

MINNESOTA  
COMPREHENSIVE  
HIV  
PREVENTION PLAN  
2003 - 2005

Community Cooperative Council on  
HIV/AIDS Prevention  
and  
Minnesota Department of Health

Update for 2005



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# Minnesota Comprehensive HIV Prevention Plan

2003 – 2005

*Developed by the*  
Community Cooperative Council on  
HIV/AIDS Prevention

*and the*

Minnesota Department of Health  
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# Acknowledgements

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## Introduction

*This introduction describes the community planning process and its relation to HIV prevention in Minnesota. The introduction also provides an overview of the Community Cooperative Council on HIV/AIDS Prevention.*

### HIV Prevention Community Planning

Prevention strategies still remain our best defense in the battle against HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome). Our experience shows that unless HIV prevention programs are developed with input from the communities they propose to reach, they are unlikely to receive the support they need to be effective. In 1993, the Centers for Disease Control and Prevention (CDC) issued a guidance to all state and territorial health departments on how to implement ongoing HIV Community Prevention Planning through the establishment of a community planning group (CPG).

The purpose of having a CPG is to share with the community the responsibility for identifying and developing effective, culturally specific prevention education interventions.

The primary task of the CPG is to develop a comprehensive HIV prevention plan; thus, the development of this document. The comprehensive HIV prevention plan includes detailed information on the following work that is completed through the community planning process:

**Epidemiological Profile:** The epidemiological profile (epi profile) describes the scope of the HIV epidemic within different populations in the state.

**Community Services Assessment:** The community services assessment (CSA) is made up of three components: needs assessment, resource inventory, and gap analysis. *Needs assessments* describe how social and cultural characteristics impact HIV infection within specific populations, and

identify what the HIV prevention service needs of those populations are. *Resource inventory* is a listing of HIV services that have been implemented to address the needs. *Gap analysis* is a process that is used to determine which prevention needs are still unmet.

**Prioritized Target Populations:** Populations that have been identified and prioritized as needing prevention efforts due to high rates of HIV infection and high incidence of risky behaviors. The prioritized target populations are identified through using the epi profile and the community services assessment.

**Appropriate Science-based Prevention Activities/Interventions:** Interventions to reduce infection or transmission that have been identified for each of the prioritized target populations. The interventions are chosen based on effectiveness and cultural/ethnic appropriateness to the target population.

**Letter of Concurrence / Concurrence with Reservations / Non-concurrence:** A written response from the community planning body that describes to what extent the prevention activities proposed in the health department's grant application agree with the priorities in the comprehensive HIV prevention plan.

The updated community planning guidance developed by the CDC in 2003 describes three goals and eight objectives for HIV prevention community planning. The goals provide overall direction for how community planning should be implemented. However, the goals were purposefully written in broad terms to allow the health departments and community planning groups flexibility in determining how to achieve them.

## **GOALS AND OBJECTIVES**

### **Goal One**

Community planning supports broad-based community participation in HIV prevention planning.

*Objectives:*

- A. Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.*
- B. Ensure that the CPG membership is representative of the diversity of populations most at risk for HIV infection and community characteristics, and includes key professional expertise and representation from key governmental and non-governmental agencies.*
- C. Foster a community planning process that encourages inclusion and parity among community planning members.*

### **Goal Two**

Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

*Objectives:*

- D. Carry out a logical, evidence-based process to determine the highest priority, population specific needs.*
- E. Ensure that prioritized target populations are based on an epidemiological profile and a community services assessment.*
- F. Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with the intended target populations for cultural appropriateness, relevance, and acceptability.*

### **Goal Three**

Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

*Objectives:*

- G. Demonstrate a direct relationship between the comprehensive prevention plan and the health department's prevention grant application.*
- H. Demonstrate a direct relationship between the comprehensive prevention plan and funded interventions.*

Perhaps the most important and controversial part of community planning is the prioritization of target populations and identification of interventions. Since there is a finite amount of resources available for HIV prevention, and an infinite number of ways in which to use those resources, the community planning process is responsible for deciding what those resources should be used for, and to which communities the resources should go. This responsibility is becoming ever more challenging as the amount of available resources continues to decrease.

## **The CCCHAP**

In 1994, in order to implement all these aspects of community planning, Minnesota formed the Commissioner's Task Force on HIV/STD Prevention Planning (Task Force). In 2004, the group decided to change its name to the Community Cooperative Council on HIV/AIDS Prevention (CCCHAP). This group is selected by, and composed of, community members that represent the cultural and geographic diversity of the HIV epidemic in Minnesota. The CCCHAP is responsible for prioritizing HIV prevention target populations and identifying interventions for each population.

The CCCHAP works closely with the Minnesota Department of Health (MDH) to carry out the community planning process. The MDH receives funding from the CDC and the state to implement HIV prevention programming, and receives limited CDC funding to address sexually transmitted diseases (STDs).

## **CCCHAP MEMBERSHIP**

The CCCCHAP may have up to 35 members. At least 25 percent of the membership should be people who are living with HIV/AIDS. The membership of the CCCHAP should reflect the HIV epidemic in Minnesota in terms of gender, race/ethnicity, age, sexual orientation, risk behavior, and geography. Additionally, the membership should include individuals who have expertise

in the areas of epidemiology, health planning, behavioral and social sciences, and program evaluation.

New members are brought on once a year in December. Members may serve up to three consecutive two-year terms. The CCCHAP is chaired by three co-chairs. Two are community co-chairs elected by the membership. The third co-chair is appointed by the MDH. The membership also elects a Parliamentarian, who is responsible for advising the co-chairs on CCCHAP procedures and decision making processes.

### **CCCHAP PLANNING PROCESS**

MDH and the CCCHAP implemented a restructured planning process in April 2004. Under this new process, the full CCCHAP currently meets three to four times a year for two full days, instead of maintaining the previous schedule of monthly meetings that lasted four hours. Committees only meet four to five times a year instead of meeting monthly.

The restructured process involves a three-year planning cycle, with Year A being the major prioritization year. The next major prioritization process will occur in 2005. Prioritization will be conducted during the first several months of the year and an RFP will be issued in the spring of Year A, with three-year contracts being implemented at the beginning of Year B. In terms of the planning cycle, Years B and C are "gap analysis" years, during which the CCCHAP will identify needs that have not been met as a result of the major prioritization and RFP process. Unmet needs may be the result of numerous factors, including insufficient funds or emerging trends that were not identified during the last prioritization process.

An additional focus of the new planning structure is to increase input from community (non-CCCHAP) members into the planning process. CCCHAP members will be expected to gather community input related to prioritization and gap analysis through attendance at established community groups or by convening community forums.

### **Goals of Restructured Planning Process**

- To improve participation (better attendance at CCCHAP meetings and more interest in CCCHAP membership) in community planning by:
  - Changing the requirements related to time spent in meetings
  - Clarifying roles and responsibilities of CCCHAP members
  - Clarifying the purpose/objectives of work to be completed at each meeting.
- To maintain balance between flexibility to address emerging needs and stable support for grantees.
- To improve input into the community planning process by non-CCCHAP members.
- To reduce MDH's administrative burden.

For a broad overview of the new planning process, please refer to the diagram found on page 9. An updated organizational chart of the CCCHAP reflective of the new process is on page 10.

### **COMMITTEE STRUCTURE**

The work of the CCCHAP has historically been done through its committees and then brought back to the full body for approval. However, with the new planning model, much of the work that was previously done in committee will be completed during the full CCCHAP meetings. As a result, two former committees of the CCCHAP have been eliminated.

The Executive Committee and the Community Access Committee have continued as ongoing committees under the new planning process, although the names of the committees have changed. The Community Access committee is now called the Membership & Training Committee. The Executive Committee is now the Process & Procedures Committee.

CCCHAP members are required to serve on at least one committee during both years of their first membership term. During their

second or third membership term, they are only required to serve on a committee for one year of each two-year term.

Community members have always been welcome to participate in the committees and in the past were able to become voting members of a committee after attending three meetings. Under the new planning structure, community members may attend any committee meeting and are able to fully participate in the decision making process. At full CCCHAP meetings, community members may participate in discussion, but not in decision making.

### ***Membership & Training Committee***

The Membership & Training Committee is responsible for implementing Goal One of community planning by ensuring that the membership of the CCCHAP fosters parity, inclusion and representation (PIR). Goals Two and Three are conducted by the full CCCHAP.

**Parity:** The ability of members to equally participate and carry out planning tasks/duties. In order to achieve parity, members should be provided with opportunities for orientation and skills building to participate in the planning process and to have equal voices in voting and other decision making activities.

**Inclusion:** Meaningful involvement of members in the process with an active voice in decision making. An inclusive process assures that the views, perspectives, and needs of all affected communities are actively included.

**Representation:** The act of serving as an official member reflecting the perspective of a specific community. A representative should truly reflect that community's values, norms and behaviors (members should have expertise in understanding and addressing the specific HIV prevention needs of the populations they represent). Representatives must be able to participate as group members in objectively weighing the overall priority prevention needs of the jurisdiction.

The Membership & Training Committee considers the make-up of the current CCCHAP (gender, race/ethnicity, age, sexual orientation, risk behavior, place of residence) and compares it to the demographics of who is becoming infected with HIV, and who is living with HIV and AIDS in Minnesota. They also consider any gaps in areas of expertise among the current membership and to what extent HIV positive individuals are represented. This assists the committee in understanding who to target for recruitment for membership on the CCCHAP.

The Membership & Training Committee conducts interviews with all potential candidates and makes recommendations for membership. New members are elected at a joint meeting of the Membership & Training and the Process & Procedures Committees, and are brought on in December of each year. The committee is also responsible for overseeing the orientation of new members and ongoing training for the full membership.

The Membership & Training Committee is currently focusing its work on increasing the size of the CCCHAP membership and ensuring that the membership is reflective of the epidemic in Minnesota. At this time, there are gaps in membership from the men who have sex with men (MSM) community, from the Latino, Asian and African communities, from the suburbs and Greater Minnesota, and from HIV positive individuals. A targeted recruitment effort was launched at the end of the summer for new members to start in December 2004.

### ***Process & Procedures Committee***

The Process & Procedures Committee is charged with reviewing and refining processes and materials used by the CCCHAP to make planning decisions. The committee is responsible for assigning roles and responsibilities for managing CCCHAP meetings, reviewing planning processes and making recommendations for improvement, and for making recommendations regarding changes in the bylaws. The Process & Procedures Committee, jointly with the Membership & Training Committee, also

reviews community planning evaluations and determines how to most effectively address identified issues.

The two community co-chairs, the MDH co-chair, and the Parliamentarian are required to serve on this committee. The remaining membership is made up of CCCHAP members who are interested in serving on this committee.

### ***Executive Team***

The Executive Team is made up of the two community co-chairs, the MDH co-chair, the Parliamentarian, and MDH staff. While not officially a committee, the Executive Team meets on an as-needed basis for the purpose of strategizing the overall planning process and/or any special planning projects, identifying resources needed to complete specific tasks, considering appeals from CCCHAP members who have been removed, and for considering grievances related to CCCHAP process.

## **Youth Council**

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From 1997 through 2003, the Youth Council served as an advisory council to the CCCHAP on issues related to youth. The Youth Council began as a way to involve young people in HIV prevention community planning, and expanded to also implement some HIV/STD prevention activities with youth.

The Youth Council has been involved in developing and distributing a HIV/STD prevention curriculum to city parks programs, in conducting outreach to tattoo parlors, and in planning and implementing a youth oriented STD health fair and testing event. They have served as a model to other states, and have been asked on many occasions to provide technical assistance.

During the CCCHAP restructuring process, it was decided that the focus of the Youth Council would no longer include community planning. While the group has been very active and effective in implementing prevention activities and in providing technical assistance to youth-serving agencies, it had

proven to be a challenge to involve the Youth Council in the community planning process in a way that was meaningful and effective.

The Youth Council will continue to provide technical assistance to youth-serving organizations and to implement HIV and STD prevention activities with youth. In order to maintain the voice of young people, the CCCHAP has placed an emphasis on recruiting and maintaining members under the age of 25.

## **Community Involvement**

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The CCCHAP relies on the involvement and input of community members to accomplish its work. All CCCHAP and committee meetings are open to the community and community members are welcome to participate in the conversation. As mentioned earlier, community members may attend any committee meeting and participate in the discussion and decision making.

In addition, CCCHAP members attend established community groups and/or conduct community forums in order to gather feedback and information from members of at-risk populations to help ensure that prevention interventions will really meet the needs of those populations.

## **Training for CCCHAP Members**

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In 2002, a consultant was hired to develop a training curriculum for CCCHAP members, which included two core trainings for new members focused on community planning, roles and responsibilities, epidemiology, and prevention interventions. An ongoing education curriculum was also developed for more experienced members, which included trainings on participating in groups, group facilitation, policy, community planning models, and understanding power and privilege.

Some of these trainings were delivered in 2003 and were well received by CCCHAP members. However, due to budget

constraints, future training efforts will be focused in three areas. An orientation will be provided for all new members, which will cover much of the information included in the core trainings developed by the consultant. Additionally, trainings will be provided on prioritization and gap analysis each time the processes are implemented.

## **Evaluation of HIV Prevention Community Planning**

The basic evaluation question related to the community planning process is the following, "Is community planning being implemented as intended and achieving its objectives?" The first part of the evaluation plan is designed to evaluate to what degree the community planning process is meeting the goals and objectives defined by CDC, which are presented on page 2 of this chapter. The second part of the evaluation plan describes activities to evaluate how effectively the new planning process is meeting the desired goals of restructuring (summarized on page 3).

### **PERFORMANCE INDICATORS**

In the new community planning guidance released in 2003, the CDC includes four performance indicators that will be used to monitor the progress that health departments and CPGs are making in meeting the goals and objectives of community planning.

#### **Performance Indicator #1**

The first performance indicator is designed to measure to what degree the membership of the CCCHAP is reflective of the HIV epidemic in the state, and corresponds to Community Planning Goal 2, Objective B. It is defined as, *"the proportion of populations most at risk (up to 10), as documented in the epidemiological profile and/or the priority populations in the comprehensive plan, that have at least one CPG member that reflects the perspective of each population."*

This will be measured by calculating how many of the top ten prioritized target populations in the comprehensive plan are

represented by at least one CCCHAP member. Representation of a target population may be by a person who is an advocate for and/or works with that population.

#### **Performance Indicator #2**

The second performance indicator is designed to measure CCCHAP members' perceptions of the quality and relevance of the community planning process. It is defined as, *"the proportion of key attributes of an HIV prevention planning process that CPG membership agree have occurred."*

This indicator refers to 52 key attributes that are included in the community planning guidance. The key attributes provide more detail as to how the three goals and eight objectives of community planning should be implemented. The CDC has designed a survey that will be completed by CCCHAP members on an annual basis to determine how many of the key attributes the membership agrees have occurred.

#### **Performance Indicator #3**

The third performance indicator is designed to measure to what extent the priorities identified by the CCCHAP in the comprehensive plan are reflected in MDH's grant application to CDC. This indicator is related to Community Planning Goal 3, Objective G. The indicator is defined as, *"the percent of prevention interventions/other supporting activities in the health department CDC funding application specified as a priority in the comprehensive HIV prevention plan."*

This indicator will be measured by comparing the target populations and interventions included in the comprehensive prevention plan to the interventions proposed for each target population in the grant application.

#### **Performance Indicator #4**

The final performance indicator is designed to measure to what extent the priorities in the comprehensive prevention plan are actually being funded by the health department, and is related to Community Planning Goal 3,

Objective H. This indicator is defined as, *“the percent of health department-funded prevention interventions/other supporting activities that correspond to priorities specified in the comprehensive HIV prevention plan.”*

This indicator will be measured by comparing the target populations and HIV prevention interventions that have been funded by the MDH to the target populations and interventions recommended in the comprehensive plan.

### **USE OF INFORMATION COLLECTED**

The information that is gathered to evaluate the community planning process will be used to:

- Document the extent to which HIV prevention community planning objectives are achieved (monitor progress).
- Determine the factors affecting implementation of HIV prevention community planning (identify strengths and weaknesses).
- Apply the findings to improve the planning process as needed.
- Generate concrete information that can be used to inform stakeholders of progress.
- Report on HIV prevention program performance indicators.

### **EVALUATION PLAN**

The evaluation plan for community planning is presented in table form at the end of this chapter, starting on page 11. The plan describes the purpose, goals, and objectives of the evaluation of community planning, evaluation questions that address each objective, data collection methods used to answer evaluation questions, data collection timeline, and data use and reporting information.

## **The Comprehensive HIV Prevention Plan**

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The Minnesota Comprehensive HIV Prevention Plan provides a description of all the work performed by the CCCHAP. The plan is developed every three years, and updated on an annual basis.

Based on the results of the CCCHAP’s work, the plan sets HIV prevention priorities that will be used by MDH to guide its public health efforts around the control of HIV. It also represents a call and a guide to the community at large to respond most effectively to the needs expressed by their fellow Minnesotans throughout this process.

The plan identifies two groups of needs. One is a simple demand for more and better programs, more education, more outreach and new kinds of behavioral interventions. These sorts of needs are readily addressed through program development and allocation of funds. However, it should be noted that it is probably an unrealistic expectation that HIV transmission can be prevented absolutely 100 percent of the time, or that individuals will choose safer behavior ALL of the time, even with an abundance of HIV prevention programs in place.

HIV is the only public health problem where full compliance to safe behavior is expected. We talk about and plan for relapses related to smoking and substance abuse. We expect people to “fail” multiple times at dieting, seat belt usage, etc. We plan medication adherence programs because we don’t expect that all HIV positive individuals will be able to fully adhere to HIV treatment because of the very difficult regimens. However, when it comes to safer sex or needle use, we expect 100 percent compliance.

The second group of needs is much more complex and difficult to address. At almost every CCCHAP meeting, issues such as poverty, racism, sexism, homelessness, and homophobia were identified as hindrances to public health efforts designed to address HIV and other STDs. Participants all recognized

and were adamant that while new programs could address certain gaps in HIV prevention, effects would be short-term and minimal unless these social problems were also addressed.

