors

Condom Use

It is thought that HIV and STD infection among District youth is mostly the result of unprotected sexual behavior. High rates of both gonorrhea and Chlamydia demonstrate that

youth in the District are engaging in high risk behaviors that will carry on until adulthood, where there are increased rates of HIV/AIDS. In reviewing the Youth Risk Behavior Survey (YRBS) from 1997-2007among students who had ever had sex, there was both an increase and a decrease in condom use at last sex intercourse among middle school and high school students. Among middle school students, students reported only a slight increase in condom use at last sexual intercourse from 1997-2007 (76.7% vs. 78.6%, respectively). Among high school students, students reported an increase in condom use from 1997-2005 (71.0% to 79.9%), but a decline in 2007 (74.5%).[95] Though youth have the highest documented condom use in the District compared to adults (35.4%)[96], the measure used only asks of condom use at last sex, but not sexual activity overall.

Concurrent Partners

The Youth Risk Behavior Study (YRBS) from 1997-2007 showed that though there were declines in the number of students reporting one or more sexual partners in the last 3 months (53.1% to 40.5%), there is still a large proportion students that are engaging cin oncurrent partnerships in short periods of time. In asking about lifetime number of sexual partners, there was a decline from 1997-2007, with 16.8% of middle school students reporting 3 or more partners in their lifetime, compared to 12.5% in 2007. There was a decline from 1997-2007 among high school students who reported having 4 or more lifetime sexual partners, with 38.2% in 1997compared to 21.5% in 2007. Though these numbers show that there is a decline in students reporting concurrent sexual partners, the proportion of students having multiple sexual partnerships in their lifetime remains at an alarming rate.

Substance use

It is known that substance use before sexual intercourse can lead to high risk behaviors, leading to HIV and other STD infections. The YRBS showed that there had not been a large change in high school students who reported alcohol use during last sexual intercourse (in the last 3months). In 1997, 20.5% of high school students reported alcohol use during their last sexual encounter (in the last 3 months) compared to 17.4% in 2007. Among high school student who had ever had sexual intercourse 17.5% used drugs or alcohol before their last sexual encounter in 1997 and 14.6% 2007.[97]

The availability of drugs to youth has been steady over the years. The YRBS shows that 24.8% of high school students surveyed indicated that they had been offered, sold, or given an illegal drug on school property during the past 12 months. That percentage remained nearly the same at 25.7% in 2007. It should be noted that reported methamphetamine and heroin use increased from 1999 to 2007 from 1.9% to 6.1% for methamphetamine use and 1.5% to 5.4% for heroin use. [98]

Barriers to Accessing/Using Prevention Services

There are nearly as many barriers to effectively reaching young people as there are sub populations. Youth may be vulnerable to HIV simply because they are unable to access information and they may not have the skills needed to make healthy choices about sex that

[95] DCPS Trend Analysis Report, 2010
[96] BRFSS 2009
[97] DCPS Trend Analysis Report, 2010
[98] Ibid.

would ultimately protect them. In the real world of limited resources, it is important to recognize that certain youth are particularly vulnerable and require special attention.

Currently the majority of HIV prevention education is carried out by the DC Public Schools, but there is limited data on the extent and quality of these efforts. High dropout rates within the school system make it unlikely that the schools are reaching the youth most at risk for HIV infection. Many youth live with a personal fable that gives them the perception of invulnerability ("It can't happen to me.") Their inexperience with sexual activity makes it less likely that they will employ low risk behavior, and even when using condoms, they are more likely to use them incorrectly.

Not all adolescents are equally at risk for HIV and STD infection. Teens are not a homogenous group, and various subgroups of teens participate in higher rates of unprotected sexual activity and substance use, making them especially vulnerable to HIV and other STDs. Nationally, these include teens who are gay/exploring same-sex relationships, drug users, juvenile offenders, school dropouts, runaways, homeless and migrant youth. Both nationally and locally, there are very few HIV prevention programs that target out-of-school youth, and programs for other youth typically address heterosexual relationships and do not address the issues of LGBTQ youth. These youth are often hard to reach for prevention and education efforts since they may not attend school on a regular basis and have limited access to health care and service-delivery systems. Thus, young MSM, homeless youth and incarcerated youth are groups that might be missed by HIV prevention efforts for youth.

HIV Prevention Needs

Though HIV/AIDS among youth is still relatively low, STDs are a marker of high risk sexual behaviors among this population. Continued efforts in streamlining operations and implementing innovative approaches for disease prevention and intervention are needed in schools and community centers. The School-based STD Screening Program (SBSP) routinely tests high school (grades 9-12) adolescents for Chlamydia and gonorrhea. Although the school based screening programs has entered into schools, programs reaching youth need to be expanded into non-traditional settings, including continuation schools and juvenile detention facilities, in order to reach youth who are no longer in the public school system. The SBSP and other programs reaching youth also need to incorporate issues and sexual behaviors related to LGBTQ youth. Continued sex education, risk reduction counseling, linkage to services, distribution of condoms, partner services and the identification of infected youth in non-traditional settings are needed to reduce STDs and HIV/AIDS among youth.

Transgender Individuals

Data for transgender individuals in the District is limited; however, HAHSTA began collecting data on this population in 2006. Currently, there is an estimated 71 transgender individuals living with HIV/AIDS, 90% of which are transgender women, also known as Male-to-Female (MTF). Thirteen percent of transgendered persons were diagnosed between the ages of 13 and

19, while 71.8% were diagnosed between the ages of 20 and 39. An estimated 59% who are living with HIV/AIDS in DC are currently between the ages of 30 and 49.

In 2000, a Washington Transgender Needs Assessment Survey estimated the prevalence rate of HIV among transgender MTF persons living in DC at 32%. This is higher than the national average estimated at 28%.[99] Although the transgender population is an under-studied population in the District, the available data found that an estimated 70-75% of transgender individuals are African American, which is similar to national estimates.[100] However, exact estimates are difficult to obtain because population size is difficult to determine and the misclassification of transgender MTFs under MSM occurs.[101]

Risk Behaviors

Substance Use

Alcohol and drug use during sex was reported to be common practice among MTFs.[102] The Washington DC Needs Assessment Survey (2000) concluded that nearly half (46%) of respondents admitted to having sex while drunk or high, 22% admitted to having unsafe sex because of drug use, and 9% admitted to having unsafe sex in order to obtain drugs.

Community Service Assessment focus group participants stated that substance use of some kind is fairly common within the MTF community. Participants agreed PCP (dippers) and powder cocaine were commonly used. They said that illicit substance use was a common coping mechanism for managing mental health issues, sex work life, and homelessness. Behaviors participants attributed to substance use were having multiple partners in the same night while not using condoms due to poor judgment and lack of condom use in exchange for more money or more drugs.

Focus group participants said that injecting recreational drugs was not as widespread in the District compared to non-injection drugs. However, silicone and hormone injections as well as sharing needles used to inject these substances were mentioned frequently. Hormones and silicone are commonly acquired through the black market and on the internet, or substituted for similar compounds if individuals are unable to acquire them through a physician.

Commercial Sex Work

Commercial sex work is recognized as a significant contributor to positive HIV status among transgender individuals, specifically MTFs.[103] HIV prevalence among adult transgender MTF sex workers in a meta-analysis was 27%.[104] Most transgender individuals engage in sex work out of economic vulnerability[105], however other studies have found that sex work is used to earn money to pay for sex reassignment treatments and procedures including hormone therapy and surgical reassignment.[106] The 2000 Needs Assessment Survey found that 12% of respondents reported sex work as the reason they had unprotected sex, and of those, 72% were HIV positive.[107]

[99] Herbst et al. 2008
[100] DOH, 2005; Herbst et al. 2008
[101] San Francisco, 2010
[102] Herbst et al., 2008; Xavier, 2006
[103] Herbst et al., 2007; Wilson et al., 2008
[104] Operario et al., 2008
[105] Xavier, 2006
[106] Sugano et al., 2006
[107] DOH, 2000

The District, as a whole, was commonly described by CSA focus group participants as a popular destination for transgender commercial sex workers. Many MTFs from other states and cities (examples given were Baltimore, Virginia, New York, Ohio and North Carolina) come to the District from Thursday to Sunday in order to make extra money. According to participants, two reasons were given on why the District was chosen as a common place to go for sex work: Transgender MTF sex workers make more money in the District than elsewhere and specific areas of the city are commonly known for transgender sex workers. Because areas are known for transgender sex workers, the District is seen as a "safer" or more acceptable place for Transgender MTF sex work when compared to other cities.

Many participants described different reasons why transgender individuals often turn to sex work. These reasons included survival sex work because they have no other method of supporting themselves, seeking gender acceptance by engaging in sexual encounters with men, or earning money for hormone or surgical therapies.

Condom use among transgender sex worker participants was inconsistent. Participants said that low self-esteem, drug addiction, and engaging in sex work for survival were common reasons for not using condoms. Sharing clients was often described by participants as a form of protection, however, participants described interacting with multiple men in one night as a way to train new sex workers. In cases like this, condoms were inconsistently used. Condom use was frequently determined by incentives given by the client (more money or drugs).

Unprotected Sex and Concurrent Sexual Partners

Unprotected receptive anal intercourse is commonly discussed in the literature as being a high risk behavior practiced by transgender MTFs. The reported reasons for engaging in unprotected anal intercourse were to feel more feminine and to affirm the transgender person's gender identity. In the District, 42% of the Washington DC Needs Assessment Survey participants reported to ever engaging in unprotected anal sex.[108] Unprotected anal intercourse was a behavior most commonly practiced between transgender individuals and non-transgender males.[109] In the District, two-thirds of those were HIV positive believed they became infected through this method.[110]

Focus group participants discussed unprotected sex in two contexts: one during commercial sex work (as discussed above) and the second in intimate relationships. Reasons given for engaging in unprotected sex in intimate relationships were "gender identity validation" and the desire to build an intimate relationship.

It was a common occurrence for focus group participants to be involved with men who are engaged in concurrent relationships with heterosexual women. These relationships remained private and not public. Many participants discussed engaging in unprotected sex with partners who openly have other relationships in exchange for an intimate relationship. Unprotected sex was discussed as a way to please one's partner or as a way to build trust within the relationship. It is important to note that these relationships are not necessarily based on sex, but on intimate emotional feelings. Participants described these relationships as such and in some cases described the deep connections they felt with their partners.

Little information is known about the male partners of transgender women in the District. However, participants disclosed that many of their heterosexual-identified male partners were

[108] DOH, 2000
[109] Xavier, 2006; Virginia, 2005; Virginia, 2007
[110] DOH, 2000

not just insertive anal sex partners but receptive anal sex partners as well and condom use was inconsistent during both sexual encounters.

Barriers to Accessing/Using Prevention Services

Basic Needs vs. HIV Prevention

A primary issue is the minimal concern for HIV and HIV prevention expressed by several CSA focus group participants. *"I think that it's so many other bigger issues out there that they look at as far as 'well I don't have HIV. If I do have it, I'm not dying from it. Right now I need to eat; right now I need this drug up in me; right now I need a roof over my head, I need money in my pocket, I need to get my silicones done, I need to look like a female so they feel like its other things that's more important than the HIV so the HIV piece is like a back burner piece."* Another barrier to seeking services is many transgender individuals are in denial about their HIV diagnosis, and therefore do not believe they require services. In some cases, they are too preoccupied with other issues (e.g., housing, employment) and because they are not suffering from any HIV-related health symptoms or complications, they do not seek services. In other cases, affected transgender individuals do not have adequate resources available to get the support they need to accept that they are HIV-positive and the concomitant responsibility. As a result many transgender individuals do not take the necessary steps to keep themselves and others healthy. For instance, some transgender individuals are not comfortable seeking services in clinics or community based organizations (CBO) that are known to treat HIV patients. More alarming is that in a number of instances there are individuals who do not take the necessary steps to adjust their behaviors after they know they are positive (e.g., use condoms). This could be because they lack the knowledge about what their diagnosis means and the absence of adequate support from services to assist in adjusting behaviors to adapt responsibly to an HIV diagnosis.

Health Care Services

There was a widespread belief among focus group participants that most services (e.g., housing, health care, mental health care) are mainly given to those who are HIV-positive. As a result, many transgender individuals think they either do not qualify or are not likely to receive these services and therefore, may not pursue them. Another barrier expressed by several participants was the poor post-test counseling they or others received after testing positive. Participants said that they were aware of instances where there were no recommendations or referrals provided by post-test counselors, resulting in their inability to make the link into appropriate care systems. As a result, many transgender individuals who are newly-diagnosed are not provided adequate resources to utilize services necessary to maintain their health and are not provided the necessary tools and education to protect others from becoming infected.

Cultural Sensitivity

According to CSA focus group participants, barriers to accessing or seeking HIV prevention services include a need for increased sensitivity and cultural competency among agency staff when engaging with transgender clients. Many participants expressed the need for organizations to incorporate transgender sensitivity courses for their staff because transgender individuals have experienced poor interactions with staff. Focus group participants described how staff appear uncomfortable around transgender individuals or frequently will refer to them as "Mr.," "Sir," "he," or "him," when they are clearly dressed as women. Another concern was with the

competency level of physicians and other health care professionals when caring for transgender patients.

Participants expressed frustration that it is difficult to find a provider who understands medical issues as they pertain to a transgender individual. *"I mean I walked into a doctor's office and I was told something about a urinary tract infection and I was like "I don't have a vagina." And then it was just this whole breakdown of "what do you mean you don't have a?" And it's like you're supposed to be competent you're supposed to have this knowledge already. I'm coming to the professional you're supposed to know about medical situations."* Several organizations are known by the transgender community as not transgender-friendly. *"I've tried to participate in things… and they were like this is for gay men. You know there's nothing we can do for transgender, not those words, but you know."* These agencies are thus avoided regardless of the services they provide. In addition, several focus group participants agreed that there were only a few organizations which offered transgender-competent healthcare specifically for transgender individuals and considered transgender-friendly in providing various other services.

Predictors/Drivers

Social Stigma

Social stigma, exclusion and discrimination faced by transgender individuals are believed to be the root causes for most behavioral risk factors that lead to a positive HIV status.[111] Social isolation caused by exclusion and discrimination in addition to internalized transphobia results in depression, suicidal ideation, substance use and risk taking behaviors.[112] Discrimination is felt by the transgender community in terms of finding housing, employment and obtaining health insurance.

The unemployment rate estimates among DC transgender residents was estimated at 42%,[113] much higher when compared to Herbst and colleague's nationwide estimate of 23%.[114] Twenty nine percent of the Washington DC Needs Assessment Survey (2000) participants had no source of income and 31% reported an annual income of less than $10,000, while nearly half (47%) reported having no health insurance.[115]

Participants in the Community Service Needs Assessment (2010) reported difficulty finding employment and housing due to discrimination. Many found it difficult to find work as a transgender individual, thus forcing them to seek employment as a male. After becoming comfortable at work, many slowly incorporated feminine characteristics into their appearance, which resulted in job loss.

Obtaining safe and stable housing was described as a difficult task for transgender individuals in the District. Focus group participants described personal instances of where the housing voucher program discriminated against them for being transgender women. Others reported feeling uncomfortable and not safe in shelters due to violence and discrimination they faced in

[111] Virginia, 2005; Virginia, 2007; Sugano et al., 2006; Caseres et al., 2008; Edwards et al., 2007
[112] DOH, 2000; Virginia, 2005; Virginia, 2007; Sugano et al., 2006
[113] DOH, 2000
[114] Herbst et al. 2007
[115] DOH, 2000

these types of facilities. Without reliable income or shelter, participants described turning to sex work to survive.

Health Care

Accessing appropriate health care can be challenging for transgender persons for numerous reasons other than lack of health insurance. For many, receiving transgender-related care (hormone/surgical therapies) is a priority when it comes to health care.[116] Another deterrent from accessing proper health care is social stigma/discrimination from agencies and identity documentation.[117] Past experiences with insensitive members of health clinics, fear of their transgender status being revealed, and lack of willing or experienced providers to care for transgender individuals have been reported as barriers to health care access.[118] Additionally transgender individuals have repeatedly expressed negative experiences seeking gynecological care and therefore have avoided necessary medical care.[119]

Passing and Other Health Priorities

"Passing" is when a transgender person is viewed and accepted as the gender they identify with. Society views the transgender woman as a biological woman. Passing can diminish unwanted stares and daily discrimination.[120] Many participants said that the ability to pass is essential to finding employment, housing, improving intimate relationships, and self-acceptance. CSA focus group participants said that many transgender women desire the ability to pass so much so they inject black market hormones and silicone. Some reverted to injecting compounds similar to silicone and acquiring hormones off the internet if they could not acquire them through a physician.

Qualitative data found limited transgender specific healthcare available within the District. It was stated by many focus group participants that the clinics that do have transgender specific health care have waiting lists up to three months, however with an HIV positive status, the individual could be a "walk in" client and be seen the next day. This was a re-occurring theme throughout all needed services within the transgender community interviewed, especially health care and housing. Participants emphasized the basic needs many transgender individuals lack while explaining that with appropriate HIV medication, they could live a long life while obtaining the services they need. To focus group participants, it seemed better to live with HIV than to live a long, difficult life where assistance is hard to procure. This is a difficult issue to address within HIV prevention activities.

HIV Prevention Needs

Housing

Focus group participants said that transgender MTFs felt they did not have equal access to employment and housing resources. *"And… that problem to a large degree is housing discrimination (which) is so prevalent in our community. We have, can get, there are voucher programs that may get 160 vouchers and I will bet you they might only have one transgender that get a housing voucher."* In many cases, they expressed that meeting these two needs were

[116] Xavier, 2006; Virginia, 2007
[117] Ibid.
[118] DOH, 2006; Xavier, 2006; Virginia, 2007
[119] Rachlin, et al., 2008; DOH, 2000; DOH, 2007
[120] Shelly, 2009

key to reducing HIV risk behaviors among transgender. Specifically, without reliable income or shelter, many MTFs turn to survival commercial sex work. As previously described, several CSA focus group participants have experienced discrimination or violence in shelters. Participants expressed the need for safe transgender-friendly shelters and public accommodations. Many participants said that transgender MTFs would rather engage in commercial sex work than to stay the night in a shelter for safety reasons, regardless of the HIV-related risk behaviors involved. The second area was the need for access to more city housing vouchers.

Mental Health

A significant number of CSA focus group participants expressed the need for services to address their mental health issues. Participants acknowledged many transgender individuals suffer from mental illness due to the discrimination they face from their families and society. *"I think the primary health issues of the young transgenders as well as the older transgenders are the quote unquote mental health issues. Cause a lot of transgenders believe it or not suffer from depression because of one [R: Society.] how either society has treated them or two how their family has treated them growing up. And a lot of us we're looking for acceptance from our families because we look to our families for guidance [R: Correct] especially in the world. And when our families quote unquote disown us or tell us you know you're not part of this family any more that really hurts. [R: It do.] And so a lot of us are suffering from depression and other mental health issues."*

Several focus group participants correlated their mental health issues to their substance use and involvement in commercial sex work. They expressed the increased need for mental health services for young transgender individuals who are marginalized at home and in school. Focus group participants felt that providing mental health services to adolescent transgender individuals could prevent them from dropping out of school, running away from home, and turning to survival commercial sex work.

Post HIV Test Counseling/Linkages to Care

Mental health services are also needed for adult transgender individuals who do not have the ability to overcome their mental health issues on their own and in turn cope with them through substance use and commercial sex work. Additionally, several participants described unhealthy responses to their receiving an HIV diagnosis, including denial of their status and therefore, not using condoms; using drugs because of the belief that they have just been given a death sentence; or becoming severely depressed or angry and intentionally participating in high risk behaviors including having unprotected sex.

Focus group participants described several reasons for not seeking treatment right away: denial, not feeling sick so it wasn't a priority, and not having knowledge of available resources.

Participants also described feelings of denial after being diagnosed with HIV, leading to no change in behavior to protect themselves or their sexual partners.

They discussed poor post-test counseling, where mental health concerns were not discussed (e.g. depression and denial) and felt that inadequate resources were given at the time of HIV diagnosis. *"And one goes back to testing and kind of being, cause that's a big theme is kind of being in denial when you find out that you're positive. So how do we fix that? Cause I feel like that a lot of people have been telling me lately that like they get tested positive and then they go into denial and then they go back to their normal life and they don't change anything which means that I'm probably infecting a lot of people out there. Because like it doesn't matter whether or not I use condoms I don't care cause I'm not even admitting to myself…"*

Not addressing this issue has resulted, according to participants, in no linkages to care; lack of education and tools given to protect others from becoming infected; and a lack of information given to individuals, which led to a feeling of hopelessness.

Transgender Specific Health Care

As previously discussed, for many transgender individuals, hormone or surgical therapy is a prioritized concern. Focus group participants said that many MTFs would engage in high-risk behaviors in order to obtain these therapies. Examples of these high-risk behaviors include commercial sex work to earn money for sexual reassignment surgeries or purchasing hormones from either legal prescriptions or via the black market. In order to prevent these high-risk behaviors, participants expressed the need for more transgender-specific healthcare services. They said that the ability to "pass" as the gender with which they identify is essential to finding employment, housing, improving intimate relationships, and self-acceptance. In order to "pass," they require access to prescribed hormones and surgical therapies.

"Transgender" as a Population Classification:

According to several key informants, transgender MTF data and formal grouping within the bureaucratic systems, which describes the population, has traditionally been categorized with MSM data in the District. The participants expressed concern over combining these two populations under MSM because the two are distinct populations, particularly as it relates to HIV prevention. The distinction is an important one to make, especially when designing HIV prevention interventions and programs because MTFs do not identify as men and those who are sexually involved or in a committed relationship with them do not identify them as men, either. Thus, MSM prevention programs do not match the needs of individuals who do not identify as MSM.

One participant gave an example of how prevention efforts developed for MSM do not reach the transgender community, saying, *"The MSM population, a lot of times you can get to them through the venue. It's a venue-based kind of a thing. So, you could just go to the bars, you can pretty much reach 'em. Uh, less so with the transgender population, since there is no one tranny bar."*

Another concern with this method of categorization is that funding is given to MSM organizations that do not necessarily provide services for the transgender community. One key informant summarized this concern with combining the two populations, saying, "*Transgender [women] are not men who have sex with men. We must be very clear that in this point and time much of the numbers that are going into MSM, some of those numbers are transgender numbers because we've not the ability to separate them so therefore it is making the disease look more progressive in one population giving more funding to that population and lesser funding and attention to this population that so badly needs it."* While the DC DOH has modified its policy and recognizes the transgender population as a separate and distinct category from MSM, there continues to be an issue whether "transgender" should be considered a gender identity, a sexual orientation, or a mode of transmission.

Individuals Involved in the Sex Trade

Sex is usually traded in the context of commercial sex work , where an individual makes a living from exchanging sex for money, and survival sex, where an individual might not identify as a sex worker but sometimes trades sex based on their needs at the time (i.e. housing, food, drugs, employment).

Male, female and transgender sex workers who are most vulnerable to HIV are street-based workers, most of whom are poor or homeless, and likely to have had a history of sexual or physical abuse. Street-based sex workers are also commonly dependent on drugs or alcohol, and at a greater risk for violence from clients and police.[121]

Little research has been done on rates of HIV infection among street-based sex workers across the US. In one study of drug-using female sex workers in Miami, FL, 22.4% of the women tested HIV+. In a study of male sex workers in Houston, TX, 26% reported testing HIV+.[122]

For the subgroup of heterosexual MSM who engage in sex with men primarily for survival or to support addictions, the risk of trading sex for money, drugs, or housing may come into play. In one study, MSM-IDU in San Francisco who identify as heterosexual were more likely to be homeless and to trade sex for money or drugs than gay or bisexual MSM-IDU.[123]

The following information is excerpted from the descriptions of other populations inj the CSA.

Men Who Have Sex with Men MSM)

Among CS focus members, drug use was also discussed in connection with commercial sex work. Some focus group participants said that commercial sex workers use drugs while engaging in exchange sex in order to cope with the lifestyle. Others said that drug addiction drives commercial sex work and the risky sexual behaviors associated with it. *"So what I'm saying is, that date might pull up and not want to use a condom, but I want that money so I can get high, so, okay, the hell with the condom."* In addition to substance addiction, financial instability was also described as driving risky sex behaviors in commercial sex work, especially among youth who do not have the resources to obtain other sources of income. Condom use also varied among ethnicities, according to participants. On one hand, condom use among Black commercial sex workers was characterized as inconsistent and was frequently based on the customer's willingness to pay more if they desired not to use condoms. *"Condom use is a secondary negotiation to how much money I am going to get out of this exchange."* On the other hand, a Latino participant described condom use as the standard practice among Latino commercial sex workers.

Sex work among Latinos was reported as mostly advertized on the internet via Craigslist because many sex workers are undocumented (illegal) immigrants, and thereby believe they are at less risk of being arrested than if they were on the streets, while African American sex workers, meanwhile, reported they do most of their recruitment of clients from the streets. Although there is some sex exchange that occurs at P Street Beach, a large proportion of participants discussed that anonymous sex is even more common

[121] What are sex workers' HIV prevention needs?, Center for AIDS Prevention Studies, 2008
[122] What are sex workers' HIV prevention needs?, Center for AIDS Prevention Studies, 2008
[123] Kral AH, Lorvick J, Ciccarone D, et al. (2005) HIV prevalence and risk behaviors among men who have sex with men and inject drugs in San Francisco. J Urban Health 82(1 Suppl 1):i43-50.

than exchange sex in that area. Other areas where anonymous sex is common among MSM, according to participants, were the bathrooms at Union Station, Macy's, Library of Congress and the Martin Luther King library. CSA focus group participants admitted that condom use in these areas is sparsely practiced either because they believe they do not have the time to put one on or because it will reduce the stimulation that is sought from an anonymous sexual encounter.

Transgender Individuals

Commercial sex work is recognized as a significant contributor to positive HIV status among transgender individuals, specifically MTFs.[124] HIV prevalence among adult transgender MTF sex workers in a meta-analysis was 27%.[125] Most transgender individuals engage in sex work out of economic vulnerability[126], however other studies have found that sex work is used to earn money to pay for sex reassignment treatments and procedures including hormone therapy and surgical reassignment.[127] The 2000 Needs Assessment Survey found that 12% of respondents reported sex work as the reason they had unprotected sex, and of those, 72% were HIV positive.[128]

The District, as a whole, was commonly described by CSA focus group participants as a popular destination for transgender commercial sex workers. Many MTFs from other states and cities (examples given were: Baltimore, Virginia, New York, Ohio, North Carolina) come to the District from Thursday to Sunday in order to make extra money. According to participants, two reasons were given on why the District was chosen as a common place to go for sex work: Transgender MTF sex workers make more money in the District than elsewhere and specific areas of the city are commonly known for transgender sex workers. Because areas are known for transgender sex workers, the District is seen as a "safer" or more acceptable place for Transgender MTF sex work when compared to other cities.

Many participants described different reasons why transgender individuals often turn to sex work. These reasons included survival sex work because they have no other method of supporting themselves, seeking gender acceptance by engaging in sexual encounters with men, or earning money for hormone or surgical therapies.

Condom use among transgender sex worker participants was inconsistent. Participants said that low self-esteem, drug addiction, and engaging in sex work for survival were common reasons for not using condoms. Sharing clients was commonly said by participants as a form of protection, however, participants described interacting with multiple men in one night as a way to train new sex workers. In cases like this, condoms were inconsistently used. Condom use was frequently determined by incentives given by the client (more money or drugs).

Latino Heterosexual Men and Women

[124] Herbst et al., 2007; Wilson et al., 2008
[125] Operario et al., 2008
[126] Xavier, 2006
[127] Sugano et al., 2006
[128] DOH, 2000

Commercial sex work was frequently discussed by CSA focus group participants as both a nuisance in their community as well as a necessity for undocumented immigrants who cannot find other means of obtaining financial support. "*Some women make sex a job out of necessity. Unemployment forces women into sex work.*" Participants also said the discreet ways sex workers recruit clients. One participant stated sex workers can be found online more easily than on the street because they are less likely to get caught by the police online. Another participant gave this example of how women recruit clients: "*For example there are women that hand out business cards stating they are [hair dressers] cut hair but actually engage in sex work. The 14th street area is well known for this type of activity.*"

Homeless Individuals

The economic recession coupled with the lack of affordable housing assistance programs designed to meet the needs of persons living with HIV/AIDS, has had a devastating impact on individuals in the District. Homeless persons have high rates of exchange sex, where literature reports nearly half of homeless persons reporting ever exchanged sex for money and almost 15% of homeless persons reporting exchange sex in the last 12 months.[129, 130]

Non-Injection Drug Users

As described by CSA focus group participants, an addiction to drugs puts individuals at extremely high risk for HIV due to the seemingly endless lengths that some will go to in order to obtain drugs. *"I think what happens is that it becomes so about getting the drug and it doesn't become, it's not about the sex, it's not about the protection at that point. It's just about that next high. I need to do whatever I need to do in order to get that next high."*

Participants also described situations that occur even after an individual "becomes sober" or stops using intoxicants. Because of their earlier drug using behaviors, they have learned to use sex as a vehicle to get what they need, so they often still engage in high risk sexual behaviors to get their needs met.

Incarcerated or Recently Released Individuals

Nearly 7 million people are under justice supervision, including jail, prison, probation or parole in the U.S.[131]. Nationwide, the AIDS case rate was six times higher in state and federal prisons

[129] Ibid
[130] Robertson et al, 2004
131 Prison Statistics, Bureau of Justice Statistics, US Department of Justice, June 2008.

than in the general U.S. population[132]. Nearly a quarter (20-26%) of people living with HIV/AIDS in the U.S. has spent time in the correctional system.[133] Unfortunately, no precise count is available of HIV cases in prisons and jails; brief incarceration, limited access to health care, and inadequate health services prevent identification and diagnosis of inmates with HIV infection. Furthermore arrestees may choose not to declare their HIV status and there is no national system for reporting prison cases in the U. S. The CDC surveillance information does not include patients' custody status.

The Washington DC criminal justice system is large and complex and plays a large role in the lives of many of the DC residents. For example, in the District, 60% of the District population is Black, but 89% of the people under justice supervision (prison, jail, probation, parole, or pretrial release), are Black according to the DC's Department of Corrections Facts & Figures 2008.[134]

In the District alone, 21,000 people pass through correctional facilities each year. A recent study on reentry from jail reveals that there are an estimated 12 million individuals released annually from U.S. Jails[135]. Many of these individuals will be returning to their local communities and need assistance in successfully navigating the reentry process and getting linked into critical care services in their respective local communities. The federal prison population within Washington DC has hundreds of diagnosed cases of HIV/AIDS. In the District, 15,966 inmates were screened for HIV between June 2006 and August 2007, yielding a 3.1% positivity rate; which is comparable to the general population at 3.2%. Among incarcerated individuals newly testing positive, about one-third (32.9%) did not have previous knowledge of their HIV status. Heterosexual contact and non-injection drug use were the primary risk factors among those identified as living with HIV/AIDS in this screening. What is most important to remember is that the criminal justice system is not a vector HIV infection, but rather a temporary destination where HIV testing is routinized and therefore able to capture the disease status of individuals coming from communities of high HIV prevalence.

Risk Behaviors

Condom use

Because recidivism is extremely common and many inmates are serving short sentences, HIV-positive inmates move frequently between prison and their home communities. Past studies have shown that recently released individuals engage in sexual behaviors soon after being released, and are less likely to wear a condom during intercourse.[136,137,138]

Substance use

A major challenge for newly released individuals is avoiding substance use. Without adequate preparation, newly released inmates return to communities where they may return to past situations and lifestyles, leading to drug and alcohol use. Literature suggests that many people leaving the jail system are not adequately prepared for release[139], and upon release, face a

[132] Ibid
[133] Ibid
[134] District of Columbia, Department of Corrections: "DC Department of Correction Facts and Figures," July 2008.
[135] Life After Lockup: Improving Reentry from Jail to the Community, May 2008
[136] Grinstead O, et. al, 2001
[137] Kassira et al, 2001
[138] Beckwith et al., 2010
[139] van Olphen,, et al, 2006

myriad of obstacles to overcome past issues, including substance use. In a study of male and female inmates in Texas jails, nearly 30 percent of inmates who used drugs and alcohol and previously served time in jail/prison stated that substance use was a "very important factor' in their behavior in the community and their return to jail.[140]

Barriers to Accessing/Using Prevention Services

Incarcerated individuals are especially complex in the District, where maintaining contact with formerly incarcerated individuals with HIV or AIDS is very challenging. For incarcerated persons living with HIV/AIDS being released from prison, highest priorities typically are stable housing, a source of income, and access to medical care. Unfortunately, medical care is typically the lowest of these priorities and given limited resources with the District. In addition, offering assistance for housing and income can be extremely difficult. It is very important to assist newly released individuals with continued access to medical care and medication, particularly if they have initiated antiretroviral treatment. Linkages among the correctional systems and the care continuum of services are critical for retaining people in care and reducing the transmission of the disease.

HIV Prevention Needs

Creating effective re-entry programs is critical for assisting formerly incarcerated individuals. Programs especially important for newly released individuals are those that promote safer sex behaviors, as data has shown that recently released persons have sex within 24-48 hours of their release.[141, 142] Programs should also contain a component on substance abuse and how to cope when returning to past situations that may lead to use. Without significant programming to address the primary medical needs of formerly incarcerated individuals, including substance abuse treatment and prevention for positives, those individuals may be at risk for recidivism and for spreading HIV in the community. Availability of HIV medical care in the various correctional settings and its quality varies. A recent study suggested an expansion nationwide by correctional facilities on antiretroviral treatment. However, the treatment was insufficient to meet the needs for the estimated number of prisoners who need them.[143] The complexity of creating effective re-entry programs for both HIV- negative and positive individuals coupled with linkages to the federal systems for Washington DC has, been a great challenge and requires stronger linkages and collaborative partnerships between public health and the corrections system.

Homeless Individuals

[140] Texas Commission on Drugs and Alcohol, 2001

[141] S Millroy et/ al *BMC Public Health* 2009, **9:**156

[142] Clements-Nolle AJPH 2008, 98:. 4

[143] Limited Spending: An analysis of Correctional Expenditures on Antiretroviral for HIV Infected Prisoners, Zaller, Thurmond & Rich , Public Health Report 2007, Jan-Feb: 122(1) 49-54.

There were 6,228 homeless individuals living in Washington DC according to the 2009 Homeless Enumeration Report[144]. Homelessness is defined as a person who resides in some form of emergency or transitional shelters, domestic violence shelters, runaway youth shelters and places not meant for human habitation, which include streets, parks, alleys, abandoned buildings and stairways; "unstably housed" includes those who are at very high risk for imminent homelessness, or who are housed inadequately with friends or family members. The number of homeless individuals has increased by 3% since 2008 in the DC, while the number of persons in families that are homeless has increased by 19.8% since the same time period[145]. HIV infection rates are "3-16 times higher" among homeless persons or persons with unstable housing, compared to similar persons who have stable housing.[146] Prevalence of HIV/AIDS varies among the homeless, overall exceeds that of the total population (6.3% vs. 3.2% respectively). High prevalence combined w/ limited access to care and treatment, along with poor living conditions contribute to HIV/AIDS becoming a leading cause of death in homeless population.[147]

Low-income housing is inconsistently available in the District. Washington DC continues to have inadequate funding to provide rental subsidies to the low-income people with HIV in need of housing assistance. Clients choosing to move to less expensive areas are sometimes at risk of disrupting their continuity of care. Due to cutbacks in local funding in Washington DC, several shelters (non-HIV specific) are closing, which may increase demand on care programs to assist with EFA vouchers for housing assistance.

Risk Behaviors

Substance use

Substance use is a major issue among homeless persons. Homeless persons are more likely than other people to engage in behaviors that are associated with increased risk of acquiring or transmitting HIV including alcohol use, injection drug use, and sharing needles.[148, 149, 150] In a study comparing HIV risk behaviors among homeless and non-homeless persons, results showed that homeless respondents were more likely to have used any illicit drug in the past 12 months, injected drugs in their lifetime, and in the past 12 months, and had more potential alcohol abuse.[151]

Exchange sex work

The economic recession coupled with the lack of affordable housing assistance programs designed to meet the needs of persons living with HIV/AIDS, has had a devastating impact on individuals in the District. Homeless persons have high rates of exchange sex, where literature reports nearly half of homeless persons reporting ever exchanged sex for money and almost 15% of homeless persons reporting exchange sex in the last 12 months.[152, 153]

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[144] Homeless Enumeration Report for the Washington Metropolitan Region 2009: Prepared by the Homeless Services Planning and Coordinating Committee.
145 Ibid.
[146] Kerker, B et al, 2005
[147] Cheung AM, Hwang SW Canadian Medical Association Journal 2004, 170:1243
[148] Aidala et al, 2005
[149] Cululhane et al, 2001
[150] Wolitski et al, 2007
[151] Kidder et al, 2008
[152] Ibid

Condom use

Among homeless individuals, basic needs, such as food, clothing, and shelter, often supersede considerations regarding safer sex practices. Studies have shown that homeless persons are more likely to engage in unprotected vaginal or anal sex with a partner of unknown serostatus and have more sex partners in the last 12 months.[154, 155]

Barriers to Accessing/Using Prevention Services

There are many challenges facing the homeless and unstably housed with respect to HIV/AIDS. According to the 2009 Homeless Enumeration Report, 38% of homeless persons (excluding children in homeless family households) in Washington DC report a chronic substance abuse problem, 22% report a severe mental illness, 23% have a chronic health problem and nearly 17% were physically disabled.

Of particular concern when treating homeless individuals is adherence to antiretroviral treatment. Several factors may lead to decreased adherence. Homeless individuals are less likely to be able to access food, water, and medication storage facilities to promote adherence. In addition, homeless individuals are less likely to have supports and physical facilities such as bathrooms that help manage side effects. And finally, homeless individuals are more likely to face internal barriers to adherence such as substance abuse, mental illness, and/or other physical disabilities.[156] In early 2008, a focus group of homeless HIV/AIDS cases in Washington DC indicated that homelessness makes it difficult to safely keep important papers related to HIV care, including prescriptions, and also complicated communications with providers via phone or mail.

HIV Prevention Needs

The needs of homeless individuals may shift in the coming years due to local policy changes. Limited data from a focus group with homeless individuals with HIV/AIDS conducted in 2008 combined with service utilization data found that homeless individuals need access to the full continuum of core services, both HIV specific and non-specific services. These services include substance abuse treatment programs, medical care, mental health treatment programs and housing facilities. Focus group results indicated increased needs for housing, transportation, oral health care, and nutritional counseling.

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[153] Robertson et al, 2004
[154] Kidder et al, 2008
[155] Robertson et al, 2004
[156] Cheung AM, Hwang SW Canadian Medical Association Journal 2004, 170:1243

Individuals 50 and Older

An emerging population is individuals over the age of 50, composed of two cohorts: individuals who contracted the disease before the age of 50 and have lived to the age of 50, and individuals who are becoming infected at age 50 and older. Medical advances and improved HIV treatment regimens are helping people live longer with the disease. However, for older people the naturally aging process increased co-morbidities associated with age such as diabetes or hypertension[157]. Changes in social norms, sexual behaviors and the availability of erective dysfunction drugs can increase the risk of HIV exposure and transmission among seniors.

According to the CDC, approximately 29% of people living with AIDS are older than the age of 50, and the age group accounted for 15% of all new HIV/AIDS diagnoses in 2005[158]. In Washington DC, 7.4% of living HIV/AIDS cases and 40.5% of living AIDS cases are among persons currently aged over the age of 50. In this age group, men living with HIV/AIDS outnumber women living with HIV/AIDS at a rate of approximately 2:1. The leading mode of transmission in this population is among MSM (32.3%), followed by injecting drug use (24.6%) and heterosexual contact (23.5%).

Risk Behaviors

Risk Perception

Older adults may not perceive themselves at risk for HIV infection. Participants of the Older Adults and HIV Workgroup agreed that older adults still believe that this population is not at "great risk" for HIV infection. There are still beliefs that HIV/AIDS and STDs are diseases among young adults, men who have sex with men and injecting drug users.

Condom Use

HIV/AIDS infection among people over the age of 50 is mostly the result of unprotected sexual behavior. Nearly two-thirds (62.3%) of people living with HIV/AIDS who were ≥50 at diagnosis can attribute their diagnosis to heterosexual and MSM contact. Among those newly diagnosed with HIV/AIDS from 2004-2008, 25.4% were among those who were 50 years of age and older. As the "threat" of pregnancy is no longer an issue, condom use among this population is known to be low. Participants in the older adults and HIV workgroup reported that condom use among older adults may be seen as taboo, where sex is still seen as "dirty," so going out to get or ask for condoms is seldom done.

Concurrent Partnershi

Concurrent partnerships are also risk behavior among people aged 50 and older. Coupled with low HIV risk perception, the lack of condom use and pregnancy no longer a factor, partner turnover is widespread. Members from the Older Adults and HIV Workgroup report that partner concurrency is an ongoing occasion among older adults, especially in assisted living facilities and communities.

[157] CDC HIV/AIDS Surveillance Report 2005. Vol. 17, Vol. 17, Atlanta: US Department of Health and Human Services, CDC; 2007; 1-54

[158] Kaiser Family Foundation, news:New York Times, New York Times Examines HIV/AIDS Among Seniors, Wednesday, 12, 2008;

Barriers to Accessing/Using Prevention Services:

Older adults living with HIV/AIDS may go undiagnosed as a result of the failure of physicians to incorporate HIV testing and prevention education into routine medical care, lack of age appropriate educational messages and cessation of dialogue about sexuality beyond the reproductive years, usually ending around 45 years of age. Older women, in particular, are vulnerable since they are less likely to be informed, may choose to discontinue condom use once pregnancy is no longer an issue and may be biologically more susceptible to HIV due physical changes associated with menopause[159]. The National Health Interview survey found that 47% of women aged ≥50 years were totally uninformed regarding the transmission of HIV, compared to 14% of younger women[160].

Older adults are often diagnosed late in the progression of HIV disease and disease sequelae prognoses are exacerbated due to complications related to aging. General practitioners often find it difficult to distinguish between HIV-related illnesses and those caused by aging. Common symptoms, e.g., fatigue, shortness of breath, chronic pain, weight loss, and rashes are associated with HIV disease[161]. For women with HIV/AIDS who aged 50 years and older, symptoms such as hormonal (estrogen and testosterone) changes, sudden rises and lowering of body temperature or hot flashes, night sweats, and depression may be misdiagnosed as normal symptoms that accompany menopause[162]. These symptoms may also occur in men and could be misdiagnosed as *andropause*. Misdiagnoses of symptoms may delay early intervention and timely access to HIV health services.

HIV Prevention Needs

Many old or outdated beliefs about HIV still hold true for older individuals living in the District. Even though HIV is a generalized epidemic in DC, the elderly continue to primarily believe that HIV/AIDS is a disease of gay men, intravenous drug users and those of the younger population. Dispelling myths within the healthcare system is extremely important as well. Encouraging health providers to offer HIV testing to this population is tremendously imperative. Medical advances and improved HIV treatment regimens are helping people live longer with the disease, however, for the older population, changes in social norms, sexual behaviors and the availability of erective dysfunction drugs can increase the risk of HIV exposure and transmission among seniors.

Additionally, although research in older individuals with HIV is fairly limited, initial results indicate that older adults with HIV may be more susceptible to depression or other forms of mental illness[163]. Therefore, it is important for the District to ensure a smooth transition into primary care and mental health services for older adults. While antiretroviral therapy is accepted as the norm for HIV treatment, it may cause medical complications, side effects or worsen conditions such as hypertension, diabetes, elevated cholesterol, and heart disease, particularly in seniors. This requires additional monitoring and treatment education that

[159] Older Women and HIV. The Body.com, June 2008, (Online) http://www.thebody.com/content/whtatis/arrt48358.html
[160] Ibid.
[161] Zablotsky, D. (1994). An Examination of Social Forces Shaping the Place of Post Reproductive Women in the HIV/AIDS Epidemic. Paper Presented at the Annual Meeting of the Gerontological Society of America, Atlanta, Georgia.
[162] Links, N. HIV Among Older Adults: Age Specific Issues in Prevention and Treatment, The AIDS Reader, 10(7): 430-440, 2000.
[163] Brennan, S & Karpiak, S. Depression and Older Women with HIV. TheBody.com. Winter 2008. (Online) http://www.thebody.com/content/whatis/arrt 45490.html.

encourages seniors to partner with their primary medical care provider and to communicate about new symptoms or health issues as they occur. An integrated chronic disease treatment model may be necessary to treat older persons with HIV most appropriately. Additional prevention needs among people 50 and older include HIV education and awareness material specifically geared toward this population. These should include educational curriculum, prevention messages, advertisements, stigma reduction and condom distribution programs specifically geared toward the aging community.

Latino/a Heterosexual Men and Women

The 2009 Annual Report Update reports 2.1% of Hispanics are living with HIV/AIDS. When further broken down, 0.7% of Hispanic females and 3.4% of Hispanic males are living with HIV/AIDS. From 2001-2006, the Hispanic community accounted for 3.7% of new HIV infections attributed to heterosexual contact.[164] The 2009 "Holla Back" report, which included qualitative finding on specific populations, found a large education gap about basic HIV information among Latino heterosexuals.[165]

Risk Behaviors

HIV Testing

There is limited data for this population. However the 2009 "Holla Back" focus groups found many myths surrounding HIV testing procedures among Latino heterosexuals, leading to the conclusion that most had never been tested for HIV.

Low Perceived Risk

Many of the CSA focus group participants had low perceived risk for HIV. When asked which populations were at risk for HIV, participants described adolescents, homosexuals, those who are addicted to drugs, homeless, suffer from mental illness, and sell sex. There were only a few instances where participants acknowledged their own risk of contracting HIV. This low level of perceived risk may inherently place individuals at risk by resulting in low condom use and low rates of HIV testing.

Condom Use

Sex and condom use in relationships can vary and are often influenced by many factors. One CSA female participant said that some women will use sex early in the relationship to prove their commitment to their partner. This was more commonly reported among immigrant women with children who have very limited resources. *"And usually when they come with children from our countries because they feel they do not want to be here alone. They have responsibilities, to pay school, to pay uniforms, to pay for everything. I know some people take aid from the government but some women don't like it because some people don't have papers."* Furthermore, some women are reportedly intentionally becoming pregnant by not using condoms in order to secure a relationship with their partner. This scenario is made possible

[164] Prioritization of Populations Draft
[165] Octane Public Relations and Advertising, Holla Back: DC Listens to You about HIV/AIDS, 2009

primarily because, according to participants, many men agree that it is the woman's responsibility to use condoms since she has most at stake by becoming pregnant if she does not use them. Accordingly, CSA female participants concede that the primary reason they use condoms is to prevent pregnancy, not to prevent HIV or other sexually transmitted infection as reflected in a statement by this participant: "*Latinas only worry about not getting pregnant and not so much about HIV.*" Moreover, due to the widespread belief that it is the woman's responsibility to use condoms, female condoms are very popular among Latinas, more so than male condoms. In fact, there is a reported stigma against a woman carrying male condoms because it implies that she is having a lot of sex. As for married couples, condom use was reported to be low. Interestingly, men who were interviewed warned that married women are unknowingly at risk for HIV due to infidelity from their husbands. "*Women are also at risk. They have their partners; they are at risk through their husbands who can have other partners.*"

From the 2009 "Holla Back" focus groups, Latino heterosexual men felt that though condom use was the responsibility of the man, they were not necessarily used if they were not readily available. Men also said that they preferred "the skin to skin feeling." It was obvious from the discussion that "Holla Back" participants were not routinely using condoms during sex, as some of the participants asked the moderator for a demonstration of proper condom use.

Commercial Sex Work

Commercial sex work was frequently discussed by CSA focus group participants as both a nuisance in their community as well as a necessity for undocumented immigrants who cannot find other means of obtaining financial support. "*Some women make sex a job out of necessity. Unemployment forces women into sex work.*" Participants also said the discreet ways sex workers recruit clients. One participant stated sex workers can be found online more easily than on the street because they are less likely to get caught by the police online. Another participant gave this example of how women recruit clients: "*For example there are women that hand out business cards stating they are [hair dressers] cut hair but actually engage in sex work. The 14th street area is well known for this type of activity.*"

Substance Use

Key informants stated that there is a significant amount of alcohol use among Latinos in DC. Additionally, they reported that marijuana and cocaine (crack) were the drugs of choice among Latino substance users. For instance, one of the female key informants discussed Latino drug use and compared living in DC to the situation prior to entering the US: "*Marijuana, cocaine. I don't know anything else. They may have depression, life issues, abuse, and abandonment. Here, no one is looking after them. New found freedom puts people at risk or lack of family no one here to look over you or just too busy working. Sometimes we don't stop to think about things we do.*" Participants agreed that substance use can lead to risky behaviors for HIV but said that individuals have common reasons for engaging in substance use. Several participants described stress from lack of work as well as too much work as a reason for substance use. For example, one participant stated that many Latinos work long hours or work more than one job in order to bring home enough income. These individuals may then use substances to relieve the stress from all of their work.

Barriers to Accessing/Using Prevention Services

There were two broad barriers to services discussed by focus group participants. The first was that most of the heterosexual participants did not perceive themselves as being at risk for HIV. Most regarded HIV as an infection that affects drug addicts, sex workers, those with mental health problems, and most of all, homosexuals. This perception that HIV happens to "them" results in a low perceived level of risk which may lead to lower condom use, lower testing among this population, and thus lower use of HIV prevention services.

The second barrier was possibly the most salient concern for participants: undocumented immigration status. Participants were very concerned that those who are undocumented generally do not seek services for fear of being deported or not being able to seek services without proper documentation. "*Sometimes when accessing services being undocumented can be a barrier. Sometimes it is necessary to have some form of legal ID in order to use services in the community. However, Whitman Walker has an open clinic for STDs services that are free, they do not require an ID. There is another one in Northeast. Many times, however, the Latino community does not have knowledge of services available such as this one that exist already."* Immigration status as a barrier to services is a great concern for participants because they agree that it is the undocumented population that is most vulnerable to risky behaviors such as substance use and sex work.

HIV Prevention Needs

CSA focus group participants agreed on several areas of need within their community that would assist with HIV prevention. The first was the need to address the causes for risky behaviors such as substance use and commercial sex work. They stated that the inherent lack of social support that comes with being foreign born- regardless of immigration status often results in risky behaviors. For instance, when individuals are away from family and friends, they often lack their emotional support that may lead someone to turn to substance use or they may lack financial support which may lead to survival sex work. Similarly, participants agreed that mental health issues such as depression, as well as stress from work situations, loneliness and even shame from their illegal status may result in self-medicating with substances.

Most CSA focus group participants were able to name agencies that provided HIV services to Latino populations specifically, La Clinica del Pueblo, Whitman Walker, and Mary's Center. Many described pleasant experiences at these agencies. For example, one participant said she prefers to use female condoms over male condoms and relies on these agencies to supply them to her for free. If there were not available, she would not be able to afford them and would not be likely to carry male condoms due to the social stigma against women carrying male condoms. Although these agencies were praised for providing culturally competent and skilled services to Latinos, there was an underlying concern for such agencies. Because they are the only ones that are targeting services to the Latino population, they are considered a precious resource in these communities. Participants said how important it is to have culturally competent services in order to effectively deliver prevention strategies. "*To reach us we need people like us that can speak face to face in our language. [We need] People like health promoters that are skilled and can get our trust and who are also Latinos, who are friendly and that can speak Spanish and be able to communicate with us. We need Spanish-speaking outreach workers to work with Latinos. For me, language is a primary barrier, documentation and racism."* The need to sustain the agencies that provide this level of service to the Latino community was expressed as one of the most salient needs by participants.

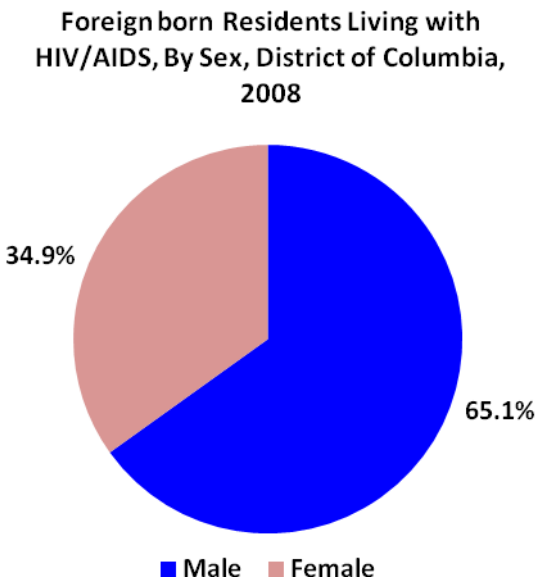
Participants described a number of needs for prevention. First, the need to address the social and financial lack of support many Latino immigrants confront that can result in substance use to cope with these issues or sex work used to survive financially. Second, the need to support and sustain existing agencies and clinics that deliver targeted services to the Latino population in the neighborhoods they live in.

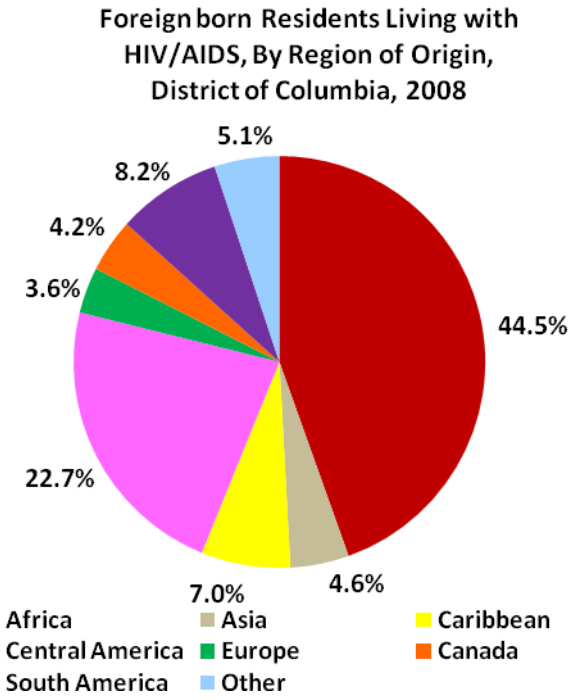
Recent Immigrants

A 2003 Brookings Institution study reveals that the Washington Metropolitan area ranked seventh of all U.S. metropolitan areas for the number of foreign-born residents. Immigration into the area has been rapid and multi-faceted. Representing 193 countries, immigrants have come from: Latin America and the Caribbean (39%); Asia (36%); Europe (12%); Africa (11%) and many other countries (2%). Many arrive from developing countries where HIV is widespread, including Sub-Saharan Africa.

Individuals living with HIV/AIDS in the District represent more than 25 different countries. Among the 16,513 adults and adolescents living with HIV/AIDS at the end of 2008, 687 were foreign-born (4.2%). Of these, 65.1% were men.

By race/ethnicity, 52.6% and 37.4% were among Blacks and Hispanics, respectively. Nearly three quarters (70.1%) of foreign-born residents living with HIV/AIDS were aged 30 and older at the time of diagnosis, and 88.1% are currently aged 30 and older. Nearly half (44.5%) of foreign born residents living with HIV/AIDS were African-born and nearly a quarter (22.7%) were Central American-born.





Region of Origin	%
Africa	44.5
Asia	4.6
Caribbean	7.0
Central America	22.7
Europe	3.6
North America (not including US)	4.2
South America	8.2
Other	5.1

Risk Behaviors

A 2004 survey conducted by DOH highlighted the risk behaviors common to immigrants from all countries who have resettled in the DC entitled, *A Survey of Health Status, Risk Behavior and Health Care Access of Immigrant Populations in the District of Columbia*. The study revealed that 4% out of 1,281 respondents reported being HIV positive and another 18% refused to answer the question pertaining to HIV status. In addition, 16% reported using non-injecting and chewing drugs; 56% reported using alcohol to varying degrees; 5% had exchanged sex for money; and 25% never used a condom. In spite of these circumstances, 80% did not perceive themselves at risk for acquiring HIV, and 25% had never been tested for HIV antibodies. Of those who had never been tested, 48% reported fear of knowing their status, 36% reported costs

as the reason for not being tested, and 59% lacked information about testing sites. Of those who had been tested, 12% did not obtain their test results.

Barriers to Accessing/Using Prevention Services

A lack of culturally competent care, limited English proficiency and cultural beliefs and norms about health and sexuality influence access to and utilization of HIV/AIDS care services in the District. Traditional and cultural norms may discourage identification and reporting of HIV/AIDS among immigrants and foreign-born citizens. Gender inequality and imbalance of power in relationships inhibit many women from accessing services freely. Often times, the power imbalance in relationships increases when a couple moves from a foreign country to the U.S., where many women become even more disempowered in the new culture. Immigrants are less likely to use mainstream and preventive health services, may be more likely to depend on traditional folk medicine and home remedies and may experience cultural stigma and loss of support due to an HIV diagnosis.

HIV Prevention Needs

Misconceptions about HIV disease persists in immigrant communities. Many believe that they can avoid infection by engaging in anal or oral sex, or by older men having sex with younger women. Contrarily, these and other sexual practices commonly used for birth control may actually increase the risk of HIV transmission. For a large segment of recent immigrants, the migration process plays a role in the increased likelihood of infection, particularly for those who have been refugees. Overcrowding, violence, rape, despair and the need to sell or exchange sex to survive characterize refugee camps are components in the transmission of HIV among immigrants. These factors haven reported by the UNAIDS Program as contributing to the increase in HIV infection. Additionally, as a result of culture shock and the stress of trying to become economically independent, many immigrants and refugees continue their risk behaviors, including substance abuse and multiple sex partners, upon arrival to the U.S.

The Deaf and Hard of Hearing

Since there are limited studies on the deaf or hard of hearing, little is known about how many people in this subpopulation are living with HIV/AIDS. There a wide range of estimates, between 8,000 to 40,000 people, based on several studies, where one indicates a prevalence rate of slightly less than 1 percent, and the other of approximately 5 percent.[166] National AIDS surveillance data do not include information on hearing status; thus, little is known about the transmission of HIV among the deaf and hard of hearing. The District of Columbia enhanced HIV/AIDS reporting system does not collect data on the deaf and hard of hearing, therefore, no DC specific data are available.

Risk Behaviors

Substance Use

[166] U.S. Department of Health and Human Services., 2000

The major HIV risk behavior found describing the deaf and hard of hearing was substance use. In the deaf community, it has been note that 1 in 7 people have a substance abuse problem (compared to 1 in 10 in hearing population.[167] This is very concerning because substance abuse and sexual risk behaviors are the principal routes of HIV transmission.

Condom Use

In a 2004 study conducted at Gallaudet University, more than 80% of the respondents in the study confirmed being sexually active and only one third of the participating college students reported using a condom during their most recent sexual encounter.[168] The majority of the students surveyed expressed the belief that having a regular sexual partner eliminated the need for birth control. The most common type of birth control reported was withdrawal, followed by condoms and oral contraception.[169]

Barriers to Accessing/Using Prevention Services:

Communication

Difficulties in communication with medical providers, limited access to health information and proper medical care among the deaf and hard of hearing are major barriers to accessing HIV prevention services.[170] Studies have found that for the deaf and hard of hearing, there is a shortage of culturally appropriate providers and material, as well as interpreters available for patients.[171] For the mentally ill, recognizing that there is a problem is one of the greatest barriers to accessing HIV prevention services.

Education

Schools for deaf generally have no HIV/AIDS programs as part of curriculum, and general sexual education is underemphasized at these schools as well. There is very little HIV or sexuality education in schools for the deaf, especially for adolescents. Because of this, deaf persons have much less knowledge and awareness of HIV transmission, prevention and treatment. If deaf children don't learn about HIV and other sexually transmitted diseases, they won't have the vocabulary necessary to talk about these topics with each other. One study of students at schools for the deaf found that adolescents in 9-12 grades had extremely limited knowledge of AIDS. Students knew correct answers to only 8 of 35 basic questions asked about AIDS.[172]

Stigma

In the deaf and hard of hearing community, social networks are close, where confidentiality may be broken. The literature states that deaf persons would rather go alone to an all-hearing HIV testing and counseling clinic and risk miscommunication and misunderstanding, than bring an interpreter or go to a deaf clinic and risk being recognized and losing confidentiality.[173]

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[167] Peinkofer, J 1994
[168] Job, 2004
[169] Ibid
[170] Bat-Chava Y, Martin D, Kosciw JG. AIDS Care. 2005 Jul;17(5):623-34.
[171] Gaskins S. 1999.
[172] Baker-Duncan N, Dancer J, Gentry B, et al. 1997
[173] Morrone JJ, 1993

HIV Prevention Needs

There is a significant shortage of prevention and care providers who can adequately serve the deaf and hard of hearing. The need for education regarding HIV/AIDS, sexual risk behaviors, stigma in the deaf community and substance abuse among the deaf and hard of hearing is greatly needed as well. The collaboration with organizations and schools affiliated with the deaf and hard of hearing should provide resources specifically relating to this population and the issues they face.

Individuals with Disabilities: The Mentally Ill

Mental illness or disabilities may be acute or chronic conditions that affect an individual's way of life and decision making. Strains on mental health functioning can influence thought and decision-making processes, and can hamper physical functioning, which may lead to an increased risk for HIV infection.

Though mental health issues in the context of HIV is an important topic to address, the District of Columbia enhanced HIV/AIDS reporting system does not collect data on individuals with disabilities, therefore, no DC specific data are available.

Risk Behaviors

Condom Use

The literature has found that condom use among the disabled, especially the mentally ill, is low. According to Akhtar et al., there is a decreased likelihood of using contraceptives, including condoms among the mentally ill, especially during exchange sex, where drugs, shelter or food are needed.[174] In a study conducted on psychiatric patients, condoms were 'never used' by 41% of the patients and 'almost never used' by another 25%. In spite of these behaviors, 65% reported no concern of HIV infection.[175]

Substance Use

Among the mentally ill, substance use is a major factor in HIV risk behaviors. Studies have found high rates of illicit drug use, with frequent use of drugs or alcohol in association with sexual activity.[176] In a study conducted on chronically psychiatric outpatients, 31% of patients reported sexual activity after drug use or intoxicants and 38% reported trading sex for drugs.[177]

Barriers to Accessing/Using Prevention Services

Treating severe mental illness alone is a complex task, and it is widely agreed that alcohol and other drug use undermines treatment efforts. Treatment adherence is the major barrier to prevention service use and this is greatly heightened by substance use. Mentally ill individuals

[174] Akhtar & Thomson, 2001
[175] Grassi, 1999
[176] **SC Kalichman, JA Kelly, JR Johnson and M Bulto. 1994**
[177] Kelly, 1992

with severe and persistent mental illness who use alcohol and other drugs constitute one of the most difficult challenges facing clinicians and treatment systems today. Another major barrier to accessing and using HIV prevention services among the mentally ill is having the knowledge of what services are actually available and where to locate them. Since mental health substance use and HIV services are separate entities, it may be difficult for an individual with mental health issues to use these services as well as make the decision as to which is most important.

HIV Prevention Needs

For persons with long-term mental illness and developmental disabilities, HIV prevention services are needed that include conflict management training, training in ways to manage high risk situations, and explicit instruction in correct condom use. Behavioral change to reduce risk of AIDS is a slow and complex process even within a healthy population.[178] For patients with mental illness, impulsivity, and severe disturbance of self-esteem may prevent compliance. HIV/AIDS programs should also work more closely with their mental health and substance abuse counterparts. The need for education regarding HIV/AIDS, sexual risk behaviors and substance abuse among the developmentally disabled is greatly needed as well.

Other Populations

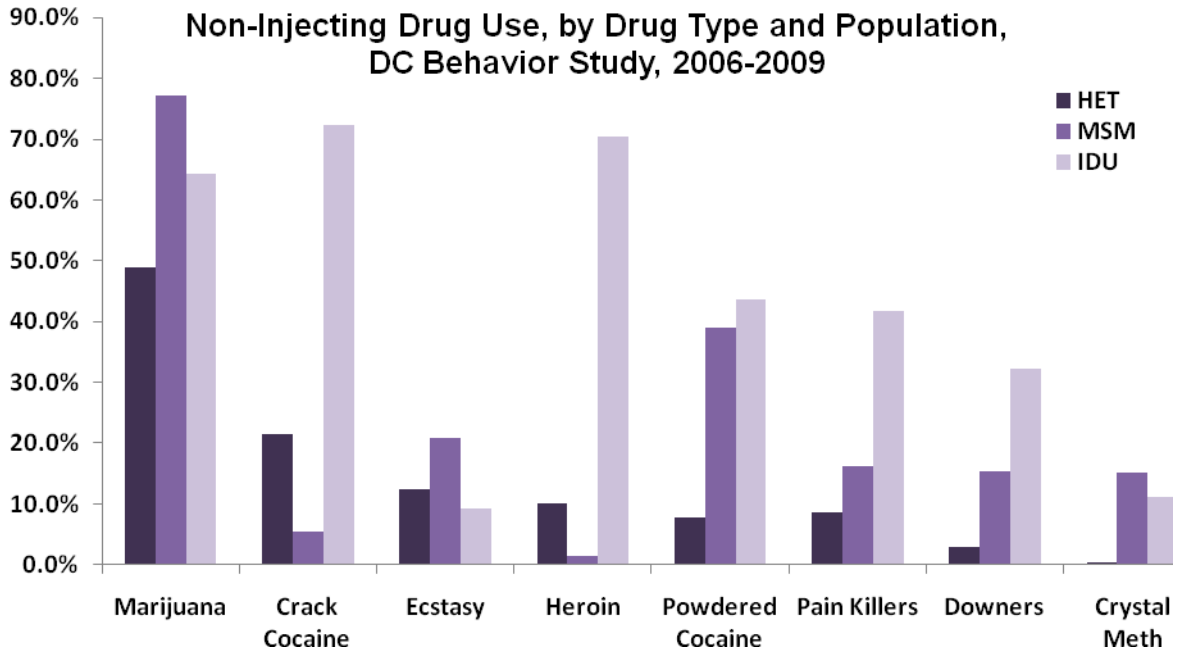
Non-Injection Drug Users

A less-discussed but equally relevant high-risk behavior of significant concern in Washington, D.C., is non-injection substance use. The National Institute on Drug Abuse (NIDA) defines substance use as chronic, compulsive drug seeking and usage despite harmful consequences to both the user and those around him/her.[179] For heavy drinkers, alcohol use may fall under the category of "abused substances," though many drinkers are light to moderate drinkers who do not self-identify as dependent. All drug use, including alcohol, alters users' behaviors in ways that make them more susceptible to acquiring HIV or infecting others in their social networks.

Drug	Total U.S.	District of Columbia
Illicit Drug/Alcohol Use	4.7%	8.9%
Alcohol	3.7%	6.9%
Cocaine	0.3%	1.8%
Heroin	0.1%	0.6%
Marijuana	1.0%	2.4%
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2000.		

[178] Carmen & Brady, 1990
[179] NIDA, 2009

According to NIDA, substance users in the District of Columbia prefer marijuana as the most commonly used drug and cocaine as the second most widely used drug, as shown in Figure XX. The comprehensive report from the Community Epidemiology Work Group (CEWG) at NIDA shows that cocaine use is followed by marijuana, heroin and then methylenedioxymethamphetamine (popularly known as methamphetamine). However, according to the DC Behavior studies (below), the most commonly used non-injection drugs of participants among participants of each cycle at high HIV risk in the District were marijuana and crack cocaine and heroin and powdered cocaine, with pain killers, downers and crystal methamphetamines following.[180] The various data sources show inconsistencies between the highest rated substances used in D.C.; however, one conclusion is that marijuana and crack/cocaine are commonly used drugs within the District.



In 2006, five substances accounted for 96% of all Treatment Episode Dataset admissions (TEDS): alcohol (40%); opiates (18%; primarily heroin); marijuana/hashish (16%); cocaine (14%); and stimulants (9%, primarily methamphetamine). DC specific TEDS data reports that heroine is the leader of admissions by primary substance from 2000-2003 with it being 42% of admissions in 2003, followed by cocaine (29%), alcohol (18%), marijuana (7%) and PCP (4%).[181]

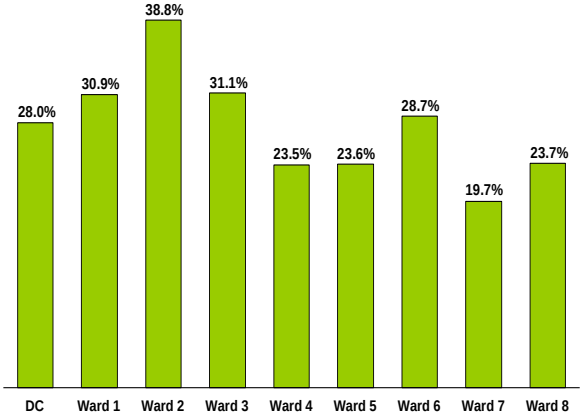
Drug	Total U.S.	District of Columbia
Alcohol	40%	18%
Opiates (heroine)	18%	42%
Marijuana/Hashish	16%	7%

[180] DC Heterosexual Behavior Study, 2007, 2008 and 2009
[181] Office of Applied Studies, 2008

Cocaine	14%	29%
Stimulants (methamphetamines)	9%	--
PCP	3%	4%
Other	--	--
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, TEDS 2003-2006.		