## HOW TO USE THE PLAN

This comprehensive plan is designed to be used by anyone proposing to develop or fund an HIV prevention program. In particular, the following chapters may be useful to you:

**Chapter One: *Epidemiological Profile*** describes how HIV/AIDS, and other STDs impact different populations in Minnesota.

**Chapter Two: *Community Services Assessment*** contains information on needs assessment, resource inventory and gap analysis:

The *Needs Assessment* section provides a description of why HIV has impacted specific target populations in the ways described in epidemiological profile. You should use this section to learn about the population you intend to reach with your HIV prevention program.

The *Resource Inventory* lists programs that are already in place in Minnesota to reach different target populations.

The *Gap Analysis to Determine Unmet Prevention Needs* section combines our understanding of the prevention needs and resources available for each target population. By comparing them, we are able to identify gaps in programming for specific target populations.

**Chapter Four: *Potential Strategies and Interventions*** describes some of the research available about *how* to address the problem of HIV among the target populations described in the epidemiological profile and needs assessment sections. You should use this section to help you decide on the kinds of interventions you would like to use to prevent HIV in your proposed target population.

**Chapter Five: *Prioritized Interventions and Strategies*** lists recommended interventions and strategies for each target population. These interventions and strategies were reviewed by members of the target populations in question and prioritized by the CCCHAP. You should use this chapter to help you select the interventions thought to be most effective in your target population, and to help you describe the ways in which you will implement those interventions.

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## Information Regarding the CCCHAP

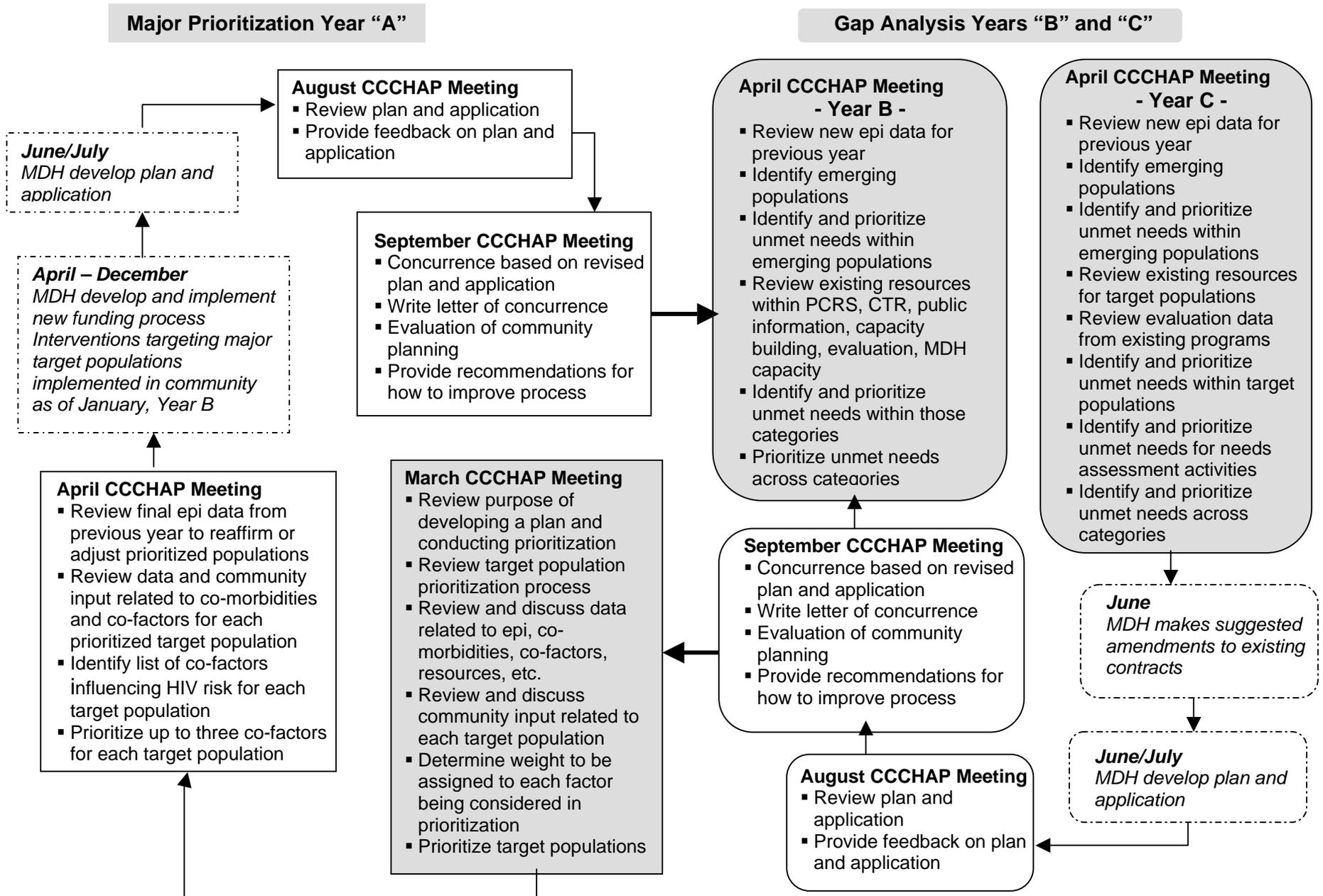
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For further information regarding the CCCHAP or the Minnesota Comprehensive HIV Prevention Plan, please contact:

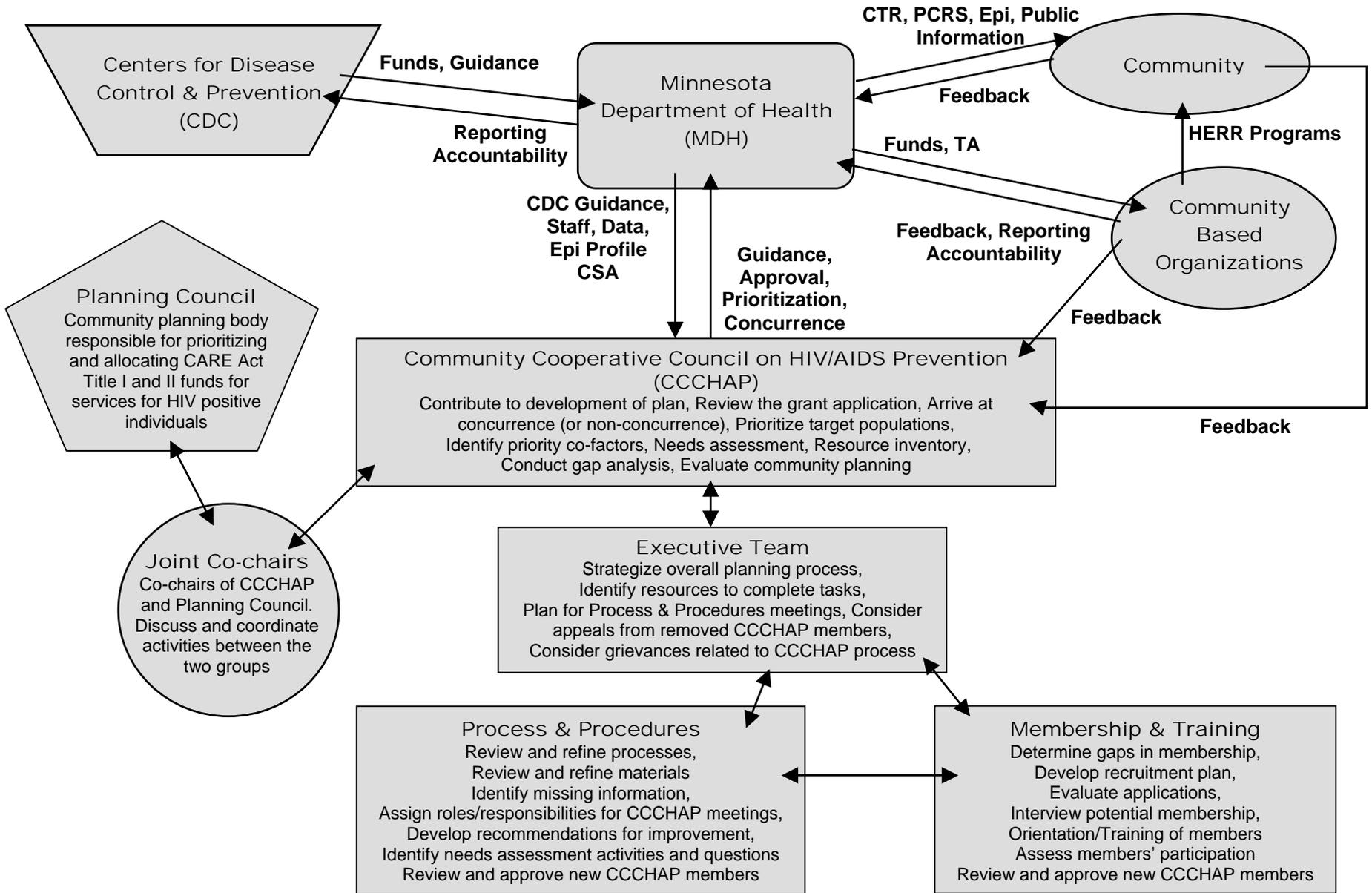
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# Restructured HIV Prevention Community Planning Process



# RESTRUCTURED CCCHAP ORGANIZATIONAL CHART



# Community Planning Evaluation Plan

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## COMMUNITY PLANNING EVALUATION PART 1

**Purpose:** To assess the degree to which community planning goals and objectives are met

### **Community Planning Goals and Objectives:**

#### **Goal One – Community planning supports broad-based community participation in HIV prevention planning.**

- Objective A: Implement an open recruitment process (outreach, nominations, and selection) for CPG members.
- Objective B: Ensure that the CPG membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.
- Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.

#### **Goal Two – Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.**

- Objective D: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.
- Objective E: Ensure that prioritized populations are based on an epidemiological profile and a community services assessment.
- Objective F: Ensure that prevention interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance and acceptability.

#### **Goal Three – Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.**

- Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.
- Objective H: Demonstrate a direct relationship between the Comprehensive Prevention Plan and funded interventions.

## Community Planning Evaluation Part 1

Evaluation Questions	Data Collection Method(s)	Data Collection Timeline	Using the Data
<p>To what degree are the objectives of community planning being met (see list of objectives above)? To what degree do CPG members agree that the objectives are being met? What gaps exist in the planning process? What are the strengths and weaknesses of the planning process?</p>	<p>Checklist of 52 key attributes (indicator that objective is being met) of the community planning objectives</p> <p>The Community Planning Membership Survey includes questions about whether or not the respondent agrees or disagrees that key attributes of community planning process have been met</p> <p>CPG meeting evaluation form to collect information from CPG members about information presented and decisions made at each meeting</p>	<p>MDH staff maintains the checklist and supporting documentation (written procedures, meeting minutes, etc) ongoing during 3 year planning process</p> <p>CPG members complete the Community Planning Membership Survey each September</p> <p>CPG members complete a meeting evaluation form after each meeting of the full CPG</p>	<p>Results from the surveys and the attributes checklist are reviewed by MDH and the CPG committees each November to identify strengths, weaknesses and gaps in the community planning process, and used to make recommendations for how to improve the process</p> <p>Results from the Community Planning Membership Survey are used to report Indicator 2 to CDC</p>
<p>Is CPG membership representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and include key professional expertise and representation from key agencies?</p>	<p>Community Planning Membership Survey</p> <p>CPG membership application</p> <p>Summary table that provides epidemiological data for Minnesota by gender, race/ethnicity, age, mode of exposure, and geography</p>	<p>CPG members complete the Community Planning Membership Survey each September</p> <p>CPG member candidates complete the membership application during the application process</p> <p>MDH epidemiologist prepares the table and presents information to the Membership and Training Committee each May</p>	<p>Results of the survey, membership applications, and the table are reviewed by the Membership and Training Committee to address gaps in membership and to target recruitment each May</p> <p>Results from the Community Planning Membership Survey are used to report Indicator 1 to CDC</p>

## Community Planning Evaluation Part 1

Evaluation Questions	Data Collection Method(s)	Data Collection Timeline	Using the Data
<p>What is the quality of the orientation and training process for CPG members? To what degree do participants understand the material that is presented? How many CPG members attend the required training sessions?</p>	<p>Evaluation forms are completed for each training session to assess what participants learned as well as strengths and weaknesses of the training</p> <p>A sign-in sheet is used to monitor attendance</p>	<p>CPG members complete the Evaluation form after participating in training (Orientation training held each December/January; Gap analysis training held in March of gap analysis years, and Prioritization training held in January of prioritization years)</p> <p>CPG members sign-in at the training</p>	<p>Results are used by MDH and Membership and Training Committee to identify strengths, weaknesses and gaps in orientation trainings and apply findings to improve trainings</p>
<p>To what extent does the health department address community-planning priorities in the CDC funding application and in RFPs, contracts, and programs funded by the MDH?</p>	<p>CDC required data variables (method of data collection TBD)</p>	<p>TBD</p>	<p>Information is reviewed by MDH and the CPG to identify strengths, weaknesses and gaps in the planning process and information is incorporated into the gap analysis</p> <p>Information used to report Indicators 3 and 4 to CDC</p>

## COMMUNITY PLANNING EVALUATION PART 2

**Purpose:** To assess if the goals of a restructured community planning process are met

**Goals of new model:**

- To improve participation (better attendance at CPG meetings and more interest in CPG membership) in community planning by:
  - Changing the meeting time requirement (Under the new process, there will be more time spent in full CPG meetings, and less time in committees. The total number of meetings a member has to attend will decrease.)
  - Clarifying roles and responsibilities of CPG members (Focus the work on planning and not on other MDH processes.)
  - Making the purpose/objectives and work to be completed at each meeting clear
- To improve the input into the community planning process for non CPG members through community forums and annual visits by CPG members to community groups
- To reduce administrative burden (MDH)
- To maintain balance between flexibility to address emerging needs and stable support for grantees

Evaluation Question(s)	Data Collection Method(s)	Data Collection Timeline	Using the Data
<p>Is meeting attendance improved under the new community planning process? Is meeting attendance consistent regardless of the topic to be presented at the meeting?</p>	<p>Review meeting attendance records</p>	<p>Spring 2004 – MDH staff will review CPG meeting minutes from 2000-2002 and record attendance  2004-2007 - MDH will record attendance at CPG meetings</p>	<p>MDH will monitor attendance from 2004-2007 and make changes to meeting schedule if needed. MDH will compare attendance from 2000-2002 to attendance at CPG meetings 2004-2007 to answer the evaluation questions</p>
<p>Does the new process result in a change in the number of CPG applicants and members? Does the new process result in a change in the demographic characteristics and expertise of CPG members?</p>	<p>Community Planning Membership Survey includes questions about demographic characteristics and professional experience  CPG membership application</p>	<p>CPG members complete the Community Planning Membership Survey each September  CPG member candidates complete the membership application during the application process</p>	<p>MDH will review summary of CPG membership including number of members and member characteristics, and compare CPG membership from 2000-2002 to 2004-2007 to answer evaluation questions. (Results also used to target recruitment)</p>

Evaluation Question(s)	Data Collection Method(s)	Data Collection Timeline	Using the Data
<p>To what degree is the work and discussion at each meeting focused on the stated objective? Is the appropriate decision point reached at each meeting? Does the new meeting structure allow CPG members enough time to use information presented to make informed decisions? How much time is spent on topics unrelated to the meeting objective?</p>	<p>Record topics discussed and decisions made at each meeting</p> <p>CPG meeting evaluation form will collect member feedback about their ability to understand and use information presented, and about the degree to which meeting objectives were met</p>	<p>MDH will record decisions made and topics discussed at each meeting</p> <p>CPG members complete a meeting evaluation form after each meeting of the full CPG</p>	<p>MDH and the CPG committees will review meeting minutes and results from evaluation forms about decisions made to identify meeting strengths and weaknesses and to make recommendations for how to improve future meetings</p>
<p>To what degree do CPG members believe the changes to the community planning process foster active participation?</p>	<p>Survey new and departing CPG members about the effect of time requirements, member roles and responsibilities, and meeting objectives on their ability and desire to actively participate in the group</p>	<p>Similar questions will be asked of 2 groups using different methods: an exit survey will be developed in May/June 2004 for use when members resign and questions will be included on the CPG membership survey for current members conducted in September</p>	<p>MDH will review survey results and make changes to improve the planning process</p>
<p>How many community forums are convened each year? How many and what type of community groups meet with CPG members to provide input about HIV prevention for their communities each year? How is input used by the CPG?</p>	<p>Record of forums convened and community groups visited</p> <p>Evaluation form for community forum participants and community groups about the process</p> <p>Community Planning Membership Survey will include questions about the process of gathering community input</p>	<p>CPG keeps a summary record of where input is gathered, forum/group attendance, what input is gathered, and how input is put to use</p> <p>CPG members complete the Community Planning Membership Survey each September</p>	<p>MDH and CPG review the summary of community input, evaluation and survey results each year to identify strengths and weaknesses of the community input processes and to make recommendations for improvement</p>

## Chapter One Epidemiological Profile

*This chapter describes the overall epidemic of HIV in Minnesota, as well as providing information about the epidemic in specific populations. Data about new infections, data about people living with HIV/AIDS, and data on Ryan White CARE Act Services utilization in the state of Minnesota are presented.*

### The Epidemiological Profile

The epidemiological (epi) profile presents data on the HIV epidemic in the state of Minnesota. The profile gives the CCCHAP and the Planning Council a thorough understanding of the epidemic in our state. By showing us who is becoming infected and who is living with the disease, the epi profile helps us to identify the people who are in need of prevention *and care* services, both those who are infected and those at risk. The epi profile serves as a starting point for the CCCHAP and the Planning Council in their consideration of which prevention and care services are needed.

The profile presents data for both the state as a whole and the Minneapolis-St. Paul Eligible Metropolitan Area<sup>1</sup> (EMA), consisting of eleven MN counties and two WI counties.