Though evidence of substance use exists in all eight wards of the District, it is not equally distributed across all wards. Wards 1, 2, and 3 show the highest percentages of residents aged 12 and older reporting past month binge drinking (30.9%, 38.8% and 31.1%, respectively). With regards to illicit drug dependence and cocaine use, Wards 2, 5, and 8 stand out, with 5.2% of residents reporting cocaine use in Ward 2, 5.8% reporting illicit drug dependence in Ward 5, and 4.8% reporting illicit drug dependence in Ward 8.

Prevalence of Binge Alcohol Use in the Past Month among Persons Age 12 or Older, NSDUH 2004-2006



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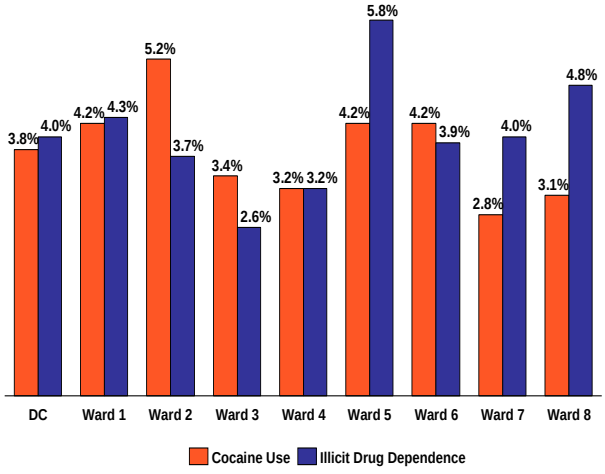
Prevalence of Drug Use in the Past Year among Persons Age 12 or Older, NSDUH 2004-2006



Substances – both illicit and legal – affect the user's mental, physical, and emotional states of being. These effects have been shown to adversely affect the user's risk behaviors with regard to HIV. Non-injecting drug users are at a high risk of HIV transmission, particularly as it relates to an increased risk of sexual risk-taking, gateway opening to injection-drug use and sexual partnerships with other members of IDU communities.[183] According to the DC Heterosexual Behavior Study, nearly half of all participants used alcohol and/or drugs during their last sexual encounter, with alcohol being the most commonly used substance, followed by marijuana.[184]

[182] National Survey on Drug Use and Health, 2006
[183] Celentano et al., 2008
[184] DC DOH, 2009

Substance abuse is also linked to higher rates of sexually transmitted infections (STI) besides HIV, including syphilis, gonorrhea, Chlamydia and genital herpes.[185] Cocaine use has been specifically linked to reduced immune system efficiency and increased susceptibility to infections in general and HPV in particular.[186] A study of Black men and women in Alabama found high-risk sex behaviors were far more prevalent among cocaine users than marijuana or alcohol users.[187] Given that sexually transmitted infections and their related lesions comprise independent risk factors for HIV transmission, the high rate of substance abuse in Washington DC is of concern, as it directly precipitates higher STI rates and thus increased risk for contracting HIV as well. In Washington DC, in 2007, 37% of adult arrestees tested positive for cocaine.[188]

Unlike illicit drugs, alcohol plays a significant and much more pervasive role in facilitating HIV transmission globally, nationally and in Washington, D.C. Alcohol is widely documented as a contributor to risky sexual behavior by reducing inhibitions.[189] Alcohol is prevalent across virtually all cross-sections of society. More than half of all DC residents aged 12 or older reported past month alcohol use with residents' aged 18 to 25 reporting higher estimates of alcohol use than any other age bracket (roughly 75%).[190] Though detailed statistics were not found regarding consumption patterns and number of drinks consumed, available data on alcohol dependence or abuse may act as a surrogate for this information. Based on annual averages for 2005-06, an estimated 8.5 to 11.5% of DC residents aged 12 or older reported past year alcohol dependence or abuse.[191] The National Survey on Drug Use and Health does include binge drinking figures, though the data is not supported by a definition of binge drinking. It may be noted, however, that roughly one quarter of all DC residents aged 12 and older reported past month binge drinking.[192] The DC Heterosexual Behavior Study data revealed that 39% of male participants and 40% of female participants reported binge drinking over the last 12 months.[193]

Risk Behaviors

Enhancing Sexual Desire

CSA focus group participants said that drugs are often used to enhance their libido and to improve their sexual experiences. As previously noted, some drugs are used just for this purpose such as crystal meth. Other participants reported using substances for sexual activities on a much more consistent basis than just for use at the club or on the weekends. One focus group participant admitted that the only way s/he could engage in sexual behaviors was if s/he used crack cocaine. Another individual said that sexual intercourse occurred exclusively while using substances, "*I'm thirty-seven and I can't tell you a time where, where I had, uh, sexual intercourse and I didn't have a mood altering substance in my body. I don't even know how to… I can't even explain how sex would feel without alcohol, marijuana, crack, E-pill, any kind of drug."*

[185] Semaann et al., 2006
[186] Minkoff et al., 2008
[187] Wang et al., 2000
[188] APRA-SAMHSA 2007
[189] Semaann et al., 2006
[190] APRA, 2008
[191] Ibid
[192] Ibid
[193] District of Columbia, 2008

Many CSA focus group participants acknowledged that some drugs exaggerate their desire for sex. Although participants agreed that all drugs do not affect everyone the same way, many said that PCP and crack cocaine more commonly result in a hyper-sexual drive than heroin. On the other hand, participants reported that a few young male substance users engage in heroin use because of experiences when they are able to maintain prolonged erections and delayed ejaculations.[194]

Exchange Sex

As described by CSA focus group participants, an addiction to drugs puts individuals at extremely high risk for HIV due to the seemingly endless lengths that some will go to in order to obtain drugs. *"I think what happens is that it becomes so about getting the drug and it doesn't become, it's not about the sex, it's not about the protection at that point. It's just about that next high. I need to do whatever I need to do in order to get that next high."*

Participants also described situations that occur even after an individual "becomes sober" or stops using intoxicants. Because of their earlier drug using behaviors, they have learned to use sex as a vehicle to get what they need, so they often still engage in high risk sexual behaviors to get their needs met.

Men who have Sex with Men and Women (MSMW)

Focus group participants and Key Informants both described recovering drug addicts (most notably previous crack users) who, upon reflecting on their actions while actively using drugs, admitted they would have done anything to obtain more drugs. Among their examples, they described individuals who would step outside of their primary sexual orientation in order to exchange sex for drugs, such as heterosexual men or lesbian women who have sex with men in order to obtain drugs.

The issue of concurrent relationships and men on the "down low" was also referred to among focus group participants as a HIV-risk sexual behavior. While concurrent relationships were mentioned as promoting the spread of HIV, men on the "down low" were often included in this discussion. CSA focus group participants said that men may be married or engaged in intimate relationships with women only as a cover up to their true sexual orientation. These men, according to participants, engage in sexual intercourse with other men or transgender male-to-females often without condoms and then have sex with their primary partners, also without condoms.

Low Condom Use

All behaviors above occur with infrequent condom use. Also, exchange partners will incentivize, providing more drugs or money if the person agrees to have sex without a condom.

Barriers to Accessing/Using Prevention Services

Confidentiality

Lack of confidentiality was a common theme that surfaced as a major deterrent to seeking services in DC agencies. There is a pervasive belief, among substance users, that because of the small geographic size of the District, everybody knows everybody and personal information can travel fast. Focus group participants expressed concern that employees in District agencies or

[194] CSA Needs Assessment

even clients in waiting rooms can recognize them while seeking HIV services and inadvertently disclose their status to others in the community by being in these settings.

Staff Bias

Some focus group participants mentioned experiences with substance use health professionals who have personal conflicts with treating clients who are currently engaging in substance use. The concern with these value conflicts was that it may lead to diminished quality of care to those individuals seeking services who are still using drugs. One perception was that these health care professionals are ill prepared to work with an urban community that face multiple risk factors for substance use where it is much more difficult to overcome an addiction.

Knowledge of Services

Focus group participants expressed concern with several contextual barriers they or others they know have experienced with accessing services. According to focus group participants, there is a general lack of knowledge of how to seek HIV services. This lack of knowledge was attributed to receiving inadequate counseling when diagnosed with HIV on the next steps to take to continue treatment and care. As one participant described, *"They can tell you got HIV you gotta call here and there but they don't know which clinic to go to. A lot of people like this group right here they don't know nothing about these types of things where you can get information from."* As a result, participants and their peers turn to their network members, other friends and family to obtain this knowledge.

Multiple Instabilities: Mental Health, Housing, and Addiction

According to focus group participants, substance users face multiple issues that can interfere with seeking and maintaining treatment and services. These issues include mental health problems, homelessness, active substance use and addiction. The many issues that substance users face often interfere with complying with medication adherence for those who are HIV positive, seeking preventive services at clinics who offer them, complying with substance use treatment, and can even keep them from obtaining resources such as housing (for individuals who are using drugs). As a result of these experiences, perceptions, and compounding problems, this population is often neglected and disengaged from much needed services that would otherwise be available for them.

Agency Staff Cultural Competency and Sensitivity

The structural barriers that emerged during the focus groups and interviews focused on agency-specific barriers as well as barriers observed system-wide in the District. There was concern among participants that substance use treatment staff is not trained to competently serve clients who are HIV positive. According to focus group participants, this apparent lack of training often leads to lack of HIV sensitivity and a lack of understanding of the unique medical needs of HIV positive clients.

Active Addiction

Focus group participants reported that several service agencies only provide service to clients who have stopped using drugs, which is problematic because according to participants, there is a lack of treatment centers in the District. Without access to these treatment centers, substance users must overcome their addiction on their own before getting access to much needed services in the city. In addition to the need for more treatment centers in the District, CSA focus group participants expressed concern with the length of time it takes for substance users to have access to treatment. Many times, clients must go through an application process that takes a significant

amount of time. During that application process, many substance users end up back on the streets using drugs, resulting in lost treatment opportunities for these clients. Concerns were also expressed for substance users who eventually did receive treatment. Even after a client has completed treatment, there can be little or no supportive resources offered to that client that will keep them from relapsing. According to participants, these lacking resources include housing, medication, and mental health counseling which all play a vital role in substance use.

Priority for HIV-Negative Residents

Key informants said that there is the critical need for services that can prevent them from becoming infected. However, they mentioned another concern was the lack of services for substance users who were not HIV positive. Participants said that in many cases, priority for access to services and resources is given to those who are positive for HIV. These services include access to healthcare and free medication and resources include housing. Participants were concerned that these services and resources can be key to preventing HIV negative substance users from becoming infected.

Lack of Agency Communication and Coordination

System-wide, focus group participants report that there is a general lack of coordination between agencies that provide services and resources. In large part because some agencies are competing for the same federal funding, promoting competition between agencies and possibly inhibiting collaboration. As a result, it is very difficult for those who need these services to navigate the system efficiently. Substance users may not be aware that there is a clinic in their neighborhood that offers more comprehensive care than the one they currently attend, or that a different agency's needle exchange or HIV testing van offers its services on a different block or on a different day.

Limited Resources

CSA focus group participants also said that many agencies often reach their limits to how much they can do because they find themselves providing services to Maryland and Virginia residents. One example given by a key informant was that residents outside the District do not have access to needle exchange services in their jurisdictions. As a result, they come to needle exchange programs offered in DC to access these preventive services. Unfortunately, according to participants, serving residents outside the District in addition to District residents depletes agency resources much quicker than anticipated.

HIV Prevention Needs

System Navigation

CSA focus group participants said that many substance users do not benefit from the services available because they do not know how to navigate through the system to access these services. According to participants, many people do not know how to obtain health insurance, where to go for health care, or where to find mental health care. As a result, many people are not aware of how to access these services and in a number of cases are not even aware that the services exist. Focus group participants identified several points of contact where the opportunity to educate substance users on needed services could be improved. One of these points of contact include HIV testing vans and centers that, according to participants, many times fail to adequately connect these individuals with needed services or provide them with clear and simple instructions for next steps.

Comprehensive care

Another area of need for substance users is the need for comprehensive care that treats the entire individual and not just substance use or just HIV. Focus group participants said that there is an enormous need to address the complex issues that affect substance users' lives. Many of the issues often promote further substance use and other risky HIV behaviors. One of the most commonly reported issues that need to be addressed in order to curb substance use is homelessness. Homelessness often perpetuates substance use, according to participants, and is therefore one of the most salient issues that face this population. Another issue that requires attention is the need for mental health services for substance users because mental health problems are also believed to cause further substance use. There was concern that failure to address these issues often leads to the neglect of health maintenance and HIV prevention by the individual. As participants said, individuals suffering from mental health conditions and/or homelessness cannot seek preventive healthcare when they perceive there are more pressing issues to handle.

Substance Use Services

A similar need for comprehensive prevention services emerged during the key informant interviews and focus groups for individuals seeking substance use treatment. Participants said that substance users need support prior to receiving treatment because there is often an application process or a waiting list that can stall their admission to these facilities. As a result of this gap between when an individual decides they want treatment and when they get that treatment, they often return to the streets where they may lose interest or the will to seek treatment. As illustrated by a key informant, "*If you let them out the door they're going to go get high and forget about what they want to do. And in this city because there are not a lot of places that we can send them right then, we lose 'em. So I think that's a major, major challenge of not having formal intake that we don't use at that moment to hook them into treatment.*"

Many focus participants said the need for some form of pre-treatment housing where substance users interested in treatment can remain on the radar and have immediate access to treatment when it becomes available. In addition to providing housing for those awaiting entry to treatment facilities, participants expressed the need for housing for those who are trying to refrain from drug use in order to access services that require clients to be drug free.

When substance users leave treatment centers, CSA focus group participants said that there is a lack of supportive services thereafter. Specifically, participants mentioned that when leaving drug treatment they are often placed in subsidized housing which is located in areas where they are surrounded by illicit drug activities. In order to reduce relapse rates and other risk factors that increase substance use, all of the issues described above must be addressed following treatment. In addition to housing and mental health services, participants report a need for education opportunities and job assistance, as well as continued access to health services.

Number of Treatment Facilities

Focus group participants said that there are not enough treatment facilities, *"And again I think a lot of the treatment facilities that I know are not here in the city and they're spread out elsewhere. We have some here but they're always filled."* A consensus among focus group participants as well as key informants is that many of the treatment slots in DC are prioritized for the Criminal Justice System. The participants cited experiences where individuals who are under the custody of the criminal justice system were provided with priority access to substance use treatment. Participants perceived this as a shortage of available treatment and felt that

more treatment centers are needed. In addition to more treatment centers, focus group participants stressed the need for a more efficient admission process into these centers. A new process is needed where substance users can quickly be placed in centers in order to reduce the number of individuals who get discouraged by the time consuming process.

Comprehensive Care

Another system-wide need posited by participants was the need for a change in the focus of HIV prevention efforts. Participants said that many HIV prevention programs geared toward substance users focus exclusively on injection drug users (IDUs), specifically needle sharing. Therefore, because their strategies are specific to IDUs, they cannot be effective in preventing HIV among non-IDUs. Focus group participants are concerned that the large numbers of substance users who are addicted to crack cocaine are not being reached through these efforts. One participant elaborated on this issue, *"But I don't ever recall, I recall numerous initiatives to supported by [--?--], CDC, other programs that specifically looked at injection drug users. I have never seen interventions that come out and say we really want to look at chronic crack users and the associated behaviors with crack use and develop a program that's designed to address those issues. I have never seen that. Because I think that because it's not a direct mode of transmission like injecting is that people don't see the value in that."*

Community Outreach

Another strategy that is in need of change, according to participants, is community outreach efforts. Participants report that prevention strategies have shifted from meeting people in their communities through outreach to more long-term interventions in stationary locations where members of the target population are personally required to seek out programs. This shift in prevention strategy abandoned the methods that reach individuals who would normally not seek services. Participants agree that there is a need for increased outreach efforts in HIV prevention especially among the substance use population which can be reluctant to seek services or because of their lifestyle have limited knowledge about available services.

Cultural Competency of Staff

Focus group participants also expressed concern with the level of HIV and cultural competency among agency staff that serve the substance use population. According to participants, substance use agency staff does not have adequate training to deal with HIV positive clients and the needs of those clients. Therefore, staff needs proper training in HIV so they are prepared to make referrals and offer appropriate services unique to HIV positive clients in a culturally competent manner.

Similarly, referring to white college kids and upper income individuals specifically, focus group participants expressed concern with volunteer outreach workers who did not look like or come from the community they are serving. Just having volunteers to do outreach is not enough because these volunteers cannot relate to the target populations and therefore, are unable to provide culturally sensitive services. One participant summarized this point, *"Well, and this is going to sound cruel but I'm going to say it anyway is that well we train young white kids from XXXXX University who've never been across the bridge to come over to Barry Farms to do outreach. A lot of times those kids are terrified to first of all to go into Barry Farms and to be culturally sensitive to that community, they're not."*

Additionally, focus group participants said that several volunteer outreach workers are not indigenous to the community they are required serve. Therefore, their approach is not congruent with the norms in those communities and lacks proficiency in providing culturally

competent services. Participants were concerned with the need for more outreach workers that look like the community they serve and therefore can be more effective in gaining entree to the community and effectively reaching the target population.

HIV Prevention Interventions

July 2008

The primary task of the District of Columbia HIV Prevention Community Planning Group (HPCPG) is to develop a comprehensive HIV Prevention Plan that includes prioritized target populations and recommended prevention interventions/activities for each target population. Prevention interventions should be chosen based on their ability to prevent as many new infections as possible.

The DC Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) is funded by the Centers for Disease Control and Prevention, which requires that all recipients of CDC HIV prevention program funding – including funds received by the DC Department of Health – must fund organizations that provide services based on scientific theory or evidence of demonstrated or probable outcome effectiveness.

Health departments may also fund interventions with insufficient evidence of effectiveness based on prior outcome monitoring data suggesting positive effects, but that cannot be rigorously proven. These interventions must be based on sound science and theory; a logic model that matches the science and theory to the intended outcomes of interest; and a logic model that matches relevant behavioral-epidemiologic data from their community and target population. For additional requirements for locally developed interventions please see Page 81.

This section of the DC HIV Prevention Plan provides information on CDC-recommended interventions, including information on what training and/or replication materials may be available for each intervention.

This section also provides information on interventions that have CDC guidance even though they have not been classified in the CDC hierarchy, such as Comprehensive Risk Counseling and Services (CRCS), and on interventions with HAHSTA guidance, including individual prevention counseling.

In addition to this section, you should consult the DC HIV Prevention Plan's section on Recommended Interventions before choosing an intervention. That section lists the interventions that the HIV Prevention Community Planning Group has recommended for each of the four prioritized populations: People living with HIV, Heterosexuals, Injecting Drug Users and Men who have Sex with Men. The section was updated in 2008 based on new CDC recommendations.

Caveat: Adapt the interventions to meet the needs of your target populations

No intervention can be designed to demonstrate efficacy in every group at risk for transmission or acquisition of HIV. However, because the theories of behavior change upon which interventions are based are generalizable across a number of behaviors and populations, the interventions can be adapted and tailored to meet the specific needs of groups that were not part of the original research. Information on adaptation can be found on Page 78.

Contents

CDC's new Classification System for Prevention Interventions

From the CDC Website

The CDC's Tiers of Evidence framework provides a multi-tiered system for classifying all HIV behavioral interventions based on the type and level of evidence for reducing HIV risk. This framework (1) clarifies the spectrum of interventions that may exist with various degrees of efficacy or evidence that the intervention brings about risk behavior change, (2) describes how the CDC designates evidence-based interventions (Tiers I and II) identified in the research literature, and (3) distinguishes between those interventions that have been identified in the research realm as being efficacious (Tiers I and II) and those locally-developed interventions that may be currently implemented in the prevention program field.

Tiers I and II comprise the evidence-based interventions, because they are based on direct, high-quality, empirical evidence that demonstrates a reduction in HIV/STD incidence or reduced HIV-related risk behaviors. Tiers III and IV comprise the theory-based interventions, which are based on sound behavioral science theory, but do not have sufficient empirical evidence to satisfy CDC criteria for evidence-based interventions. These interventions, however, do have some empirical evidence in the form of process data or outcome monitoring data. A description of the criteria needed to be satisfied for an intervention to be classified into one of these four tiers is presented in the Tiers of Evidence Table on Page 88. The lowest category in the Tiers of Evidence diagram, "unevaluated interventions," represents all other interventions that have never really been evaluated.

Many community-based prevention providers are implementing interventions that are part of the Diffusion of Effective Behavioral Interventions (DEBI), which provides both training and implementation manuals for several interventions that fall into Tiers I and II, as well as some interventions that have not been evaluated. Other community-based prevention providers have not selected a DEBI and are implementing a locally developed intervention. Some of these locally-developed interventions fall into Tiers III and IV as well as the unevaluated intervention level.

As of December 2007, this framework focuses on classifying individual and group-level interventions and does not include community-level (CLI) or structural-level interventions (SLI). The CDC's Prevention Research Synthesis project (PRS) is currently reviewing the CLI/SLI research literature and expects to add this information in 2008.

Recommendations

The CDC encourages health departments and community based organizations (CBOs) to select and implement those evidence-based HIV behavioral interventions with the strongest level of evidence, that is Tier I and Tier II interventions. These are interventions that have been scientifically shown to prevent HIV infections.

CDC recommends that interventions with packages and available training, especially DEBIs, be considered first by agencies conducting HIV prevention interventions. CDC hopes that health departments will work with their grantees and the jurisdiction's community planning group to consider these interventions in future funding cycles as soon as the packages and trainings are made available.

The selected intervention should meet the prevention needs of the target audiences that the agency wants to address, and the agency should have the capacity to implement the intervention as it was designed and packaged. CDC recommends agencies to select and implement Tier I or

Tier II interventions as is, or to adapt these interventions to fit local community needs while maintaining the core elements.

The evidence-based interventions, listed in this Updated Compendium, have been identified by CDC's Prevention Research Synthesis project (PRS) through a series of efficacy reviews. The current ongoing PRS efficacy review process has identified and catalogued evidence-based interventions as either ***best-evidence,*** or ***promising-evidence.*** A complete listing of each catalogue is available below.

The current listings of best-evidence and promising-evidence interventions include individual- and group-level behavioral interventions for high-risk populations whose evaluation study was published from 1988 through 2005. PRS is continuously conducting the efficacy review to identify new evidence-based interventions and is currently reviewing community-level interventions.

Interventions by Target Population (as of July 2008)

Intervention	Delivery: Group level, individual level or community level	Training Available	Training and Replication Package Under Development	Replication Package Available	No Training or Replication Package Available
People Living with HIV					
CRCS	**ILI**	✓			
Healthy Relationships	**GLI**	✓			
Holistic Health Recovery	**GLI**	✓			
Individual Prevention Counseling	**ILI**	✓			
Outreach and Recruitment	**ILI**	✓			
Partner Counseling and Referral Services	**ILI**	✓			
Partnership for Health (Loss-Frame)	**ILI**	✓			
STD Screening	**ILI**	✓			
Together Learning Choices (TLC)	**GLI**	✓			
CLEAR	**ILI**		✓		
WiLLOW	**GLI**		✓		
SUMIT Enhanced Peer-led	**GLI**				✓
Heterosexuals					

Intervention	Delivery: Group level, individual level or community level	Training Available	Training and Replication Package Under Development	Replication Package Available	No Training or Replication Package Available
CRCS	ILI	✓			
Outreach and Recruitment	ILI	✓			
HIV Counseling and Testing	ILI	✓			
STD Screening	ILI	✓			
Individual Prevention Counseling	ILI	✓			
Heterosexual Men & Women					
PROMISE	CLI	✓			
Real AIDS Prevention Project (RAPP)	CLI	✓			
RESPECT: Brief Counseling	ILI	✓			
RESPECT: Brief Counseling + Booster	ILI	✓			
RESPECT: Enhanced Counseling	ILI	✓			
VOICES/VOCES	GLI	✓			
"light"	GLI		✓		
Nia	GLI		✓		
Project Connect	GLI and ILI		✓		
Sister-to-Sister	GLI		✓		
START	GLI		✓		
Doing Something Different	GLI			✓	
Project S.A.F.E.	ILI, GLI			✓	
CHOICES	GLI				✓
Cognitive Behavioral STD/HIV Risk-Reduction	ILI				✓
Communal Effectance-AIDS Prevention	GLI				✓
Condom Promotion	GLI				✓

Intervention	Delivery: Group level, individual level or community level	Training Available	Training and Replication Package Under Development	Replication Package Available	No Training or Replication Package Available
HIP	GLI				✓
HIV Education and Testing	GLI				✓
Insights	ILI				✓
Project FIO	GLI				✓
Salud, Educación, Prevención y Autocuidado (SEPA)	GLI				✓
WHP	GLI				✓
Heterosexual Youth					
FOK + ImPACT (*Renamed Focus on Youth with ImPACT by CDC)*	GLI	✓			
Street Smart	GLI	✓			
¡Cuídate!	GLI		✓		
Focus on Kids (FOK)	GLI		✓		
Project AIM	GLI		✓		
SiHLE	GLI		✓		
BART	GLI			✓	
Be Proud! Be Responsible!	GLI			✓	
Assisting in Rehabilitating Kids (ARK)	GLI				✓
Safer Sex	ILI				✓
Sisters Saving Sisters	GLI				✓
IDUs					
CRCS	ILI	✓			
HIV Counseling and Testing	ILI	✓			
Individual Prevention Counseling	ILI	✓			
Modelo de Intervención Psicomédica (MIP)	ILI	✓			
Outreach and Recruitment	ILI	✓			

Intervention	Delivery: Group level, individual level or community level	Training Available	Training and Replication Package Under Development	Replication Package Available	No Training or Replication Package Available
PROMISE	**CLI**	✓			
Safety Counts	**GLI, ILI**	✓			
STD Screening	**ILI**	✓			
Sniffer (for intranasal drug users)	**GLI, ILI**			✓	
BRAINE	**ILI**				✓
Female- & Culturally-specific Negotiation (drug injectors and crack cocaine smokers)	**ILI**				✓
Intensive AIDS Education	**GLI**				✓
Needle Exchange	**ILI**				✓
Women's Co-Op (for women who use crack)	**ILI, GLI**				✓
MSM					
CRCS	**ILI**	✓			
HIV Counseling and Testing	**ILI**	✓			
Individual Prevention Counseling	**ILI**	✓			
Many Men, Many Voices	**GLI**	✓			
Mpowerment	**CLI**	✓			
Outreach and Recruitment	**ILI**	✓			
Popular Opinion Leader (POL) (adapted for Black MSM as d-up!)	**CLI**	✓			
PROMISE	**CLI**	✓			
STD Screening	**ILI**	✓			
Brief Group Counseling	**GLI**			✓	
EXPLORE **(not recommended by author)**	**ILI**			✓	

Intervention	Delivery: Group level, individual level or community level	Training Available	Training and Replication Package Under Development	Replication Package Available	No Training or Replication Package Available
Personalized Cognitive Risk-reduction Counseling	**ILI**				✓

Best-Evidence and Promising-Evidence Interventions

Best-Evidence HIV behavioral interventions include interventions that have been rigorously evaluated and have shown significant effects in eliminating or reducing Gender of participants during evaluation:- or drug-related risk behaviors, reducing the rate of new HIV/STD infections, or increasing HIV-protective behaviors. These interventions meet the PRS efficacy criteria for best evidence and are considered to provide the strongest scientific evidence of efficacy.

Promising-Evidence HIV behavioral interventions include interventions that have been sufficiently evaluated and have shown significant effects in eliminating or reducing Gender of participants during evaluation:- or drug-related risk behaviors, reducing the rate of new HIV/STD infections, or increasing HIV-protective behaviors. These interventions meet the PRS efficacy criteria for promising evidence and are considered to be scientifically sound and to provide sufficient scientific evidence of efficacy.

KEY to abbreviations:

heterosexual=Heterosexual
HIV+=HIV-positive
High-risk=High-risk youth
MSM=Men who have sex with men
DU=Drug users
Gender of participants during evaluation:
M=Males
F=Females
W=White
AA=African American/Black
AI=American Indian
H=Hispanic/Latino
API=Asian/Pacific Islander
O=Other racial/ethnic group
GLI=group-level intervention
ILI=individual-level intervention

Assisting in Rehabilitating Kids (ARK)

Target: Black and white substance-dependent youth

Delivery: GLI **Training:** Not Available

Replication Package: An intervention package is not available at this time. Please contact Dr. Janet S. St. Lawrence, Mississippi State University, Meridian, 1000 Highway 19 North,

Meridian, MS 39307. email: jlawrence@meridian.msstate.edu for details on intervention materials.

NOTE: *This intervention is based on Becoming a Responsible Teen (BART), which has an intervention package and is identified by CDC as a best-evidence intervention.*

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/ARK.htm

Description

Assisting in Rehabilitating Kids (ARK) is a small group, 12-session intervention consisting of educational, behavioral skills training, and motivational risk-sensitization manipulation components designed to reduce and maintain reductions of risky sexual behaviors among substance-dependent adolescents. The intervention is delivered to groups of 6-10 mixed-gender youth over a period of 28 days after their initial detoxification while the youth are still in the drug treatment program facility. The first 2 intervention sessions provide standard HIV/STD information. Five sessions addressing behavioral skills are based on the Becoming a Responsible Teen (BART) intervention and provide specific training and practice regarding correct condom use, partner negotiation, refusal of unwanted sex, and communicating this information and newly acquired skills to peers. Four other sessions are used to teach problem-solving skills and anger management skills important for drug-dependent adolescents. One additional session focuses on the motivational aspects of behavior change, particularly the level of perceived risk, by introducing an emotion-based risk-sensitization manipulation. A digital photograph of each adolescent is taken at baseline, downloaded into a computer, electronically transformed to visually depict how the adolescent might appear at end-stage AIDS. After adolescents complete their skills training sessions, the original and digitally transformed images are given to each adolescent. Next, discussion focuses on adolescents' emotional responses to the images, how these images may affect their willingness to engage in risky or safer sexual behaviors, and emphasizes that the adolescents already have the necessary skills to avoid HIV/STDs. This risk-sensitization manipulation is designed to increase awareness of personal vulnerability and, along with their improved self-efficacy, to motivate youth to adopt and be able to maintain risk reduction behaviors.

Intervention Duration

Twelve 90-minute sessions delivered over 28 days

Significant Findings of the Intervention's Evaluation

- A significantly greater percent of ARK intervention participants reported abstinence at the 6-month ($p < .05$) and 12-month ($p < .05$) follow-ups when compared to the health education participants and at the 12-month follow-up ($p < .05$) when compared to the behavioral skills training participants.
- ARK intervention participants reported a significantly lower frequency of unprotected vaginal sex and greater frequency of condom-protected sex than the health education participants at the 6-month and 12-month follow-ups (all p's $< .05$).
- ARK intervention participants also reported a significantly lower frequency of unprotected vaginal sex ($p < .05$) and greater frequency of condom-protected sex ($p < .05$) than participants in the behavioral skills training intervention at the 12-month follow-up.
- ARK intervention participants reported significantly greater percentages of condom-protected sex at the 6-month ($p < .05$) and 12-month ($p < .05$) follow-ups when compared to

the health education participants and at the 12-month follow-up ($p < .05$) when compared to the behavioral skills training participants.

Gender of participants during evaluation: 68% M, 32% F

Race/ethnicity of evaluation sample: 75% W, 22% AA, 2% AI, 1% H

Considerations

- This intervention fails to meet the best-evidence criteria due to assigning groups of individuals to study condition while analyzing at the individual level and small analytical sample sizes.
- This intervention is based on the Becoming a Responsible Teen (BART) intervention, which already has an intervention package available and is identified by PRS as a best-evidence intervention. BART is an 8-session small-group intervention that was originally tested with African American adolescents in family public health clinics. This intervention was designed for substance-dependent adolescents and included additional sessions focusing on problem-solving skills, anger management skills, and motivating youth to change behavior.
- All participants in this study received the standard 3-week detoxification program provided by the drug treatment facilities and remained in the facility for 30 days after initial detoxification. Drug treatment programs were based on the 12-step Alcoholics Anonymous program and involved group sessions around substance abuse, educational classes, and recreational activities.

BART (Becoming a Responsible Teen)

Target: African American Adolescents (14 to 18)

Delivery: GLI

Training: Not Available

Replication Package: Available for purchase from www.etr.org

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/BART.htm

Description

Becoming a Responsible Teen (BART) is a group-level, education and behavior skills training intervention designed to reduce risky sexual behaviors and improve safer sex skills among African American adolescents. The 8 intervention sessions, delivered to groups of 5-15 youth, provide information on HIV and related risk behaviors and the importance of abstinence and risk reduction. The sessions were designed to help participants clarify their own values and teach technical, social, and cognitive skills.

Through discussions, games, videos, presentations, demonstrations, role plays, and practice, adolescents learn problem solving, decision-making, communication, condom negotiation, behavioral self-management, and condom use skills. The participants also have a discussion with local, HIV-positive youth to promote risk recognition and improve their perception of vulnerability. In addition, the intervention encourages participants to share the information they learn with their friends and family and to provide support for their peers to reduce risky behaviors.

Intervention Duration

Eight 90-120 minute sessions delivered over 8 weeks

Significant Findings of the Intervention's Evaluation

- Overall, a significantly lower percentage of intervention youth reported being sexually active compared to comparison youth at the 12 month follow-up ($p < .05$).
- For the subgroup of youths who were not sexually active at baseline, there was a significantly smaller percentage of intervention youth who reported initiating sexual activity compared to the comparison youth by 12 months ($p < .01$).
- Sexually active intervention youth reported a significantly greater percentage of sexual intercourse occasions that were condom-protected than comparison youth at the 6-month ($p < .01$) and 12-month ($p < .05$) follow-ups
- For the subgroup of sexually active female youths, the intervention participants reported a significantly lower frequency of unprotected vaginal sex than those in the comparison at the 12- month follow-up ($p < .01$). (While the above findings meet best evidence, this finding meets the promising-evidence criteria.)

Gender of participants during evaluation: 28% M, 72% F

Race/ethnicity of evaluation sample: 100% AA

Be Proud! Be Responsible!