### Description of Minnesota<sup>2</sup>

#### GEOGRAPHY

Minnesota is a geographically diverse state. Its 84,363 square miles are comprised of farmlands, river valleys, forests, and lakes. Minnesota has one large urban center made up of Minneapolis and St. Paul (the Twin Cities) in Hennepin and Ramsey Counties, respectively. The Twin Cities are located on

<sup>1</sup> The Minneapolis-St. Paul EMA includes the following counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright in Minnesota and Pierce and St. Croix in Wisconsin.

<sup>2</sup> All data presented in this section are from the U.S. Census Bureau, unless otherwise noted.

opposite banks of the Mississippi River in the southeastern area of the state. The majority (58%) of the state's 4,919,479 residents live in the Twin Cities and the surrounding eleven-county metropolitan region. Duluth (northeast), St. Cloud (central), Rochester (southeast), Mankato (south central), and Moorhead (northwest) are other moderately sized population centers. The rest of Minnesota's population resides in smaller towns, the majority of which have populations of less than 2,000.

Three large interstate highways traverse the state, two of which pass through Minneapolis-St. Paul. I-35 runs north-south and I-94 runs northwest-southeast. I-90 parallels the southern border of Minnesota. A host of state and county roads connect the remaining regions of the state.

#### AGE

Minnesota's population is growing and, like the rest of the nation, getting older. The median age in Minnesota increased from 32.4 years in 1990 to 34.9 years in 2000 mainly due to the aging "baby boomer" population. Despite the rising median age, population growth was most apparent in younger age groups, particularly among 15 to 19 year olds whose number increased by 26 percent between 1990 and 2000 (compared to 14 percent nationally). According to the 2000 census, 3.25 million persons (66%) living in Minnesota were under the age of 45. As seen in Table 1, there is little difference in the age distribution for the state and EMA.

**Table 1. Age distribution in Minnesota and in EMA**

Age	Minnesota (n = 4,919,479)		Minneapolis – St. Paul EMA (n = 2,968,806)	
	Male	Female	Male	Female
< 13	18.5%	18.5%	19.3%	19.3%
13 – 19	10.7%	10.7%	10.1%	10.1%
20 – 24	6.6%	6.6%	6.5%	6.5%
25 – 29	6.5%	6.5%	7.3%	7.3%
30 – 34	7.2%	7.2%	8.1%	8.1%
35 – 39	8.4%	8.4%	9.1%	9.1%
40 – 44	8.4%	8.4%	8.7%	8.7%
45 – 49	7.4%	7.4%	7.5%	7.5%
50 – 54	6.1%	6.1%	6.2%	6.2%
55 – 59	4.6%	4.6%	4.4%	4.4%
60 +	15.7%	15.7%	12.8%	12.8%

**Table 2. Race and Ethnicity distribution by gender in Minnesota and EMA**

Race / Gender	Minnesota (n=2,435,631)   (n=2,483,848)		Minneapolis – St. Paul EMA (n=1,466,277)   (n=1,502,529)	
	Male	Female	Male	Female
White	89.1%	89.7%	85.7%	86.5%
Black / African American	3.6%	3.3%	5.5%	5.2%
American Indian	1.1%	1.1%	0.7%	0.7%
Asian / Pacific Islander	2.9%	2.9%	4.2%	4.2%
Other race	1.5%	1.2%	1.8%	1.3%
Two or more races	1.7%	1.7%	2.1%	2.1%
Hispanic / Latino (all races)	3.2%	2.6%	3.7%	3.0%

## RACE/ETHNICITY

While Minnesota is predominantly White (approximately 89 percent), there has been an increase in the number of Black, Hispanic, and Asian/Pacific Islander persons living in Minnesota since 1990. At that time, 94 percent of Minnesotans were White, 2.2 percent Black, 1.2 percent Hispanic, 1 percent Native American, and 1.8 percent Asian. Due to changes in reporting, it is impossible to directly compare 1990 Census data to year 2000 data. However, excluding the 1.7 percent of the Minnesota population that indicated two or more races, Black, Hispanic, and Asian/Pacific Islander populations increased by about 75 percent, 150 percent, and 100 percent respectively. As of 2000, there were approximately 202,000 Black, 143,000 Hispanic, and 168,000 Asian/Pacific Islander persons living in Minnesota. Additionally, data from the 2000 Census shows that foreign-born individuals account for 5 and 7 percent of the state and EMA population, compared to 2.6 and 3.5 percent in 1990.

Table 2 shows the race/ethnicity distribution for Minnesota and the EMA. While the race distribution does not differ greatly by gender it varies by geography. A significantly larger percent of both white males (89.1% vs. 85.7%) and females (89.7% vs. 86.5%) reside in the rest of the state as compared to the EMA. Additionally, Census data also shows differences in age for whites versus other groups. Twenty four (24) percent of Whites in Minnesota were under the age of 18 compared to 37.5 percent for African Americans and Asians, 38 percent for Hispanics and American Indians, and 53 percent of those identifying as multi-racial (two or more races).

Of note is the growing number of African immigrants in Minnesota. Census data shows a 600 percent increase in the number of African immigrants in Minnesota between 1990 and 2000. According to the 2000 Census the number of African emigrants living in Minnesota is 35,188, however anecdotal estimates put that number closer to 50,000. Somalia, Ethiopia, and Liberia are the most common countries of origin although nearly every country in Africa is represented in Minnesota. Between 1998 and 2000, nearly 7,000

primary refugees<sup>3</sup> from African countries were resettled in Minnesota<sup>4</sup>.

Additionally, in 2000 Minnesota became one of six initial sites in the U.S. to receive HIV-infected refugees. Typically immigrants, including refugees, are not permitted entry into the United States if they test positive for HIV during their overseas physical exam. For humanitarian reasons, the federal government reinterpreted this rule in 2000 and as a result 10 national social service agencies were authorized to resettle HIV-infected refugees. Two of these agencies with local offices in the Twin Cities coordinated the arrival of 49 HIV-infected African refugees to Minnesota between August 2000 and September 2001<sup>5</sup>.

## SOCIOECONOMIC STATUS

### *Poverty and Income*

Minnesota overall has fared somewhat better than the nation as a whole in regards to poverty and income. In 2000, an estimated 8 percent of Minnesotans were living at or below poverty level compared to 13 percent nationally. Likewise, the per capita income in 2000 for the United States was \$21,690, \$23,198 in Minnesota and \$26,219 in the EMA. While these aggregate numbers are favorable, they misrepresent the disproportionate impact poverty has on persons of color. According to Census 2000 data, 6 percent of Whites in Minnesota were living at or below the poverty level compared to 10 percent of Asians, 16 percent of Hispanics, 25 percent of Blacks, and 30 percent of American Indians.

<sup>3</sup> Note: A refugee is a specific type of immigrant. A refugee is a foreign-born person who cannot return to his or her country of origin because of a well-founded fear of persecution due to race, religion, nationality, political opinion, or membership in a particular social group. Primary refugees in Minnesota are those persons who first relocated here; secondary refugees moved to Minnesota after arrival at another site in the United States. The approximated number of 7,000 does not include secondary refugees nor does it include other forms of immigration to the United States.

<sup>4</sup> Refugee Health Program, Minnesota Department of Health

<sup>5</sup> Ibid

## **Employment**

According to Census 2000 data, only 2.9 percent of Minnesota's workforce was unemployed compared to the national average of 3.5 percent. Estimates of unemployment rates for Blacks and Hispanics were 4.5 percent and 3.4 percent, respectively; the rate of unemployment for American Indian men was 7.0 percent. By the end of 2003, the unemployment rate in Minnesota had increased to 5 percent compared to the national average of 6 percent<sup>6</sup>. However, differences are again noted across racial/ethnic groups.

## **Education**

Minnesota's emphasis on education is reflected in the low statewide percentage (12%) of persons age 25 years or older who have less than a high school education; the national average is 18 percent. However, for persons of color in Minnesota the percentage of those with less than a high school education is greater. For example, among Blacks, 17 percent of men and 19 percent of women are estimated to have less than a high school education compared to 10 percent and 8 percent of White men and women, respectively.

## **ACCESS TO HEALTH CARE**

### **Health Insurance**

Overall, Minnesota has one of the lowest rates of uninsured residents in the nation. According to data released from the 2001 Minnesota Health Access Survey, only 5.4 percent of Minnesotans were not covered by health insurance at the time of the survey<sup>7</sup>. However, the findings in this study suggest that significant differences exist according to geography, race/ethnicity, and country of birth. The major urban centers of Minneapolis and St. Paul had higher rates of uninsured compared to the statewide average (11.0 percent and 9.5 percent respectively versus 5.4 percent statewide). Certain regions in Greater Minnesota<sup>8</sup> also experienced rates of uninsured that were significantly greater than the state average. Specifically, in north central and northwest

Minnesota approximately 10 percent of residents were lacking insurance. Whereas in southeastern Minnesota the rate of uninsured was significantly lower than the state average (3.2 percent versus 5.4 percent statewide).

Notable differences also occurred among the different race/ethnicity groups. While only 5 percent of Whites were uninsured in 2001, the percentages among Hispanics (18%), Blacks (16%), and American Indians (16%) were considerably higher. For persons born outside of the U.S. rates were higher yet. In 2001, 37 percent of persons born in a Hispanic nation and 24 percent of those born in an African nation were uninsured.

Unfortunately, as of July 2003 several changes were made to the Minnesota Health Care Programs that will affect the number of uninsured. As of July 2003, undocumented individuals, with the exception of pregnant women, are no longer eligible for Minnesota Health Care Programs. Additionally, in October of 2003, the income eligibility guidelines for MinnesotaCare and General Assistance Medical Care (GAMC) changed from 175 percent to 75 percent of the federal poverty level. Individuals with incomes between 75 percent and 175 percent are still eligible under the MN Care Limited Benefit Program, but this benefit can be exhausted before the end of the year and after that the individual is left without coverage. The full effect of these changes is not yet known.

### **Prenatal Care**

Minnesota is known for its caliber of health care. Unfortunately, when it comes to prenatal care women do not access health services equally. Overall, 86 percent of Minnesota mothers giving birth in 2002 began prenatal care in the first trimester. However, while 90 percent of White women received adequate or better prenatal care only 70 percent of Black women and 68 percent of Hispanic women did; the national averages for Black women is 75 percent and for Hispanic women is 77 percent<sup>9</sup>.

<sup>6</sup> Minnesota Workforce Center, 2004

<sup>7</sup> 2001 Minnesota Health Access Survey, MDH, 2002

<sup>8</sup> Greater Minnesota is defined as the area outside of the eleven-county metropolitan area surrounding Minneapolis-St. Paul.

<sup>9</sup> Centers for Disease Control and Prevention (CDC), 2003

## **GAY, LESBIAN, BISEXUAL AND TRANSGENDER (GLBT) PERSONS IN MINNESOTA**

Accurate estimates of the GLBT population in Minnesota are unavailable. However, the 2000 U.S. Census provides some data related to GLBT persons in Minnesota. Although not a valid measure of the extent of same sex relationships in Minnesota, unmarried partners of the same sex made up an estimated 9,940 households in Minnesota in the year 2000, with approximately 74 percent of those in the EMA.

While there have been some national studies that have attempted to estimate same sex behavior, that is different from the number of GLBT persons, since some people may engage in same sex behavior but not identify as GLBT.

Nationally, some research has been done attempting to estimate the prevalence of same sex behavior. In early work by Kinsey and colleagues in the 1940s and 1950s, 8 percent of men and 4 percent of women reported exclusively same-gender sex for at least three years during adulthood<sup>10,11</sup>. Generalizing these findings to the general population is very questionable because these data were based on convenience samples.

Subsequent to this work, studies more representative of the general U.S. population have been undertaken. Comparing national surveys from 1970 and 1991, Siedman and Rieder<sup>12</sup> estimated that from 1-6 percent of men had sex with another man (MSM) in the preceding year. In another population-based study, Sell et al<sup>13</sup> estimated the incidence of same sex behavior in the preceding 5 years at 6 percent for males and 4 percent for females. Estimates vary for any number of reasons including varying definitions of homosexuality and/or methods of data collection.

Approximately 146,000 men and 99,400 women in Minnesota would be predicted to engage in same sex behavior using the percentages from the Sell study. The accuracy of these numbers is difficult to gauge, at best.

More recently a study conducted in Hennepin County, found that 4 percent of males and 2 percent of females in Hennepin County identified as GLBT<sup>14</sup>. Applying these percentages to the entire state we would estimate approximately 97,400 men and 49,600 women to identify as GLBT.

Also relevant to the context of GLBT life in Minnesota is the fact that Minnesota and the Twin Cities, in particular, attract individuals with a variety of sexual orientations. A strong gay community exists in the Minneapolis-St. Paul area.

Additionally, Minnesota is one of three states in the country that has laws banning discrimination based on sexual orientation and gender identity.

A nationally renowned center for individuals seeking transgender support/services is located in Minneapolis. Although transgender people identify as heterosexual, bisexual, gay, and lesbian, variances in gender identity complicates the categorization. Some male to female transgender individuals identify as lesbian, some as heterosexual, and others as bisexual. Similarly, some female to male individuals identify as gay, some are heterosexual, and others are bisexual. Politically, and sometimes for access to services, many transgender individuals find alliances within the gay and lesbian community.

All of these factors may contribute to a larger GLBT population in Minnesota than would be predicted based upon national averages. Any estimates for the GLBT population must be used with caution.

## **SENSORY DISABILITY**

Written and/or verbal communication can be hindered for persons with a sensory disability(ies). Depending on the medium, general HIV awareness and prevention messages cannot be assumed to reach such populations. According to Census 2000 data, just over 63,000 (2.2%) Minnesotans between

<sup>10</sup> Kinsey et al, 1948

<sup>11</sup> Kinsey et al, 1953

<sup>12</sup> Seidman et al, *Am J Psychiatry* 1994

<sup>13</sup> Sell et al, *Arch Sex Behavior* 1995

<sup>14</sup> SHAPE 2002, Hennepin County Community Health Department

the ages of 21 and 64 are estimated to be living with a sensory disability (defined in the survey as "blindness, deafness, severe vision, or hearing impairment").

## **Epidemiological Surveillance – Data Quality and Sources**

### **HIV/AIDS REPORTING SYSTEM (HARS)**

The Minnesota Department of Health (MDH) collects confidential name-based case reports of HIV infection (since 1985) and AIDS diagnoses (since 1982) through a passive and active HIV/AIDS surveillance system. In Minnesota, laboratory-confirmed infections of human immunodeficiency virus (HIV) are monitored by the MDH through this active and passive surveillance system. State law (Minnesota Rule 4605.7040) requires both physicians and laboratories to report all cases of HIV infection (HIV or AIDS) directly to the MDH (passive surveillance). Additionally, regular contact is maintained with the following five clinical sites to help ensure completeness of reporting (active surveillance): Hennepin County Medical Center, Regions Hospital, HealthPartners Clinic in Robbinsdale, Park Nicollet Medical Center, and the HIV/AIDS Clinic at the University of Minnesota. Demographic, exposure, and clinical data are collected on each case<sup>15</sup> and entered into Minnesota's HIV/AIDS Reporting System (HARS) database developed by the U.S. Centers for Disease Control and Prevention (CDC).

Factors that impact the completeness and accuracy of HIV/AIDS surveillance data include: compliance with case reporting, timeliness of case reporting, test-seeking behaviors of HIV-infected individuals, and the availability and targeting of HIV testing services.

Given the long period of time between infection with HIV and the clinical manifestation of AIDS, patterns of new HIV case reports are believed to describe the current epidemic more accurately than AIDS case reports. The introduction of highly active antiretroviral therapies in the mid-1990s

further delayed the onset of AIDS for many patients and makes AIDS case reporting a weak tool for describing the present epidemic. Including AIDS case reports is useful for looking at the whole epidemic or trends over time.

While HIV case reports do represent persons more recently infected than AIDS case reports, there are still several limitations that affect the completeness and timeliness of the data. There are multiple ways for a case to be undetected by the state surveillance system promptly after seroconversion.

First, CDC estimates that about 30 percent of HIV-infected individuals are unaware of their status<sup>16</sup>. And for gay/bisexual men, recent evidence suggests this percentage is much higher (77%)<sup>17</sup>. This is partly because early HIV infection does not produce severe nor distinct symptoms and so delays in testing are common. Additionally, many people acknowledge avoiding testing for fear of a positive test result or believing that they are not at risk.

Second, cases of new HIV infection can also go undetected by disease surveillance due to the availability of anonymous testing. Once a person begins care, however, other HIV/AIDS surveillance reporting mechanisms would most likely detect the case.

Thus, although HIV case reporting is our best estimate of new HIV infections, the system does not capture all new cases and there are varying amounts of delay between infection, testing, and reporting.

New testing methodologies are becoming more widely available (e.g. STARHS<sup>18</sup>) and will enable more timely descriptions of the epidemic as it continues to unfold. In addition, continued efforts to encourage testing and counseling help limit the amount of undiagnosed HIV infection.

Annual HIV/AIDS summaries are available on the web at:

<http://www.health.state.mn.us/divs/idepc/diseases/hiv/hivstatistics.html>

<sup>15</sup> CDC has refined the case definition for AIDS over the years. The most recent change to the case definition occurred in 1993 when (in conjunction with confirmed HIV infection) tuberculosis, recurring pneumonia, invasive cervical cancer, or a CD4 count of less than 200 (or below 14% of lymphocytes) joined 23 other AIDS-defining infections/conditions.

<sup>16</sup> CDC, Division of HIV/AIDS Prevention

<sup>17</sup> MacKellar et al, 2002

<sup>18</sup> STARHS: Serologic Testing Algorithm for Recent HIV Seroconversion

## **ADDITIONAL HIV/AIDS SURVEILLANCE ACTIVITIES**

### ***HIV Subtyping in Minnesota***

Minneapolis/St. Paul has experienced the highest growth rate in its African-born population of any city in the country in the last ten years, and most particularly within the last five years. Non-B subtypes of HIV-1 have become more common in Minnesota due to this increased immigration from and subsequent travel to regions where diverse strains of HIV are endemic.

In 2003 the Minnesota Department of Health (MDH) began surveillance activities to monitor non-B subtypes of HIV circulating in the state, including HIV-2. Presently these activities take the form of targeted and sentinel surveillance.