Target: High Risk Black Youth (Mean age of 15 years)

Delivery Unit: GLI

Training: Not Available

Replication Package: Available for purchase from Select Media

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/Be_Proud.htm

Description

Be Proud! Be Responsible! is a small group skills building and motivational intervention to increase knowledge of AIDS and sexually transmitted diseases (STDs) and to reduce positive attitudes and intentions toward risky sexual behaviors among African-American male adolescents. The intervention consists of one 5-hour session delivered to groups of 5-6 males. The intervention includes facts about HIV/AIDS and risks associated with intravenous drug use and sex behaviors; clarifies myths about HIV; and helps adolescents realize their vulnerability to AIDS and STDs. Videos, games, exercises, and other culturally and developmentally appropriate materials are used to reinforce learning and build a sense of pride and responsibility in reducing HIV risk. Adolescents also engage in role-playing situations to practice implementing abstinence and other safer sex practices, including practicing condom use skills.

Intervention Duration

One 5-hour session

Significant Findings of the Intervention's Evaluation

- At the 3-month follow-up, adolescents in the intervention group reported significantly less risky sexual behavior (using the combined scale, $p < .01$) and fewer number of female sex partners ($p < .003$) than adolescents in the comparison group.

- At the 3-month follow-up, adolescents in the intervention group reported a significantly fewer days of having sex ($p < .008$), fewer female sex partners involved with other men ($p < .05$), and fewer days not using a condom during sex ($p < .003$). In addition, adolescents in the intervention group were significantly less likely to report engaging in heterosexual anal sex ($p < .02$) than adolescents in the comparison group at the 3-month follow-up. (While the above findings meet best evidence, these findings meet the promising-evidence criteria.)

Gender of participants during evaluation: 100% M

Race: 100% AA

BRAINE (Brief Alcohol Intervention for Needle Exchangers)

Target: White IDU men and women

Delivery: ILI

Training: Not Available

Replication Package: An intervention package is not available at this time. Please contact Dr. Janet S. St. Lawrence, Mi

ssissippi State University, Meridian, 1000 Highway 19 North, Meridian, MS 39307. email: jlawrence@meridian.msstate.edu for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/BRAINE.htm

Description

BRAINE is a brief motivational interviewing intervention consisting of two individualized sessions focusing on alcohol use and HIV risk-taking. The first session, lasting 60 minutes, consists of assessing the participant's degree of hazardous drinking, providing feedback, identifying relationships between drinking and negative consequences including HIV risk behaviors, reviewing HIV drug risk behaviors, and identifying personal goals and potential barriers for behavior change. The counselor provides an atmosphere to enhance the participant's motivation to change, uses an empathic therapeutic style, and supports the participant's self-efficacy for behavior change. The counselor helps the participant with setting goals and developing a "change plan" concerning future alcohol consumption designed to reduce the link between drinking and other hazardous behaviors, particularly borrowing injection equipment from someone else. A copy of the "change plan" is given to the participant to refer to at home. A second motivational interviewing session, lasting 30-45 minutes, occurs 1 month later for reinforcement. This session is to review the "change plan," discuss any recent negative consequences from drinking, and help participant's assess their own alcohol-related injection risk behaviors and come up with ways to reduce this risk. The counselor helps the participant set goals and develop another "change plan" for achieving these goals. A copy of the "change plan" is again provided to the participant. Participants are also given a list of referrals for substance abuse and medical treatment at both sessions.

Intervention Duration

One 60-minute and one 30-45 minute session delivered 1 month apart

Significant Findings of the Intervention's Evaluation

- This intervention fails to meet the best-evidence criteria due to small analytical sample sizes.
- Among those that shared equipment at baseline, IDUs in the intervention group were significantly more likely than those in the control group to reduce the number of injection-related risk days by 75% ($p < .05$) or by 1 or more days ($p < .05$) at the 5-month follow-up.
- Among those that shared equipment at baseline, IDUs in the intervention group were significantly more likely than those in the control group to move to a lower risk category (based on the number of injection-related risk days) from baseline to the 5-month follow-up ($p < .05$).

Gender of participants during evaluation: 62% M, 38% F

Race/ethnicity of evaluation sample: 90% W, 10% O

Considerations

- Among those that shared equipment at baseline, more intervention participants than control participants, reported 25%, 50%, and complete (100%) reductions in their number of injection-related risk days, although the findings using these percent reduction categories were not statistically significant (all p's < .10).

Brief Group Counseling — Target: Asian/Pacific Islander MSM

Delivery Unit: GLI **Training:** Not Available

Replication Package: Available for purchase from Sociometrics, Inc.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/brief_group.htm

Description

The *Brief Group Counseling* intervention is a group-level counseling and skills training intervention for homosexual API men. The intervention, delivered to groups of approximately 8 men, consists of one 3-hour culturally tailored session with four key components: (1) development of positive self identity and social support; (2) safer sex education; (3) promoting positive attitudes toward safer sex; and (4) negotiating safer sex. HIV transmission facts and correct use of a condom were presented. An interactive game is used to discuss risks associated with different types of sexual partners. Participants also engage in group discussion about negative experiences associated with being API and with being homosexual, feelings toward safer sex, as well as ways to build support around their self image and personal strengths. The participants build safe-sex negotiation skills through role play and demonstrations.

Intervention Duration

One 3-hour session

Significant Findings of the Intervention's Evaluation

- Intervention participants reported significantly fewer sex partners than control participants at the 3-month follow-up ($p < .001$). This significant intervention effect was also found among the sub-sample of men with 0-1 sex partners at baseline ($p < .05$), among men with ≥ 2 sex partners at baseline ($p < .01$), and among Chinese and Filipino men combined ($p < .01$).
- Among Chinese/Filipino men, intervention participants were significantly less likely to report unprotected anal intercourse compared to control participants at the 3-month follow-up ($p < .05$).

Gender of participants during evaluation:: 100% M

Race: 100% API

Considerations

The intervention's effect on unprotected anal intercourse was not found to be significant for the overall sample or for the diverse sub-sample of API men who were not Chinese or Filipino. The intervention's most consistent effect was on reduction in the number of sex partners.

CHOICES **Target: Heterosexual Women**

Delivery Unit: GLI **Training:** Not Available

Replication Package: An intervention package is not available at this time. Contact Dr. Blair Beadnell, University of Washington, School of Social Work, 4101 15th Avenue, NE, Seattle, WA 98105 USA, e-mail: blairb@u.washington.edu, for details on intervention materials

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/CHOICES.htm

Description

Choices is a small-group (5-10 women), skills training intervention designed to reduce STD infections and risky sex behaviors of women at risk for STDs, including HIV. The intervention focuses on skills that emphasize initial behavior change as well as the maintenance of behavior change over time. Motivational and decision-making exercises help women choose safer sex strategies best suited to their circumstances; and skill building exercises, using role plays, teach how to implement these successfully. Skills include using condoms correctly, negotiating safe sex with their partners, and creating lifestyle balance. The intervention also encourages women to evaluate their relationship choices, and explore how those choices affect their health and well being.

Intervention Duration

16 weekly 2-hour group sessions

Significant Findings of the Intervention's Evaluation

Over 12-months of follow-up, women in the skills training intervention group were significantly less likely to acquire a new STD than women in the comparison group ($p = 0.05$).

Gender of participants during evaluation: 100% F

Race: 54% W, 29% AA, 5% AI, 3% H, 3% API, 6% O

Considerations

Women in both intervention groups significantly reduced risky sex behaviors from baseline levels.

CLEAR (in person) **Target Group: HIV+ Youth (16-29)**

Delivery Unit: ILI **Training:** Under Development (Expected availability July 2009)

Replication Package: An intervention package and training, modified for inclusion with Comprehensive Risk Counseling Services (CRCS), are currently being developed by the CDC. Contact DEBI Technical Monitor John Mosier, 404-639-8166, email: JMosier@cdc.gov, for

details on intervention materials. The intervention manual is available on the following website: http://chipts.ucla.edu/interventions/manuals/intervclear.html

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/CLEAR.htm

Description

Choosing Life: Empowerment, Actions, Results (CLEAR) is a 3-module intervention that is delivered in one-on-one sessions to young people living with HIV. Each of the 3 modules is comprised of 6 sessions that focuses on different target behaviors. Module 1 focuses on improving youths' physical health, including the use of and adherence to antiretroviral medication, implementing new daily routines to stay healthy, and coping with their serostatus. Module 2 aims to reduce unprotected sex acts and substance use through the identification of situations that elicit risky behavior. In this module, participants build skills in condom use self-efficacy and negotiation of safer sex. Module 3 aims to reduce emotional distress and to increase quality of life of participants. Each participant is taught relaxation, self-instruction and meditation techniques in order to control negative emotional states. Participants also identify long-term life goals in this module.

Intervention Duration

18 sessions total (6 sessions per module); each session lasts 1.5 hours

Significant Findings of the Intervention's Evaluation

At 15 months post baseline, participants who received the In-person CLEAR intervention reported significantly greater increases in the proportion of protected sex acts with all sex partners ($p < 0.01$) and proportion of protected sex acts with HIV-seronegative partners ($p < 0.05$) than wait list control participants. Participants receiving the In-person intervention also reported a significantly greater increase in the proportion of protected sex acts with HIV-negative partners at 15 months post baseline than participants in the Telephone-delivered intervention ($p < 0.01$).

Other targeted outcomes – substance use, HIV medication adherence, health behaviors, and emotional distress – were not significantly improved by the intervention.

Gender of participants during evaluation: 78% M, 22% F

Race: 42% H, 26% AA, 23% W, 8% O

Considerations

The telephone-delivered intervention was not efficacious in reducing risk behaviors relative to the control group. Only the In-person CLEAR intervention is considered to meet the Best Evidence criteria.

Cognitive Behavioral STD/HIV Risk-Reduction **Target: Black, white Heterosexuals**

Delivery: ILI **Training:** Not Available

Replication Package: An intervention package is not available at this time. Please contact Dr. Cherrie B. Boyer, Department of Pediatrics, Division of Adolescent Medicine, University of California, San Francisco, 400 Parnassus Avenue, Box 0503, San Francisco, CA 94143. email: boyerc@peds.ucsf.edu

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/risk-reduction.htm

Description

The *Cognitive-Behavioral STD/HIV Risk-Reduction* is a multi-component, individual-level intervention that aims to prevent STDs among high risk Heterosexual Men & Women. The four intervention sessions, delivered to adults attending a public STD clinic, emphasize a cognitive/behavioral approach to reduce patient's risk of acquiring STD/HIV. The sessions include information on the transmission, types, symptoms, and treatment of various STDs. The counselor and the patient discuss patient's risk, personal triggers, and alternative behaviors. The counselor helps the patient develop a risk reduction plan, follows up on the plan in following sessions, and provides feedback and support for enacting the plan. Discussions also include key elements to successful communication with sex partners, ways to begin risk-reduction strategies, and sources for social support. In addition, patients practice condom application skills and are provided condoms. Through video, written materials, individual counseling, discussion, goal setting, vignettes, and role play, patients are able to recognize their risky behaviors, make a commitment to change, and enact risk reduction strategies to prevent STD/HIV infection.

Intervention Duration

Four 60-minute sessions delivered over 4 consecutive weeks

Significant Findings of the Intervention's Evaluation

Overall, intervention participants reported significantly fewer sexual encounters without condoms than comparison participants at the 3-month follow-up ($p < .05$).

- Among men, intervention participants reported significantly fewer sexual encounters without condoms than comparison participants at the 3-month follow-up ($p = .04$).
- Among sexually active men, intervention participants reported a significantly greater percentage of sexual encounters with condoms than comparison participants at the 3-month follow-up ($p < .05$).
- Among sexually active men, intervention participants reported significantly fewer sexual partners without condom use than comparison men at the 5-month follow-up ($p < .01$).

Gender of participants during evaluation: 63% M, 37% F

Race/ethnicity of evaluation sample: 46% AA, 29% W, 17% H, 8% O

Considerations

- This intervention fails to meet the best-evidence criteria due to low retention rates.
- In the article by Boyer et al. (1997), an error occurred in one outcome label in Table 5 on page 365. The label should have read "Mean % of sexual intercourse with condoms," to agree with the text on page 363-364, "Among men who reported sexual intercourse at 3 and 5 months, those in the intervention group increased the percentage of the time in which they used condoms at 3 months compared with those in the control group (56.8% versus 42.3%)." Correspondence with the author confirmed the information in the text is correct and the table label should read "with condoms."

- There were no statistically significant intervention effects on the acquisition of new or probable STDs at the 5-month follow-up.
- The overall intervention effect on sex without condoms was primarily due to a significant effect among men; there were no significant intervention effects on any behavioral outcome for women alone.
- Intervention effects on mean number of sexual encounters with condoms or mean number without condoms were not found to be significant at the 5-month follow-up ($p < .01$).

Communal Effectance-AIDS Prevention **Target: Heterosexual Women**

Delivery Unit: GLI **Training:** Not Available

Replication Package: An intervention package is not available at this time. Contact Dr. Steven E. Hobfoll, Applied Psychology Center, Kent State University, Kent, OH 44242, e-mail: shobfoll@kent.edu, for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/CE-AP.htm

Description

The Communal Effectance – AIDS Prevention intervention is a small group (3-6 women) intervention that emphasizes negotiation skills training and the idea that women's sexual behavior not only affects themselves but also those around them. Women are taught to protect themselves from HIV infection through cognitive rehearsals, role plays, discussions, and interactive videos. The intervention sessions provide women with general HIV and AIDS prevention information, and instruct women how drugs and alcohol can lead to risky sex behaviors. The sessions also offer condom use skills and teach women how to take control of their sexual encounters. Women are also taught skills on how to refuse unwanted sexual propositions and how to negotiate sexual safety with their partners. The final 3 sessions emphasize the maintenance of behavior change, review skills and techniques discussed in earlier sessions, and focus on relapse prevention

Intervention Duration

Six sessions lasting 1.5 to 2 hours each delivered over 2 to 3 months

Significant Findings of the Intervention's Evaluation

At the 6 to 7-month follow-up, women who received the HIV prevention intervention reported significantly fewer episodes of unprotected vaginal or anal sex than women in the standard care group ($p < .001$).

Gender of participants during evaluation:: 100% F

Race: 55% AA, 42% W, 3% O

Considerations

Among women with a prior STD, those in the HIV prevention group were significantly less likely to test positive for an STD at follow-up than women in the health promotion group ($p<.005$).

There was no difference, however, when comparing the HIV prevention group to the standard care group.

Condom Promotion **Target: White Heterosexual Women**

Delivery: GLI **Training:** Not Available

Replication Package: An intervention package is not available at this time. Please contact Dr. Angela D. Bryan, Department of Psychology, Campus Box 345, Muenzinger D-351C, University of Colorado at Boulder, Boulder, CO 80309-0345, email: angela.bryan@colorado.edu for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/condom.htm

Description

The multi-component *Condom Promotion* intervention is a small group level, skill-building intervention to reduce risky sex behaviors and STDs among young women (mean age of 19 years). The single intervention session, delivered to groups of 8-12 women, emphasizes perceptions about sexuality, beliefs about STDs, and self-efficacy for condom use. To increase acceptance of sexuality and encourage planning for sexual activity women are shown a video depicting women's' sexuality in popular media. An informational presentation on symptoms, prevalence, and transmission of STDs is provided to increase perceived susceptibility to STDs, and a video is shown to alleviate apprehension associated with purchasing condoms. Women are taught how to properly use condoms, how to be assertive in discussing condom use with their partner, and how to deal with partner resistance to condoms. Through videos, presentations, role play, discussions and practice, women learn how to increase their sense of control over their sexual encounters, increase their STD awareness and perceived susceptibility, and increase self-efficacy for condom use.

Intervention Duration

One session lasting 45 minutes

Significant Findings of the Intervention's Evaluation

Intervention participants were significantly more likely to report having used a condom at most recent sexual intercourse than comparison participants at the 6-month follow-up.

Gender of participants during evaluation: 100% F

Race/ethnicity of evaluation sample: 79% W, 8% H, 5% API, 4% AI, 3% AA, 1% O

Considerations

This intervention fails to meet the best-evidence criteria due to small analytical sample sizes and using a one-tailed test.

¡Cuídate! **Target: High-Risk Hispanic / Latino Youth (13-18)**

Delivery Unit: GLI **Training:** Under development

Replication Package: An intervention package is currently being developed under the

Replicating Effective Program (REP) project. Please contact Dr. Antonia Villarruel, University of Michigan, School of Nursing, 400 N Ingalls, Room 4320, Ann Arbor, MI 48109-0482 avillarr@umich.edu for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/cuidate.htm

Description

¡Cuídate! (Take Care of Yourself) is a small-group, culturally based intervention to reduce HIV sexual risk among Latino youth. The intervention consists of six 60-minute modules delivered to small, mixed-gender groups. *¡Cuídate!* incorporates salient aspects of Latino culture, including familialism (i.e., the importance of family) and gender-role expectations (i.e., *machismo, which is described as the man's responsibility in caring for and protecting one's partner and family*). These cultural beliefs are used to frame abstinence and condom use as culturally accepted and effective ways to prevent sexually transmitted diseases, including HIV. Through the use of role plays, videos, music, interactive games and hands-on practice, *¡Cuídate!* addresses the building of HIV knowledge, understanding vulnerability to HIV infection, identifying attitudes and beliefs about HIV and safe sex, and increasing self-efficacy and skills for correct condom use, negotiating abstinence, and negotiating safer sex practices. The intervention curriculum is available in English and Spanish.

Intervention Duration

Six 60-minute modules delivered over two consecutive Saturdays

Significant Findings of the Intervention's Evaluation

- Across the three follow-ups, intervention participants were significantly less likely to report sexual intercourse ($p < .05$) and multiple partners ($p < .05$) and reported fewer days of unprotected sexual intercourse ($p < .05$) compared to comparison participants
- Among those sexually active at baseline, intervention participants were more likely to report using condoms consistently across the three follow-ups when compared to comparison participants ($p < .05$).
- Among sexually inexperienced adolescents at baseline, intervention participants reported significantly fewer days of unprotected sex across the three follow-ups than comparison participants ($p < .05$).
- Among Spanish speakers, intervention participants reported a greater proportion of protected sex ($p < .01$) and were more likely to have used a condom at last sex ($p < .05$), across the three follow-ups, than comparison participants.

Gender of participants during evaluation:: 45% M, 55% F

Race: 100% H

Considerations

The development of this intervention was based on Be Proud! Be Responsible!, an intervention targeting African American youth and tested originally with inner-city African American male youth.

Doing Something Different **Target: Black Heterosexuals**

Delivery: GLI **Training:** Not Available

Replication Package: An intervention package is currently available from Sociometrics, Inc.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/different.htm

Description

Doing Something Different consists of one single skill-building group session to encourage change in norms, expectations, and social skills for promoting safer sex and condom use. The intervention session begins with a video, "Let's Do Something Different," which depicts condom use as socially acceptable. After the video an African-American female health educator facilitates a group discussion (10-25 participants) on methods of preventing STDs and promoting condom use. This discussion includes the reasons why people like and dislike condoms. Role-playing gives the clinic patients an opportunity to practice condom negotiation, first with the health educator and then with another patient. Questions relating to medical aspects of STDs are referred to clinic nursing and medical personnel. All participants are offered 10 free condoms by clinic nurses.

Intervention Duration

One session

Significant Findings of the Intervention's Evaluation

- A significantly smaller percentage of intervention participants reported any STD reinfection risk than comparison participants at 7 to 9 months after intervention.
- Among male STD clinic patients, a significantly smaller percentage of intervention participants reported any STD reinfection risk than comparison participants at 7 to 9 months after intervention ($p < .01$).

Gender of participants during evaluation: 71% M, 29% F

Race/ethnicity of evaluation sample: 92% AA, 8% O

Considerations

- This intervention fails to meet the best-evidence criteria due to assigning groups of individuals (e.g. morning patients or afternoon patients) to study condition while analyzing at the individual level.
- The significant intervention effect observed for the whole study sample is primarily driven by the intervention effect for men. There was no evidence that the intervention was effective in reducing STD reinfection risk among female STD clinic patients.
- This intervention is similar to the VOICES/VOCES intervention on various aspects: intervention goal, target population, intervention setting, group-delivery format, and same intervention video ("Let's Do Something Different"). The main difference is that the Doing Something Different intervention has an additional role playing activity. The intervention package and training are available for the VOICES/VOCES intervention through CDC's REP and DEBI projects.

EXPLORE **Target: White MSM**

Delivery Unit: ILI **Training:** Not available

Replication Package: The intervention manual is available online. Contact Dr. Beryl A. Koblin, Laboratory of Infectious Disease Prevention, New York Blood Center, 310 East 67th St., New York, NY 10021, e-mail: bkoblin@nybloodcenter.org, for details on intervention materials. Based on the non-significant effect of the intervention on the primary outcome of the study, HIV incidence. ***The EXPLORE Study Team does not recommend use of the intervention in its present form.***

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/EXPLORE.htm

Description

The *EXPLORE* intervention consists of 10 core counseling sessions delivered one-on-one to participants. The first 3 sessions are intended to establish rapport between the counselor and the participant, and to provide personalized risk assessments. The remaining 7 sessions cover topics such as sexual communication, knowledge of personal and others' HIV serostatus when making sexual decisions, and the role of alcohol and drug use in risk behavior. Sessions also address coping with triggers of unsafe sex and skills needed to modify risky behavior. Motivational interviewing is used to help participants make and sustain knowledge, attitude, belief and behavior changes. Maintenance counseling booster sessions are delivered every 3 months after the initial 10 sessions.

Intervention Duration

Ten 1-hour core counseling sessions delivered within 4 to 6 months, followed by up to 7 maintenance booster sessions delivered every 3 months up to 45 months. Participants also received HIV testing and counseling every 6 months.

Significant Findings of the Intervention's Evaluation

Men in the intervention group were significantly less likely to report any unprotected anal sex, serodiscordant unprotected anal sex, and serodiscordant receptive unprotected anal sex at the 12- and 18-month follow-ups as compared to men receiving the standard comparison intervention (p's < .001).

Gender of participants during evaluation:: 100% M

Race: 72% W, 15% H, 7% AA, 6% O

Considerations

- A modest 18% reduction in HIV incidence, the primary outcome, was observed in the intervention relative to control arm, however, this did not achieve statistical significance.
- Few significant effects were reported at follow-ups longer than 18 months.

Female- & Culturally-Specific Negotiation **Target: African-American female drug injectors and crack cocaine smokers**

Delivery Unit: ILI **Training:** Not available

Replication Package: An intervention package is not available at this time. Contact Dr.

Claire Sterk, Emory University, Rollins School of Public Health, Department of Behavior Sciences and Health Education, 1518 Clifton Road N.E., Atlanta, GA 30322, e-mail: csterk@sph.emory.edu for details on intervention materials

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/female.htm

Description

The Enhanced Negotiation intervention includes 4 individual sessions that focus on the social context of women's daily lives. The intervention explores the meaning of gender-specific behaviors and social interactions, norms and values, and power and control. The intervention emphasizes the local HIV epidemic, sex- and drug-related risk behaviors, HIV risk reduction strategies, and the impact of race and gender on HIV risk and protective behaviors. Intervention sessions teach women correct condom use, safer injection, and communication and assertiveness skills. Women develop and evaluate their short-term goals for communication, gaining control, and developing assertiveness. Women learn to identify unhealthy triggers that can lead them to deviate from their goals and to develop a tailored negotiation and conflict resolution style.

Intervention Duration

Four 20 to 40 minute sessions delivered over a 3 to 4 week time span

Significant Findings of the Intervention's Evaluation

At 6-month follow-up, the Enhanced Negotiation intervention group reported significantly greater reductions in the proportion of women who had a paying sex partner ($p < 0.05$), the proportion of women who traded sex for money or drugs ($p's < 0.01$), and the mean number of injections ($p < 0.05$) than women who received the NIDA standard intervention.

- The women in the Enhanced Negotiation intervention also reported significantly greater reductions in frequency of alcohol use during sex ($p < .001$) than women receiving the Enhanced Motivation comparison intervention at 6 months.
- Crack-smoking women who received the Enhanced Negotiation intervention reported a significantly greater reduction in the number of times they had sex with a paying partner ($p < .001$) and a significantly greater increase in condom use with steady partners ($p < .01$) than crack-smoking women receiving the NIDA standard at 6 months. They also reported a significantly greater reduction in the number of sex acts with a paying partner ($p < .001$) than women receiving the Enhanced Motivation intervention at 6 months.

Gender of participants during evaluation:: 100% F

Race: 100% AA

Considerations

Other outcomes related to intervention goals (number of days injecting heroin or speedball, number of paying partners for vaginal sex) yielded non-significant findings in the hypothesized direction.

Focus on Kids (FOK) **Target: Low-income Black youth (9-15)**

Delivery: GLI **Training:** Under development

Replication Package: A package of the primary 8-session intervention series is currently available from ETR Associates, 4 Carbonero Way, Scotts Valley CA 95066-4200. The FOK intervention is currently being packaged as Focus on Youth (FOY) with funding from CDC's DEBI project. The FOY package and training will be available soon. Contact DEBI Technical Monitor Winifred King, 404-639-0892, email: WKing@cdc.gov, for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/FOK.htm

Description

Focus on Kids (FOK) is an 8-session intervention delivered to small naturally formed peer friendship groups (3-10 youths) via discussions, games, and multimedia formats. The intervention consists primarily of seven 90-minute sessions focused on decision-making, which include discussions concerning extrinsic (social approval) rewards with exercises related to communication and negotiating skills and information regarding the high prevalence of peer condom use. Other discussions focus on intrinsic (personal pleasure) rewards and emphasize values clarification and goal setting. Facts regarding AIDS, STDs, contraception, and human development are presented and condoms are provided. In the seventh session, youths develop community projects with specific target audiences and intervention messages. The primary intervention series concludes with the eighth session, which is an all-day field trip in which projects are presented and a "graduation" ceremony is conducted. The intervention is followed by monthly and annual booster sessions in which youth are given specific challenges to work through to reinforce the skills (e.g., decision making, communication, and condom use) they acquire in the primary sessions.

Intervention Duration

Eight weekly meetings: seven 90-minute sessions and one day-long session plus monthly and annual 90-minute booster sessions

Significant Findings of the Intervention's Evaluation

Sexually active FOK intervention participants were significantly less likely to report unprotected sex compared to those in the comparison at the 18-month follow-up ($p < .05$)

Gender of participants during evaluation: *56% M, 44% F*

Race/ethnicity of evaluation sample: *AA*

Considerations

- This intervention fails to meet the best-evidence criteria due to low retention rates and small analytical sample sizes.
- While the intervention meets promising-evidence criteria based on the 18-month findings, findings at the 24- and 36-month follow-ups do not meet the criteria because of low retention rates and small sample sizes.
- Significant intervention effects for unprotected sex were not found at the shorter follow-ups or maintained at the 24- and 36-month follow-ups, probably due to the small sample sizes at those follow-ups.
- Intervention effects were not found to be significant for the other relevant outcomes at any follow-up, probably due to small sample sizes.

- Very few participants attended the booster sessions, which led the researchers to the conclusion that boosters did not affect findings and to the decision not to include booster sessions in the current intervention package.
- Agencies interested in FOK, may also be interested in FOK+ImPACT. The FOK+ImPACT intervention, which includes the 8 FOK sessions plus the single parent-child session from ImPACT focusing on parental communication, has been identified as a best-evidence intervention. The FOK+ImPACT intervention is currently being packaged as Focus on Youth with ImPACT (FOY with ImPACT) with funding from CDC's Diffusion of Effective Behavioral Interventions (DEBI) project. The FOY with ImPACT package and training will be available through DEBI soon. Contact DEBI Technical Monitor Winifred King, 404-639-0892, email: WKing@cdc.gov, for details on intervention materials.

FOK + ImPACT

Renamed Focus on Youth with ImPACT by CDC

Target: Black High-Risk Youth (9-15) and their Parents

Delivery Unit: GLI

Training: Training will be available through CDC's DEBI project.

Replication Package: The FOK+ImPACT intervention has been packaged as Focus on Youth with ImPACT, and training will be available through the DEBI project. Contact DEBI Technical Monitor Winifred King, 404-639-0892, email: WKing@cdc.gov, for information,

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/FOK-ImPACT.htm

Description

FOK+ImPACT is a skill-building intervention to reduce substance and sex risk behaviors of high-risk youth. The first component, FOK, is an 8-session HIV risk reduction intervention delivered to small groups of 5-12 youth. The intervention emphasizes decision-making, goal setting, communication, negotiation, and consensual relationships. Through the use of games, discussions, homework, and videos, youth receive information on abstinence and safe sex, drugs, alcohol, drug selling, AIDS and STDs, contraception, and human development. ImPACT, the second component, is a single-session intervention delivered to each youth and his/her parent or guardian. ImPACT begins with a 20-minute video emphasizing parental monitoring and communication. After the video, the parent and youth role-play a vignette where the parent is confronted with evidence of a child's involvement in a sexual relationship. Finally, the youth and parent are taught and practice correct condom use.

Intervention Duration

The 9 intervention sessions (8 for FOK and 1 for ImPACT) last approximately 1.5 hours each, and are generally delivered one session per week. ImPACT is delivered to the parents at the beginning of the FOK delivery.

Significant Findings of the Intervention's Evaluation

At the 6-month follow-up, youth receiving the FOK+ImPACT intervention who were sexually active at baseline reported significantly lower rates of sexual intercourse ($p = .05$) and unprotected sex ($p = .005$) than youth in the FOK only comparison.

Gender of participants during evaluation:: 42% M, 58% F

Race: 100% AA

Considerations

- Compared to the FOK only comparison group, youth who received the FOK+ImPACT intervention were less likely to report other risk behaviors, including: cigarette smoking at 6 and 24 months, alcohol use at 6 and 12 months, marijuana use at the 12-month follow-up, and been pregnant or gotten a girl pregnant at 24 months.
- The FOK+ImPACT+Booster intervention, which included booster sessions at 7, 10, 13, and 16 months, did not meet the best evidence criteria. A significantly larger percent of youth participating in this intervention reported a pregnancy compared to youth participating in the FOK+ImPACT intervention at 24 months.

Healthy Relationships **Target: HIV-positive Individuals**

Delivery Unit: GLI **Training:** Training is available through CDC's DEBI project.

Replication Package: The intervention package and training are available through CDC's DEBI project.

Additional information: http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/healthy-relationship.htm

Description

Healthy Relationships is a small-group, skills-based behavioral intervention for men and women living with HIV. The intervention focuses on skills building, self-efficacy, and positive expectations about new behaviors. Through group discussions, role plays, videos and skill-building exercises, the intervention helps persons living with HIV develop skills to cope with HIV-related stressors and risky sexual situations. Intervention sessions also enhance decision-making skills for self-disclosing HIV-serostatus to sex partners, and help participants develop and maintain safer sex practices. Participants receive personalized feedback about their own risk practices, and with the help of the intervention group, develop strategies to maintain satisfying relationships while protecting both themselves and their partners. Intervention sessions are conducted separately for men and women in groups of 6-10 participants

Intervention Duration

Five 2-hour sessions, with 2 sessions delivered weekly for 2.5 weeks

Significant Findings of the Intervention's Evaluation

- At both the 3- and 6-month follow-ups, participants in the Healthy Relationships intervention reported significantly fewer occasions of unprotected vaginal/anal sex with non-HIV+ partners than those in the comparison intervention.
- At the 6-month follow-up, intervention participants significantly reduced their total number of occasions of vaginal/anal sex and occasions of unprotected vaginal/anal sex, and reported fewer non-HIV+ partners than participants in the comparison group.

- Finally, intervention participants reported a significantly greater proportion of condom use for vaginal/anal sex and refusal of unsafe sexual practices at the 6-month follow-up than comparison group participants.

Gender of participants during evaluation:: 70% M, 29% F, 1% transgender

Race: 74% AA, 22% W, 4% O

Considerations

- The comparison group participants were unexpectedly, but significantly, more likely to have refused unsafe sexual practice at the 3-month follow-up. This finding was reversed at the 6-month follow-up.

HIP **Target: Heterosexual Men & Women**

Delivery Unit: GLI **Training:** None Available

Replication Package: An intervention package is not available at this time. The intervention manual is available on the principal author's website. Contact Dr. Michael P. Carey, Center for Health and Behavior, 430 Huntington Hall, Syracuse University Syracuse, NY 13244-2340, e-mail: mpcarey@psych.syr.edu, for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/HIP.htm

Description

The *Health Improvement Project (HIP)* intervention is a small group, skills training intervention to reduce risky sex behavior among persons with mental illness. Through interactive group discussions and motivational exercises, the first 4 sessions provide participants the facts about sexual behavior, HIV, and STDs; increase awareness of HIV risk; offer healthy alternatives to unsafe sex; discuss social norms concerning risky and safe sex; and address the benefits and costs of behavior change. Through the use of role plays, the remaining 6 sessions provide participants the skills necessary to use male and female condoms, develop coping strategies to deal with risky situations, and negotiate condom use with sex partners. Standard outpatient psychiatric care—including medication, psychotherapy and case management—is also provided on an ongoing basis.

Intervention Duration

10 sessions delivered twice weekly for 5 weeks

Significant Findings of the Intervention's Evaluation

- Over 6 months of follow-up, patients in the HIV risk reduction intervention showed greater significant reductions in their frequency of unprotected vaginal sex (p=.004 and p=.001) and number of casual sex partners (p=.001 and p=.015) than patients in the standard care group and substance use reduction intervention, respectively.
- Patients in the HIV risk reduction intervention also reduced their total number of sex partners significantly greater than patients in the standard care group (p=.037).
- Compared to patients in the substance use reduction intervention, those in the HIV intervention reported a significantly greater increase in safer sex communication over time (p=.001).

Gender of participants during evaluation: 45% M, 54% F

Race: 67% White, 21% African American, 12% other

Considerations

- Women were more responsive than men to the HIV intervention with regard to frequency of unprotected vaginal sex. Patients diagnosed with a major depressive disorder were more likely to benefit from the intervention then patients diagnosed with schizophrenia or bipolar disorder.

HIV Education and Testing **Target: Black Heterosexual Men and Women**

Delivery: GLI **Training:** Not Available

Replication Package: An intervention package is not available at this time. Please contact Dr. Neil S. Wenger, UCLA Division of General Internal Medicine and Health Services Research, 911 Braxton Plaza, RM 309, Los Angeles, CA 90095-1736. email: nwenger@mednet.ucla.edu for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/HIV_Education-Testing.htm

Description

The intervention consists of an educational component and an HIV blood test for STD patients. The educational component includes a (a) written pamphlet that explicitly discusses safe and unsafe sexual acts and explains condom use; (b) 15-minute video that examines HIV risk behavior, promotes condom use, and discusses potential risks with sex partners; and (c) 10-minute, one-on-one counseling session with a physician. The counseling session, which includes all usual aspects of HIV pretest counseling, focuses on assessing personal risk, discussing the elements of HIV testing, and answering any questions about HIV/AIDS or testing. After completing the educational module, intervention participants have blood drawn for an HIV test. Test results are revealed approximately 2 weeks after study entry and are accompanied by the same risk reduction messages as those presented during the pre-test counseling (for seronegative results) or in-depth counseling (for seropositive results).

Intervention Duration

Two sessions approximately two weeks apart (one prior to and one after HIV testing)

Significant Findings of the Intervention's Evaluation
Intervention participants were significantly more likely than comparison participants to report having avoided vaginal or anal intercourse without a condom with their last sexual partner at 6 weeks after intervention ($p = .05$).

Gender of participants during evaluation: 67% Male, 33% Female

Race/ethnicity of evaluation sample: 88% African American, 12% Other

Considerations

- This intervention fails to meet the best-evidence criteria due to a short follow-up time.
- At 6 weeks after intervention, a significantly greater percentage of intervention participants used a condom, had only oral sex, or stated that they knew their partner's

HIV serostatus was negative compared to comparison participants ($p < .003$). The difference between the groups in protected sexual activity was greater when knowledge of a partner's risk factors was taken into account.

- Although both intervention and comparison groups received the AIDS Education module, the intervention effect should be considered in the context of AIDS Education and HIV testing combined rather than HIV testing only.
- This two-session AIDS Education + HIV testing intervention is similar to the more current HIV testing protocols described in the RESPECT project (see 2-session brief intervention). The RESPECT brief counseling intervention, which meets the best-evidence criteria, is theory-based, includes goal setting and exercises, was evaluated using a more rigorous design, larger sample size, more diverse sample, and had stronger intervention effects. The intervention package and training are available for the RESPECT brief intervention through CDC's REP and DEBI projects.

Insights **Target: Young Heterosexual Women**

Delivery: ILI **Training:** Not Available

Replication Package: An intervention package is not available at this time. Please contact Dr. Delia Scholes, Center for Health Studies, Group Health Cooperative, 1730 Minor Ave., Suite 1600, Seattle, WA 98101. email: scholes.d@ghc.org for details on intervention materials

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/insights.htm

Description

Insights is an individually-tailored minimal self-help intervention that consists of two prevention packets mailed to participants three months apart. The information in the packets is tailored to the individual based on a baseline risk assessment. The first packet includes a tailored 12-page self-help magazine-style booklet, called Insights, male and female condoms, a condom carrying case, and instructions on how to use condoms. The magazine-style booklet includes non-tailored and tailored elements. The tailored elements are pulled from a "library" of all possible prevention messages to coordinate with responses from the baseline risk assessment survey. The tailored messages are developed utilizing the stages of readiness to use condoms, beliefs and norms about condom use, intentions and efficacy to use condoms, perceived barriers/facilitators to use condoms, and perceived risk. Messages are also tailored based on the following participant characteristics: type of sex partner, ethnicity, binge drinking, STD history, number of sex partners, oral contraceptive use, and whether or not the participant had children. The booklet contains 11 sections – 4 generic sections and 7 sections with varying degrees of tailoring, including an advice column and testimonial stories. Three months later, the participants are mailed a follow-up tailored feedback newsletter, called *Extra Insights*. *Extra Insights* focuses on reinforcing messages, removing barriers, and enhancing facilitators to condom use and contains some information tailored to the 3-month telephone survey responses.

Intervention Duration

Risk assessment followed by two rounds of materials mailed approximately 3 months apart

Significant Findings of the Intervention's Evaluation

- At 2 months after intervention, sexually active participants in the intervention group were significantly more likely to use condoms during sex with any partner ($p = .0005$) and with a primary partner ($p = .0003$) than those in the comparison group. These findings were also demonstrated over the two assessment time points ($p = .0005$ and $p = .0001$, respectively).
- At 2 months after intervention, sexually active participants in the intervention group had a significantly greater percent of condom-protected sex with any partner ($p = .05$) than those in comparison group.

Gender of participants during evaluation: 100% Female

Race/ethnicity of evaluation sample: 69% White, 19% African American, 12% other

Considerations

- This intervention fails to meet the best-evidence criteria due to a short follow-up time.
- At 2 months after intervention, there were no differences in self-reported STD diagnoses among those sexually active in the prior 3 months between groups ($p = .93$). Detecting effects on STD diagnoses, however, was not a primary goal of the study.
- Sexually active participants who received the intervention in North Carolina were significantly more likely to report consistent condom use with all partners ($p = .002$) and reported a significantly greater percent of condom-protected sex with any partner ($p = .001$) than participants in the comparison group, at 2 months after the intervention.
- The intervention had a significantly positive effect on other non-relevant outcomes at 2 months after the intervention. Intervention participants were more likely to report carrying condoms in the prior 3 months ($p < .0001$), more likely to report discussing condom use with a male partner in the prior 3 months ($p < .01$), and had greater self-efficacy to use condoms ($p = .03$) than control participants.
- Almost all intervention participants (96%) recalled receiving one or both of the tailored self-help packets; and, of these, 60% reported reading at least some of the materials while another 33% reported "skimming" the materials.
- Face-to-face contact is not required to deliver this intervention; however, a risk assessment does need to be conducted to inform the prevention messages in the individually-tailored materials. In this study, the risk assessments were done using a computer-assisted telephone interview (CATI).
- Due to the intervention duration, the 6-month assessment is equivalent to a 2-month post-intervention follow-up for the intervention group but a 6-month follow-up for the comparison group.

Intensive AIDS Education **Target: Incarcerated, male adolescent drug users**

Delivery: GLI **Training:** Not Available

Replication Package: An intervention package is not available at this time. Please contact Dr. Stephen Magura, Director of Science and Research, National Development and Research Institutes, 71 West 23rd Street, 8th Floor, New York, NY, 10010. email: magura@ndri.org for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/intensive-AIDS-ed.htm

Description

This intervention is a four-session, small-group, interactive, AIDS education program based on problem solving therapy delivered to youth in jail. The intervention is delivered to small groups of 8 male inmates and focuses on relevant health education issues, emphasizing HIV/AIDS-related issues. The Problem-Solving Therapy approach is used to guide group discussions and includes the following steps: problem orientation, defining and formulating the problem, generating alternative solutions, decision-making, and implementing a solution. As part of the first step in the discussion – problem orientation – participants share and discuss facts and beliefs about HIV. Then, participants define and formulate the problem by identifying specific attitudes or behaviors that need to be modified in order to prevent against HIV. For generating alternative solutions, participants suggest and compile possible courses of action. During the decision-making step, participants critique and evaluate the alternative solutions. Finally, participants engage in role-play and rehearsal exercises to practice implementing the solution. Topics covered during the group discussions are general HIV education information, factors related to drug initiation or drug use, the meaning and consequences of sexual activity, and the relationship between drug use and sexual activity and HIV risk, and how to seek health care services, social services, and drug treatment.

Intervention Duration

Four 1-hour sessions delivered twice a week over a 2-week period

Significant Findings of the Intervention's Evaluation

Intervention participants reported a significantly greater frequency of condom use during vaginal sex than the control participants ($p = .02$, one-tailed test) at the 5-month or greater follow-up.

Gender of participants during evaluation: 100% M

Race/ethnicity of evaluation sample: 66% AA, 33% H, 2% W

Considerations

- This intervention fails to meet the best-evidence criteria due to a potential small to moderate bias resulting from the assignment method, low retention rates, and using a one-tailed test.
- Intervention participants reported significantly greater frequencies of condom use during anal and oral sex ($p= .04$, one-sided test) and during general (vaginal, anal, and oral) sex ($p = .002$, one-sided test) compared to the control participants at the 5-month or greater follow-up.
- Intervention participants had significantly more favorable attitudes towards condoms than control participants ($p = .05$, one-tailed test) at the 5-month or greater follow-up.
- The separate retention rates for the intervention and control groups were not reported and the original data are no longer available. The author conducted back-calculations to try to establish these follow-up rates. Follow-up rates as low as 59% in either group would be inconsistent with the published statistics; thus, the rate must have been greater

than 59% for both study groups. The author does not recall a follow-up rate of less than 60% for either group.

- The intervention and original research targeted male teens, including mostly youth aged 16 to 18, but the study sample also included a few 19 year olds who were in the detention center.

"light" **Target: Heterosexual Men & Women**

Delivery Unit: GLI **Training:** Under development

Replication Package: The intervention package has been completed but is not yet available from CDC. The CDC's REP website says "future availability of this intervention is uncertain." The intervention manual is available on the principal author's website. Contact Dr. Michael P. Carey, Center for Health and Behavior, 430 Huntington Hall, Syracuse University Syracuse, NY 13244-2340, e-mail: mpcarey@psych.syr.edu, for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/light.htm

Description

"light" (Living In Good Health Together) is a 7-session, small-group HIV-risk reduction intervention to stimulate motivation for behavior change along with individualized skill building required to accomplish personal HIV-related goals. The intervention covers topics, including HIV/AIDS knowledge, identification and management of triggers for risk acts, problem-solving in risk situations, condom use, interpersonal assertiveness to negotiate safer sex, and maintenance of new behavioral routines. Each session has a focus, but skills are reinforced and practiced throughout the 7 sessions. Each participant practices skills specific to his or her risk circumstances involving steady partners, casual partners, drug-using partners, and other personally relevant relationships. Goals to reduce risk are set every session and revised at the following session for feedback, review or problem-solving as appropriate. Each session contains scripted role plays and activities to facilitate group interaction and learning. The intervention is delivered to same-sex small groups of 5 to 15 persons twice weekly.

Intervention Duration

Seven 90- to 120-minute sessions conducted twice weekly.

Significant Findings of the Intervention's Evaluation

- Intervention participants reported significantly fewer unprotected vaginal and anal intercourse acts than comparison participants at each of three follow-ups and longitudinally over time (all p's < .0001). The intervention effect for this outcome was also found to be significant at each follow-up and longitudinally over time for the following subgroups: male STD clinic patients, female STD clinic patients, and female patients.
- Intervention participants reported significantly greater proportion of condom-protected vaginal or anal intercourse acts than comparison participants at each of three follow-ups and longitudinally over time (all p's < .0001). The intervention effect for this outcome was also found to be significant at each follow-up and longitudinally over time for the

following subgroups: male STD clinic patients, female STD clinic patients, and female patients.

- Intervention participants were more likely to report either consistent condom use or abstinence than comparison participants at each of three follow-ups and longitudinally over time (all p's < .0001). The intervention effect for this outcome was also found to be significant at each follow-up for male STD clinic patients and female patients, at the 3- and 12-month follow-ups for female STD clinic patients, and longitudinally over time for all subgroups.
- Intervention participants were less likely to report STD symptoms at one or more follow-ups than comparison participants (p = .001). The intervention effect for this outcome was also found to be significant for the following subgroups: male STD clinic patients, female STD clinic patients, and female patients.
- A significantly smaller percentage of intervention participants were diagnosed with incident gonorrhea (based on medical chart review) than comparison participants during the 12-month follow-up period (p < .05). This finding was also found to be significant among the subgroup of male STD clinic patients.

Gender of participants during evaluation:: 42% M, 58% F

Race: 74% AA, 25% H, 1% O

Considerations

- Intervention effect was consistent across racial/ethnic subgroups of African American and Hispanic.
- Participants who attended more "light" intervention sessions exhibited greater magnitudes of behavior change.
- Significant intervention effects were observed for self-reported STD symptoms and medical chart review of gonorrhea rates, but urine assessments for point prevalence of Chlamydia and gonorrhea were not found to be significant.
- The reduction of gonorrhea rates was found to be significant among men but not among women, which may be due to the fact that gonorrhea is more prevalent among men than women over the age of 24 years and is generally more symptomatic in men than women.

Modelo de Intervención Psicomédica (MIP) **Target: Hispanic / Latino Drug Injectors**

Delivery Unit: ILI **Training:** Training is available through CDC's DEBI project

Replication Package: Training is being developed by CDC and information is available on the DEBI project website.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/MIP.htm

Description

MIP is an intensive intervention that combines counseling and case management. The 6 one-on-one counseling sessions conducted by a registered nurse use motivational interviewing

strategies to engage injection drug users for behavior change. The first 3 counseling sessions focus on participants' motivation to change behavior, the development of a work plan to facilitate behavior change, encouragement to enter into drug treatment, and strategies for relapse prevention. Session 4 focuses on strategies participants can use to explain to their peers why they rejected the practice of needle sharing. Session 5 provides skill building for safer sex negotiation and correct male and female condom use. The final session reinforces self-efficacy to reduce risk behaviors and drug injection and to increase the use of health care and drug treatment services. The case management component involves active assistance from a case manager to help participants get through the intervention and to provide access to drug treatment, primary health care services, and other legal or social welfare services. Participants also received standard HIV counseling and testing

Intervention Duration

6 weekly sessions with ongoing case management

Significant Findings of the Intervention's Evaluation

At the follow-up, injection drug users receiving the MIP intervention reported a significantly greater reduction in continued injection drug use than those in the comparison group ($p = 0.04$). This significant reduction in injection drug use was also found among the subsample of drug injectors who entered drug treatment ($p < 0.05$). Among participants who continued to inject at follow-up, those receiving the MIP intervention were significantly less likely to report needle sharing than those receiving the comparison intervention ($p < 0.05$).

Gender of participants during evaluation: 89% M, 11% F

Race: 100% H

Considerations

There were no significant differences in sexual risk behaviors between the intervention and comparison groups at the follow-up.

Nia **Target: Black Heterosexual Men**

Delivery: GLI **Training:** Under development (estimated availability July 2010)

Replication Package: An intervention package is currently being developed with funding from CDC's Replicating Effective Programs (REP) Project. An intervention manual is available at: http://socialpsych.uconn.edu/downloads.html

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/nia.htm

Description

Nia is a video-based motivational skills-building small-group intervention consisting of 6-10 participants in each group. The intervention includes videos, movie clips, and discussion to educate men about HIV/AIDS, elevate their mood, and entertain them while reinforcing information and motivating behavior change. Facilitators discuss with participants ways to prevent HIV/AIDS, including condom use, condom attitudes and the pros and cons of condom use, and teach problem-solving, safer sex, and decision-making skills. Facilitators also teach male condom use skills through demonstration, modeling and practice with feedback using

penile anatomical models, as well as show and discuss female condoms. The intervention also teaches personal risk reduction and sexual communication skills such as negotiating safer sex, sexual assertiveness, and risk refusal through movie clips and discussion.

Intervention Duration

Two 3-hour sessions delivered over a week

Significant Findings of the Intervention's Evaluation

- The intervention participants reported significantly lower rates of unprotected vaginal intercourse than the comparison participants at the 3-month follow-up.
- At the 3-month follow-up, intervention participants reported a significantly greater proportion of condom-protected vaginal sex than comparison participants ($p < .05$), and a significantly greater proportion of intervention participants than comparison participants reported "almost always" using condoms ($p = .02$).

Gender of participants during evaluation: 100% M

Race/ethnicity of evaluation sample: 100% AA

Considerations

- This intervention fails to meet the best-evidence criteria due to small analytical sample sizes.
- While the intervention meets promising-evidence criteria based on the 3-month findings, findings at the 6-month follow-up do not meet the criteria because of small sample sizes.
- At the 3-month follow-up, relative to comparison participants, intervention participants reported significantly less alcohol use before sex ($p < .05$) and significantly less drug use in conjunction with sex ($p < .05$), and a significantly greater proportion of intervention participants reported talking with a partner about AIDS ($p = .01$).

Partnership for Health **Target: HIV-positive Men and Women**

Delivery: ILI **Training:** Available through the CDC-funded STD./HIV Prevention Training Centers (see below)

Replication Package: Dissemination of the PfH program is now coordinated through the Capacity Building Assistance Center at University of Texas Southwestern Allied Health Sciences School, 400 S. Zang, Suite 520, Dallas TX. 75208 : Attention: Daniel Casillas [Daniel.Casillas@UTSouthwestern.edu] (214) 645-7313. An intervention manual and other material are also available on the principal author's website.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/PfH.htm

Description

The *Partnership for Health* (PfH) Loss-frame intervention is a one-on-one, brief provider-administered safer sex intervention for HIV-positive persons in care. The intervention

emphasizes the importance of the patient-provider relationship to promote patients' healthful behavior. At each clinic visit, the provider delivers a brief counseling session (3-5 minutes) with messages that focus on self-protection, partner protection, and disclosure. Loss-framed messages are framed in a way that emphasizes the risks or negative consequences of risky behavior. The provider also uses the brochures, informational flyers and posters with the loss-framed messages to facilitate counseling and work with the patient to identify goals for the patient to work on.

Intervention Duration

A 3- to 5-minute session at every clinic visit over 10 to 11 months

Significant Findings of the Intervention's Evaluation

- Among HIV-positive patients who had 2 or more sex partners at baseline, those assigned to the Loss-frame intervention were significantly less likely to report unprotected anal/vaginal intercourse than those in the comparison group at 1 to 7 months after intervention ($p = .03$). This intervention effect was also found to be significant among men who have sex with men with 2 or more sex partners at baseline ($p = .04$).
- Among HIV-positive patients who had any casual/exchange partners at baseline, the Loss-frame intervention participants were significantly less likely to report unprotected anal/vaginal intercourse than the comparison participants at 1 to 7 months after intervention ($p = .04$).

Gender of participants during evaluation: 86% M, 14% F

Race/ethnicity of evaluation sample: 41% W, 37% H, 16% AA, 6% O

Considerations

- The Partnership for Health Loss-frame intervention fails to meet the best-evidence criteria due to a short follow-up time and low retention rates.
- Although, the Loss-frame intervention reduced unprotected anal/vaginal sex among HIV-positive patients with 2 or more sex partners, patients with one sexual partner at baseline were unaffected by the intervention.
- The Gain-frame intervention, which has the same format as the loss-frame intervention but emphasizes the benefits or positive consequences of protective behavior, fails to meet the promising-evidence criteria due to no statistically significant intervention effects on sex risk behaviors at the follow-up and low retention rates.
- This intervention could be considered a structural-level intervention as the entire clinic procedures were altered and all clinic patients received the intervention while only a sample of patients were included in the evaluation. Since the evaluation used a cohort design, which can be reviewed with these criteria, this intervention is included within this review and also will be updated later in the community-level and structural-level intervention section of the website.

Personalized Cognitive Risk-Reduction Counseling — **Target: White, Hispanic / Latino MSM**

Delivery Unit: ILI — **Training:** Not available

Replication Package: An intervention package is not available at this time. Contact Dr. James W. Dilley, Executive Director, AIDS Health Project, University of California, San Francisco, P.O. Box 0884, San Francisco, CA 94143-0884, e-mail: jdilley@itsa.ucsf.edu, for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/pcrrc.htm

Description

The Personalized Cognitive Risk-Reduction Counseling intervention (previously referred to as Self-Justifications Counseling) involves a single counseling session delivered to clients during the 1- to 2-week period between standard "pre-test" (risk-assessment) and "post-test" (results disclosure) HIV counseling. During the session, counselors ask the client to recall a recent encounter of unprotected anal sex with another man of unknown or serodiscordant HIV status. The client describes the encounter with as much detail as possible. The client is then encouraged to identify and express the thoughts, feelings, or attitudes that might have led to the high-risk behavior. Together, the client and the counselor examine the encounter to identify any thoughts that may have led the client to make a decision to engage in high transmission risk sex. Finally, the client and the counselor agree on strategies that can be used to deal with similar situations in the future.

An optional sex diary can be used to supplement the single counseling session. The diary asks clients to keep track of and describe all sex encounters for 90-days. The sex encounters include type of sex act (e.g., anal sex or oral sex), whether a condom was used, relationship to sex partners, and HIV serostatus of sex partners.

Intervention Duration

One session that lasts approximately 1 hour

Significant Findings of the Intervention's Evaluation

At 6- and 12-month follow-ups, men receiving the Standard + Personalized Cognitive Risk-Reduction Counseling intervention had a significant decrease in percent ($p < 0.002$ and $p = 0.001$, respectively) and in mean number of episodes ($p < 0.008$ and $p < 0.001$, respectively) of unprotected anal sex compared to those receiving standard HIV counseling alone.

Gender of participants during evaluation: 100% M

Race: 74% W, 11% H, 6% API, 3% AA, 6% O

Considerations

The addition of the diary to the Standard + Personalized Cognitive Risk-Reduction Counseling intervention also produced significant positive results, but did not produce results significantly better than those produced by the Standard + Personalized Cognitive Risk-Reduction Counseling intervention. Thus, the inclusion of the sex diary is optional.

Project AIM **Target: Low-income Youth (11-14)**

Delivery Unit: GLI **Training:** Under Development (Expected availability July 2010)

Replication Package: An intervention package is currently being developed with funding from CDC's Replicating Effective Programs (REP) Project. Contact Leslie Clark for additional

information on this intervention: Clark@chla.usc.edu

Description

Project AIM (Adult Identity Mentoring) is a strength-based, future-oriented program developed to steer at-risk youth away from risky behavioral choices by engaging them in defining their possible positive future adulthood. Project AIM provides specific problem-solving and goal-setting skills to support youth in imagining a successful adulthood. Project AIM is a HIV prevention program designed to address early adolescent (11-14 years old) risk, emergence of environmental risk (e.g. peer pressure), and the debilitating effects of poverty and racism. Through group activities and with youth-generated content, Project AIM provides for discussions about youths' life goals and current risky behaviors as barriers to achieving these goals.

Goals

The goal of Project AIM is to reduce sexual risk behaviors among low-income middle school youth by providing them with the motivation to make safe choices and to address deeper barriers to sexual risk prevention (e.g. hopelessness, poverty, risk opportunities in low income environments). Project AIM is especially appropriate for youth impacted by racism and poverty, who live in areas where adolescent risk behaviors are high and perceive their future opportunities as limited.

How it Works

Project AIM is a youth development, group-level intervention designed to encourage young people to think about their desired future and how current risky behavior choices can adversely affect it. The program enhances youths' skills to articulate their personal goals and uses exercises to teach them the skills required to achieve these goals. Small groups and role models are used to create and sustain group norms of delaying or abstaining from behaviors that could disrupt achievement of their goals. In these ways, the program promotes youth to take responsibility for and invest in their future by setting goals, persevering in their efforts, and reaching out to resources to protect their future.

Core Elements

1. Engage youth in thinking about a positive possible future self
   - ✓ Look ahead to the future as successful adults.
   - ✓ Envision a positive future self.
   - ✓ Set goals and plans to achieve a positive future as an adult.
   - ✓ Articulate the specific details of a positive future self.
2. Engage youth in present actions to achieve future success
   - ✓ Promote skills to achieve effective communication
   - ✓ Identify strengths and the resources needed for future success
   - ✓ Experience success experiences to reinforce youths' positive future self
3. Encourage youth to safeguard the likelihood of a positive future self through risk reduction
   - ✓ Help youth develop strategies to protect the likelihood of a positive future

Implementation Core Elements

4. Use two skilled and trained facilitators whom youth find credible to deliver Project AIM.
5. Deliver multiple intervention sessions, with sufficient time between sessions for youth to process information they are learning, draw conclusions, and invest in their goals

Intervention Duration

Project AIM is implemented twice a week, over a six-week period. It is a 12-session program delivered by 2 facilitators. Each session lasts for 50 minutes. Project AIM has been packaged for agency or school settings and can be delivered by a variety of staff (educator, social worker, activities leader, and counselors).

Significant Findings of the Intervention's Evaluation

Project AIM has been rigorously tested in a behavioral trial of 240 African American seventh graders using random assignment of health education classes to Project AIM or what was the usual curriculum for the health education class. [1] Results showed that the 12-session curriculum was effective in reducing sexual intentions, increasing sexual abstinence, and delaying initiation among virgins. A secondary set of analyses showed that Project AIM participants also improved in academic outcomes and decreased in school suspensions.

Gender of participants during evaluation: 50% M, 50% F

Race: 55% AA, 39% H, 6% O

Project Connect **Target: Black and Hispanic/Latino couples or women only**

Delivery Unit: GLI **Training:** Under Development (estimated availability October 2009)

Replication Package: An intervention package is currently being developed with funding from CDC's Replicating Effective Programs (REP) Project. Contact Dr. Nabila El-Bassel, Social Intervention Group, Columbia University School of Social Work, 622 West 113th Street, Box 713, New York, NY 10025, e-mail: ne5@columbia.edu, for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/project-connect.htm

Description

The Project Connect can be delivered to the couple or the woman alone. The Couples intervention consists of an orientation session and 5 relationship-based sessions delivered to each couple. An initial orientation session is delivered one-on-one to each woman and her partner. The orientation session increases participants' motivation for attendance, heightens risk awareness, and prepares participants for the intervention. The 5 relationship-based sessions are delivered to intact intimate couples (i.e., a woman and her regular male sex partner). These sessions emphasize the importance of relationship communication, safer sex negotiation and problem solving skills. The sessions also highlight how relationship dynamics are affected by gender roles and how social supports can help maintain safer sex behavior. The intervention

delivered to each woman alone is identical in content and session format as the Couples intervention.

Intervention Duration

Six 2-hour sessions delivered over 6 weeks

Significant Findings of the Intervention's Evaluation

The Couples and Woman-alone interventions each significantly increased the proportion of protected vaginal sex acts compared to the Education control ($p \leq .05$ for each comparison). The Woman-alone intervention significantly reduced the number of unprotected vaginal sex acts when compared to the education control ($p \leq .05$).

Gender of participants during evaluation: 50% M, 50% F

Race: 55% AA, 39% H, 6% O

Considerations

No significant differences were reported between couples receiving the intervention together or women receiving the intervention alone.

Project FIO (8 session) **Target: Black Heterosexual Women**

Delivery Unit: GLI **Training:** Not available

Replication Package: An intervention package is not available at this time. Contact Dr. Anke A. EHigh-riskhardt, HIV Center for Clinical and Behavioral Studies, 1051 Riverside Drive, New York State Psychiatric Institute Unit 15, New York, NY 10032, e-mail: eHigh-riskharda@child.cpmc.columbia.edu, for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/FIO.htm

Description

Project FIO (the Future Is Ours) is a small group, cognitive-behavioral intervention. The interactive sessions allow women to connect with each other by sharing their feelings about relationships with men, values and personal vulnerability. Women learn to understand and personalize their risk for HIV and other STDs, identify barriers to safer sex, and gain practical knowledge about a range of risk-reduction strategies, including male and female condoms and mutual HIV testing. The intervention provides women with the skills necessary to communicate and negotiate safer sex with their partners (including how to identify and respond to abuse in relationships), and how to solve problems to avoid relapses. A single booster session reviews progress and reinforces the skills learned in the intervention in the supportive group environment.

Intervention Duration

Eight 2-hour sessions delivered over 8 weeks, followed by a 2-hour booster session delivered about 7 months after completion of the intervention

Significant Findings of the Intervention's Evaluation

At 5 months post-booster, women in the 8-Session FIO intervention group reported significantly fewer unprotected vaginal or anal intercourse occasions (p<.001) and a greater proportion of condom-protected occasions than women in the control group.

- Among women engaging in unprotected sex at baseline, those assigned to the 8-session intervention were twice as likely to report decreased unprotected sex (OR=2.08, 95% C.I.=1.06, 4.10, p = .03) and reported significantly fewer unprotected vaginal or anal intercourse occasions (p<.001).

Gender of participants during evaluation: 100% F

Race: 73% AA, 17% H, 10% W, 0.3% API

Considerations

- Significant effects for the 8-session intervention were reported at the 12-month follow-up, which occurred approximately 5 months after completion of the booster session.
- The 4-session intervention, which covered comparable content to the 8-session intervention, was not found to significantly reduce sex risk behaviors at either the 6- or 12-month follow-ups.

Project S.A.F.E. (Standard Version) **Target: Black and Hispanic/Latina Heterosexual Women**

Delivery Unit: ILI, GLI **Training:** Not available

Replication Package: An intervention package is currently available for purchase from Sociometrics, Inc.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/SAFE.htm

Description

The Standard SAFE intervention is a small group, motivational and skill building intervention to reduce risky sexual behaviors and STDs among minority women. The 3 intervention sessions, delivered to groups of 5-6 women, emphasize recognizing risk, increasing commitment to change behavior, and facilitating the acquisition of protective skills. Women participate in group discussions to increase awareness of AIDS and other STDs and prevention methods, address myths of HIV acquisition, increase awareness of personal risk, and discuss relationship issues and barriers to condom use. Women are taught how to ask partners about their current behaviors, apply condoms, and make safer decisions regarding sexual health. Preventive strategies discussed included abstinence, monogamy, correct condom use, and reducing the number of sex partners. Through videotapes, games, discussions and practice, women learn skills to facilitate communication and negotiation of safer sex, raise feelings of self-efficacy in partner selection and communication about condom use, identify triggers to unsafe sex, and encourage the sharing of information with others to build a support network. Standard STD counseling and testing is also provided to everyone by a nurse clinician.

Intervention Duration

Three 3-hour sessions delivered over 3 weeks. Ongoing STD counseling, testing, and treatment is also provided to everyone.

Significant Findings of the Intervention's Evaluation

- At the 1 year follow-up, the women in the Standard SAFE intervention were significantly less likely to report unprotected sex with untreated or incompletely treated partners ($p = 0.001$) than women in standard care.
- In addition, women in the Standard SAFE intervention were significantly less likely to report having more than one sexual partner at the 1 year follow-up ($p = 0.001$), at the 2 year follow-up, ($p < 0.005$) and across all follow-up ($p < 0.002$) compared to women receiving standard care.
- Women who received the Standard SAFE intervention were significantly less likely to acquire a new STD during the 1st year follow-up ($p = 0.006$), during the 2nd year follow-up ($p = 0.03$), and over the entire 2 year follow-up ($p < 0.008$) than women in the standard care comparison.

Gender of participants during evaluation: 100% F

Race: AA 77% H, 23%

Considerations

- The Enhanced SAFE intervention, which consisted of the Standard SAFE intervention plus 5 monthly 90-minute support group sessions, compared to the standard care intervention, produced results similar to those of the Standard SAFE intervention. The Standard SAFE intervention is highlighted here since it does not require the optional support group sessions.

RESPECT **Target: Heterosexuals**

Brief Counseling *(Best Evidence)*

Enhanced Counseling *(Promising Evidence)*

Delivery Unit: ILI **Training:** Available through the DEBI project

Replication Package: The intervention package and training are available through CDC's DEBI) project.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/RESPECT.htm

Description

There are two RESPECT interventions – Brief Counseling (Best-evidence) and Enhanced Counseling (Promising-evidence). Both are one-on-one, client-focused HIV/STD prevention counseling interventions, consisting of either 2 (Brief) or 4 (Enhanced) interactive counseling sessions. In the first session (20 minutes) of both *Brief* and *Enhanced Counseling* interventions, HIV counselors help STD clinic patients to identify personal risk factors and barriers to risk reduction and work with patients to develop an achievable personalized risk-reduction plan. HIV-antibody testing is offered at the end of the first session. The second session of the *Brief Counseling* intervention (20 minutes) includes a discussion of the HIV test result and additional counseling to support patient-initiated behavior change and help patients develop a longer-term risk-reduction plan. Patients in the *Enhanced Counseling* intervention receive three weekly 60-minutes counseling sessions in addition to the first session. The additional sessions address condom use attitudes, social norms and support for condom use, build condom use self-efficacy, discuss prior week's behavior change success and barriers, and develop a strategy for taking a risk-reduction step before the next session. HIV test result is given at the end of the third session and a longer-term personalized risk reduction plan is developed at the last session.

Intervention Duration

Brief Counseling: Two 20-minute sessions (40 minutes total) delivered over 7-10 days
Enhanced Counseling: One 20-minute and three 60-minute sessions (200 minutes total) delivered over 3-4 consecutive weeks

Significant Findings of the Intervention's Evaluation

Brief Counseling intervention compared to Didactic Messages (Best Evidence):

- The Brief Counseling intervention group had a significantly lower rate of new STD infections over the 5 and 11 months after intervention (all ps < .05) than the comparison group.
- A significantly greater percentage of Brief intervention participants reported no unprotected vaginal intercourse than comparison participants at 5 months after intervention ($p < .05$).
- Additionally, the following findings met the promising evidence criteria: at 2 months after intervention, a significantly greater percentage of Brief intervention participants than comparison participants reported no unprotected vaginal intercourse, ≤ 1 sex

partner, no causal partners, no new sex partner, and condom use with other partners during last sex episode (all p's < .05).

Enhanced Counseling compared to Didactic Messages (Promising Evidence):

- The Enhanced intervention group had a significantly lower rate of new STD infections over the 5-month and 11-month periods after intervention (all ps < .05) than the comparison group.
- At 2 months after intervention, a significantly greater percentage of Enhanced participants than comparison participants reported no unprotected vaginal intercourse, any condom used, and having ≤ 1 sex partner in past 3 months, and condom use with primary partner and condom use with other partner in the last sex (all ps < .05). A significant intervention effect was also found for any condom use at 5 months after intervention ($p < 0.05$).

Gender of participants during evaluation: 57% M, 43% F

Race: 59% African American, 19% Hispanic, 16% White, 6% Other

Considerations

- The Brief Counseling intervention is considered to meet the best-evidence criteria. The Enhanced Counseling intervention did not meet the best-evidence criteria due to the retention rates, but met the promising-evidence criteria.
- While both Brief and Enhanced Counseling interventions are effective in reducing new STD infections over the 5-month and 11-month periods after intervention, the intervention effects on sex risk behaviors were not found to be significant beyond 5 months after intervention.

RESPECT Brief Counseling + Booster **Target: Heterosexuals**

Delivery Unit: ILI **Training:** Not Available

Replication Package: An intervention package is not available at this time. Please contact Dr. Thomas A. Peterman, Centers for Disease Control and Prevention, Mailstop E-02, 1600 Clifton Road NE, Atlanta, GA 30333, for details on intervention materials

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/RESPECT-2.htm

Gender of participants during evaluation: 54% M, 46% F

Race: 51% AA, 22% W, 18% H, 9% O

Significant Findings of the Intervention's Evaluation

- At 3 months after intervention, a significantly smaller percentage of intervention participants than comparison participants reported the following sex risk behaviors: ≥ 2 sex partners, unprotected sex with non-primary partner, sex with a new partner on day of meeting, and sex with a 1-time partner (all p's < .05).

- Among female clinic patients, a significantly smaller percentage of intervention participants reported sex with a 1-time partner than comparison participants at 3 months after intervention ($p < .05$).
- Among men who did not have male partners at enrollment, a significantly smaller percentage of intervention participants than comparison participants reported ≥ 2 sex partners and unprotected sex with non-primary partner at 3 months after intervention (all p's < .05).