The purpose of the targeted surveillance program is to document the existence, variety and relative frequency of HIV types/subtypes present in Minnesota. Blood samples from consenting African-born patients receiving medical care for their HIV infection at a participating clinic are sent to the MDH Public Health Laboratory for subtype determination and eventually HIV-2 screening. Approximately half of the 335 African-born persons known to be living with HIV in Minnesota at the end of 2002 were receiving care at one of the participating clinics. Through August 15, 2003, 46 patient samples had been processed, each of which contained a non-B subtype of HIV-1.

The purpose of the sentinel surveillance program is to detect the introduction of HIV-2 and/or non-B HIV-1 subtypes into the general Minnesota population. At present, HIV-2 and non-B HIV-1 infections have not been detected in non-African-born residents of Minnesota. Sentinel surveillance for HIV-2 and non-B HIV-1 subtypes was initiated in January 2003 at a publicly funded STD clinic that serves a diverse cross-section of the Twin Cities sub/urban population and identifies approximately 40 new HIV infections per year. HIV testing for this clinic is carried out at the Public Health Laboratory at the MDH. HIV-1 subtype is determined for 100% of HIV-1 EIA/Western Blot-positive isolates submitted to MDH for HIV testing; isolates will also be screened for HIV-2. Through August 15, 2003 all 20 specimens found to be HIV-1 positive have been subtype B.

Divergent strains of HIV have implications for testing, clinical care, and vaccine research/implementation. Systems to monitor the introduction and spread of non-B subtypes of HIV-1 and, to a lesser extent, HIV-2 in the U.S. will be critical for biotechnology to evolve effectively alongside a dynamic epidemic.

### ***The SHAS Project***

MDH received funding for several years to implement the Supplemental to HIV and AIDS Surveillance (SHAS) Project. Sadly, the funding ended as of December 31, 2003, and the project was terminated.

The project was designed so that an MDH staff person conducted an in-depth interview with HIV positive persons who agree to participate and who have known about their diagnosis for six months to three years.

Participants received a stipend of \$25 and a \$10 certificate for use at Cub Foods. Participants were recruited through several means: physicians informed individuals when they were diagnosed that this was an opportunity in six months, flyers were distributed to clinics and HIV service providers, and individuals were referred by other persons who had participated in the project.

The interview included in-depth questions related to demographics, substance use, sexual behavior and STD history, reproductive and gynecological history, HIV testing and medical therapy, and utilization of health and social services.

## SEXUALLY TRANSMITTED DISEASE (STD) SURVEILLANCE SYSTEM

In the state of Minnesota, laboratory-confirmed infections of chlamydia, gonorrhea, syphilis, and chancroid are monitored by the MDH through a passive, combined physician and laboratory-based surveillance system. State law (Minnesota Rule 4605.7040) requires both physicians and laboratories to report all cases of these four bacterial STDs directly to the MDH. In 2002, the Minnesota Department of Health added an active component to the surveillance system for chlamydia and gonorrhea infections, and in 2004 changed the case report form to include gender of sexual partners and country of origin to better describe STDs in Minnesota. Other common sexually transmitted conditions caused by viral pathogens, such as herpes simplex virus (HSV) and human papillomavirus (HPV), are not reported to the MDH. Factors that impact the completeness and accuracy of the available data on STDs include: level of screening, accuracy of diagnostic tests, and compliance with case reporting. Thus, any changes in STD rates may be due to one of these factors, or due to actual changes in STD occurrence.

Annual STD surveillance summaries are available on the web at:

<http://www.health.state.mn.us/divs/idepc/dtopics/stds/stdstatistics.html>

## BEHAVIORAL SURVEILLANCE

MDH collects a small amount of behavioral data as it relates to HIV and AIDS surveillance information. For example, reports of HIV infection received by MDH include information on drug use and sexual behaviors. Additionally, from time to time the MDH will undertake special projects with the intent of collecting behavioral data on specific populations. Examples of these are the Minnesota STD Prevalence Study (ages 12-24) and the Twin Cities Men's Health Survey (MSM 18 and older).

## OTHER DATA SOURCES

Data regarding risk factors for acquiring HIV that are presented in this report include sexually transmitted disease rates<sup>19</sup>, teen pregnancy rates<sup>20</sup>, chemical health indicators<sup>21</sup>, behavioral survey data<sup>22</sup>, a variety of social and economic data from the 2000 U.S. Census<sup>23</sup>, and results from specific scientific studies. Additionally, some data from the Counseling, Testing and Referral (CTR) system in Minnesota is also presented<sup>24</sup>. These data serve to characterize the population at risk for acquiring or transmitting HIV.

## Impact of HIV/AIDS on Minnesotans

Compared with the rest of the nation, Minnesota is considered to be a low to moderate HIV/AIDS incidence state. In 2002, state-specific AIDS rates ranged from 0.5 per 100,000 persons in North Dakota to 34.8 per 100,000 persons in New York. Minnesota had the 10th lowest AIDS rate (3.2 AIDS cases reported per 100,000 persons). Compared with surrounding states (IA, ND, SD, & WI), Minnesota's AIDS rate was about average. State-specific HIV rates cannot be compared nationally because some states have not yet instituted HIV case surveillance. The states that have HIV case surveillance are at various stages of implementation.

## CUMULATIVE CASES

As stated earlier, AIDS has been tracked in Minnesota since 1982 and HIV since 1985. As of December 31, 2003, a cumulative total of 7,356 cases of HIV infection have been

<sup>19</sup> Minnesota Department of Health, Epidemiology and Surveillance Unit

<sup>20</sup> Minnesota Center for Health Statistics

<sup>21</sup> Minnesota Behavioral Risk Factor Surveillance System

<sup>22</sup> Minnesota Student Survey (Department of Children, Families, and Learning) and Minnesota Behavioral Risk Factor Surveillance System

<sup>23</sup> U.S. Census Bureau

<sup>24</sup> Minnesota Department of Health, STD & HIV Section

reported among Minnesota residents. This includes 4,183 AIDS cases and 3,173 HIV, non-AIDS cases. Of these 7,356 HIV/AIDS cases, 2,583 are known to be deceased through correspondence with the reporting source, other health departments, reviews of death certificates and obituaries, active surveillance, and matches with the National Death Index.<sup>25</sup>

## OVERVIEW OF HIV/AIDS IN MINNESOTA, 1990-2003

Two common terms used throughout the epi profile are incidence and prevalence. **Incidence**, or **incident cases**, refers to new HIV and/or AIDS infections diagnosed during a particular time period; for example, from January 1, 2003 through December 31, 2003. **Prevalence**, or **prevalent cases**, refers to the number or percentage of people living with HIV and/or AIDS at any given time; for example, at the end of 2003.

As depicted in Figure 1 on the following page, the annual number of new AIDS cases increased steadily from the beginning of the epidemic to the early 1990s, reaching a peak of 370 cases in 1992. Beginning in 1996, both the number of newly diagnosed AIDS cases and the number of deaths among AIDS cases declined sharply, primarily due to the success of new antiretroviral therapies including protease inhibitors. These treatments do not cure, but can delay progression to AIDS among persons with HIV (non-AIDS) infection and improve survival among those with AIDS. Thus the declines slowed during the late 1990s and the numbers have become relatively stable the past few years.

The number of newly diagnosed HIV (non-AIDS) cases has remained fairly constant since the mid 1990s at just under 200 cases per year. Furthermore, the number of prevalent HIV/AIDS cases has continued to increase over time. An estimated 4,985 persons with HIV/AIDS are

assumed to be living in Minnesota as of December 31, 2003. This number includes persons whose most recently reported state of residence was Minnesota, regardless of residence at time of diagnosis.

### Geography

Historically, about 90 percent of new HIV infections diagnosed in Minnesota have occurred in Minneapolis, St. Paul and the surrounding eligible metropolitan area (EMA). New HIV infections refer to any HIV-infected Minnesota resident who was diagnosed in a particular calendar year and reported to the MDH. This includes persons whose first diagnosis of HIV infection is AIDS (AIDS at first diagnosis). As depicted in Figure 2, this trend continued in 2003 with 39 percent of new cases diagnosed among residents of Minneapolis, 15 percent in St. Paul, 35 percent in the surrounding suburbs, and 11 percent outside of the EMA. Over the past three years, residents in the suburban EMA have accounted for an increased percent of new infections, from 30 percent in 2000 to 35 percent in 2003. Although HIV infection is more common in communities with higher population densities and greater poverty, there are people living with HIV or AIDS in over 80 percent of counties in Minnesota (Figure 3). However, 88 percent of those infected live in the EMA.

<sup>25</sup> This number includes persons who reported Minnesota as their state of residence at the time of their HIV and/or AIDS diagnosis. It also includes persons who may have been diagnosed in a state that does not have HIV reporting and who subsequently moved to Minnesota and were reported here. HIV-infected persons currently residing in Minnesota, but who resided in another HIV-reporting state at the time of diagnosis are excluded.

Figure 1. HIV/AIDS in Minnesota: Number of New Cases, Prevalent Cases, and Deaths by Year, 1990-2003

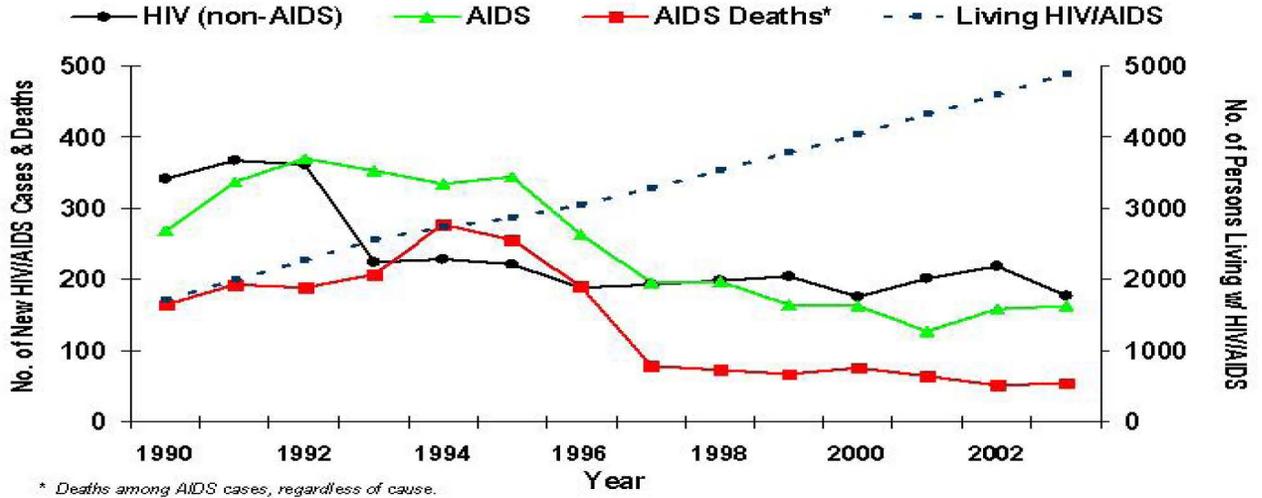


Figure 2. New HIV Infections\* in Minnesota by Residence at Diagnosis, 2003

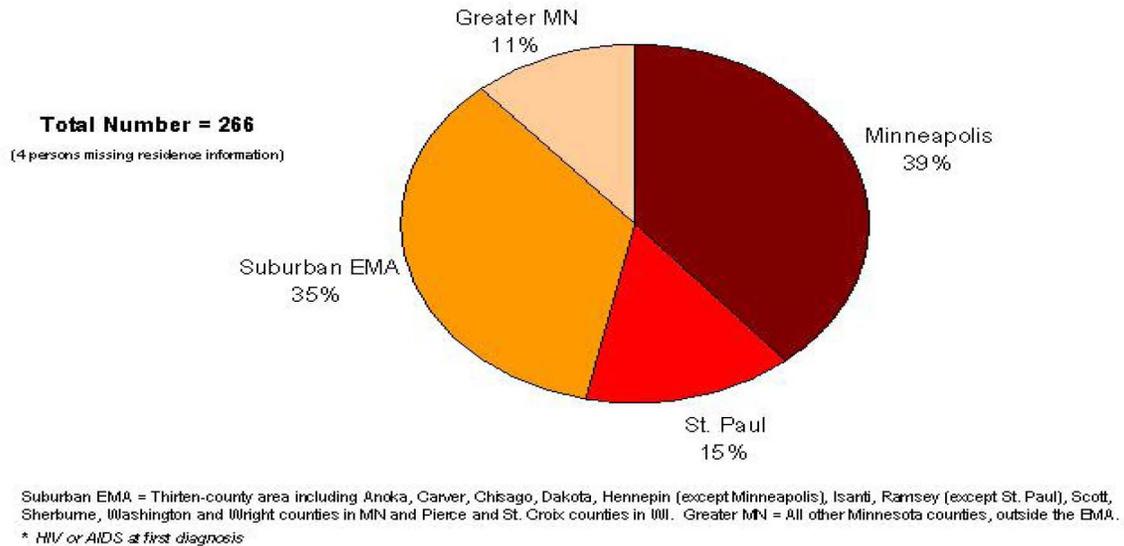
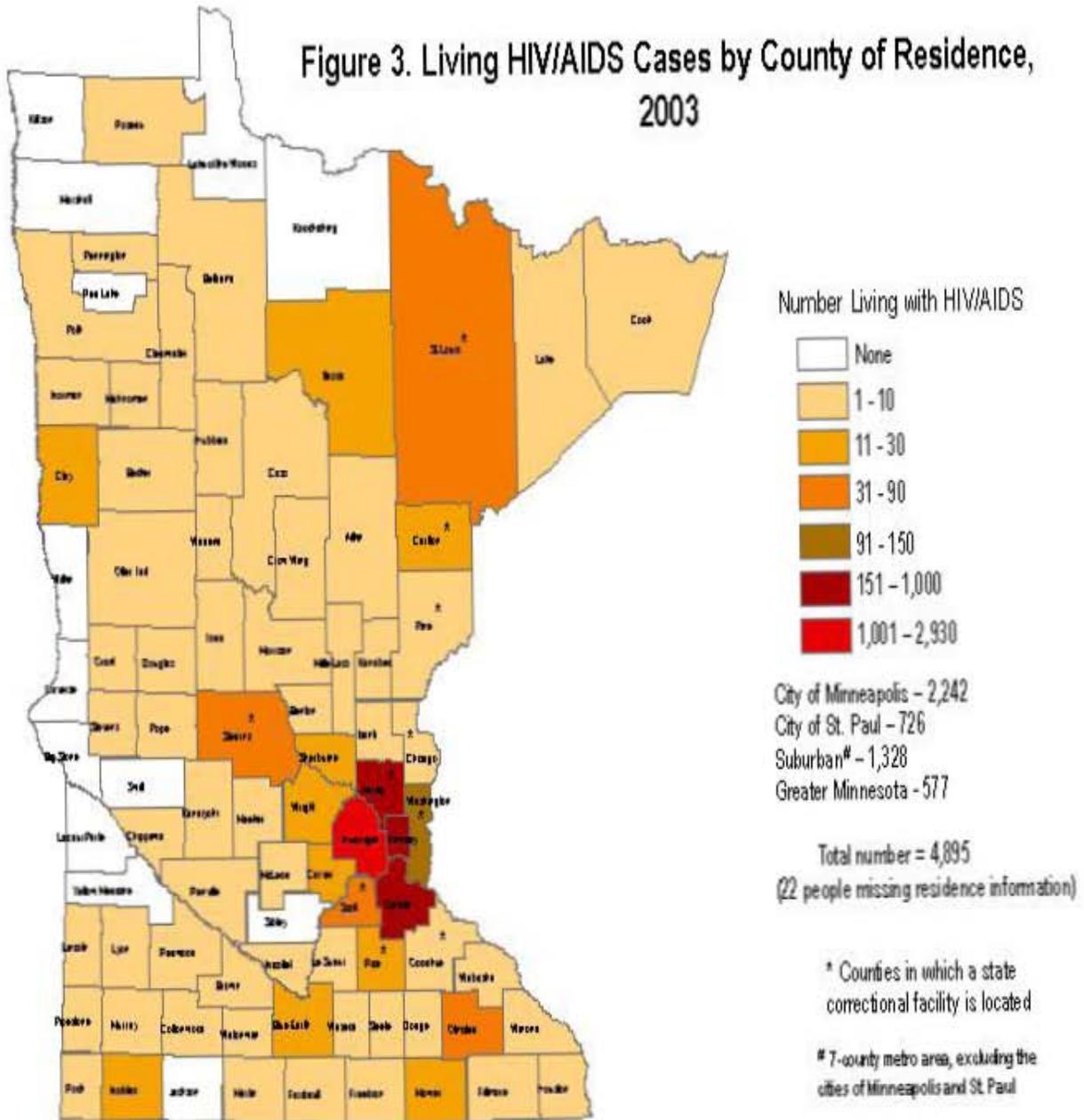
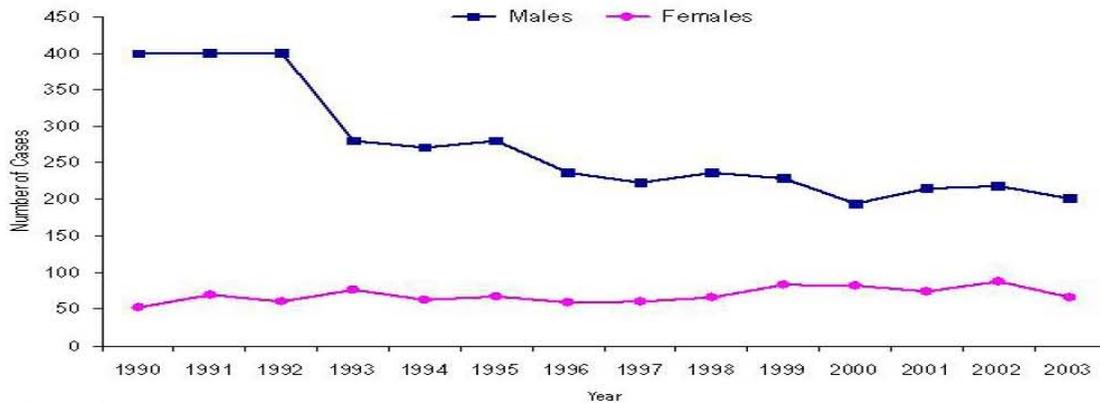


Figure 3. Living HIV/AIDS Cases by County of Residence, 2003



**Figure 4. New HIV Infections\* by Gender and Year of Diagnosis, Minnesota 1990-2003**



\* HIV or AIDS at first diagnosis

**Gender**

Since the beginning of the epidemic, males have accounted for a majority of new HIV infections diagnosed per year. However, during the past 10 years the number of cases among females increased while the number of cases among males decreased (Figure 4). In 1990, males accounted for 90 percent of new HIV infections. In 2003, 74 percent of new infections occurred among males and 26 percent among females. Males currently account for 79 percent of those living with HIV/AIDS in Minnesota.