Considerations

- The Brief Counseling + Booster intervention was not more effective than Brief Counseling alone in reducing new STD infections during the 6-month period after booster counseling.
- The intervention effect was significant in reducing sex risk behaviors at 3 months, but not at 6 months after intervention.
- Participants were tested for HIV at enrollment using either a rapid or standard HIV test. The type of testing method did not significantly modify the intervention effects, so the effects of the booster counseling reported above are based on all subjects combined, regardless of type of HIV test.

Description

The RESPECT Brief Counseling + Booster intervention is a one-on-one, client-focused HIV/STD prevention intervention, consisting of two 20-minute interactive counseling sessions and one 20-minute booster session approximately 6 months later. The intervention is based on the 2-session model used in Project RESPECT Brief Counseling Intervention. HIV counselors help STD clinic patients identify personal risk factors and barriers to risk reduction, work with patients to develop an achievable personalized risk-reduction plan, and support patient-initiated behavioral change. At the initial clinic visit, STD clinic patients receive the first counseling session and are tested for HIV with either a rapid or standard HIV test. HIV test results and the second counseling session are given at the end of the initial clinic visit (rapid test group) or 1 week later (standard test group). The additional booster counseling session reinforces the previous counseling and includes a review of the risk-reduction plan, a revised risk assessment, the negotiation of a new risk-reduction plan, and identification of sources of support in carrying out the risk-reduction plan.

Intervention Duration

Two 20-minute sessions delivered in one day (rapid test group) or 1 week apart (standard test group) and a single 20-minute booster session delivered 6 months after the initial clinic visit

Safer Sex **Target: Adolescent Heterosexual Women**

Delivery: ILI **Training:** Not Available

Replication Package: An intervention package is not available at this time. Please contact Dr. Lydia Shrier, Division of Adolescent/Young Adult Medicine, Children's Hospital, 300 Longwood Avenue, Boston, MA 02115. email: sHigh-riskier@a1.tch.harvard.edu for details on intervention materials.

Additional information:

http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/SaferSex.htm

Description

Safer Sex is an individualized skills-building intervention designed to increase condom use, reduce other risky sexual behaviors and prevent recurrent STDs among female adolescents. The 1-session intervention begins with a 7-minute video to normalize condom use. The video highlights condom types, purchasing condoms, condom negotiation, and demonstrated condom use. Each participant completes a stage of change self-assessment exercise to identify their thoughts about changing their sexual risk behaviors. A female health educator reviews the video, discusses STD transmission and abstinence, and individualizes the session, based on the participant's stage of change. Topics included imparting information about unsafe sex, risk perception, pregnancy, condoms, talking about sex, and pros and cons about condom use. Each participant can role-play condom use negotiation, if ready, and is shown how to use a female condom. Each participant is instructed in correct male condom use and allowed to practice with a penile model. Written materials about safer sex and condoms are provided. Follow-up boosters are conducted with the educator, at 1, 3, and 6 months after this initial session to discuss interim sexual behavior, review the intervention, view the video if interested, and provide condoms and written materials.

Intervention Duration

One session, over 30 minutes in length, followed by three booster sessions at 1, 3 and 6 months after randomization

Significant Findings of the Intervention's Evaluation

At 3 months after second booster, intervention participants were less likely than comparison participants to report having a non-main sexual partner ($p = .01$).

Gender of participants during evaluation: 100% F

Race/ethnicity of evaluation sample: 49% AA, 18% H, 17% O, 14% W

Considerations

- This intervention fails to meet the best-evidence criteria due to small sample sizes.
- This significant finding was shown 3 months after the initial intervention session and two of the three planned booster sessions.
- While the intervention meets promising-evidence criteria based on the findings 3 months after the third booster, findings at other time points do not meet the criteria due to no statistically significant intervention effects on sex risk behaviors or STD recurrence, low retention rates, or small sample sizes.
- Reducing the number or type of sexual partners was not a primary outcome of interest.
- The primary relevant outcomes of interest, condom use and recurrence of STDs, were not found to be significantly different by study group at the .05 alpha level. At 6 months (a 3-month follow-up) there were slightly more intervention participants reporting condom use at last sex than comparison participants ($p = .09$). And, at 12 months (a 6-month follow-up), fewer intervention participants reported having a recurrent STD than comparison participants, although this was not statistically significant ($p = .17$).
- Although not considered as sufficient findings to meet the promising-evidence criteria, intervention participants had greater levels of sexual risk knowledge ($p = .02$) and

positive attitudes toward condoms (p = .007) one month after the initial session and higher positive attitudes towards condoms (p = .007) at 6 months (a 3-month follow-up).

- The intervention and original research targeted youth at a children's hospital, but included young adults up to 22 years old in the study sample

Safety Counts **Target: IDUs**

Delivery: GLI, ILI **Training:** Available through the CDC's DEBI project

Replication Package: The intervention package and training are available through CDC's DEBI project

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/safetycounts.htm

Description

The *Safety Counts* intervention consists of a total of 9 sessions focusing on developing and implementing a personalized risk reduction plan. First, 2 individual standard pre- and post-test counseling sessions incorporate drug-focused prevention education to review basic HIV/AIDS information and provide optional HIV testing and counseling. Next, 2 interactive group workshop sessions, employing stages of change framework, are implemented with structured exercises involving 3-7 clients to help them develop a personal HIV risk reduction plan, consider potential barriers and solutions, identify sources of social support through group discussion, view role model videos, and complete 2 worksheet exercises to identify their own HIV risks and place themselves in on a stages-of-change continuum for each risk behavior. Then a one-on-one individual counseling session is conducted to refine the client's personal risk reduction plan, strengthen commitment to personal goals, ensure availability of social support for risk reduction, and assess and arrange referral needs. One month after the client receives the individual counseling session, a minimum of two 15-20 minute field-based supportive follow-up outreach contacts are scheduled to reinforce progress toward risk reduction and encourage achievement and maintenance of personal risk reduction goals. Also, a minimum of 2 monthly social events, each lasting 2 hours, are provided, including lunch and planned HIV risk reduction activities, games, and skits for clients and their peer support buddies (15-25 clients and 10-15 guests) to provide support for HIV risk reduction, influence perceived social norms, and increase self-efficacy for reducing HIV risks. Lastly, food bank grocery bags and food coupons are made available to clients in storefront offices as a program incentive every other week.

Intervention Duration

Nine sessions over a 4-6 month period

Significant Findings of the Intervention's Evaluation

- The participants in the Enhanced intervention were significantly less likely to report injecting drugs ($p < 0.05$) than those in the Standard at 1 to 5 months after intervention.
- Among injectors only, the percentage of times people did not use their own works was significantly lower in the Enhanced intervention compared to the Standard at 1 to 5 months after intervention ($p < 0.05$).

Gender of participants during evaluation: 67% M, 33% F

Race/ethnicity of evaluation sample: 47% AA, 28% W, 20% H, 4% AI, 1% API

Considerations

- This intervention fails to meet the best-evidence criteria due to assigning groups of individuals to study conditions while analyzing at the individual level, a small number of participants being excluded from analyses after assignment, and a short follow-up time.
- There were three significant baseline demographic differences. The standard intervention group included more Hispanics (23% vs. 19%), fewer Asians (0.6% vs. 2%), and fewer married people (8% vs. 12%) than the Enhanced intervention group.
- Of the 687 participants assigned to the Enhanced intervention group, 462 (67%) did not receive all 9 sessions as allocated, whereas only 61 (9%) of the 675 participants assigned to the Standard intervention participants did not receive the full 2 sessions as allocated.
- Among those that completed the intervention as allocated, participants in the Enhanced group were significantly less likely to report having sex at follow-up compared to those in the standard group ($p < .05$). This finding does not satisfy promising-evidence efficacy criteria due to a potentially biased restriction based on complete exposure.
- Among those that completed at least 7 out of 9 sessions, participants in the Enhanced group were significantly more likely to report an increase in condom use from baseline to follow-up as compared to those in the Standard group ($p = .01$). This finding does not satisfy promising-evidence efficacy criteria due to a potentially biased restriction based on complete exposure.
- Among injectors that completed at least 7 out of 9 sessions, participants in the Enhanced group were significantly more likely to report decreases in high-risk drug behaviors from baseline to follow-up – stopped injecting drugs, $p < .001$, decreased number of days injected drugs, $p = .001$, decreased frequency of injecting drugs, $p < .001$ – as compared to those in the Standard group. These findings do not satisfy promising-evidence efficacy criteria due to a potentially biased restriction based on complete exposure.

SEPA (Salud, Educación, Prevención y Autocuidado) **Target: Hispanic/Latina Women**

Delivery: GLI **Training:** Not available

Replication Package: An intervention package is not available at this time. Contact: Dr. Nilda Peragallo, University of Miami School of Nursing, PO Box 248153, Coral Gables, FL 33124, e-mail: nperagallo@miami.edu for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/SEPA.htm

Description

SEPA is a six-session, culturally-tailored, small-group, skills building intervention designed to prevent high-risk sexual behaviors among low-income Mexican and Puerto Rican women. The intervention, delivered to groups of 11-13 women, promotes self-efficacy, builds skills and focuses on topics including: HIV/AIDS in the community, human anatomy and sexuality,

education about HIV and other STDs, condom use, negotiation of safer sex, and preventing domestic violence. The intervention content and prevention messages are delivered using several methods, including: group discussions, videos, hands-on activities, role playing, skills demonstration, quizzes, and homework to build self-efficacy. Skills building activities focus on the correct use of male and female condoms, effective skills in communication, assertiveness, and negotiating safer sex with partners, and problem solving. After each session, their homework is to educate their peers about what they have learned. The intervention is sensitive to Latinas' values and beliefs and addresses issues relevant for this population, such as intimate partner violence.

Intervention Duration

Six weekly sessions

Significant Findings of the Intervention's Evaluation

Across the 2 follow-ups, intervention participants were significantly more likely than control participants to report consistent condom use during vaginal sex ($p = .006$).

Gender of participants during evaluation: 100% Female

Race/ethnicity of evaluation sample: 100% Hispanic (85% Mexican, 15% Puerto Rican)

Considerations

This intervention fails to meet the best-evidence criteria due to a short follow-up time, low retention rates, and no intent-to-treat analyses.

- Across the 2 follow-ups, intervention participants, compared to control participants, had significantly greater partner communication about HIV issues ($p < .001$), HIV knowledge ($p = .006$), and risk-reduction behavioral intentions ($p < .001$).
- Analytic sample excludes those intervention participants who completed less than 3 of the 6 sessions (i.e., excluding if exposed to less than 50% of the intervention).

SHIELD **Target: Low-income, Black IDUs**

Delivery Unit: GLI **Training:** Not Available

Replication Package: An intervention package is currently being developed with funding from CDC's Replicating Effective Programs (REP) Project. For details on intervention materials contact Dr. Carl A. Latkin, De partment of Health, Behavior, & Society, Johns Hopkins Bloomberg School of Public Health, Faculty of Social and Behavioral Sciences, Johns Hopkins University, 624 North Broadway, Baltimore, Maryland 21205, e-mail: clatkin@jHeterosexualph.edu

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/SHIELD.htm

Description

SHIELD is a small-group, interactive intervention that relies on peer networks to reduce drug and sex risk behaviors. Participants are asked to make public commitments to increase their own health behaviors and to promote HIV prevention among their networks and community contacts. The intervention includes multiple training and skill building sessions that involve setting goals, role plays, demonstrations, and group discussions. In addition, one session

occurred in the community and provided a "street outreach" practice session. These sessions teach participants techniques for personal risk reduction and the development of correct condom use and safer sex negotiation skills. The intervention also addresses injection drug use risk and the avoidance of risky situations. To present HIV risk within a broader community context, the intervention emphasizes the interrelatedness of HIV risk among individuals, their risk partners, and their community. Participants are also provided tools and strategies for effective community outreach, and are encouraged to conduct HIV education and become advocates of risk reduction among their sex and drug partners, family and friends, and other community members.

Intervention Duration

Ten 90-minute sessions

Significant Findings of the Intervention's Evaluation

- At 6-months follow-up, injection drug users receiving the SHIELD intervention reported significantly greater reductions in needle sharing ($p < 0.05$) and injection drug use frequency ($p < 0.05$) and were more likely to stop injecting drugs ($p < 0.05$) than those in the control group.
- Among sexually active drug users, those receiving the SHIELD intervention reported significantly greater increases in condom use with casual sex partners ($p < 0.05$) than those in the control group.

Gender of participants during evaluation: 61% M, 39% F

Race: 94% AA, 6% O

Considerations

- The participation rate in the evaluation was low because 59% of participants who completed the baseline assessment did not bring in network members, and an additional 13% did not return for the intervention.

SiHLE **Target: Black adolescent women (14-18)**

Delivery Unit: GLI **Training:** Not Available

Replication Package: An intervention package and training are currently being developed with funding from CDC's DEBI project. For details on intervention materials contact DEBI Technical Monitor Miriam Phields, 404-639-4957, e-mail: MPhields@cdc.gov

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/SiHLE.htm

Description

The SiHLE intervention is a small group, skills training intervention to reduce risky sex behavior among African-American adolescent females. Through interactive discussions in groups of 10-12 girls, the intervention emphasizes ethnic and gender pride, and enhances awareness of HIV risk reduction strategies such as abstaining from sex, using condoms consistently, and having fewer sex partners. Through the use of role plays and cognitive rehearsal, the intervention enhances confidence in initiating safer-sex conversations, negotiating for safer sex, and refusing unsafe

sex encounters. In addition, intervention deliverers model proper condom use skills and emphasize the importance of healthy relationships.

Intervention Duration

Four 4-hour sessions delivered weekly on consecutive Saturdays

Significant Findings of the Intervention's Evaluation

- Participants in the SiHLE intervention reported significantly greater increases in consistent condom use, percentage of condom-protected vaginal sex acts, frequency of applying condoms on a sex partner, and condom use during last sex over the 6- and 12-month follow-up periods than participants in the comparison intervention.
- In addition, the SiHLE intervention group reported significantly fewer new vaginal sex partners and episodes of unprotected vaginal sex during the 6- and 12-month follow-up periods than the comparison group.
- Women in the SiHLE intervention group were significantly less likely to acquire a new Chlamydia infection over 12 months of follow-up than women in the comparison group.

Gender of participants during evaluation: 100% F

Race: 100% AA

Considerations

- Women in the SiHLE intervention group were significantly less likely to report being pregnant ($p<.05$) relative to the comparison group at 6 months, but this finding was not sustained at 12 months.

Sisters Saving Sisters **Target: Black and Latina adolescent women (Mean age 16 years)**

Delivery Unit: GLI **Training:** Not Available

Replication Package: The intervention package is not available at this time. Please contact Dr. John B. Jemmott, University of Pennsylvania, Annenberg School for Communication, 3535 Market Street, Suite 520, Philadelphia, PA 19104. email: jjemmott@asc.upenn.edu

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/sisters-saving-sisters.htm

Description

The Skill-Based HIV/STD Risk-Reduction intervention is a single-session, small group intervention to reduce risky sexual behaviors and STDs among African American and Latina adolescent girls. This intervention is culturally and developmentally appropriate, and is delivered to groups of 2-10 participants. Through the use of group discussions, videotapes, games and exercises, the intervention addresses beliefs relevant to HIV/STD risk reduction, illustrates correct condom use, and depicts effective condom use negotiation. Participants handle condoms, practice correct use of condoms with anatomical models, and engage in role playing to increase condom use negotiation skills. Participants also learn about their personal vulnerability to HIV, and barriers to condom use including alcohol and drug use.

Intervention Duration

One 250-minute session

Significant Findings of the Intervention's Evaluation

Skills-based compared to Health Promotion:

- Skills-based participants, compared to Health Promotion participants, reported significantly fewer days of sex without condom use ($p = .002$) and significantly fewer days of unprotected sex while high on drugs or alcohol ($p = .02$) at the 12-month follow-up.
- Skills-based participants, compared to Health Promotion participants, reported significantly fewer sexual partners ($p = .04$) and were significantly less likely to report having multiple sex partners ($p = .002$) at the 12-month follow-up.
- Skills-based participants were significantly less likely to test positive for a new STD during the 12-month follow-up period than Health Promotion participants ($p = .05$).

Skills-based compared to HIV/STD Information:

- At the 12-month follow-up, Skills-based participants reported significantly fewer days of sex without condom use than HIV/STD Information participants ($p = .03$).

Gender of participants during evaluation: 100% F

Race: 68% AA, 32% H

Considerations

- Skill-based intervention effects were not significant for condom use, number of partners, and new STD infections at the 3- or 6- month follow-ups.
- Skills-based participants, compared to Health Promotion participants, reported significantly fewer days of sex while high on drugs or alcohol at the 3-month ($p = .03$) and 6-month ($p = .005$) follow-ups.
- Skills-based participants, compared to HIV/STD Information participants, reported significantly fewer days of sex while high on drugs or alcohol at the 3-month follow-up ($p = .03$).

Sister-to-Sister **Target: Black women**

Group Skill-building (Best Evidence)

One-on-one Skill-building (Best Evidence)

Delivery Unit: GLI **Training:** Under development (estimated availability October 2009)

Replication Package: An intervention package for the individual-level format is currently being developed with funding from CDC's Replicating Effective Programs (REP) Project. Please contact Dr. Loretta Sweet Jemmott, University of Pennsylvania School of Nursing, Room 239 Claire M. Fagin Hall, 418 Curie Blvd., Philadelphia, Pennsylvania 19104-6096. email: jemmott@nursing.upenn.edu

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/sister-to-sister.htm

Description

Sister-to-Sister includes two skills-building interventions – Group (Best-evidence) or One-on-one (Best-evidence). These Skills-building interventions are culturally-sensitive, gender-appropriate, single-session interventions developed to increase self-efficacy and skills to use condoms correctly and to negotiate condom use with sex partners. The interventions encourage women to respect and protect themselves, not only for their own sake, but also for their family and community. The interventions are delivered by female African-American nurses and can be delivered to small groups of women (3-5 women) or individuals. Both group and one-on-one formats involve video viewing, condom demonstration, practice with an anatomical model, and role playing to increase self-efficacy and skills to negotiate condom use. The additional activities used in the group format include group discussions, brainstorming, and interactive exercises and games.

Intervention Duration

One session, 20 minutes for the group format and 20 minutes for the one-on-one format

Significant Findings of the Intervention's Evaluation

Combined Group and One-on-one Skills compared to Health Promotion:

- Skills Intervention women, compared to Health Promotion women, reported a significantly lower frequency of unprotected sexual intercourse at the 3-month follow-up ($p = .02$) and a significantly greater proportion of condom protected sexual intercourse at the 12-month follow-up ($p = .03$), and were significantly more likely to report using a condom at last sexual intercourse at the 3- and 12-month follow-ups ($p = .05$, $p = .03$, respectively).
- Skills Intervention women were significantly less likely to test positive for STD than comparison women at the 12-month follow-up ($p = .03$).

Group Skills compared to Health Promotion:

- At the 12-month follow-up, Group Skills women, compared to Health Promotion women, reported a significantly greater proportion condom-protected sexual intercourse ($p = .003$) and were significantly more likely to report using a condom at last sexual intercourse ($p = .05$).

One-on-one Skills compared to Health Promotion:

- One-on-one Skills women were significantly less likely to test positive for STD than comparison women at the 12-month follow-up ($p = .03$).

Combined Group and One-on-one Skills compared to Combined Group and One-on-one Information:

- Skills intervention women, compared to Information women, reported a significantly greater proportion of condom protected sexual intercourse at the 3- and 12-month follow-ups ($p = .02$, $p = .05$, respectively), a significantly lower frequency of unprotected sexual intercourse at the 3- and 12-month follow-ups ($p = .01$, $p = .02$, respectively), and were significantly more likely to report using a condom at last sexual intercourse at the 12-month follow-up ($p = .01$).

Gender of participants during evaluation: 100% F

Race: 100% AA

Considerations

- The Group Skills intervention had a marginally significant effect in reducing new STD infections at the 12-month follow-up (p = .08) compared to Health Promotion.
- The One-on-one Skills intervention also has a marginally significant effect in increasing condom use at most recent sexual intercourse at the 12-month follow-up (p = .07) compared to Health Promotion.
- Women receiving the Group Skills intervention reported a significantly greater proportion condom-protected sexual intercourse at the 12-month follow-up compared to women receiving the One-on-one Skills intervention (p = .05).
- There were no significant intervention effects on any sex behavior or STD outcomes at 6 months follow-up.
- The 5th study group (Health promotion comparison group) was added in year 2 and, thus, resulted in a smaller number of participants being assigned to that group. The authors report that the findings from the entire study sample were similar to the findings when restricting to years 2 and 3 of the study.

Sniffer **Target: Intranasal Drug Users**

Delivery: GLI, ILI **Training:** Not available

Replication Package: An intervention package is currently available from Sociometrics, Inc.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/sniffer.htm

Description

SNIFFER is a four-session, small-group, social learning based, AIDS/drug injection prevention intervention for intranasal drug users. The intervention is designed to create a support-group type of atmosphere so participants feel comfortable discussing personal problems and seeking help from the facilitators and their peers. The sessions include information on AIDS, drug use, drug injection, sexual behavior and AIDS, and seeking entry into drug treatment programs. Coping skills, such as self-assertion, dealing with depression, and seeking treatment, are addressed. Through role play, participants learn how to refuse an offer to inject drugs and learn to seek entry into a drug treatment program. Participants are taught 'safer' injection procedures, such as cleaning drug injection equipment with bleach to decontaminate. As part of the intake procedures, all participants are provided HIV pre-test counseling and are offered HIV testing. Post-test counseling is provided to those electing to take the HIV test, and Hepatitis B testing was required for all participants.

Intervention Duration

Four 60-90 minute sessions delivered over 2 weeks, plus HIV pre- and post-test counseling

Significant Findings of the Intervention's Evaluation

At follow-up, the intervention participants were significantly less likely to report injecting any drugs than control participants ($p < .05$, one-tailed test).

Gender of participants during evaluation: 70% M, 30% F

Race/ethnicity of evaluation sample: 51% W, 26% AA, 23% H

Considerations

This intervention fails to meet the best-evidence criteria due to small analytical sample sizes, low retention rates, and using a one-tailed test.

- As part of intake procedures, all study participants were given HIV pre-test counseling and offered HIV antibody testing. Post-test counseling was provided to all who accepted HIV testing (87%). Hepatitis B testing was required for those not electing to take the HIV antibody test to be used as a surrogate measure for HIV sero-status.
- The total baseline (n = 104) and follow-up (n = 83) sample sizes were reported, but baseline sample sizes and retention rates by group were not reported and are not available. The sample sizes were reported at follow-up, so lowest possible retention rates were calculated by subtracting all baseline subjects that were not retained (n = 21) from each group in turn. Since the actual retention rates would have been as good or better than the worst-case calculated rates, this study meets the promising-evidence criteria.
- The intervention targets heroin "sniffers" at high risk of transitioning into injection drug use. At baseline, 45% had injected in the past and 12% reported injecting in the past 6 months.

START **Target: Young men soon to be released from prison**

Delivery Unit: GLI **Training:** Under Development (estimated availability October 2009)

Replication Package: An intervention package is currently being developed with funding from CDC's Replicating Effective Programs (REP) Project. For details on intervention materials please contact Barry Zack, Centerforce, 2955 Kerner Blvd., 2nd Fl, San Rafael, CA 94901, email: bzack@centerforce.org

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/START.htm

Description

START is a 6-session individual-level HIV, STD, and hepatitis risk reduction intervention for men soon to be released from prison incorporating features of prevention case management, motivational interviewing, and incremental risk reduction. This intervention consists of 2 individual sessions conducted within the 2 weeks before release and 4 individual sessions at 1, 3, 6, and 12 weeks after release. In the first in-prison session, the interventionist assessed the participant's knowledge of HIV/AIDS, STD, and hepatitis, conducted a brief HIV-risk assessment, and helped the participant develop a personal risk-reduction plan. The interventionist also provided information, skills training, and referrals and helped to identify incremental steps towards risk reduction. The second in-prison session focused on community reentry needs and referrals for housing, employment, finances, substance abuse, mental treatment, legal issues, and avoiding reincarceration. The post-release sessions involved a review of the previous sessions and discussion of the facilitators and barriers to implementing

the risk reduction plan. Additional sessions were available for participants in the enhanced session as needed during the intervention period.

Intervention Duration

The pre-release sessions lasted 60 to 90 minutes and were provided during the 2 weeks prior to release from prison; the post-release sessions lasted 30 to 60 minutes and were provided approximately 1, 3, 6, and 12 weeks after release from prison, totaling approximately 4 – 7 hours over a period of 14 weeks

Significant Findings of the Intervention's Evaluation

At 3 months after intervention, intervention participants were significantly less likely to report unprotected vaginal or anal sex at last sex ($p < .05$), with any partner ($p < .05$), with a main partner ($p < .05$) or with an at-risk partner at last sex ($p < .05$) when compared to comparison participants.

Gender of participants during evaluation: 100% Male

Race: 52% AA, 23% W, 14% H, 12% O

Considerations

- The significant findings described above were based on data collected 3 months after the intervention for both groups, however, due to the difference in number of sessions between the two groups the outcomes were measured at 24-weeks post-release for the Intervention group and 12-weeks post-release for the Comparison group.
- Given the low prevalence of injection drug use in both the intervention and comparison groups, analyses for this outcome were not performed.
- Intervention effects were also found to be significant when comparing the 24-week post-release assessment for both treatment groups, however, the actual follow-up time since the intervention differs greatly by group and is over twice as long for the comparison group (as described above).
- Intervention effects were not found to be significant at the 12-week post-release assessment, which was collected just prior to the final 12-week post-release intervention session for the Intervention group).
- In California only, at the 12-week post-release assessment only (prior to the last session in the intervention group), the intervention group had a greater proportion of men reporting having been reincarcerated than the comparison men ($p < .05$), however, this finding could be attributed to site-specific differences in tracking procedures rather than the intervention itself.

Street Smart **Target: Heterosexual Runaway Youth (11-18)**

Delivery: GLI **Training:** Available through the DEBI project.

Replication Package: The intervention package and training are available through CDC's DEBI project.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/StreetSmart.htm

Description

Street Smart is a 10-session intensive small-group skills-based intervention for runaway youth. The intervention focuses on providing access to health resources, making condoms available, training youth on personal skills, and training staff to help support the youth in changing their behavior. In small groups of 5-6, the youth discussed the following topics: basics about HIV/STD risk, assessing personal risk and avoiding sexual risk, the correct use male and female condoms, how substance use affects sexual control and judgment, identifying and managing triggers for unsafe sex, and problem solving. Each session, youth use a "Feeling Thermometer" to help the youth recognize and discuss their feelings. Youth are taught to cope with their feelings by practicing coping skills and relaxation skills to control feelings of anxiety, depression, anger, and desire. The intervention focuses on positive self-talk to build self esteem, help with difficult situations, and increase self-efficacy for safer sex. Tokens of appreciation and compliments are exchanged among the youth to provide positive support for appropriate behavior and meeting HIV-related goals. Activities to promote positive attitudes, increase self-efficacy, and build effective communication, personal, and technical skills include games, exercises, practicing, role-playing. In addition, youth attended video and art workshops to develop media messages through soap opera dramas, public service announcements commercials, or raps to reinforce safer sex. An individual counseling session is provided to discuss attitudes, identify triggers and barriers, and develop a plan for coping and overcoming barriers to practice safer sex. Finally, youth visit a local community-based agency providing health and mental health care to learn about other available resources in the community.

Intervention Duration

10 sessions (9 small-group and 1 individual) delivered over a 3 week period

Significant Findings of the Intervention's Evaluation

Among female youth, intervention participants reported significantly fewer unprotected sex acts than control participants at 21 months after the intervention ($p = .018$).

Gender of participants during evaluation: 51% M, 49% F

Race/ethnicity of evaluation sample: 53% AA, 30% H, 16% O

Considerations

- This intervention fails to meet the best-evidence criteria due to low retention rates and assigning groups of individuals to study conditions while analyzing at the individual level.
- The intervention was available at the intervention shelters throughout the 3 month period after assignment, so it is unclear if youth received more than the intended 10 sessions. This also means that the follow-up assessments translate to approximately 0, 3, 9, 15, 21 months after the intervention.
- Among female youth, intervention participants were more likely to report abstinence from vaginal and anal sex than control participants at 15 months after the intervention ($p = .088$), although this finding was not statistically significant and was at a follow-up with low retention rates.
- After identifying a propensity-matched sub-sample, baseline differences still existed. Those in the control group were more likely to report recent alcohol and marijuana use at baseline than those in the intervention group (p's $< .05$).

- There were no significant intervention effects among male youth for any of the intended outcomes except for a lower proportion of male youth reporting marijuana use immediately following the intervention, compared to control youth ($p < .05$). This finding does not meet promising-evidence criteria due to the type of outcome, no follow-up time, and low retention rates.
- At 9 months after the intervention, female youth in the intervention were less likely to report using alcohol ($p = .053$) or marijuana ($p = .005$) and reported fewer numbers of drugs used ($p = .019$) than female youth in the control group. Similar findings were found for marijuana use and number of drugs used at 3 months after the intervention. These findings do not meet promising-evidence criteria due to the type of outcome and low retention rates at 9 months.
- There were baseline differences in the original study sample. A propensity score matching that identified similar baseline sub-groups of intervention and control youth was conducted to protect the findings from confounding bias.
- This intervention could be considered a community-level intervention as the intervention was available on an ongoing basis in the shelters for 3 months. Since the evaluation, utilizing a cohort design, can be reviewed using these criteria, this intervention is included within this review and will be updated later in the community-level intervention section of the website.

SUMIT Enhanced Peer-led **Target Group: HIV-positive MSM**

Delivery Unit: GLI **Training:** Not Available

Replication Package: An intervention package is not available. Because this intervention led to modest change in only one outcome that was not sustained at the 6-month follow-up, the lead author recommends the use of other interventions for persons living with HIV. Contact Dr. Richard Wolitski, Prevention Research Branch, Division of HIV/AIDS Prevention, NCHheterosexualTP, CDC, 1600 Clifton Rd (M/S E-37), Atlanta, GA 30333, e-mail: rwolitski@cdc.gov, for details on intervention materials

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/SUMIT.htm

Description

The SUMIT enhanced peer-led intervention is delivered to groups of gay or bisexual men living with HIV in order to reduce risky sexual behavior. Led by HIV-seropositive gay or bisexual peer facilitators, structured group activities focus on sexual and romantic relationships, HIV and STD transmission, drug and alcohol use, assumptions about the HIV status of sex partners, disclosure of HIV status, and mental health. Intervention sessions seek to increase knowledge of sex risk practices, increase motivation to adopt reduced risk practices, encourage disclosure of HIV status to partners, promote personal responsibility to prevent HIV transmission, increase awareness of substance use and mental health issues, and encourage identification and management of personal risk triggers. These topics were delivered using audio and video tapes, didactic presentations, and group discussions.

Intervention Duration

6 weekly 3-hour group sessions

Significant Findings of the Intervention's Evaluation

- At the 3-month follow-up, men in the Enhanced Peer-led intervention group were significantly less likely to report unprotected receptive anal sex than men in the comparison intervention group ($p < 0.05$).

Gender of participants during evaluation: 100% Male

Race: 51% W, 23% AA, 17% H, 1% API, 1% AI, 7% O

Considerations

- There were no significant group differences in other sex risk behaviors, HIV disclosure, or STD prevalence at the 6-month follow-up.

Together Learning Choices (TLC) **Target: HIV-positive Adolescents & Young Adults (13-24)**

Delivery: GLI **Training:** Available through the DEBI project.

Replication Package: The intervention package and training are available through CDC's DEBI project.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/TLC.htm

Description

TLC (Together Learning Choices, previously referred to as Teens Linked to Care) is a small-group intervention designed for youth and young adults living with HIV. *TLC* consists of 2 modules: *Stay Healthy* and *Act Safe*. The *Stay Healthy* module consists of 12 sessions to promote positive health behaviors. Intervention sessions are focused on coping with learning one's seropositive status, addressing issues of disclosure, and helping youth to implement new daily routines to stay healthy and actively participate in health care decisions. The *Act Safe* module consists of 11 sessions to increase self-protection and other-protection motivation to change behavior and to reduce substance use and unprotected sex acts. HIV-positive youth identify their risk behavior triggers and modify their patterns of substance use as well as increase self-efficacy of condom use and negotiation skills. The modules are delivered in sequence by male and female facilitators to mixed gender groups of HIV-positive youth. A feeling thermometer is used in each session to assist youth in identifying and controlling negative emotional states. Group discussions, role-play, video, exercises, and goal setting encourage the ability to effectively reach goals, solve problems, and effectively respond to stressful situations.

Intervention Duration

Stay Healthy module: 12 sessions, 2 hours each, conducted weekly over 3 month period.

Act Safe module: 11 sessions, 2 hours each, conducted weekly over 3 month period.

Significant Findings of the Intervention's Evaluation

- TLC participants were significantly more likely to report no sexual risk pattern (no sex or 100% condom use) than control participants ($p < .05$) at 3 months after *Act Safe* module.

- The TLC participants reported significantly lower percentages of unprotected vaginal and anal sex acts with HIV-negative partners than the control group ($p < .05$) at 3 months after *Act Safe* module.

Gender of participants during evaluation: 72% M, 28% F

Race/ethnicity of evaluation sample: 37% H, 27% AA, 19% W, 17% O

Considerations

- This intervention fails to meet the best-evidence criteria due to small analytical sample sizes and low retention rates.
- TLC was developed as a 3-module intervention. Module 3 (*Being Together*) consists of 8 sessions (2 hours each over a 3 month period) focusing on improving quality of life. No published report has evaluated the intervention effects of all three modules on HIV risk behaviors. Therefore, module 3 is not presented here.
- A substantial number of participants were not eligible for participation in the *Act Safe* module because the funding period was ending before their follow-up would have been completed. It does not appear that this logistical issue would affect the interpretation of the findings, however the analyses are based on small sample sizes.
- The original research targeted teens and youth (ages 13 to 24), however, the intervention package has been expanded to target young people (up to 29 years old).

VOICES/VOCES **Target: Black and Hispanic/Latino STD clinic patients**

Delivery Unit: GLI **Training:** Available through the DEBI project.

Replication Package: An intervention package and training are available through CDC's DEBI project.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/VOICES-VOCES.htm

Description

VOICES/VOCES is a single-session, culturally specific, video-based intervention for STD clinic patients. The small group session (3-8 patients) is gender and ethnic matched and is conducted by a gender-matched facilitator in either English or Spanish. Groups of participants first review one of the culturally appropriate STD prevention videos, "Let's Do Something Different" for African Americans and "Porque Si" for Hispanics. Both videos provide accurate risk information and corrected misinformation, portray positive attitudes about condom use, and model gender- and culturally-specific strategies for encouraging condom use. Interactive group discussions following the video reinforce the STD and HIV prevention message. Participants are encouraged to talk about problems they have experienced when trying to use condoms and discuss strategies to increase condom use. All participants are offered a selection of free condoms at the clinic and a coupon for free condoms at an area pharmacy.

Intervention Duration

One 20-minute video followed by one 25-minute group discussion session

Significant Findings of the Intervention's Evaluation

Analyses pooled data from both VOICES/VOCES interventions (Video + Group Discussion and Video Only) to test intervention effects:

- The rate of new STD infections over a 24-month period was significantly lower among men receiving the intervention than men in the comparison group ($p < .04$).
- Among men who had multiple sex partners at baseline, the intervention groups had a significantly lower rate of new STD infections over a 24-month period compared to the comparison group ($p < .025$).

Gender of participants during evaluation: 60% M, 40% F

Race: 62% AA, 38% H

Considerations

- Both Video Only and Video + Group Discussion interventions are highlighted here because the analyses combined both groups when compared to the comparison group and there were no significant differences in rates of new STD infections between the two intervention groups.
- The VOICES/VOCES interventions are effective in reducing new STD infections among men, but not among women. However, a more recent effectiveness trial of the VOICES/VOCES Video + Group Discussion intervention demonstrated a significant intervention effect on reducing new STD infections among men and women combined ($p < .01$), and particularly for women ($p < .001$).
- VOICES/VOCES participants were significantly more likely to redeem their coupon for free condoms at a private pharmacy than comparison participants ($p < .05$). The intervention effect on condom redemption was found to be significant when comparing Video Only and Video + Discussion intervention groups separately to the comparison group.
- When comparing Video Only and Video + Discussion intervention groups separately to the comparison group, the significant intervention effect on condom redemption was observed for each of the following subgroups: African-American men, African-American women, Hispanic men, and Hispanic women (all p's $< .05$).

WHP **Target: Hispanic/Latino women**

Delivery Unit: GLI **Training:** Not available

Replication Package: An intervention package is not available at this time. Please contact Dr. Anita Raj, PhD, Boston University School of Public Health, 715 Albany Street, T2W, Boston, MA 02118 e-mail: anitaraj@bu.edu

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/WHP.htm

Description

The Women's Health Promotion (WHP) intervention includes twelve intensive 90- to -120-minute sessions delivered over 12 weeks. The WHP consists of four standard HIV education

sessions (lasting about 6 to 9 hours) that address HIV transmission and prevention, sexually transmitted diseases, sexual and reproductive anatomy, condom practice, and condom negotiation skills. These sessions use lectures, group discussion, and skill-building exercises and games to teach participants. The eight additional sessions involve speakers on a variety of topics deemed relevant by participants, including general mental health, depression, cervical cancer, non-HIV-related partner communication, diabetes, nutrition, partner violence, oppression, and social justice.
WHP is implemented in small, closed groups comprised of 10 to 16 women, co-facilitated by two bilingual community health educators, and conducted in Spanish.

Intervention Duration

Twelve 90- to 120-minute sessions delivered over 12 weeks

Significant Findings of the Intervention's Evaluation

Women receiving the WHP intervention were significantly more likely to use condoms during vaginal sex with their main male partner compared to women in the wait list control at the 3-month follow-up ($p < .05$).

Gender of participants during evaluation: 100% F

Race: 100% H

Considerations

- The WHP intervention effect on condom use was not significant at the 15-month follow up.
- The HIV-IP intervention fails to meet the best-evidence or promising-evidence criteria because the adjusted analyses did not yield significant findings for the relevant outcomes.

WiLLOW **Target Group: HIV-positive Black women**

Delivery Unit: GLI **Training:** Under Development (Expected availability July 2009)

Replication Package: An intervention package and training are currently being developed with funding from CDC's DEBI project. Contact DEBI Technical Monitor Miriam Phields, 404-639-4957, e-mail: MPhields@cdc.gov, for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/WiLLOW.htm

Description

The WiLLOW intervention is a small group, skill-training intervention for women living with HIV. Through interactive discussions within groups of 8-10 women, the intervention emphasizes gender pride and informs women how to identify and maintain supportive people in their social networks. The intervention enhances awareness of HIV transmission risk behaviors, discredits myths regarding HIV prevention for people living with HIV, teaches communication skills for negotiating safer sex, and reinforces the benefits of consistent condom use. WiLLOW also teaches women how to distinguish between healthy and unhealthy relationships, discusses

the impact of abusive partners on safer sex, and informs women of local shelters for women in abusive relationships

Intervention Duration

Four 4-hour sessions delivered over 4 consecutive weeks

Significant Findings of the Intervention's Evaluation

- At the 6- and 12-month follow-ups, women who received the WiLLOW intervention reported significantly fewer episodes of unprotected vaginal sex and were significantly less likely to report never using condoms than women in the Health Promotion comparison.
- Over the 12-month follow-up, women in the WiLLOW intervention were significantly less likely to acquire new bacterial STDs (Chlamydia and gonorrhea) than women in the Health Promotion comparison.

Gender of participants during evaluation: 100% F

Race: 84% AA, 15% W, 1% O

Considerations

None

Women's Co-Op **Target Group: Black women who use crack and are not in drug treatment**

Delivery Unit: ILI, GLI **Training:** Not available

Replication Package: An intervention package is not available at this time. Contact Dr. Wendee Wechsberg, RTI International, 3040 Cornwallis Drive, P.O. Box 12194 Research Triangle Park, NC 27709-2184, e-mail: wmw@rti.org, for details on intervention materials.

Additional information:
http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/women.htm

Description

The Women's Co-Op is a woman-focused intervention that incorporates gender- and culture-specific skills training for crack-using African American women. The first 2 sessions are delivered to women individually, and focus on pre- and post-test counseling for HIV. Session 1 includes a personal HIV risk assessment, and provides women with skills training on condom and dental dam use and syringe cleaning. Session 2 includes receipt of HIV test results, the development of an individualized risk assessment plan, and a repeat of the skills training from Session 1. The final 2 sessions are delivered to small groups of 2 to 5 women, and use a support-based format to help women develop skills that can reduce their risk of HIV. These sessions include the development of communication and problem solving skills that increase women's sense of power and ability to cope with stress.

Intervention Duration

Four sessions delivered over 6 weeks. Sessions 1 and 2 lasted 30-40 minutes each, and Sessions 3 and 4 lasted 60-90 minutes each.

Significant Findings of the Intervention's Evaluation

At 4.5 months post-intervention, women in the Women's Co-Op intervention group were significantly less likely to report any unprotected sex compared to women in the delayed treatment control group (p = 0.03).

Gender of participants during evaluation: 100% F

Race: 100% AA

Considerations

The Women's Co-Op intervention was also associated with significant decreases in sex trading, mean number of crack-use days, and homelessness, as well as a significant increase in full-time employment compared to the delayed treatment control at the 1.5 month post-intervention follow up. All of these outcomes were targeted by the intervention.

Un-Classified Interventions Supported by the CDC's DEBI Project

In 2008 CDC was in the process of classifying the community level interventions supported by the DEBI project: Mpowerment, Popular Opinion Leader, PROMISE and RAPP. Many Men, Many Voices and SISTA are not included among the CDC-identified Best-evidence and Promising-evidence Interventions, but CDC will continue to support both interventions.

Many Men, Many Voices **Target: Gay men of color (Blacks and Latinos)**

Delivery: GLI **Training:** Available through the DEBI project.

Replication Package: The intervention package and training are available through CDC's DEBI project.

Additional information:
http://www.effectiveinterventions.org/go/interventions/many-men-many-voices

Description

Many Men, Many Voices (3MV) is a six- or seven-session, group level STD/HIV prevention intervention for gay men of color. The intervention addresses factors that influence the behavior of black MSM: cultural, social, and religious norms; interactions between HIV and other sexually transmitted diseases; sexual relationship dynamics; and the social influences that racism and homophobia have on HIV risk behaviors. 3MV is designed to be facilitated by a peer in groups of 6-12 clients.

Sessions aim to foster positive self-image; educate participants about their STD/HIV risks; and teach risk reduction and partner communication skills. The sessions are highly experiential, incorporating group exercises, behavioral skills practice, group discussions, and role-play.

The sessions address specific influencing factors in a sequence including:

- **Session 1:** The Dual Identity Culture of black MSM

- **Session 2:** HIV Prevention for black MSM: Sexual Roles and Risks
- **Session 3:** HIV Risk Assessment and Prevention Options
- **Session 4:** Intentions to Act and Capacity to Change
- **Session 5:** Partner Selection, Communication, and Negotiation
- **Session 6:** Social Support and Problem Solving to Maintain Change
- **Session 7:** Building Bridges and Community (optional)

Intervention Duration

Six or seven 2-3 hour sessions

The intervention can also be adapted to 12 sessions of 75-90 minutes each, or condensed into a weekend retreat, covering the 18-21 hours of intervention curriculum.

The core elements of 3MV are:

- Educate clients about HIV risk and sensitize to personal risk.
- Develop risk reduction strategies.
- Train in behavioral skills.
- Train in partner communication and negotiation.
- Provide social support and relapse prevention.

Research Results

After implementation of the original intervention (12 sessions of 75-90 minutes each), participants reduced their frequency of unprotected anal intercourse and increased their use of condoms significantly more than men who did not participate in the intervention.

Mpowerment **Target: Young gay and bisexual men 18-29.**

Delivery: GLI **Training:** Available through the DEBI project.

Replication Package: The intervention package and training are available through CDC's DEBI project.

Additional information:
http://www.effectiveinterventions.org/go/interventions/mpowerment

Description

The Mpowerment intervention is run by a core group of 10-15 young gay men from the community and paid staff. The young gay men, along with other volunteers, design and carry out all project activities. Ideally, the project has its own physical space where most social events and meetings are held and which serves as a drop-in center where young men can meet and socialize during specified hours. The program relies on a set of four integrated activities:

- *Formal Outreach:* Teams of young gay men go to locations frequented by young gay men to discuss and promote safer Gender of participants during evaluation:, deliver appealing informational literature on HIV risk reduction, and distribute condoms. Additionally, the team creates their own social events (e.g., dances, video parties, picnics, and discussion groups) to attract young gay men and to promote safer sex.
- *M-groups:* These peer-led, 2-3 hour meetings of 8-10 young gay men discuss factors contributing to unsafe sex among the men (e.g., misconceptions about safer sex, beliefs that safer sex is not enjoyable, and poor sexual communication skills). Through skills-building exercises, the men practice safer sex negotiation and correct condom use skills. Participants receive free condoms and lubricant and are trained to conduct informal outreach.
- *Informal Outreach:* Informal outreach consists of young men discussing safer Gender of participants during evaluation: with their friends.
- *Ongoing Publicity Campaign:* The campaign attracts men to the project by word of mouth and through articles and advertisements in gay newspapers.

Research Results

Participants significantly decreased their rates of unprotected anal intercourse.

The Core Elements of the Mpowerment Project include:

1. Recruiting a core group of young gay men to design and carry out project activities
2. Establishing a project space where many of the project activities can be held
3. Conducting entertaining, venue-based (e.g., bars, community events) outreach by teams of young gay men
4. Sponsoring social events to promote community building among young gay men.
5. Convening peer-led, one-time discussion groups.
6. Conducting a publicity campaign about the project within the community.

Popular Opinion Leader (POL) **Target: MSM, Black women, male sex workers**

Delivery Unit: GLI **Training:** Available through the DEBI project.

Replication Package: An intervention package and training are available through CDC's DEBI project. *Farmworker Justice has developed a Latino adaptation module of POL and provides 1-day training on the module. For information contact Jennifer Freeman at (202) 293-5420 Ext: 309 or by e-mail: jfreeman@farmworkerjustice.org*

Additional information:
http://www.effectiveinterventions.org/go/interventions/popular-opinion-leader

Description

This community-level intervention involves identifying, enlisting, and training key opinion leaders to encourage safer sexual norms and behaviors within their social networks through risk-reduction conversations. The target population includes men who frequent gay bars, male Gender of participants during evaluation: workers, adolescents and business owners who cater to gay men.

A cadre of trusted, well-liked men who frequent gay bars are trained to endorse safer behaviors in casual, one-on-one conversations with peers at the bars and other settings. During these conversations, the "popular opinion leader" corrects misperceptions, discusses the importance of HIV prevention, describes strategies he uses to reduce his own risk (e.g., keeping condoms nearby, avoiding Gender of participants during evaluation: when intoxicated, resisting coercion for unsafe Gender of participants during evaluation:), and recommends that the peer adopt safer Gender of participants during evaluation: behaviors. Popular opinion leaders wear buttons displaying the project logo, which also is on posters around the bars, as a conversation-starting technique. Each leader agrees to have at least 14 conversations and to recruit another popular opinion leader.

The community changes the way it thinks about protecting itself from HIV as a result of efforts of community members. During peer-to-peer conversations, opinion leaders correct misperceptions, discuss the importance of HIV prevention, and describe strategies they use to reduce risk (e.g., keeping condoms nearby, avoiding sex when intoxicated, resisting coercion for unsafe sex). They communicate their personal approval of the targeted risk-reduction behavior, using “I” statements to emphasize personal endorsement. For example, if the targeted risk-reduction norm is routine testing, the opinion leader may say, “I think that routine testing is best; routine testing is what I intend to do. I think it is possible for me to test routinely, and I think it is possible for you to test routinely too.” Effective behavior change communication is that which targets risk-reduction attitudes, norms, intentions, and self-efficacy. Factual information is limited to that which directly promotes the targeted risk-reduction norm.

Each opinion leader may recruit new opinion leaders, thereby increasing opinion leaders and conversations. The CBO does the preparatory work, including identification and recruitment of opinion leaders, and teaches vital communications skills; as the number of trained opinion leaders increases, the number of conversations in the community that endorse HIV prevention and care also increases.

The **Core Elements** of POL are:

1. Identifying and enlisting the support of popular and well-liked opinion leaders to take on risk reduction advocacy roles;
2. Training cadres of opinion leaders to disseminate risk-reduction endorsement messages within their own social networks; and
3. Supporting and reinforcing successive waves of opinion leaders to help reshape social norms to encourage safer sex.

Research Results

POL was initially shown to increase condom use by men who have sex with men (MSM).

PROMISE (Peers Reaching Out and Modeling Intervention Strategies) **Target: All groups**

Delivery Unit: CLI

Training: Available through the CDC-funded STD/HIV Prevention Training Centers (PTC).

Replication Package: Training and intervention materials are available through the CDC-funded STD/HIV Prevention Training Center for the eastern quadrant, Eastern Region (Rochester, NY) PTC.

Additional information:
http://www.effectiveinterventions.org/go/interventions/promise

Description

PROMISE can serve any community or population, since the messages come from and are communicated within the community. It has been tested with African American, Anglo, and Latino communities, including IDUs and their Gender of participants during evaluation: partners, non-gay identified men who have Gender of participants during evaluation: with men, high-risk youth, female Gender of participants during evaluation: workers, and high-risk heterosexuals. It is also being developed for other populations and for individuals living with HIV.

PROMISE is a community-level HIV prevention intervention that relies on role model stories and peers from the target community. The intervention is based on the Stages of Change theory and other behavioral theories.

PROMISE begins with a community assessment to identify what HIV risk behaviors and influencing factors are taking place within the community. Individuals from the targeted at-risk communities are then recruited and trained to be peer advocates. Peer advocates interview members of the community about their behavior and role model stories are written based upon the interviews. These stories provide personal accounts from individuals in the target population about how and why they took steps to practice HIV risk-reduction behaviors. The stories also emphasize the positive effects the risk reduction choices had on their lives. Peer advocates distribute the role model stories and risk reduction supplies within their social networks.

Research Results

In the original research, those exposed to the intervention moved toward consistent condom use with main and non-main partners, increased condom carrying and showed positive progression in the stages-of-behavior-change for condom and bleach use.

The Core Elements of PROMISE are:

1. Community assessment to identify what risk behaviors and influencing factors are prevalent in the community
2. Recruiting and training persons from the targeted at-risk communities to become peer advocates
3. Creating role model stories based on personal accounts from individuals in the target population who already have made some risk-reduction behavior change
4. Distributing role model stories and risk reduction supplies by peer advocates.

Real AIDS Prevention Project (RAPP) **Target: Heterosexual women**

Delivery Unit: CLI **Training:** Available through the DEBI project.

Replication Package: Training and intervention materials are available through the CDC-funded DEBI project

Additional information:
http://www.effectiveinterventions.org/go/interventions/rapp

Description

RAPP is a community mobilization program that was developed to help women and their partners reduce their risk for HIV infection. The intervention objectives are to increase consistent condom use by women and their partners, to change community norms so that practicing safer Gender of participants during evaluation: is seen as the acceptable norm, and to involve as many people in the community as possible. The program has two phases: 1) community assessment, which involves finding out about the community and how to talk to women and their partners about their risk for HIV infection, and 2) getting the community involved in a combination of risk reduction activities directed toward these women and their partners.

Research Results

After the RAPP intervention, women living in high-risk intervention communities were more likely to have:

- Initiated condom use with their steady partners
- Negotiated condom use with steady and casual partners
- **Consistently used condoms (sex workers) with both steady and casual partners**

The Core Elements of RAPP are:

1. Conducting community outreach using peer volunteers
2. Having one-on-one, safer Gender of participants during evaluation: discussions based on the client's stage of readiness to change
3. Using printed stories about community members and safer Gender of participants during evaluation: decisions (role model stories)
4. Obtaining program support from community organizations and businesses
5. Sponsoring small group activities, such as safer Gender of participants during evaluation: parties and presentations

SISTA **Target: Black Heterosexual Women**

Delivery Unit: GLI **Training:** Available through the DEBI project.

Replication Package: Training and intervention materials are available through the CDC-funded DEBI project

Additional information:
http://www.effectiveinterventions.org/go/interventions/sista

SISTA is a group-level, gender- and culturally- relevant intervention designed to increase condom use with African American women. Five two-hour, peer-led group sessions focus on ethnic and gender pride, HIV knowledge, and skills training around Gender of participants during sexual risk reduction behaviors and decision-making. The sessions are gender- and culturally-relevant and include behavioral skills practice, group discussions, lectures, role-play, a prevention video, and take-home exercises.

Intervention Duration

Five 2-hour group sessions

Research Results

- Participants in the social-skills intervention demonstrated increased consistent condom use, sexual behavior self-control, sexual communication, and sexual assertiveness skills.
- The partners of participants in the social-skills intervention were more likely to adopt and support consistent condom use.

The Core Elements of the SISTA project are:

1. Convening five group sessions facilitated by a peer health educator;
2. Educating participants about condoms through hands-on exercises;
3. Emphasizing gender and ethnic pride as a means to reduce HIV risk behaviors;
4. Educating participants about HIV and other STDs; and
5. Teaching Gender of participants during sexual assertiveness and communication.

Other Interventions with CDC Guidance

Source: Provisional Procedural Guidance for Community-Based Organizations, Revised January 2008

http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pdf/pro_guidance.pdf

Comprehensive Risk Counseling and Services (CRCS)

Target: HIV-positive individuals, HIV-negative individuals that engage in high risk behavior

Comprehensive Risk Counseling and Services (CRCS), formerly Prevention Case management (PCM), is a client-centered HIV prevention activity that provides intensive, ongoing, individualized prevention counseling, support, and service brokerage. Priority for CRCS services should be given to persons at very high risk for HIV. Originally, CRCS was conceived as a combination of HIV risk-reduction counseling and conventional case management for persons at high risk of transmitting or acquiring HIV. However, information from CRCS demonstration projects indicates that a more successful model for CRCS clearly defines the prevention case manager's primary role as a prevention counselor, working closely with other referral providers to assist clients whose psychosocial needs are a barrier to their risk reduction goals. Often case management services and benefits are not available, especially for persons who are HIV negative or who do not know their status. Therefore, the prevention case manager is encouraged to provide traditional case management service such as linkage to services that may be available (for example, mental health or substance abuse services).

The fundamental goal of CRCS is promoting the adoption and maintenance of HIV risk-reduction behaviors by clients who have multiple, complex problems and risk-reduction needs.

CRCS provides several sessions of client-centered HIV risk-reduction counseling. It helps clients initiate and maintain behavior change toward HIV prevention while addressing competing needs that may make HIV prevention a lower priority. CRCS addresses the relationship between HIV risk and other issues such as substance abuse, mental health, social and cultural factors, and physical health.

CRCS prevention activities might include conventional risk-reduction objectives such as

- decreasing the number of sex partners and needle-sharing partners
- increasing condom use
- abstinence
- referral to needed psychological, social, and medical services affecting risk behavior (e.g., treatment for mental health and substance abuse, diagnosis and treatment of sexually transmitted diseases)

CRCS has the following 6 core elements:

- Provide CRCS as a combination of intensive, client-centered HIV risk-reduction counseling and linkage to other services that may be needed by clients in order to support or even make risk reduction possible.
- Base CRCS services on the premise that some people may not be able to prioritize HIV prevention when they perceive other problems to be more important and immediate.

- Consider persons whose HIV status is negative or unknown to be eligible if they have a recent history (past 6 months) of 1 or more of the following:
    - o unprotected sex with a person who is living with HIV
    - o unprotected sex in exchange for money or sex
    - o multiple (e.g., more than 5) or anonymous sex partners
    - o multiple or anonymous needle-sharing partners
    - o a diagnosis of a sexually transmitted disease
- Recruit persons who expressed some degree of commitment to participating in ongoing risk-reduction counseling.
- Hire case managers with the appropriate training and skills to complete the CRCS activities within their job description.
- Develop clear procedures and protocol manuals for the CRCS program to ensure effective delivery of CRCS services and minimum standards of care.

CDC Guidance:
http://www.cdc.gov/hiv/topics/prev_prog/CRCS/resources/PCMG/pdf/hivpcmg.pdf

HIV Counseling, Testing and Referral (CTR)

Target: HIV-negative individuals that engage in high risk behavior

CTR refers to a collection of activities designed to increase a client's knowledge of his/her HIV serostatus, encourage and support risk reduction, and to secure needed referrals for appropriate medical, prevention, and partner counseling and referral services (PCRS). CTR can be provided in a number of settings using a variety of methods, but all CTR services address 5 basic requirements:

1) Inform clients about HIV transmission routes, the HIV antibody testing process, and the meaning of a positive or a negative test result.
2) Provide client-centered counseling around issues of recognizing one's risk for HIV infection, risk-reduction, and the need for testing.
3) If appropriate, test clients using the best available method.
4) When using the rapid HIV test, all standards and procedures related to the use of the rapid test including guidelines for providing preliminary results and obtaining specimens for confirmatory testing are followed (see Procedural Guidance for Rapid Testing in Non-Clinical Settings in this document for additional information on the rapid HIV test).
5) Address needs for additional services and provide suitable referrals to meet those needs.

CTR can be delivered anonymously or confidentially, but it should be voluntary and undertaken only with informed consent. Several HIV test technologies have been approved by the Food and Drug Administration including tests of different fluids (whole blood, serum, plasma, oral fluids, and urine) and durations (e.g., rapid tests) offering flexibility in testing option to facilitate client access to and acceptability of testing.

CTR must be provided following the CDC's Revised Guidelines for HIV Counseling, Testing, and Referral (2001).

CTR has 8 **Core Elements**:

1) HIV CTR is a voluntary service that can only be delivered after informed consent is obtained.
2) Information and education are provided regarding:
    a. risk for transmission and how HIV can be prevented
    b. the type of HIV antibody test used
    c. the meaning of the test result including a discussion of the window period for HIV seroconversion (the time after infection, before antibodies are produced by the body in which and antibody test might be negative despite the presence of HIV)
    d. where to obtain further information, counseling, or other services (medical or mental health care)
3) Client-centered counseling is provided to address the client's readiness for testing as well as his/her personalized risk assessment, steps taken to reduce risk, risk-reduction goals, support systems, referral needs, and plans for obtaining results if necessary (if testing is provided and the agency is not using rapid testing).
4) In conjunction with the state and/or local health departments and community mental health providers, establish guidelines and define sobriety standards for counselors to use to determine when clients are not competent to provide consent. These guidelines should be unambiguous and easy to implement.
5) HIV testing is conducted using a Food and Drug Administration (FDA) approved testing technology. When rapid HIV testing is offered, please see the Procedural Guidance for Implementation of Rapid Testing in Non-Clinical Settings in this document.
6) Test results are delivered in a supportive fashion and in a way that is understandable to the client.
7) Referral needs in support of risk reduction or medical care are assessed and appropriate referrals are provided with assistance linking clients with providers. A system must be in place for emergency medical or mental health referral if needed.
8) Referrals made and completed are tracked.

Partner Counseling and Referral Services (PCRS)

Target: The Gender of participants during evaluation: and needle-sharing partners of all HIV-positive individuals

PCRS is one of a number of public health strategies to control and prevent the spread of HIV and STDs. PCRS assists HIV-infected persons with notifying their partners of exposure to HIV. A key element of PCRS is informing current and past partners that a person who is HIV-infected has identified them as a Gender of participants during evaluation: or injection-drug-paraphernalia-sharing partner and advising them to have HIV counseling and testing. Notified partners, who may not have suspected their risk, can then choose whether to be tested for HIV. Those who choose to be tested and are found to be HIV positive can receive early medical evaluation, treatment, and prevention services, including risk reduction counseling and PCRS. Gender of participants during evaluation: and injection-drug-paraphernalia-sharing partners might already be HIV-infected but be unaware of or deny their risks or their HIV status.

PCRS provides an opportunity for HIV primary prevention interventions for those partners not infected with HIV and an opportunity for primary and secondary prevention for those partners living with HIV. Informing partners of their exposure to HIV is *confidential*; partners are not told who reported their name or when the reported exposure occurred. As well, information about partners is not reported back to the original HIV-infected person. It is *voluntary*; the infected person decides which names, if any, to reveal to the interviewer.

PCRS can be an effective tool for reaching persons at very high risk for HIV infection: in studies of HIV PCRS, 8%-39% of partners tested were found to have previously undiagnosed HIV infection. However, a recent survey of health departments in U.S. areas with high reported rates of HIV found that, in areas with mandatory HIV reporting, only 52% of persons infected with HIV were interviewed for PCRS. Acceptability of PCRS has been indicated in surveys of individuals seeking HIV testing, HIV-infected persons, and notified partners.

PCRS must be provided following the CDC's Standards and Guidelines for HIV Partner Counseling, Testing and Referral Services (1998).

PCRS has 6 **Core Elements**:

1) All services are both voluntary and confidential.
2) Identifying and contacting all persons with HIV (index or original clients) to offer them PCRS. These may be persons with newly diagnosed HIV or persons with previously diagnosed HIV who have ongoing risky Gender of participants during sexual and injection-drug-use behaviors.
3) Interviewing index clients who accept PCRS to elicit names of and locating information for Gender of participants during evaluation: and injection-drug-paraphernalia-sharing partners.
4) Locating named partners, notifying them of their exposure to HIV, providing HIV prevention counseling to them, and recommending HIV testing.

5) Providing HIV counseling and testing to partners and ensuring they receive their test results.

6) Linking partners, especially those who test positive, to appropriate medical evaluation, treatment, prevention, and other services.

Outreach and Recruitment

Target: All individuals who may be engaging in high-risk behavior

Targeted outreach is used to recruit members of a target population to help them take advantage of HIV prevention interventions, programs, and services. It can be targeted to persons of negative or unknown HIV serostatus at high-risk for HIV (those performing behaviors that put them at risk for HIV or other STDs in high prevalence settings or with HIV-positive individuals) or to people living with HIV. For persons of unknown serostatus or negative persons who have not tested in the past 6 months, there should be a referral for counseling, testing, and referral services.

Recruitment can take different forms depending on the most appropriate approach for a given target population and on the needs and abilities of the organization engaging in the activity.

Outreach is a common means of meeting potential high-risk clients in their own environment to deliver HIV prevention messages and services and to bring them into additional prevention services. These activities may take place in specific venues where high-risk individuals congregate and/or in places where high risk behaviors take place (e.g., shooting galleries, the street, parks, bars, bathhouses) or can be conducted at virtual sites including the Internet or telephone hotlines. Finally, outreach can take place as the result of contacts established through the use of social networking techniques that demonstrate connections between high-risk persons. Agencies can work with current clients to reach partners or friends who may also be at high risk.

Targeted outreach has 5 **Core Elements**

1. Use of information from multiple sources to describe common characteristics of the target population, which can be used for targeting recruitment activities.
2. Develop and deliver appropriate health messages for the setting (either to be delivered by an outreach worker or by a referral source).
3. Recruit for specific services (e.g., counseling, testing, and referral services, CRCS, other prevention interventions). Recruitment must be linked to counseling, testing, and referral services for clients of unknown status, and to care and prevention services for people living with HIV (PLWH).
4. Track completion of referral to monitor the effectiveness of the referral strategy.
5. Revise strategies or venues, as appropriate.

Internet Outreach

Target: MSM who may be engaging in high-risk behavior

Description excerpted from the National Guidelines for Internet-based STD and HIV Prevention [1]

The Internet is a well known venue for finding sex partners and Internet-based or online outreach meets at-risk populations where they are and is an additional means of providing health information, risk reduction materials and messages, and referrals to services, thereby promoting and supporting positive behavioral changes.

Outreach workers can take "active" and a "passive" approach when attempting to engage a community or encourage individuals into a one-on-one discussion. An active approach can involve techniques that entice users to communicate in private or Instant Messaging (IM) sessions. The most common technique involves posting health-related messages regularly and openly in public chat sessions and inviting other users in the public chat room to enter into a private one-on-one interaction.

A more passive approach would involve simply sitting in a chat room without having introduced oneself or posting any chat dialogue. This approach may be less effective in terms of reaching significant numbers of people in a cost-effective manner.

Recommended Core Elements

- Conduct community assessment activities.
- State realistic, specific, measurable, and attainable program goals and objectives.
- Identify methods and activities to achieve specific goals and objectives.
- Clearly define staff roles, duties, and responsibilities.
- Define the populations to be served by: geographic locale, risk behavior(s), gender, sexual orientation, age, and race/ethnicity.
- Assure that educational materials and messages are relevant, culturally competent, and language/age-appropriate.
- Consult with IT staff to ensure program capability with network and firewalls, enable access to online venues, and support confidentiality measures, like password-protecting computers.
- Include professional development for all program staff.
- Include a written policy and personnel procedures that address stress and burnout.
- Include written procedures for the referral and tracking of clients to appropriate services inside and outside of the agency.
- Provide for collaboration with other local service providers to assure access to services for clients.
- Assure confidentiality of persons served

No studies on the effectiveness of this intervention had been published as of March 2008. A study published in 2005, *Internet-Based Health Promotion and Disease Control in the 8 Cities: Successes, Barriers, and Future Plans, can be found here:*

http://www.dph.sf.ca.us/sfcityclinic/providers/Internet-BasedHealthPromotionDiseaseControl.pdf

1. Guidelines for Internet outreach, from the National Coalition of STD Directors and the CDC:

https://my.ncsddc.org/Internet_Guidelines_Final_2008.pdf

Interventions with HAHSTA Guidance

Individual Prevention Counseling (IPC)

Target: HIV-positive individuals and high-risk HIV-negative individuals – those performing behaviors that put them at risk for HIV or other STDs in high prevalence settings or with HIV-positive individuals.

IPC provides health education and risk-reduction counseling to one individual at a time. One model of IPC is Stage-based Behavioral Counseling, which is an adaptation of the Stage of Change and the Transtheoretical Model of behavioral change theory.

The goals of IPC are:

- To help initiate and maintain behavior change to prevent the transmission or acquisition of HIV;
- To facilitate referral services, as needed, for clients' medical and psychosocial needs that affect their health and ability to change HIV-related risk-taking behavior; and
- To provide information and referrals, as needed, for HIV secondary prevention needs of persons living with HIV or AIDS.

The **Core Elements** of IPC are:

1. **Prevention Counseling:** Counseling provides a critical opportunity to assist the client in identifying his or her risk of acquiring or transmitting HIV. It also provides an opportunity to negotiate and reinforce a plan to reduce or eliminate behavioral risk.
2. **Provision of Referrals:** Clients may require referral for physical and psychological evaluations, appropriate therapies (i.e., drug treatment), and support services to enhance or sustain risk reduction behaviors. Each program should maintain complete knowledge of referral resources, including the availability, accessibility, and eligibility criteria for services.

Needle Exchange

Target: Injection drug users

Needle exchange programs (NEPs) distribute clean syringes and safely dispose of used ones for injection drug users (IDUs), and also generally offer a variety of related services, including referrals to drug treatment and HIV counseling and testing.

Needle exchange is an effective intervention.[1] Several studies have found use of needle exchange to be associated with reduced needle sharing and other injection-related risk reduction behaviors[2] as well as reduced HIV transmission.[3] A review of the literature, including government reports, overwhelmingly supports the effectiveness of needle exchange.[4]

References:

1. *CDC. (2000) Syringe exchange programs. June; http://www.cdc.gov/hiv/projects/idu-ta/facts/aed_idu_syr.htm*
2. *Guydish JR, Clark G, Garcia D, et al. (1995) Evaluation of needle exchange using street-based survey methods. J Drug Issues 25(1):33-41. Hagan H, Des Jarlais DC, Purchase D, et al. (1991) The Tacoma syringe exchange. J Addict Dis 10:81- 88. Watters JK. (1994) HIV infection among female injection drug users recruited in community settings. Gender of participants during evaluation: Transm Dis Nov/Dec:321-328.*
3. *Heimer R, Khoshnood K, Stephens PC, et al. (Undated Manuscript) Evaluating a needle exchange program in a small city: Models for testing HIV-1 risk reduction. New Haven, Yale University School of Medicine. Unpublished manuscript.*
4. *Vlahov D, Junge B. (1998) The role of needle exchange programs in HIV prevention. Public Health Rep 113(Suppl 1):75-80.*

Sources: Center for AIDS Prevention Studies (CAPS), University of California S.F. and San Francisco HIV Prevention Plan

Other theory-based HIV prevention interventions

To implement an intervention that is not on these lists of interventions using DOH funds, including using a locally developed, theory-based intervention, sub-grantees must meet the following criteria. The program must:

1. The intervention must be based on behavior change theory or theoretical models.
2. Have an intervention logic model. A description of the logic model must explain how the program is supported by formative research (e.g., needs assessment, evaluation). The logic model must illustrate the relationship between the intervention activities, behavioral determinants, and the intended short-term and long-term behavior outcome(s) of the intervention activities.
3. Make appropriate use of additional effective behavior change strategies such as:

   (a) Building interpersonal skills, or

   (b) Using multiple delivery methods (e.g., counseling, group discussions, lectures, live demonstrations, and role plays/practice), or

(c) Including two or more intervention sessions and an increased length of sessions, which have been shown in meta-analyses to be related to effectiveness of prevention interventions, or

(d) Including more than four hours of total contact time, or

(e) Including exposure to the intervention activities for three weeks or more.