**Race/Ethnicity**

In Minnesota, as well as the EMA, the epidemic affects populations of color disproportionately. According to the 2000 Census, Whites make up about 89 percent of the state population, but only 44 percent of all new HIV infections in 2003, while populations of color make up 11 percent of the population and 56 percent of new HIV infections. The same pattern is true for the EMA.

Trends in the annual number of new HIV infections diagnosed among males differ by racial/ethnic group (Table 3, Figure 4). New cases among White males drove the epidemic in the 1980s and early 1990s. Although Whites still account for the largest number of new infections among males, this number has generally been decreasing since 1991. A recent exception to this trend occurred between 2000 and 2001 when 130 cases

were diagnosed among White males in 2001 compared to only 93 cases in the previous year. However, the number of cases among White males decreased again in both 2002 and 2003. In Table 3, Black race was broken down into African-born and African American (Black, not African-born).

In contrast to the overall large decline in the annual number of new cases among White males during the last decade, the decline among African American males was more gradual. The annual number of cases for African American males peaked in 1992 at 81 and gradually decreased to 33 in 2003, after a small increase was observed in 2002. The numbers of new cases in all other racial/ethnic groups during this same time remained stable or increased.

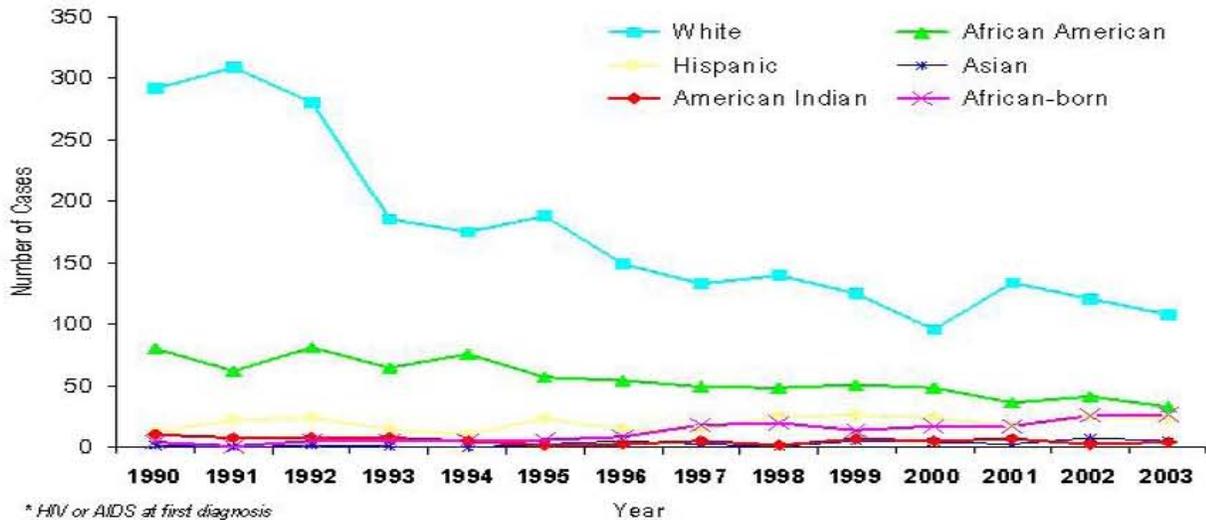
Notable exceptions to these numbers are cases among Hispanic and African-born males. Cases among Hispanic males have nearly doubled from 12 in 1990 to 23 in 2003, and among African-born males there has been a seven-fold increase from 4 cases in 1990 to 27 cases in 2003. It is worth noting that during the same time period the Hispanic population in Minnesota saw a 577 percent increase, while among African-born the increase was 620 percent<sup>26</sup>. Overall, the proportion of new HIV infections diagnosed among men of color as a whole has been increasing over time.

<sup>26</sup> 2000 Census, U.S. Census Bureau

**Table 3. Annual Number of New HIV Infections Among Males by Race/Ethnicity and Year of Diagnosis, Minnesota 1991-2003**

Race/Ethnicity	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	307	280	187	173	186	147	132	138	124	93	130	115	108
Black:													
African American	62	81	65	75	56	56	49	46	51	49	34	37	33
African-Born	1	5	5	5	6	9	17	20	14	17	19	29	27
Hispanic	22	23	15	10	21	13	14	24	25	24	16	25	23
American Indian	8	8	8	5	2	3	5	2	7	5	7	3	4
Asian	0	2	1	0	3	5	4	1	5	4	3	7	5
Unknown/Other	0	1	1	1	3	0	1	1	1	1	2	2	1
Total	400	400	282	269	277	233	222	232	227	193	211	218	201

**Figure 5. New HIV Infections\* Among Males by Race/Ethnicity and Year of Diagnosis, Minnesota 1990-2003**



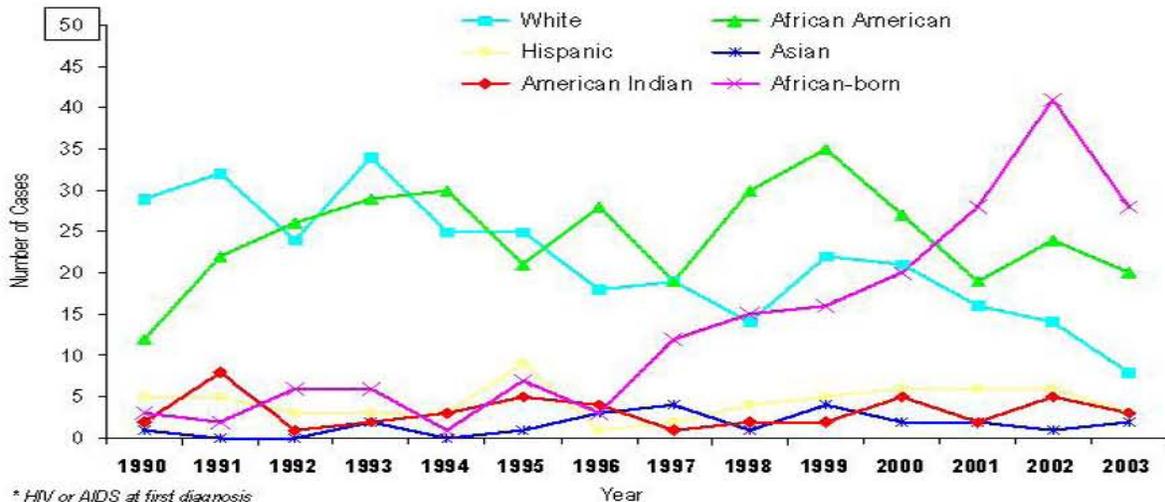
\* HIV or AIDS at first diagnosis

† "African-born" refers to Blacks who reported an African country of birth; "African American" refers to all other Blacks. Cases with unknown race are excluded.

**Table 4. Annual Number of New HIV Infections Among Females by Race/Ethnicity and Year of Diagnosis, Minnesota 1991-2003**

Race/Ethnicity	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	32	24	34	25	24	19	20	13	22	21	15	14	8
Black:													
African American	22	26	29	21	29	19	29	35	27	21	25	37	20
African-Born	2	6	6	1	7	3	11	16	14	21	26	36	28
Hispanic	5	3	3	3	9	1	2	4	5	6	5	6	3
American Indian	8	1	2	3	5	4	2	2	2	5	2	4	3
Asian	0	0	2	0	0	3	4	1	4	2	2	2	2
Unknown/Other	0	0	0	0	1	0	2	1	0	0	1	0	1
Total	69	60	76	61	67	59	60	66	82	82	72	87	65

**Figure 6. New HIV Infections\* Among Females by Race/Ethnicity and Year of Diagnosis, Minnesota 1990-2003**



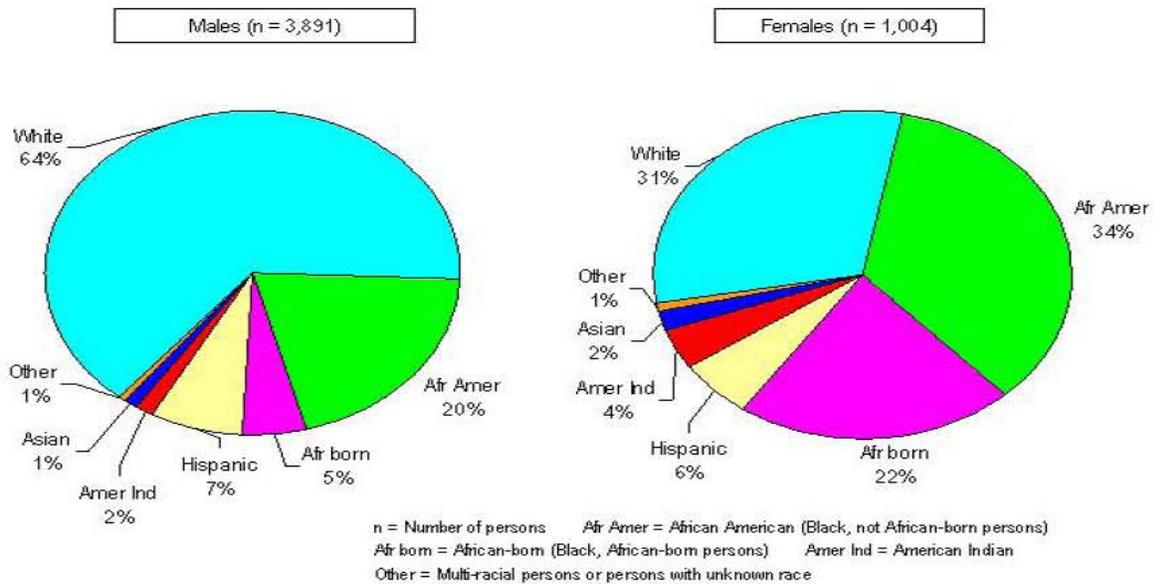
\* HIV or AIDS at first diagnosis

† "African-born" refers to Blacks who reported an African country of birth; "African American" refers to all other Blacks. Cases with unknown race are excluded.

Similarly, trends in the annual number of HIV infections diagnosed among females differ by racial/ethnic group (Table 4, Figure 6). In the beginning of the epidemic, White women accounted for a majority of newly diagnosed cases among females. Since 1991, the number of new infections among women of color has exceeded the number among White women. Among African Americans the number of new infections

has steadily increased since 1991, peaking in 2002 at 37 cases. In 2003 there were 20 new infections among African Americans. Since 1996, close to a ten-fold increase was observed among African-born females (28 cases in 2003). The annual number of new infections diagnosed among Hispanic, American Indian, and Asian females continues to be quite small.

**Figure 7. People Living with HIV/AIDS by Gender and Race/Ethnicity, Minnesota 2003**



While overall men and women of color are disproportionately affected by HIV/AIDS, in Minnesota this is most glaring among women. While Whites make up approximately 89 percent of the female population, they only accounted for 12 percent of new infections among women in 2003, whereas women of color make up approximately 11 percent of the female population and accounted for 88 percent of the new infections among women.

Whites account for 58 percent of those living with HIV/AIDS in Minnesota, compared to 23 percent for African Americans, 9 percent for African-born, 7 percent for Hispanics, and 2 and 1 percent for American Indians and Asians, respectively. However, the distribution by race varies across gender with White males accounting for 64 percent of males living with HIV/AIDS, compared to 31 percent for White females (Figure 7).

**Race/Ethnicity as a Marker**

Please note that race is not considered a biological reason for disparities in the occurrence of HIV experienced by persons of color. Race, however, can be considered a marker for other personal and social characteristics that put a person at greater risk for HIV exposure. These characteristics may include, but are not limited to, lower

socioeconomic status, less education, and greater prevalence of drug use. As previously mentioned, there are great disparities in income between Whites and communities of color. While the per capita income for Whites in Minnesota is \$24,351, it is about \$10,000 less for Blacks (\$13,741), American Indians (\$13,040), and Asians (\$15,389). The disparity is even greater in the EMA.

**Average Age at HIV Diagnosis, Three-year Averages (Table 5)**

In recent years, Hispanic males were slightly younger (approximate age = 34 years) than other males (approximate age = 38 years) at the time of HIV diagnosis. During the past ten years, the average age at HIV diagnosis has been approximately 32 years for females, for most racial/ethnic groups. While the number of cases is smaller, Hispanic women seem to be younger (average age = 29) at diagnosis while American Indian and Asian women appear to be older (average age = 38). Age at HIV diagnosis can be used as a proxy for age at HIV infection. However, due to differences in testing behavior (e.g. variable lengths of time between HIV infection and diagnosis) across time and between socio-demographic groups, comparisons of average age at diagnosis are difficult to interpret.

<b>Table 5. Average Age at HIV Diagnosis Among Men and Women: Three-Year Averages</b>			
<b>Race/Ethnicity</b>	<b>Average Age in Years (Number of Cases)*</b>		
	<b>1989-1991</b>	<b>1994-1996</b>	<b>2001-2003</b>
<b>Men</b>			
White	33 (918)	35 (512)	38 (363)
Black:			
African American	32 (214)	34 (186)	37 (110)
African-Born	30 (6)	36 (20)	36 (70)
Hispanic	32 (54)	33 (48)	34 (65)
American Indian	29 (28)	29 (10)	38 (14)
Asian	25 (5)	38 (8)	39 (16)
	<b>1989-1991</b>	<b>1994-1996</b>	<b>2001-2003</b>
<b>Women</b>			
White	30 (88)	32 (68)	32 (38)
Black:			
African American	29 (54)	30 (80)	32 (63)
African-Born	21 (6)	31 (11)	33 (97)
Hispanic	34 (14)	34 (13)	29 (15)
American Indian	29 (16)	30 (12)	38 (5)
Asian	--	--	38 (5)

\* Average age not displayed for subgroups with less than 5 cases. Cases with unknown race or age were excluded.

**Adolescents and Young Adults<sup>27</sup>**

Many people are infected with HIV for years before they actually seek testing and become aware of their HIV status. This phenomenon especially affects the observed case counts for younger age groups. And as a result, the reported number of HIV infections among youth (with few or no reports of AIDS at first diagnosis) is likely to underestimate the *true* number of new infections occurring in this age group more

than the reported number of cases in older age groups does.

In 1990, 9 percent of new HIV infections reported to the MDH were among youth. In 2003 this percentage was 14 percent. Among young men, the number of new HIV diagnoses peaked in 1992 at 43 cases and then declined through the mid 1990s to a low of 14 cases in 1997 (Figure 8). Since 1997 the annual number of cases diagnosed among young men increased steadily to 29 in 2000, but then dropped to 18 cases in 2002 before increasing to 22 in 2003.

Unlike young men, the annual number of new HIV infections diagnosed among young women has remained relatively consistent over time (Figure 8). For example, 16 cases of HIV infection were diagnosed among

<sup>27</sup> In this report, adolescents are defined as 13-19 year-olds and young adults as 20-24 year-olds; these two groups are jointly referred to as "youth." Analyses are performed for adolescents and young adults combined because case numbers are too small to present meaningful data separately for each.

young women in 1992 and 15 cases in 2003. Females accounted for 43 percent of new HIV infections diagnosed among adolescents and young adults in 2003. In contrast, adult females (25 years of age or older) only accounted for 22 percent of all adult cases.

Similar to the adult HIV/AIDS epidemic, persons of color account for a disproportionate number of new HIV infections among adolescents and young adults. Among young men, Whites accounted for 44 percent of new HIV infections diagnosed between 2001 and 2003, African Americans accounted for 22 percent and Hispanics for 19 percent of the cases. Among young women, African Americans accounted for 34 percent, Whites 23 percent, and African-born 27 percent of the new infections diagnosed during the same time period.

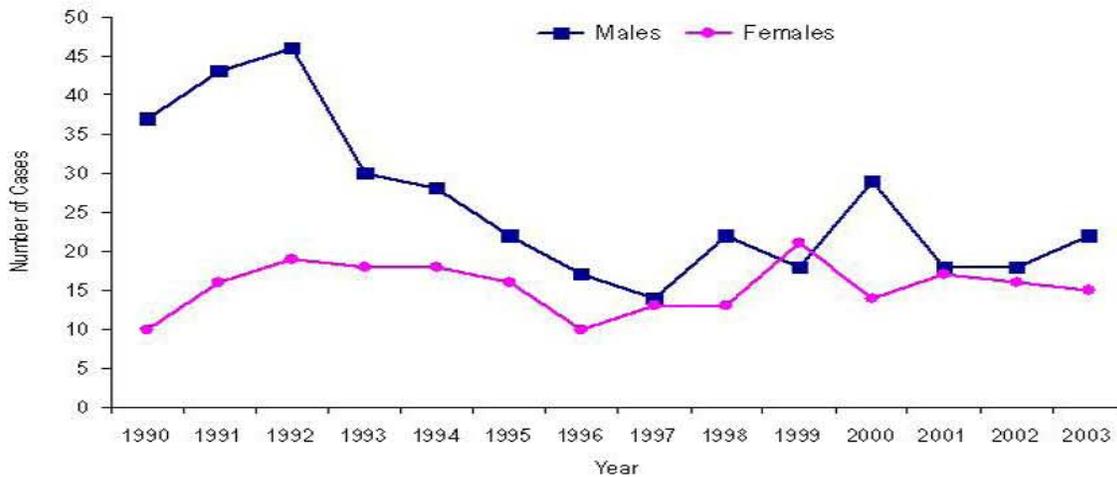
Men having sex with men (MSM) is the predominant mode of HIV exposure among adolescent and young adult males,

accounting for 69 percent of the new HIV infections diagnosed between 2001 and 2003 (Figure 7). Heterosexual contact and the joint risk of MSM and injecting drug use (IDU) accounted for 2 and 5 percent of the cases, respectively. HIV exposure risk was not specified for 24 percent of the young male cases.

Heterosexual contact accounts for 33 percent of new HIV infections diagnosed among adolescent and young adult females between 2001 and 2003 (Figure 9). IDU accounts for 6 percent of the cases. The remaining 61 percent of the young females do not have a risk specified.

Adolescents and young adults accounted for 4 percent of those living with HIV/AIDS in Minnesota in 2003. This percent has stayed constant over the past three years.

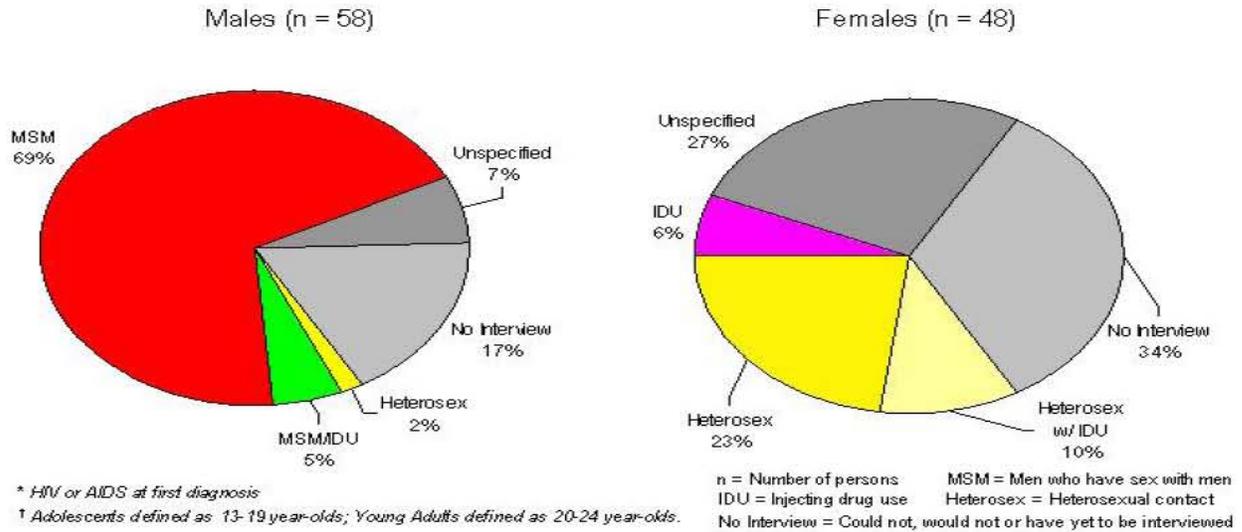
**Figure 8. New HIV Infections\* Among Adolescents and Young Adults† by Year of Diagnosis, 1990-2003**



\* HIV or AIDS at first diagnosis

† Adolescents defined as 13-19 year-olds; Young Adults defined as 20-24 year-olds.

**Figure 9. New HIV Infections\* Among Adolescents and Young Adults† by Gender and Exposure Group, 2001-2003**



**Mode of Exposure**

Since the beginning, the majority of HIV/AIDS cases in Minnesota have been among men with male-to-male sex (MSM) being the predominant mode of exposure reported. Though still the majority, both the number and proportion of new HIV infections attributed to MSM have been decreasing since 1991 (Figure 10). On a much smaller scale, the numbers of male cases attributed to IDU and MSM/IDU also have been decreasing over the past decade, while the number of cases attributed to heterosexual contact has been increasing. The number of cases without a specified risk has also been increasing (Figure 11).

Cases can have unspecified risk for two reasons. The first reason for a case to have unspecified risk is that the person has not yet been interviewed or has refused an interview by a Disease Intervention Specialist from the MDH, and therefore we have no information on their risk category. Disease Intervention Specialists have reported difficulty interviewing recent cases due to language and cultural barriers, as well as difficulty locating the individuals. Secondly, and this

applies mostly to women, the person may have no obvious risk other than heterosexual. However, heterosexual contact as a mode of HIV transmission is only assigned when the person knows that their partner was HIV-infected or at increased risk for HIV. Often this level of knowledge about sexual partners (anonymous, casual, or exclusive) may be unknown. In addition, according to a study conducted by the Centers for Disease Control and Prevention (CDC)<sup>28</sup>, it is likely that at least 80 percent of women with unspecified risk acquired HIV through heterosexual contact.

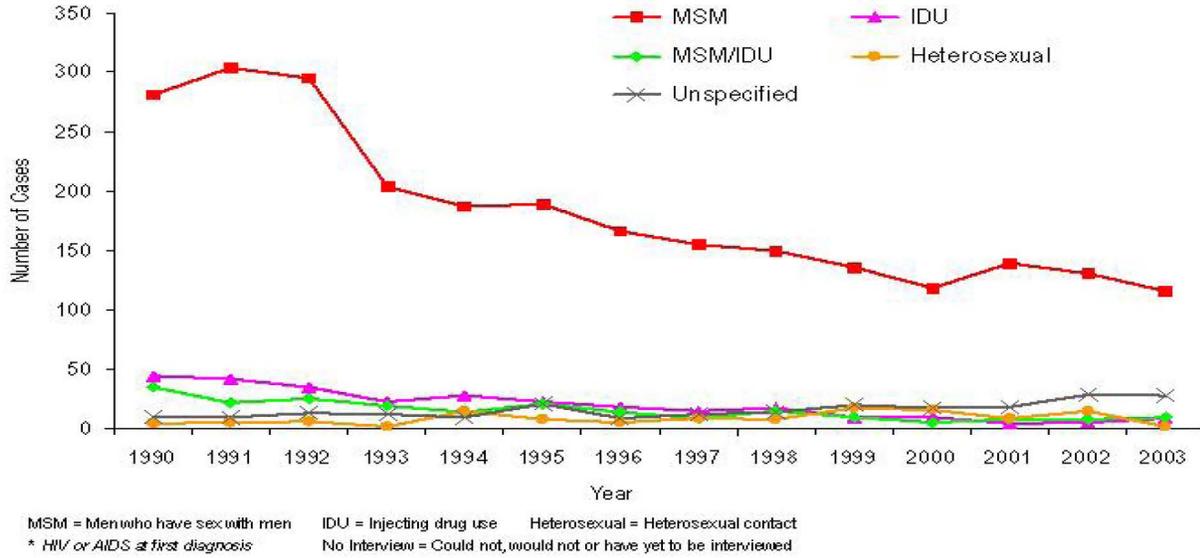
Throughout the epidemic, heterosexual contact has been the predominant mode of HIV exposure reported among females (Figure 12). IDU is the second most common mode of transmission making up 6 percent of cases among women in 2003. Unspecified risk has been designated for a growing percentage of cases for the past several years. In 1996, 7 percent of women diagnosed with HIV infection did not have a specified mode of transmission. This percentage grew to 37 percent in 2003 with an additional 28

<sup>28</sup> Lansky et al, *MMWR* 2001.

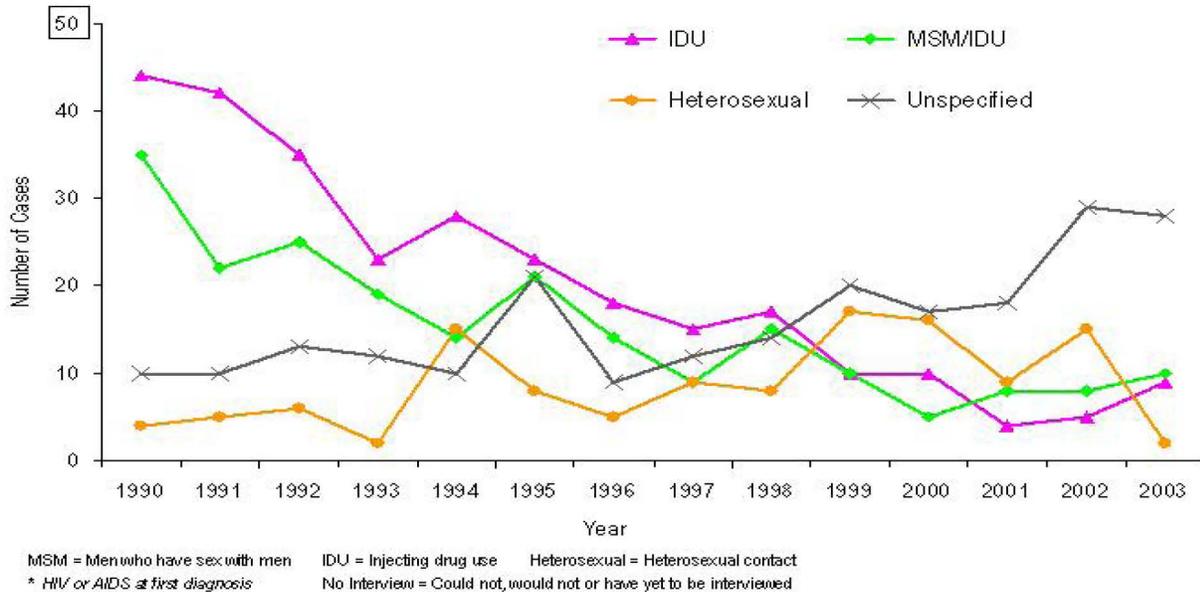
percent of female cases that would not agree to or could not be interviewed by a Disease Intervention Specialist from the MDH. Some of these cases represent women who have not

yet been interviewed and, thus, some of these women will later have an identified mode of transmission.

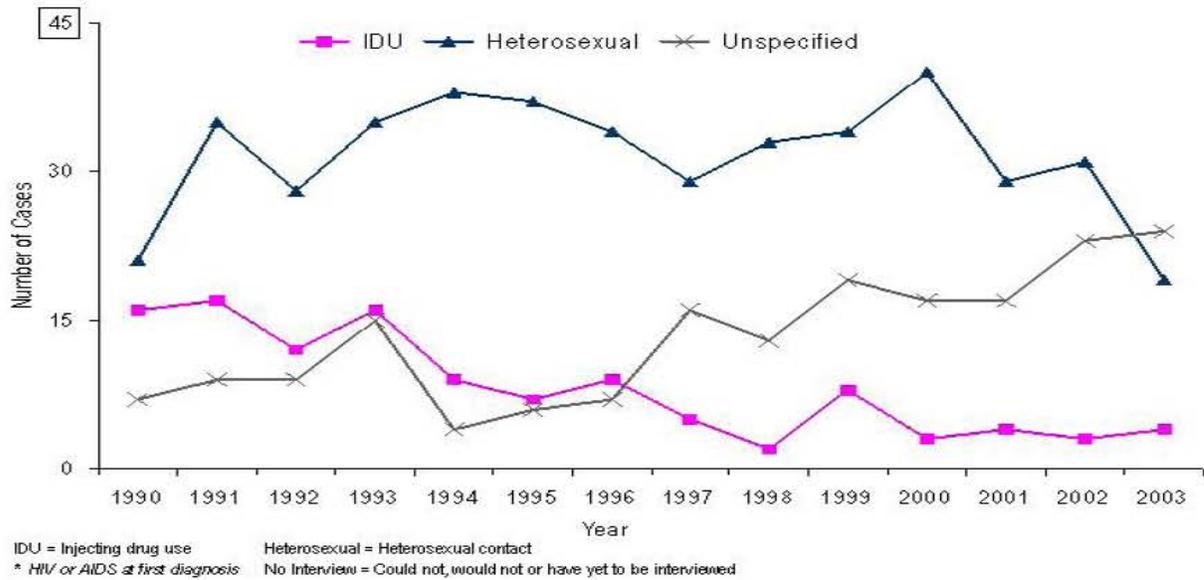
**Figure 10. HIV Infections\* Among Males by Mode of Exposure and Year of Diagnosis, 1990-2003**



**Figure 11. HIV Infections\* Among Males by Mode of Exposure and Year of Diagnosis, 1990-2003 (excluding MSM)**



**Figure 12. HIV Infections\* Among Females by Mode of Exposure and Year of Diagnosis, 1990-2003**



The proportion of cases attributable to a certain mode of exposure differs not only by gender, but also by race. Of the new HIV infections diagnosed among males between 2001 and 2003, MSM or MSM/IDU accounted for 78 percent of cases among White males, 58 percent of cases among Hispanic males, 45 percent of cases among African American males, and 3 percent of cases among African-born males (Table 6). The latter three also had some of the highest proportions of cases with unspecified risk (31%, 37%, and 96%, respectively).

It is hypothesized that due, in part, to social stigma many of the cases with unspecified risk were unclassified MSM cases. This may not hold as true for African-born cases given that heterosexual contact and contaminated medical equipment have been established modes of HIV exposure in their countries of origin. IDU or MSM/IDU was reported as a risk in 11 percent of male African American cases diagnosed during 2001-2003, compared to 7 percent among White males and 3 percent Hispanic males. The number of cases among Asian and American Indian men

during the years 2001-2003 were insufficient to make generalizations regarding risk (less than 20 cases in each group).

Heterosexual contact with a partner who has or is at increased risk for HIV infection accounted for 55 percent of cases among White females during 2001-2003, 49 percent of cases among African American females, and 15 percent of cases among African-born females (Table 7). Approximately 40 percent or more of cases in each of these groups had no specified risk. IDU accounted for 5 percent of cases among Whites, 6 percent among African Americans, and 0 percent among African-born. The number of cases among Hispanic, Asian and American Indian women during the years 2001-2003 were insufficient to make generalizations regarding risk (less than 20 cases in each group).

**Table 6. New HIV Infections Among Men by Race/Ethnicity and Mode of Exposure, Minnesota - Diagnosis Years 2001 - 2003 Combined**

Race/Ethnicity	Mode of Exposure											
	MSM		IDU		MSM/IDU		Heterosexual Contact		Unspecified		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
White	284	78%	5	1%	20	6%	10	3%	44	12%	363	100%
Black:												
African American	50	45%	8	7%	4	4%	7	6%	41	37%	110	100%
African-Born	2	3%	0	0%	0	0%	1	1%	67	96%	70	100%
Hispanic	38	58%	2	3%	0	0%	5	8%	20	31%	65	100%
American Indian	4	29%	2	14%	1	7%	2	14%	5	36%	14	100%
Asian	7	44%	1	6%	1	6%	1	6%	6	38%	14	100%

**Table 7. New HIV Infections Among Women by Race/Ethnicity and Mode of Exposure, Minnesota - Diagnosis Years 2001 - 2003 Combined**

Race/Ethnicity	Mode of Exposure									
	Heterosexual		IDU		Unspecified		Other		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
White	21	55%	2	5%	15	39%	0	0%	38	100%
Black:										
African American	31	49%	4	6%	26	41%	2	3%	63	100%
African-Born	15	15%	0	0%	79	81%	3	3%	97	100%
Hispanic	7	47%	2	13%	5	33%	1	7%	15	100%
American Indian*	4	40%	3	30%	3	30%	0	0%	10	100%
Asian*	1	20%	0	0%	4	80%	0	0%	5	100%

\*small number of cases – interpret carefully

**COUNSELING, TESTING AND REFERRAL (CTR) SYSTEM**

The CTR System consists of four MDH-funded agencies that provide free or low cost HIV testing to Minnesota residents. The initial funding cycle was from January 1, 1999 to December 31, 2000. In addition to the four agencies, in 2001, the MDH initiated a collaborative effort with HIV prevention agencies to integrate HIV testing into prevention outreach efforts. The system offers anonymous and confidential testing and tests can be conducted either in a clinical setting or during outreach. In the past year a few of the sites started offering an HIV rapid test (OraQuick) as an alternative to the traditional blood draw. Confidential tests are name-based and can therefore be reported to MDH and added to the yearly surveillance statistics. Anonymous tests are code-based and are not included in yearly surveillance. Occasionally, an anonymous test will be linked to a surveillance case if the individual mentions having received a previous positive diagnosis and recalls the date and site of that test, as well as the code given to him/her.

The number of tests conducted by the CTR agencies has steadily grown from 8,780 in 2000 to 10,517 in 2002, with the positivity percent

decreasing from 1.2 percent in 2000 to 0.8 percent in 2002. In 2003, the total number of testing sites decreased and so did the number of tests to 9,625. The positivity rate in 2003 was back to 1.2 percent.

In 2003, 18 percent of those tested chose an anonymous test and 12 percent of the tests were done during outreach. The percent of positive tests was higher among those testing anonymously (2.3%) compared to those testing confidentially (1.0%). The majority of those tested were males (66%), between the ages of 20 and 39 (68%), and living in Hennepin County (55%). Table 8 shows the number of tests by client characteristics (gender, race, age, etc.) along with positivity rate.

Additionally, in 2003, MSM accounted for 19 percent (n=1,870) of the total tests conducted and 58 percent (n=67) of all positive tests, with a positivity rate of 3.6 percent. IDU users accounted for 4 percent of all tests, and 9 percent of all positive tests.

Twenty-eight percent of those tested had never had a previous test, 41 percent had either one or two previous tests, and the remainder had three or more previous tests. Of those with a previous test, 97 percent reported a negative result for their most recent HIV test.