4. Have a recruitment strategy to reach persons at high risk of HIV acquisition or transmission (e.g., social networking).
5. Have a stable history of implementing the proposed intervention for 12 months or more (include a summary of initial target measures/goals with the outcome measures and actual number of contacts).
6. Have documented history of successful recruitment and retention of the target population for the past 12 months.
7. Have conducted process evaluation activities and outcome monitoring.

Community Mobilization Models

The Balm in Gilead

The Balm in Gilead community mobilization model for the delivery of services to churches, ASOs, CBOs, and denominational leadership incorporates a phased approach to the delivery of CBA services including awareness, engagement, capacity development, community mobilization, and advocacy. The stages of the model guides and puts into operation activities to increase knowledge, skills, social capital, and continued dialogue to develop formalized partnerships, build capacity and infrastructure, encourage ownership, and ensure sustainability.

Community Health Outreach Workers

The LINKS 2 HIV Prevention Model is a systems-based CBA model for CBOs/Health Departments/Stakeholders, that is predicated upon a consensus-based coalition of HIV and related service providers (HIV, STDs, TB, Hepatitis, Mental Health, Housing, etc.) to increase access to and utilization of HIV Prevention Services by high-risk African Americans, especially African-American *Men Who Have Sex With Men* (MSM), by increasing skills and efficacy on the part of the CBOs, Health Departments and stakeholders in the three competency areas identified by CHOW as most affecting access and utilization among the target population of African-American MSM: (1) Coalition Building, (2) Referral Network Development, and (3) Health Services Marketing.

Metropolitan Interdenominational Church

The model of Communication for Social Change is based on an iterative process where community dialogue and collective action work together to produce social change in a way that improves the health and welfare of all of its members. Seven outcome-indicators of social change are (1) leadership, (2) degree and equity of participation, (3) information equity, (4) collective self-efficacy, (5) sense of ownership, (6) social cohesion, and (7) social norms.

My Brother's Keeper

My Brother's Keeper (MBK) is conducting a project entitled Community-Regional Enhancement Approaches for Combating HIV (Community REACH). This model is designed to target African-American communities heavily affected by AIDS using strategies based on the Community Guide's Model for Linking the Social Environment to Health. This structural model links HIV prevention efforts for African Americans to the multiracial, multicultural nature of our society, and other social and economic factors/conditions such as poverty, underemployment, and poor access to health care. The fundamental premise is that access to societal resources determines community health outcomes.

National Black Leadership Commission on AIDS

The National Black Leadership Commission on AIDS (NBLAC) leadership mobilization model builds the capacity of African-American CBOs and community leadership structures by informing, coordinating and organizing efforts through five programmatic committees' public policy, medical, media, ecumenical, and fund development. The focus on this model is to actively engage African-American leaders with local CDC-funded CBOs, health departments, and other community stakeholders to jointly develop and implement community plans of action that increase access to and utilization of HIV testing and services.

National Youth Advocacy Coalition

National Youth Advocacy Coalition (NYAC) model for Focus Area 3 work encompasses a multidimensional approach involving community mobilization, organizational training and social marketing components to increase the access and utilization of HIV counseling and testing services for African-American youth. NYAC has organized regional coalitions in Florida, New York and Washington, DC and has conducted organizational skills-based training on conducting HIV counseling and testing services to young people in each of the three regions. Last year, NYAC created launched a youth-driven social marketing campaign in each of the three regions.

- Conduct needs assessments
- Conduct readiness assessments and preparation
- Develop materials and resources
- Test health messages and conduct medical outreach
- Mobilize and develop multi-sector partnership
- Conduct quality assurance and evaluation
- Develop service linkages to counseling and testing sites

Adapting Interventions

This section of the District's HIV Prevention Plan describes several interventions that have been successful with different populations, and community-based organizations (CBOs) may be interested in adapting or tailoring those interventions for their own target populations. Adopting HIV/AIDS interventions that have been effective in other settings can reduce start-up time and resources.

But adaptation and tailoring adoption is not as simple as moving an intervention from one environment to another. Adapting or tailoring of an intervention must come from an understanding of the population for which the intervention is intended and should take into account both culturally relevant factors for the group being served as well as thorough knowledge of the risk behaviors and risk determinants that place the population at risk for HIV infection. Providers cannot make the assumption that because an intervention will be delivered by a member of the target population, it will be appropriate for that population. Cultural identity does not necessarily lead to cultural competency. Information about risk behaviors and determinants can only be gathered with an appropriate formative evaluation of the target population.

HAHSTA Guidance on Adapting Interventions

HAHSTA sub grantees that wish to adapt a DEBI intervention must complete 1 through 3 of the steps listed below, and submit the logic model to HAHSTA for approval. The logic model should fully describe the core elements of an intervention or strategy and how these activities work together to help prevent HIV. All intervention activities, based on the core elements of the intervention, should address the problem statement and be linked to clearly stated and planned results of the activities. Only those adaptations approved by HAHSTA may be implemented with HAHSTA funding.

Links to information on logic models can be found on this CDC web page:
http://www.cdc.gov/eval/resources.htm#logic%20model

CDC on Adapting interventions

Excerpted from the CDC's Provisional Procedural Guidance for Community-Based Organizations

When HIV was first identified, ways in which the disease was spread were also identified. Since that time, much effort has been made to develop interventions to prevent others from getting the disease. These efforts led to the development of a number of evidence-based interventions for persons who do not have HIV or whose HIV serostatus is unknown. Interventions are now offered for a variety of populations and settings. Because of this, more persons who have HIV are receiving their diagnosis earlier in their infection. As a result of better treatments, these persons are living longer and healthier lives. This has increased the prevention needs of persons living with HIV and the attention given to these needs. A number of interventions that have been shown to work are available to address the strategies of AHP; others are being tested.

The interventions in the Guidance are based on theories of behavior change that can be applied to many behaviors and populations. Because of this, interventions can be adapted to meet the

specific needs of groups that were not part of the studies done so far. Adapting these interventions will show success if changes made are based on the known needs and special conditions of the population with whom the work is to be done. When adapting, you can modify key characteristics (but not core elements) to meet the needs of your CBO or target population. Core elements and key characteristics are said for each intervention.

About formative evaluation

Before adapting an intervention, you must first do what is called formative evaluation. This type of evaluation will help you know more about the group you are trying to reach, their culture, risk behaviors, and other factors that put them at risk for HIV infection.

Following the steps of a formative evaluation can help you find answers to questions about which population is most appropriate for the intervention, what location is best for the intervention, what message(s) you need to be giving, and how best to deliver the messages and time your intervention to have the best chance of reaching the target population.

You must find out whether risk determinants that were used in an intervention that has been shown to work apply to your new target population.

> **Example:** The SISTA intervention has shown that African American women must have open discussion with their male sex partners to get these partners to use condoms. To use SISTA to reach Hispanic women, you would have to assess whether this type of discussion with male sex partners makes sense in this population.

Steps of formative evaluation

1. Interview community gatekeepers and stakeholders.

a. Determine whether an intervention can be done successfully in the group you are trying to reach by talking with the community gatekeepers and stakeholders.

> **Example:** For Popular Opinion Leader (POL), an intervention with men who have sex with men, you might interview owners of gay bars to be sure that they agree with the intervention, will allow the intervention to take place in their bars, and will support their employees in helping to identify opinion leaders.

> **Example:** For SISTA, you might need to interview the managers and guards of county and city jails to make sure that they are comfortable with the intervention being done in their facility.

b. Check to be sure they believe the service is needed.

> **Example:** For Safety Counts, community leaders and those who have an interest in the program may ask, “We already have street outreach. Why do we need another intervention in our community for drug users?” Your staff could then explain, “Safety Counts is an intervention that works with injection drug and cocaine users to get them into prevention counseling, rapid testing, partner

services, individual- and group-level interventions, medical services, and support-focused social events. Safety Counts is a specific outreach method with specific goals and is a new type of outreach and may not have been done before in your community."

2. Conduct focus groups to learn what issues are most important to members of your new target population and their community. If what you find is similar to what was found in the original evidence-based intervention, then the intervention may be the one to choose for adapting. The focus groups must also discuss all the core elements of the original evidence-based intervention. Several focus groups may be needed in order to look at each core element.

> **Example:** Mpowerment, an intervention for young gay men, has 9 core elements, of which 5 are listed below and could be explored using focus groups.

- Recruit and maintain a core group of 12 to 20 young gay and bisexual men to design and carry out project activities.
  - Conduct formal outreach, including educational activities and social events.
  - Conduct informal outreach to influence behavior change.
  - Convene peer-led, 1-time discussion groups (M-groups).
  - Conduct a publicity campaign about the project within the community.

Focus groups should find out whether each of the core elements of the evidence-based program is doable and appropriate for the new target population and settings.

3. Develop a logic model, a plan (often shown in a flow chart or table) that shows a sequence of activities that will be used to address a problem statement. These activities are then linked to measurable outcomes that show reduced HIV risk.

Your logic model should fully describe the core elements of an intervention or strategy and how these activities work together to help prevent HIV. All intervention activities, based on the core elements of the intervention, should address the problem statement and be linked to clearly stated and planned results of the activities.

Your logic model also needs information for each of the core elements of the intervention. This means that you need to find all of the resources you need to do an evidence-based intervention. Resources include

- Enough people involved (employees, managers, and volunteers)
- Supplies
- Costs for site to be used
- Travel costs
- Incentives
- Ability to develop materials

When putting together your logic model, look at the changes in behavior that happened as a result of the original research done on the intervention. Be sure that the activities in your adapted program are designed to get the same or better results.

> **Example:** Street Smart was able to get more homeless and runaway adolescents to use condoms after 8 intervention sessions.

To get similar outcomes in an adapted program, you must be willing and able to provide a similar number of sessions (8 sessions) to your new target population.

Submit the logic model to HAHSTA for approval

4. Pretest your intervention materials with a Community Advisory Board. Pretesting ensures that the materials are right for the population and meet the needs of the population. Explore things such as

- reading level of the target population
- community values and norms
- attractiveness of materials
- whether the messages and instructions are understood and can be remembered by the new target audience

5. Pilot test to check how the intervention works in a small subgroup of the population you will serve. Pilot testing shows the usefulness of the adapted intervention.

Individual- or group-level interventions can be divided into small pilot tests of each core element. Later, the entire intervention, including all core elements, can be pilot tested.

Example: For SISTA, 1 group-level session addresses gender and ethnic pride for African American women. To adapt the intervention for Hispanic women, you will need to test this session with a group of Hispanic women before carrying out the intervention on a larger scale.

Community-level interventions are hard to pilot test as a full intervention; however, core elements can be pilot tested.

Example: For Community PROMISE, peer advocates hand out role model stories to members of the target audience. Before having all of these stories handed out in the community, you may want to pilot test them by having a small group of peer advocates hand out just 1 role model story. This will help you find out how best to do this activity on a larger scale.

Choosing an appropriate population is the first step to adapting an intervention. After that, messages and strategies can be changed to help persons change behaviors that put them at risk. Also, the setting for the intervention needs to be chosen. This will help you know how to deliver the intervention.

Example: The Popular Opinion Leader intervention was first designed to reach gay men in bars. This intervention was changed successfully for use with African American women in an urban housing project.

Example: VOICES/VOCES was first tested in sexually transmitted disease clinics but has been found to also work with persons in drug treatment settings.

Tiers of Evidence Table

Tier I – Best-evidence Behavioral Interventions have:

- Significant and positive intervention effects on relevant outcomes
- No significant and negative intervention effects on relevant outcomes measured in the study
- Comparison group
- Unbiased assignment
- ≥ 3 months follow-up in both groups
- ≥ 70% retention in both groups
- Analyses adjusted for baseline differences in outcome measures (if non-RCT)
- At least 50 participants in the analytic sample in each group

For more detailed information on Tier 1 criteria go to
http://www.cdc.gov/hiv/topics/research/prs/efficacy_best-evidence.htm

Tier II – Promising-evidence Behavioral Interventions have:

- Significant and positive intervention effects on relevant outcomes
- No significant and negative intervention effects on relevant outcomes measured in the study
- Comparison group
- Unbiased or moderately biased assignment
- ≥ 1 month follow-up in both groups
- ≥ 60% retention in both groups
- Analyses adjusted for baseline differences in outcome measures (if non-RCT)
- At least 40 participants in the analytic sample in each group

For more detailed information on Tier II criteria go to
http://www.cdc.gov/hiv/topics/research/prs/efficacy_promising-evidence.htm

Theory-based Behavioral Interventions (TBIs)

Tier III – Theory-based Interventions with positive outcome monitoring have:

- Behavioral change theory
- Logic model
- Formative research
- Positive process evaluation data demonstrating fidelity, availability, and acceptance
- Outcome monitoring showing positive and significant before and after changes in relevant outcomes

For more detailed information on Tier III criteria go to

http://www.cdc.gov/hiv/topics/research/prs/tiers-of-evidence_tierIII.htm#III

Tier IV – Theory-based interventions with no outcome monitoring have:

- Behavioral change theory
- Logic model
- Formative research
- Positive process evaluation data demonstrating fidelity, availability, and acceptance

For more detailed information on Tier III criteria go to
http://www.cdc.gov/hiv/topics/research/prs/tiers-of-evidence_tierIII.htm#IV

Prioritization of Populations

August 2009

"The HIV/AIDS epidemic in the District of Columbia continues to present a major public health challenge… Every community and every population group is impacted by the virus."

Executive Summary, District of Columbia HIV/AIDS Epidemiology Annual Report 2007

The District of Columbia HIV Prevention Community Planning Group (HPCPG) prioritized populations by risk group based on the data on newly diagnosed HIV cases in 2001-2006 in July 2009, the first time that the HPCPG was able to use HIV data to conduct prioritization.

Heterosexuals, Men who have Sex with Men (MSM) and Injecting Drug Users (IDU) living with HIV were ranked as Priority 1.

High-risk HIV-negative individuals from the same risk groups were ranked as Priority 2.

All populations within each of the two groups would have the same priority.

The HPCPG also prioritized 10 Special Populations, including populations that may not be captured by surveillance data but that research suggests are at high risk for contracting HIV and populations that have specific needs associated with their HIV risk behaviors that may not be not adequately addressed in traditional HIV prevention projects.

Prioritized Populations

Priority 1	**Priority 2**	**Special Populations**
HIV-Positive Heterosexuals, MSM and IDUs	**HIV-Negative Heterosexuals, MSM and IDUs**	
Black MSM, all ages Latino MSM, 20-39 White MSM, 20-49 Black IDUs, 20-59 Latino IDUs, 40-49 White IDUs, 30-49 Black Heterosexuals, all ages	Black MSM, all ages Latino MSM, 20-39 White MSM, 20-49 Black IDUs, 20-59 Latino IDUs, 40-49 White IDUs, 30-49 Black Heterosexuals, all ages	High-Risk Youth Transgender Individuals Individuals Involved in the Sex Trade The Deaf and Hard of Hearing. Individuals who are 50 or older Latino heterosexuals between 20 and 49 years old Recent immigrants that may face challenges in accessing health services Incarcerated and recently released individuals Individuals with physical, mental or developmental disabilities Homeless individuals

The Process

At the April 9, 2009 Meeting of the HPCPG – the first meeting to include 12 new members of the HPCPG – HAHSTA presented an overview of prioritization as part of the development of a new prevention plan, which included indentifying the populations most in need of prevention services. In the traditional approach used by the HPCPG, populations had been ranked, led by the population deemed to be most in need of prevention services. A separate process was used to identify the most appropriate strategies and interventions to reduce HIV transmission in those populations.

HAHSTA posited that a limitation of this approach is that the Prevention Plan does not include goals, strategies or plans for reducing HIV transmission. The presentation asked several questions, including:

- Is a list of prioritized populations – and a separate list of recommended interventions – the most useful product that could be developed by the HPCPG?
- Is a ranked list enough, or could desired outcomes and strategies be linked to those populations?
- Does prioritization — of populations or goals — need to be thought of purely as "ranking"?

Many questions ensued about how a new plan, and a new prioritization, should be conducted, and the group agreed to hold a special meeting in May 2009 to decide what method of prioritizing populations should be used in 2009.

At the May 2009 HPCPG meeting, HAHSTA made a presentation describing three options for prioritization, including the process used in DC in 2006 and the prioritization process used in Chicago in 2005.

In 2006 the DC HPCPG identified and prioritized populations first by risk group – PLWH, Heterosexuals, IDUs and MSM – then by race/ethnicity and gender within those four groups. It used seven factors to rank the populations, including:

1. Estimated Size of population
2. AIDS Incidence (new AIDS cases) in 2000 - 2004
3. AIDS rate in 2000-2004 (cases per 10,000 population)
4. AIDS prevalence (PLWA as of Dec. 2003)
5. Risky Behaviors (Degree of transmission risk of each behavior and prevalence of risky behavior)
6. Barriers to reaching the population with prevention services (cultural, linguistic, etc.)
7. Difficulty of meeting needs (Few, moderate or substantial prevention resources currently available)

Several HPCPG members were concerned with the results of that process because of problems with factors that called for scores that were not based on data.

In 2005, Chicago used only epidemiological data in its prioritization process, rather than combining the epidemiological data with co-factor data, such as barriers to receiving HIV

prevention services or service gaps analysis – both found in the Community Services Assessment (CSA). It looked at several factors to determine who were those most at risk for infecting others with HIV and who were those most at risk of getting infected with HIV, including

- Recent HIV Diagnoses
- Risk hierarchy (the relative potential for efficiently transmitting HIV)
- And where do PLWH live (by Zip code)

The Chicago planning group decided to use Information on barriers for the process of designing strategies and selecting interventions, while information from the gap analysis data would be used for service allocation.

A third option presented by HAHSTA would identify priorities for an overall prevention portfolio for community-level impact, as well as programming priorities both within and across populations.

The group discussed the three options and agreed to adapt the Chicago prioritization model for DC and to develop a comprehensive HIV prevention plan that ties outcomes and strategies for each population after the prioritization of populations was completed.

A work group was created to review the data on HIV and AIDS in the *District of Columbia HIV/AIDS Epidemiology Annual Report 2007* (http://doh.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/epidemiology_annual_2007.pdf) and the *District of Columbia HIV/AIDS Epidemiology Update 2008* (http://doh.dc.gov/doh/lib/doh/pdf/dc_hiv-aids_2008_updatereport.pdf).

Decisions

On June 11 the HPCPG approved the recommendation to prioritize populations by risk group based on the data on new HIV diagnosis for 2001-2006. The HPCPG agreed to prioritize Heterosexuals, Men who have Sex with Men (MSM) and Injecting Drug Users (IDU) as Priority 1 and high-risk HIV-negative individuals from the same risk groups as Priority 2. All populations within each of the two groups would have the same priority.

The HPCPG agreed to focus the prioritized populations Ward, race/ethnicity, gender and age group, using new HIV case data, at the next HPCPG meeting. In addition the group agreed to prioritize several special populations at that meeting.

On July 9 the HPCPG reviewed data from two tables prepared by the Strategic Information Bureau, based on the epidemiology reports: Newly Diagnosed HIV Cases in 2001-2006, broken out by age ranges for each risk category (see below), and People Living with HIV/AIDS by Ward. The HPCPG felt that the data by Ward was not as recent as the data on Newly Diagnosed HIV Cases, because it included information on individuals who had been living with HIVAIDS for several years. No detailed breakdown was available on Newly Diagnosed HIV Cases in 2001-2006 by Ward, so the HPCPG decided not to prioritize subpopulations by Ward.

After determining the age groups where the majority of New HIV Cases had been reported for each sub-population, the HPCPG agreed to prioritize the following sub-populations of the three risk groups that were prioritized in June:

Population	Target Age Ranges
MSM	
Black	All ages
Latino	20-39
White	20-49
IDUs	
Black	20-59
Latino	40-49
White	30-49
Heterosexuals	
Black	All ages

The HPCPG also prioritized 10 Special Populations, including populations that may not be captured by surveillance data but that research suggests are at high risk for contracting HIV and populations that have specific needs associated with their HIV risk behaviors that may not be adequately addressed in traditional HIV prevention projects:

1. High-Risk Youth
2. Transgender Individuals
3. Individuals Involved in the Sex Trade
4. The Deaf and Hard of Hearing.
5. Individuals who are 50 or older
6. Latino heterosexuals between 20 and 49 years old
7. Recent immigrants that may face challenges in accessing health services
8. Incarcerated and recently released individuals
9. Individuals with physical, mental or developmental disabilities
10. Homeless individuals

Newly Diagnosed HIV Cases, 2001-2006

Mode of Transmission: Heterosexual contact

	Race/Ethnicity								Total	
	White		Black		Hispanic		Other			
	N	%	N	%	N	%	N	%	N	%
Male	20	57.1%	457	41.2%	30	66.7%	14	41.2%	521	42.6%
Female	15	42.9%	651	58.8%	15	33.3%	20	58.8%	701	57.4%
Total	**35**	**2.9%**	**1,108**	**90.7%**	**45**	**3.7%**	**34**	**2.8%**	**1,222**	**100.0%**

Age at Diagnosis	Race/Ethnicity								Total	
	White		Black		Hispanic		Other			
	N	%	N	%	N	%	N	%	N	%
13-19	<5		24	2.2%	<5		<5	8.8%	31	2.5%
20-29	7	20.0%	191	17.2%	13	28.9%	8	23.5%	219	17.9%
30-39	9	25.7%	370	33.4%	15	33.3%	10	29.4%	404	33.1%
40-49	8	22.9%	339	30.6%	10	22.2%	8	23.5%	365	29.9%
50-59	8	22.9%	140	12.6%	<5		<5		154	12.6%
60+	<5		44	4.0%	<5		<5		49	4.0%
Total	**35**	**2.9%**	**1,108**	**90.7%**	**45**	**3.7%**	**34**	**2.8%**	**1,222**	**100.0%**

% of total (3,269): 37.4%

Newly Diagnosed HIV Cases, 2001-2006

Mode of Transmission: MSM

Age at Diagnosis	Race/Ethnicity								Total	
	White		Black		Hispanic		Other			
	N	%	N	%	N	%	N	%	N	%
13-19	<5		26	4.9%	<5		<5		30	3.6%
20-29	49	20.5%	152	28.7%	14	29.2%	<5		219	26.0%
30-39	112	46.9%	159	30.0%	24	50.0%	13	52.0%	308	36.6%
40-49	62	25.9%	140	26.4%	7	14.6%	<5		213	25.3%
50-59	13	5.4%	44	8.3%	<5		<5		58	6.9%
60+	<5		9	1.7%	<5		<5		14	1.7%
Total	**239**	**28.4%**	**530**	**62.9%**	**48**	**5.7%**	**25**	**3.0%**	**842**	**100.0%**

% of total (3,269): 25.8%

Newly Diagnosed HIV Cases, 2001-2006

Mode of Transmission: IDU

	Race/Ethnicity								Total	
	White		Black		Hispanic		Other			
	N	%	N	%	N	%	N	%	N	%
Male	9	60.0%	228	56.4%	<5		<5		243	56.3%
Female	6	40.0%	176	43.6%	<5		<5		189	43.8%
Total	**15**	**3.5%**	**404**	**93.5%**	**6**	**1.4%**	**7**	**1.6%**	**432**	**100.0%**
Age at Diagnosis		Race/Ethnicity							Total	
	White		Black		Hispanic		Other			
	N	%	N	%	N	%	N	%	N	%
13-19	<5		<5		<5		<5		<5	
20-29	<5	13.3%	33	8.2%	<5		<5		36	8.3%
30-39	6	40.0%	80	19.8%	<5		<5		87	20.1%
40-49	6	40.0%	206	51.0%	<5		<5		219	50.7%
50-59	<5		80	19.8%	<5		<5		83	19.2%
60+	<5		<5		<5		<5		6	1.4%
Total	**15**	**3.5%**	**404**	**93.5%**	**6**	**1.4%**	**7**	**1.6%**	**432**	**100.0%**

% of total (3,269): 13.2%

Data Source: District of Columbia HIV/AIDS Epidemiology Annual Report 2007

RECOMMENDED INTERVENTIONS

July 2008

Introduction

The HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) is funded under by the Centers for Disease Control and Prevention, which requires that all grant recipients fund prevention services that are based on scientific theory or evidence of demonstrated or probable outcome effectiveness.

Evidenced-based interventions are interventions that have been evaluated using behavioral or health outcomes; have been compared to a control/comparison group(s) (or pre-post data without a comparison group if a policy study); had no apparent bias when assigning persons to intervention or control groups or were adjusted for any apparent assignment bias; and, produced significantly greater positive results when compared to the control/comparison group(s), while not producing negative results.

Health departments may also fund interventions with insufficient evidence of effectiveness based on prior outcome monitoring data suggesting positive effects, but that cannot be rigorously proven. These interventions must be based on sound science and theory; a logic model that matches the science and theory to the intended outcomes of interest; and a logic model that matches relevant behavioral-epidemiololgic data from their community and target population.

Choosing Interventions

The Program Initiatives Committee of the D.C. HIV Prevention Community Planning Group reviewed and scored the interventions identified and described in "HIV Prevention Interventions" which was prepared by HAHSTA for this HIV Prevention Plan. The list of interventions included in that document is not exhaustive, and sub-grantees may choose to implement interventions not included in this document if they meet HAHSTA requirements.

The recommendations were approved by the HPCPG on July 10, 2008.

The PI Committee used the scoring sheet for this process.

Scoring Sheet for Interventions

	Is there evidence that the intervention is effective in averting or reducing HIV risk behavior?	Is it designed to reach this specific population or a similar population?	Does it target specific risk behavior?	Is it feasible? (Do CBOs have, or can they easily acquire, the capacity to implement it?)
	Weight: 5	**Weight: 4**	**Weight: 4**	**Weight: 3**
Rating Choices	❑ Yes (1 point) ❑ No (0 points)	❑ Yes (1 point) ❑ No (0 points)	❑ Yes (1 point) ❑ No (0 points)	❑ Yes (1 point) ❑ A replication package is available but no training is available or planned (0.5 points) ❑ No (0 points)
Ratings				
Weight X rating				
Total Points: _____ Recommended:			**❑ Yes**	**❑ No**

The maximum possible score was 16. The committee decided that an intervention must score at least 10 points to be recommended for implementation.

Scoring of interventions

Interventions Recommended in the 2006-2009 Prevention Plan	Additional interventions considered in 2008	Score
People Living with HIV		
Comprehensive Risk Counseling and Services (CRCS)	Individual Prevention Counseling	11
Healthy Relationships	CLEAR	14.5
Partnership for Health		
Partner Counseling and Referral Services		
Safety Counts (IDUs, crack users)		
STI Screening		
Outreach and Referral & Recruitment		

Interventions Recommended in the 2006-2009 Prevention Plan	Additional interventions considered in 2008	Score
Together Learning Choices (previously called Teens Linked to Care) (Youth 13-24)		
WiLLOW		
Heterosexuals		
HIV Counseling and Testing	Individual Prevention Counseling	11
CRCS	BART (Youth 14-18)	14.5
"light" (Living in Good Health Together)	Be Proud! Be Responsible! (Youth, mean age 15)	14.5
Partner Counseling and Referral Services	¡Cuídate! (Youth 13-18)	14.5
START (young men about to be released from prison)	Doing Something Different	14.5
PROMISE	Nia	16
Real AIDS Prevention Project (RAPP)	Focus on Kids (FOK) (Youth 9-15)	14.5
SiHLE (Youth, mean age 16)	FOK + ImPACT (*Focus on Youth with ImPACT)* (Youth 9-15)	16
SISTA *	Project AIM (Out-of-school youth, 11-14)	16
STI Screening	Project Connect	16
Street Smart (Youth 11-18)	Project S.A.F.E.	14.5
Outreach and Referral	RESPECT: Brief Counseling	16
VOICES/VOCES	RESPECT: Brief Counseling + Booster	16
	RESPECT: Enhanced Counseling	16
	Sister-to-Sister	16
Injecting Drug Users		
HIV Counseling and Testing	Individual Prevention Counseling	11
Needle Exchange	Modelo de Intervención Psicomédica (MIP)	16
Partner Counseling and Referral Services	Sniffer (for intranasal drug users)	14.5
CRCS	SHIELD	14.5
PROMISE		
Safety Counts		
STI Screening		
Outreach and Referral		

Interventions Recommended in the 2006-2009 Prevention Plan	Additional interventions considered in 2008	Score
MSM		
Outreach and Referral	Individual Prevention Counseling	11
HIV Counseling and Testing	Brief Group Counseling (APIs)	14.5
Partner Counseling and Referral Services		
CRCS		
Many Men, Many Voices *		
Mpowerment		
Popular Opinion Leader (adapted for Black MSM in 2008 as d-up!)		
PROMISE		
STI Screening		

Note: *Some interventions that were recommended in 2006 are no longer recommended:*

- *Holistic Health Recovery Program, for HIV+ and HIV- injecting drug users, is not included in the updated CDC compendium of effective interventions and training is no longer being provided through the DEBI project*
- *Options and SMART CRCS are not included in the updated CDC compendium of effective interventions*

Recommended Interventions

Descriptions of these interventions can be found in the section on HIV Prevention Interventions, on Page **106.**

If no training is available or under development for an intervention listed below, a replication package is available or under development

Interventions	Type of Intervention	Target Population	Is training available
People Living with HIV			
Healthy Relationships	Group Level (GLI)	All	Yes
Partnership for Health	Individual Level (ILI)	All, in care settings	Yes
Partner Counseling and Referral Services	ILI	Partners of HIV+ individuals	Yes; implemented by Health Dept.

Interventions	Type of Intervention	Target Population	Is training available
Comprehensive Risk Counseling and Services (CRCS)	ILI	All	Yes
Safety Counts	GLI	IDUs and crack users	Yes
STI Screening	ILI	All	Yes
Outreach and Referral	ILI	All	Yes
Together Learning Choices (previously called Teens Linked to Care)	GLI	Latino, Black and white Youth 13-24	Yes
WiLLOW	GLI	Heterosexual women	July 2009
Individual Prevention Counseling	ILI	All	Yes
CLEAR	GLI	Heterosexual men and women	July 2009
Heterosexuals			
HIV Counseling and Testing	ILI	All	Yes
"light"	GLI	Black and Hispanic women and men	No
Partner Counseling and Referral Services (PCRS)	ILI	All partners of HIV-positive individuals	Yes; implemented by Health Dept.
Comprehensive Risk Counseling and Services (CRCS)	ILI	All high-risk individuals	Yes
Project START	ILI	Young men about to be released from prison	October 2009
PROMISE	Community Level Intervention (CLI)	All	Yes
Real AIDS Prevention Project (RAPP)	CLI	Black women and their sex partners	Yes
SISTA	GLI	African American women	Yes
Sister-to-Sister	GLI and ILI	African American women	October 2009 (tentative)
STI Screening	ILI	All	Yes
Outreach and Referral	ILI	All	Yes

Interventions	Type of Intervention	Target Population	Is training available
VOICES/VOCES	GLI	African American and Latino men and women	Yes
Individual Prevention Counseling	ILI	All	Yes
Doing Something Different	GLI (single session)	Black males and females	No
Nia	GLI	Black males	July 2010 (tentative)
Project Connect	ILI	Black, Latino and mixed couples or woman alone	October 2009 (tentative)
Project S.A.F.E.	GLI	Latina and Black women	No
RESPECT: Brief Counseling	ILI (CTR)	All high-risk individuals	Yes
RESPECT: Brief Counseling + Booster	ILI (CTR)	All high-risk individuals	Yes
RESPECT: Enhanced Counseling	ILI (CTR)	All high-risk individuals	Yes
Heterosexual Youth			
BART	GLI	Youth (14-18)	No
Be Proud! Be Responsible!	GLI	Black male youths (mean age 15)	No
¡Cuídate!	GLI	Hispanic/Latino youth (13-18)	July 2010 (tentative)
Focus on Kids (FOK)	GLI	Black youth (9-15)	Under Development
FOK + ImPACT (*Focus on Youth with ImPACT)*	GLI	Black youth (9-15) and their parents	Yes
Project AIM	GLI	Out-of-school youth (11-14)	July 2010 (tentative)
SiHLE)	GLI	Young Black women (14 to 18)	July 2009
Street Smart	GLI	Female and male youth (11-18)	Yes
RESPECT: Brief Counseling	ILI (CTR)	All high-risk individuals	Yes

Interventions	Type of Intervention	Target Population	Is training available
RESPECT: Brief Counseling + Booster	ILI (CTR)	All high-risk individuals	Yes
RESPECT: Enhanced Counseling	ILI (CTR)	All high-risk individuals	Yes
Injecting Drug Users			
HIV Counseling and Testing	ILI	All	Yes
Individual Prevention Counseling	ILI	All	Yes
CRCS	ILI	All	Yes
Modelo de Intervención Psicomédica (MIP)	ILI	Hispanics/Latinos and Blacks	Yes
Needle Exchange	ILI	All	No, but TA is available
Partner Counseling and Referral Services	ILI	Partners of HIV+ individuals	Yes; implemented by Health Dept.
PROMISE	CLI	All	Yes
Safety Counts	GLI	IDUs and crack users	Yes
Shield	GLI	Black IDUs	July 2010 (tentative)
Sniffer	GLI	Intranasal drug users	No
STI Screening	ILI	All	Yes
Outreach and Referral	ILI	All	Yes
MSM			
Brief Group Counseling	GLI	API MSM	No
CRCS	ILI	High Risk Individuals	Yes
d-up! (Adaptation of Popular Opinion Leader)	CLI	Black MSM	December 2008
HIV Counseling and Testing	ILI	All	Yes
Individual Prevention Counseling	ILI	High Risk Individuals	Yes
Many Men, Many Voices (African American and Latino MSM)	GLI	Black MSM	Yes

Interventions	Type of Intervention	Target Population	Is training available
Mpowerment	GLI	White, Hispanic/Latino MSM	Yes
Partner Counseling and Referral Services	ILI	Partners of HIV+ individuals	Yes; implemented by Health Dept.
Popular Opinion Leader	CLI	White MSM	Yes
PROMISE	CLI	All	Yes
STI Screening	ILI	High Risk Individuals	Yes
Outreach and Referral	ILI	High Risk Individuals	Yes