<b>Client Characteristics*</b>	<b>Number of Tests (%)</b>	<b>Positivity Rate</b>
<b>Gender</b>		
Male	6,313 (66)	1.5
Female	3,294 (34)	0.6
Transgender	15 (<1)	6.7
<b>Race/Ethnicity</b>		
White	5,065 (53)	0.9
African American/Black	3,020 (31)	1.4
Asian/Pacific Islander	240 ( 3)	1.3
American Indian	220 ( 2)	1.8
Other	710 ( 8)	2.7
Hispanic†	789 ( 9)	1.3

<b>Client Characteristics*</b>	<b>Number of Tests (%)</b>	<b>Positivity Rate</b>
<b>Age</b>		
19 and under	961 (10)	0.0
20 – 29	4,020 (42)	1.2
30 – 39	2,481 (26)	1.8
40 – 49	1,550 (16)	1.3
50 and older	610 ( 6)	0.7
<b>County of Residence</b>		
Hennepin	5,250 (55)	1.3
Ramsey	2,626 (27)	1.2
Other 11-county metro	1,100 (11)	0.6
Greater MN	188 ( 2)	2.7
Homeless	159 ( 2)	3.1
Unknown	299 ( 3)	1.0
<b>Total</b>	<b>9,625</b>	<b>1.2</b>

\*Numbers will not add to total

†Includes all races

### **Pediatric Cases of HIV/AIDS**

Pediatric cases are defined in accordance with the CDC criteria as those cases of HIV or AIDS who were less than 13 years of age at the time of test or diagnosis. In Minnesota, 86 cases of pediatric HIV infection have been diagnosed to date, 72 (84%) of whom are still assumed to be alive. Seventy-seven percent (77%) of the 86 cases resulted from perinatal exposure, 8 percent associated with hemophilia or other coagulation disorder, 6 percent associated with blood transfusion, and 9 percent were undetermined.

One of the few success stories in the history of HIV infection is the use of medication to successfully reduce perinatal transmission of the virus. Without treatment, the risk of HIV transmission from a pregnant woman to her child before or during birth is approximately 25 percent; preventive antiretroviral treatment can reduce this percentage to 1-2 percent<sup>29</sup>. If breast feeding is avoided, nearly all children born to HIV-infected mothers can be spared infection themselves.

The U.S. Public Health Service released guidelines in 1994 for the use of zidovudine to prevent perinatal transmission of HIV and in 1995 recommended universal counseling and voluntary HIV testing for pregnant women. With the widespread adoption of these guidelines, perinatal HIV transmission in the United States decreased 81 percent between 1995 and 1999<sup>30</sup>.

The trend in Minnesota has been similar but on a much smaller scale. Between 1990 and 1995, 16 cases of perinatally acquired HIV infection were diagnosed among children born in Minnesota compared to 11 cases between 1996 and 2003. While the difference in number of cases is small (5), the difference in the rate of transmission is over three-fold, from 18 percent in 1990-1995 to 5 percent in 1996-2003.

The rate of transmission for 2001-2003 was 2 percent. Figure 13 shows the trend lines for both births among HIV-infected women and the number of perinatally acquired infections, by year of birth. Reporting of births to HIV-infected women is known to be incomplete.

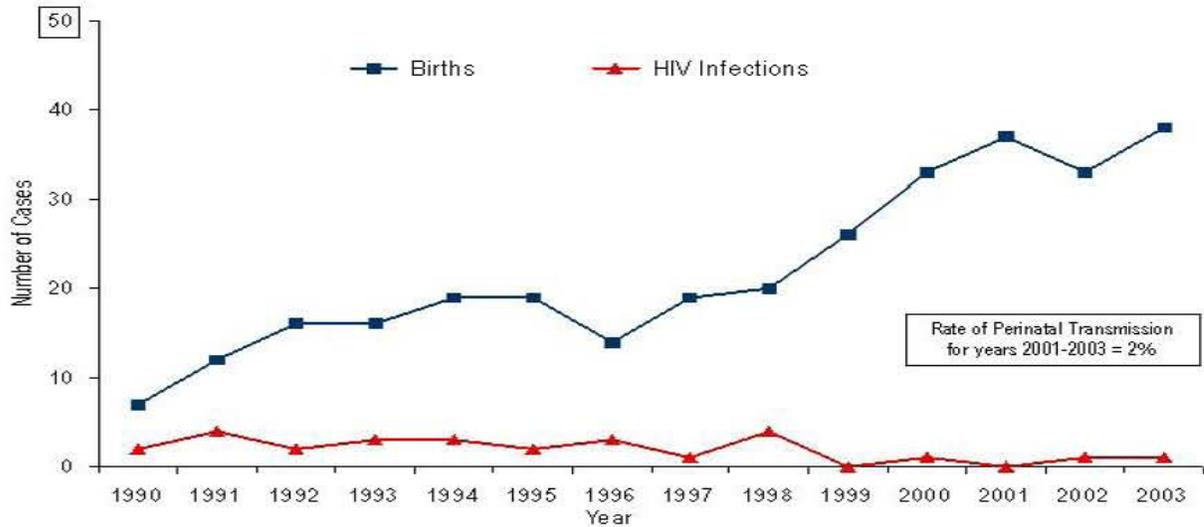
<sup>29</sup> CDC, Division of HIV/AIDS Prevention

<sup>30</sup> Bulterys et al, *AIDScience* 2002

During 2001, the MDH conducted the Enhanced Perinatal Surveillance Project, which identified 19 of 37 births (51%) to HIV-infected women. As a result of this project MDH has implemented an active component

for perinatal surveillance in collaboration with three pediatric HIV clinicians in the Twin Cities to increase reporting of births to HIV-infected mothers.

**Figure 13. Births to HIV-Infected Women and Number of Perinatally Acquired HIV Infections\* by Year of Birth, 1990-2003**



\* HIV or AIDS at first diagnosis for a child exposed to HIV during mother's pregnancy, at birth, and/or during breastfeeding.

**Differences between Greater Minnesota and the EMA**

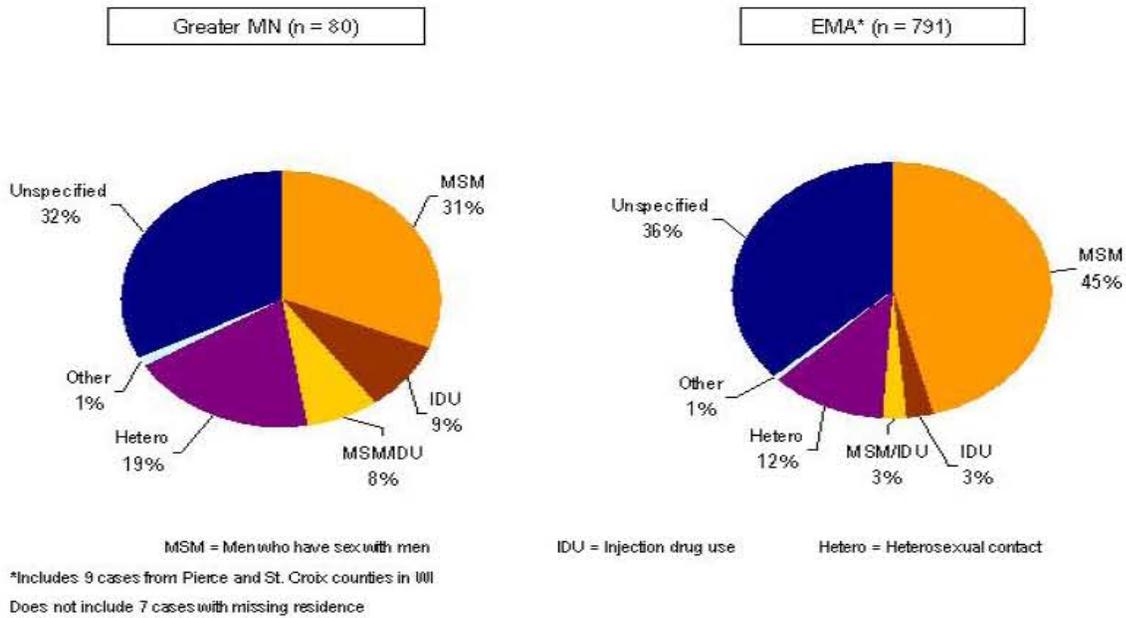
While the concentration of new HIV/AIDS infections is in the EMA (90%), there are some notable differences in the racial and risk category distribution of those infected between Greater Minnesota and the EMA.

Looking at the state as a whole, men who have sex with men (MSM) accounted for 44 percent of new HIV/AIDS infections between 2001 and 2003. However, for the same time period, MSM accounted for only 31 percent of new infections in Greater MN compared to 45 percent for the EMA. (Figure 14)

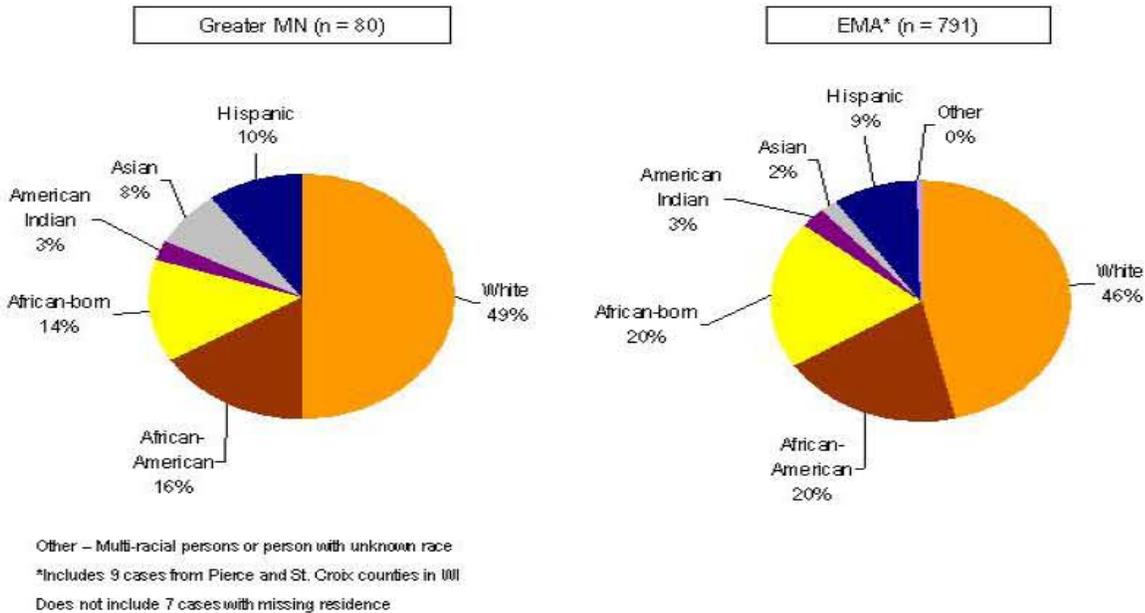
Similarly, looking at the racial/ethnic distribution of the new infections over the past three years, there are differences between Greater Minnesota and the EMA. The main differences occur in the African and Asian communities. Africans account for 14 percent of new infections in Greater Minnesota and 20 percent in the EMA, while for Asians those numbers are 8 and 2 percent, respectively. (Figure 15)

There are no significant differences in the distributions for gender and age.

**Figure 14. New HIV/AIDS Infections By Mode of Exposure, Minnesota & EMA 2001 - 2003**



**Figure 15. New HIV/AIDS Infections By Race/Ethnicity, Minnesota & EMA 2001 - 2003**



## Characteristics of HIV/AIDS in High Risk Populations

In this section of the epidemiological profile HIV/AIDS surveillance data are used to describe the state of the HIV/AIDS epidemic in certain populations. Other sources of available data are also utilized to enhance understanding of the epidemic.

### MEN WHO HAVE SEX WITH MEN (MSM)

#### *Estimates of MSM in Minnesota*

As stated previously, accurate estimates of same sex behavior in Minnesota are not available. However, a 1995 national study estimated that 6 percent of males engaged in same sex behavior during the previous 5 years<sup>31</sup>. Using this result and U.S. Census 2000 data, approximately 146,000 MSM would be predicted to reside in Minnesota, with 60 percent of those residing in the EMA. However, the estimated range for this population would be much broader.

#### *Proportion of the Epidemic Among MSM*

The majority of persons living with HIV/AIDS in Minnesota are men who have sex with men (54 percent or 2,649 cases); the remaining risk categories represent much smaller proportions of the epidemic. However, as previously stated MSM do not account for as great of a proportion of the epidemic in Greater Minnesota.

In the past, the CDC has estimated that approximately 30 percent of persons infected with HIV are unaware of their status. However, recent data presented at the 14<sup>th</sup> International AIDS Conference from a CDC study designed to estimate HIV seroprevalence among MSM using randomly selected sites in seven U.S. cities raise concern that the vast majority (77%) of HIV-infected gay/bisexual men are unaware of their status<sup>32</sup>. The estimates varied by race. Among Blacks 90 percent were unaware of

their infection followed by 70 percent of Hispanics, and 60 percent of Whites. Thus, the extent of the epidemic among MSM may be remarkably underestimated.

#### *Racial/Ethnic Trends Among MSM*

White MSM or MSM/IDU make up the largest proportion of HIV infections diagnosed in the past three years (75%, Figure 16). However, MSM of color are disproportionately represented when taking race-specific population size into account. Specifically, in the epidemic among MSM, African Americans make up 13 percent of new HIV infections diagnosed between 2001 and 2003, but African American males represented only 4 percent of the state's population in 2000. Similarly, Hispanics represent 9 percent of the recent epidemic among MSM and only 3 percent of the male population.

In general, over the last decade the number of new HIV infections diagnosed among White MSM has been declining while numbers for MSM of color have remained stable or increased (Figure 17). Thus, MSM of color have made up a growing proportion of cases among MSM.

In 2001, the number of infections among White MSM increased by 43 percent (from 74 to 106 cases). The number of new infections has decreased in both 2002 and 2003, however are still up 20 percent from 2000. Concern is still high that an increase in HIV cases among White, African American, and Hispanic MSM in the Minneapolis-St. Paul region may follow the outbreak of syphilis detected among MSM in the area that started in early 2002 and has continued through 2003. Approximately half of the syphilis cases among MSM are co-infected with HIV. This phenomenon has already been observed in a number of U.S. cities<sup>33,34</sup>

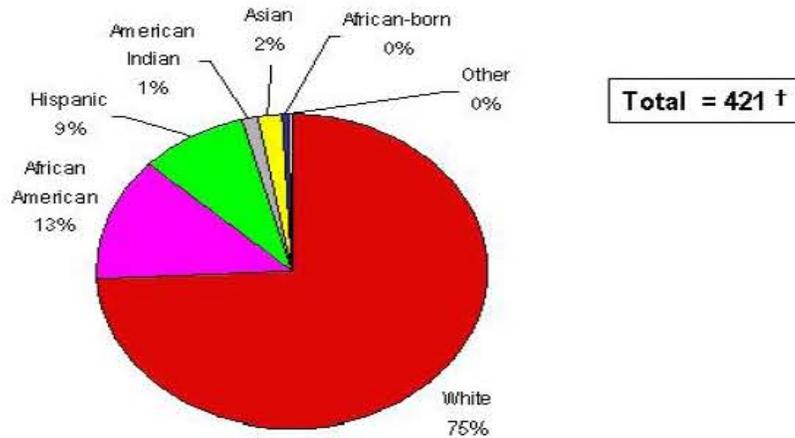
<sup>31</sup> Sell et al, *Arch Sex Behavior* 1995

<sup>32</sup> MacKellar et al, 2002

<sup>33</sup> *MMWR* 2001, CDC

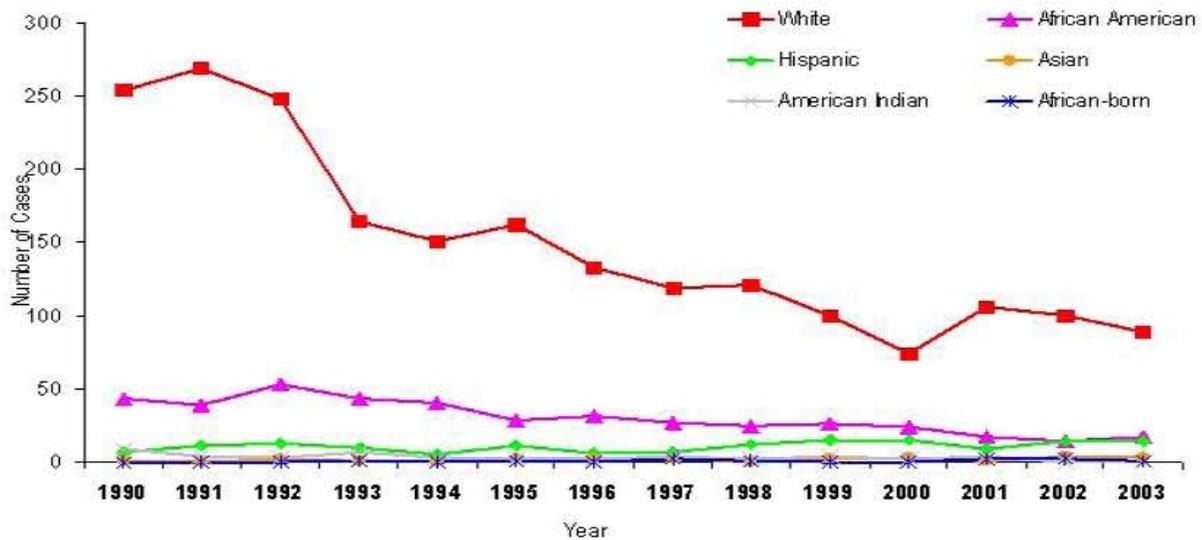
<sup>34</sup> San Francisco Department of Health website

**Figure 16. New HIV Infections Diagnosed Among MSM or MSM/IDU in 2001 - 2003 by Race/Ethnicity, Minnesota**



† Includes 9 cases from Pierce and St. Croix counties, WI.  
 Other – Multi-racial persons or persons with unknown race

**Figure 17. HIV Infections Among MSM or MSM/IDU by Race/Ethnicity, Minnesota 1990-2003**



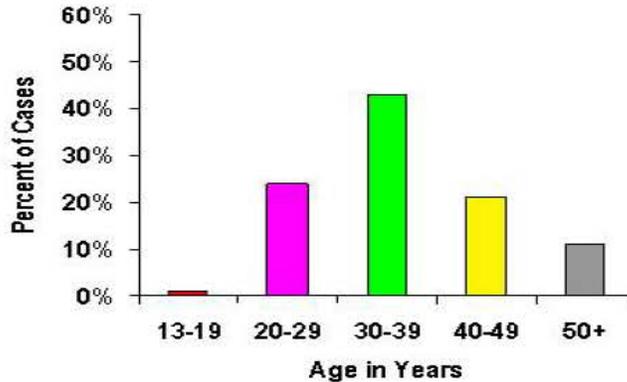
**Age Trends Among MSM**

The largest percentage of recent cases of HIV infection among MSM was among men aged 30 to 39 years (43%, Figure 18), followed by men between 20 to 29 (24%). Young adults (20 to 24 years of age) accounted for 10 percent of recent infections among MSM.

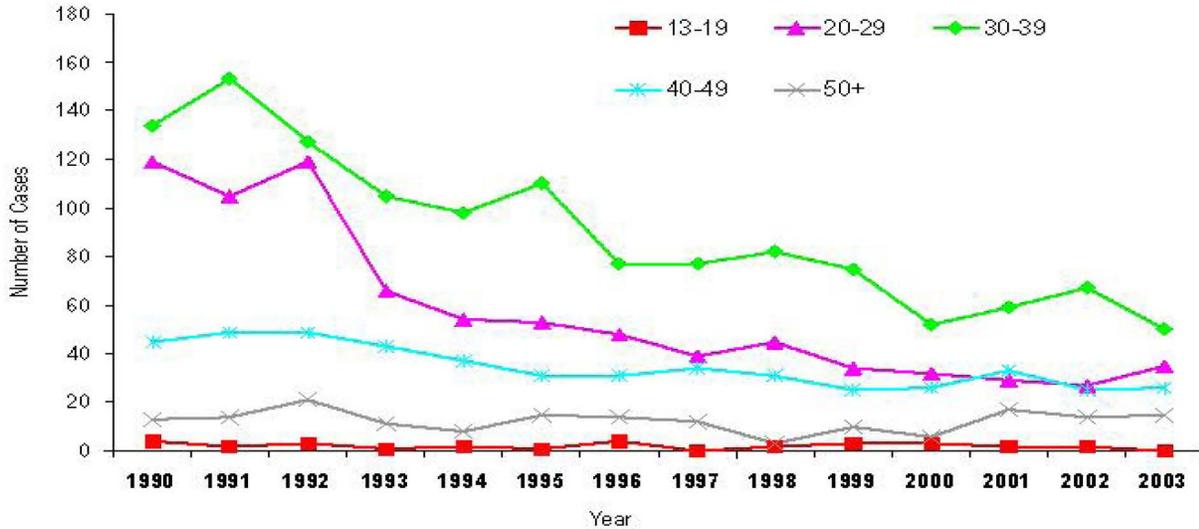
Figure 19 on the following page depicts the trends in new HIV infections diagnosed over

time for six age groups. As the annual number of new infections diagnosed among MSM aged 20-39 decreased over the past decade, the number among those 40 years and over remained relatively stable. In 2003, the 30 – 39 age group saw a decrease over the previous year, while the 20 – 29 age group saw an increase (30%) over 2002.

**Figure 18. New HIV Infections Diagnosed Among MSM or MSM/IDU in 2001 - 2003 by Age at Time of Diagnosis, Minnesota**



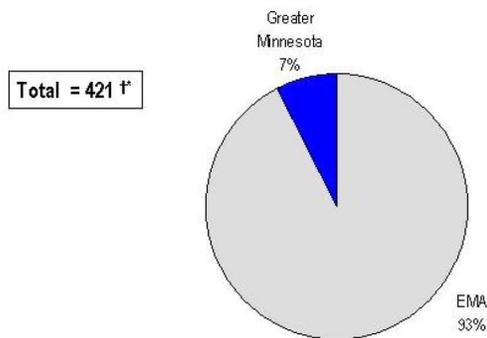
**Figure 19. HIV Infections Among MSM or MSM/IDU by Age at Diagnosis, Minnesota 1990-2003**



**Figure 20. New HIV Infections Diagnosed Among MSM or MSM/IDU in 2001-2003 by Region of Residence, Minnesota**

**Geography of HIV Among MSM**

Between 2001 and 2003, 7 percent of new HIV infections diagnosed in MSM lived outside the Minneapolis-St. Paul EMA (Figure 20). This percentage has not changed significantly over time (data not shown).



<sup>†</sup> Includes 9 cases from Pierce and St. Croix Counties, WI  
<sup>\*</sup> 5 cases missing location

### **HIV Seroprevalence Studies**

HIV seroprevalence surveys were conducted at two sexually transmitted disease (STD) clinics in Minneapolis-St. Paul from 1988 through 1995 (data not shown). Of the various groups tested, the seroprevalence of HIV among gay and/or bisexual men was greater than for any other groups - consistently 12 percent or higher in the first five surveys and dropping down to 6-7 percent by the final survey in 1995.

### **STD Surveillance Data**

An outbreak of syphilis that began in 2002 and its implications are discussed in the next section. Aside from syphilis data, STD surveillance information specific to men who have sex with men is largely unavailable because mode of exposure data has not been collected routinely and it is not feasible for MDH to systematically follow up the nearly 12,000 annual reports of chlamydia and gonorrhea to obtain sexual behavior data. In 2004, MDH added gender of sexual partners to the case report form but that data is not yet available. Additionally, site of infection for gonorrhea cases is requested on the case report form but is not provided consistently and thus cannot be validly interpreted.

### **Behavioral Data**

Unprotected sex between men accounts for the majority of HIV transmission in Minnesota. Data from within Minnesota as well as outside suggest that risky sexual behavior may be on the rise both among HIV-infected and uninfected men who have sex with men.

In early 2002 a steep increase of syphilis among MSM was detected in the Minneapolis-St. Paul area<sup>35</sup>. Compared to the first quarter of 2001 when only 1 case of syphilis was linked to male-to-male sex, 8 such cases occurred in the first quarter of 2002, 4 of who were co-infected with HIV. By the end of 2002, 80 percent of male syphilis cases were among MSM, with 45 percent of these cases being co-infected with HIV. This trend has continued in 2003, with 85 percent of new syphilis cases among males linked to male-to-male sex, of which 42 percent

are co-infected with HIV. These data provide strong evidence of risky behavior among some MSM, including HIV-infected MSM.

Many published studies suggest that multiple factors may be contributing to increases in risky sexual behavior by MSM. Some of the factors, as identified by the CDC, include the following: less concern about infection due to new treatments<sup>36</sup>; growing numbers of young males without direct experience with HIV/AIDS; incorrect assumptions about partners' HIV status; difficulty in sustaining sexual behavior change over time; racism, stigma, and lack of services in minority communities; and the continued role of substance use which studies indicate is often accompanied by increased sexual risk behavior<sup>37</sup>. In addition, the Internet is increasingly being used as an avenue for MSM to socialize and meet potential friends, sex partners, and/or lovers through chat rooms. Some of the chat rooms are devoted to unprotected sex<sup>38</sup>.

In 2000, a needs assessment study was conducted among 129 self-identified sex workers (trade sex for money, drugs, etc.) recruited from various locations around the Minneapolis-St. Paul area<sup>39</sup>. Thirty (30) of the 129 sex workers were male and nearly all had been sexual with other men. The following percentages apply to the whole study group and so are not generalizable specifically to male sex workers. On average, across six risky sexual behaviors, 60 percent of sex workers reported that they used a condom half of the time or less with their personal partners. The corresponding percentage for work partners was 42.5 percent. Condom use with known HIV-infected partners was sporadic depending on the sexual activity but typically was less than half the time. Again these do not refer exclusively to hetero- or homosexual contact.

Between 1994 and 1995 an HIV/AIDS Knowledge, Attitude, and Behavior survey of gay and bisexual men of color in the Minneapolis-St.

<sup>35</sup> STD Surveillance System, MDH

<sup>36</sup> Ostrow et al, *AIDS*, 2002.

<sup>37</sup> Purcell et al, *Journal of Substance Abuse*, 2001.

<sup>38</sup> Rebchook et al, *University of California San Francisco-in progress*

<sup>39</sup> Red Door Clinic, December, 2000.

Paul area was prepared for the MDH. A one-hour open-ended question interview of 30 questions was given and a 15 page, 100 item written questionnaire was completed with a trained interviewer. The interviewers were of the same ethnicities as the men they interviewed. Two hundred twenty-two (222) men were interviewed. Fourteen percent (14%) were HIV positive. Approximately 49 percent were Black, 26 percent Asian Pacific Islander, 12 percent Native American, and 10 percent Hispanic. The median age group was 25-32.

Of the 65 men who had been in prison, 64 percent had had sex with men while they were there. Of the 28 men who had been in the military, 36 percent had sex with men while they were there. Forty-four percent (44%) of the 222 engaged in sex with a partner on the same day (same-day sex) with at least one of their last three partners. Eighteen percent (18%) of this "same-day sex" group were HIV positive. Sixteen percent (16%) of the 222 engaged in same-day sex with all of their last three partners, and 23 percent of these participants were HIV positive.

Sixty-two percent (62%) of those engaging in oral sex in the last six months never (43%) or only sometimes (19%) used a condom. Sixty-five percent (65%) engaging in oral to anal sex (rimming) in the last six months never (57%) or only sometimes (8%) used a barrier. Thirteen percent (13%) engaged in insertive anal sex without a condom in the previous two months. Eleven and a half percent (11.5%) engaged in receptive anal sex without a condom. About ten percent (10.2%) engaged in insertive vaginal sex without a condom. Twenty to twenty-five percent (20-25%) of the sample did not use condoms consistently. Forty percent (40%) never or sometimes thought about HIV/AIDS when presented with a sexual opportunity. Eighty-six percent (86%) thought it unlikely or very unlikely that they will ever get HIV.

In a survey conducted among MSM in southwest Minnesota during 1995-1997, 60 percent of respondents did not feel that they were at risk for HIV. However, about 17 percent of respondents indicated that they had more than 10 sexual partners in the past year, and 51

percent indicated that they did not always use condoms. Fourteen percent (14%) reported that they never use condoms. Only 50 percent of the individuals that reported having more than 10 partners in the last year reported always using condoms. National research supports this finding of high levels of HIV risk behavior among gay men in rural Minnesota. In 1995, Kelly et al surveyed nearly 6,000 men entering gay bars in 16 small American cities, and found that 27 percent of the men reported engaging in unprotected anal intercourse in the past two months<sup>40</sup>.

A recent survey of men attending the Twin Cities Pride Festival in June 2004 provided some additional behavioral data on MSM. Of the 379 men interviewed, 300 (79%) said they had sex with men, and of these, 41% had had multiple sexual partners in the previous 12 months. Additionally of those engaging in anal sex in the past 12 months, 47 percent reported having unprotected sex (72 percent for men with single partners, 42 percent for men with multiple partners).

In relation to HIV testing, 88 percent of those interviewed reported having been tested, and of those 41 percent reported having had an HIV test in 2004. Of those tested, 8 percent were positive. Additionally, 5 percent of those interviewed reported having an STD diagnosis in the previous 12 months<sup>41</sup>.

### **Gay/Bisexual Youth**

In a 1994 study of 239 gay and bisexual adolescent males living in Minnesota, Remafedi found 63 percent of subjects to be at "extreme risk" for prior HIV exposure, based on histories of unprotected anal intercourse and/or intravenous drug use. Thirty-four percent (34%) of subjects reported unprotected anal sex with at least one of the last three partners in the previous year<sup>42</sup>.

Minneapolis was one of several sites in a national study of sexually active young MSM

<sup>40</sup> Kelly et al, *J of Consulting and Clinical Psych*, 1995

<sup>41</sup> MDH, Twin Cities Men's Health Survey, 2004, <http://www.health.state.mn.us/divs/idepc/dtopics/stds/tcmenshealth.html>

<sup>42</sup> Remafedi et al, *Pediatrics*, 1994

(YMSM) in 1999. Participants were randomly sampled from popular venues for structured interviews about demographic and psychosocial characteristics, sexual behavior, drug use, health care service delivery, and HIV test experience. Of 255 YMSM interviewed in Minnesota, more than one in four reported unprotected anal sex with men in the last three months (35%), and the majority reported multiple male partners in the last three months (57%). Unprotected intercourse happened more often with main partners (16%) than with non-main partners (6%). A sizeable minority reported prostitution (8%), and unprotected intercourse with women (8%)<sup>43</sup>.

Between 1994 and 1998, the Young Men's Survey recruited 3,492 15-22 year old MSM from 194 public venues in seven major U.S. metropolitan areas who agreed to be interviewed and tested for HIV. Overall prevalence was 7.2 percent, and increased with age, from 0 percent among 15 year olds to 9.7 percent among 22 year olds. HIV prevalence was higher among Blacks (14.1%), among young men of mixed or other race (12.6%), and among Hispanics (6.9%) than Whites (3.3%) or Asians (3.0%)<sup>44</sup>.

Additionally, in a study conducted in 2001 with adolescents and young adults (13 – 24) in Minnesota 4 percent identified as gay, bisexual or transgender<sup>45</sup>. When asked about condom use in the last 6 months when having vaginal, oral, oral-anal, insertive anal or receptive anal sex, 47, 75, 90, 61 and 61 percent respectively reported that they used a condom half the time or less. For vaginal, insertive and receptive intercourse, 25 percent, 21 percent and 35 percent reported never using protection, respectively.

All of these studies show that sexual risk behaviors are prevalent among gay/bisexual youth, which is of concern given the increase in HIV cases among young men seen over the last few years.

## INJECTION DRUG USERS (IDU)

### *Estimates of Injection Drug Use in Minnesota*

Data on IDU in Minnesota are very limited and are based on admissions to treatment programs and emergency room visits thereby excluding users who do not present at these locations. The estimated number of IDUs in Minnesota is between 6,000-10,000<sup>46</sup>. A more recent estimate by Friedman et al puts the number of IDUs at 8,100<sup>47</sup>.

Considerable data are available about drug use indicators, including cause-specific mortality trends, emergency room admissions, and law enforcement activities. The Hazelden Foundation of Minnesota monitors these indicators and produces a report every six months. The most recent report published in June 2004 documents evidence of a growing heroin problem in the Minneapolis-St. Paul metropolitan area<sup>48</sup>. First, opiate-related deaths have more than doubled in Hennepin and tripled in Ramsey since 1997. In 2003, there were 50 opiate-related deaths in Hennepin County and 19 in Ramsey County<sup>49</sup>.

The 2004 report again highlights an injection drug use problem in Hennepin and Ramsey counties related to another drug, oxycodone, which is a popular prescription narcotic drug introduced in 1995. Recently the abuse of oxycodone, in particular the abuse of OxyContin (long-acting oxycodone), increased. Additionally, law enforcement seizures of oxycodone have increased as well.

An additional study provides context regarding risk behavior among IDUs in the Twin Cities metro area. In order to evaluate the impact of state legislation enacted in July 1998 that provided for voluntary pharmacy sales of syringes/needles without a prescription for an accompanying drug, 270 pre- and 300 post-legislation interviews were conducted with active IDUs in 1998 and 1999<sup>50</sup>. One year after

<sup>43</sup> CDC, Community Intervention Trial for Youth, 1999 (unpublished)

<sup>44</sup> Valleroy et al, *JAMA*, 2000

<sup>45</sup> MDH, STD Prevalence Study, 1999-2001 (unpublished)

<sup>46</sup> Access Works

<sup>47</sup> Friedman et al, 2003 (unpublished)

<sup>48</sup> Falkowski C, *Drug Abuse Trends*, June 2004

<sup>49</sup> Falkowski C, *Drug Abuse Trends*, June 2003

<sup>50</sup> Cotton-Oldenburg et al, *Acquired Immune Deficiency Syndrome*, 2001

enactment of the legislation, significantly fewer IDUs reported sharing syringes. Nevertheless, 24 percent of respondents still reported sharing syringes within the past 30 days and over 80 percent reported reusing a syringe in the past month. These data demonstrate that risky drug use behavior is present among IDUs in Minnesota.

In recent study of adolescents and young adults in Minnesota conducted between 1999 and 2001 by the Minnesota Department Health (MDH), 3 percent of respondents reported ever having used heroin, and of those 11 percent reported current use<sup>51</sup>.

Unfortunately in 2003, a treatment center for IDU's closed decreasing access to health care and prevention for this group. Also in 2003, due to budget cuts, Access Works decreased the amount of HIV testing in this same community.

### ***Proportion of Epidemic Among IDUs***

IDU was an associated risk factor (either IDU alone, MSM/IDU, or heterosexual contact with an IDU) for 18 percent (886/4,950) of persons known to be living with HIV/AIDS in Minnesota (15% Greater MN, 85% EMA) at the end of 2003 (data not shown). Figure 21 depicts the proportion of cases attributed to IDU alone (8%), MSM/IDU (5%), and other factors for living HIV/AIDS cases in Minnesota at the end of 2003.

### ***Gender and Race/Ethnicity Among IDU***

Because the annual numbers of new cases among IDUs and/or MSM/IDU are quite small (e.g., 4 cases of HIV infection diagnosed among female IDU in 2003), this section will focus on all living cases of HIV/AIDS among IDU and MSM/IDU. IDU or MSM/IDU account for 13 percent (667/4,950) of persons living with HIV/AIDS in Minnesota. Among those with IDU only (n=393), 35 percent (139/393) are female and 65 percent (254/393) are male.

Among female HIV/AIDS cases in IDUs alive at the end of 2003, African Americans were extremely over represented, accounting for 47 percent of cases (Figure 22) but no more than 3

percent of the general population. Similarly, American Indian women accounted for 9 percent of cases and only 1 percent of the population. White women accounted for 38 percent of cases and 89 percent of the population. Hispanic women accounted for the remaining 6 percent of IDU cases among women living with HIV/AIDS. There are no reported cases among Asian women.

African Americans also represent the largest percentage of 254 living HIV/AIDS cases diagnosed among male IDUs through 2003 (51 percent, Figure 23), but again represent only 3 percent of the general population. White men accounted for 33 percent of cases among IDUs and 89 percent of the general population, and Hispanic males 13 percent of cases and 3 percent of the population. American Indian and Asian males accounted for the remaining 3 percent of male IDUs living with HIV/AIDS.

MSM/IDU exhibit a different racial/ethnic distribution; disparities are not quite as great for this risk category, though still present. White men accounted for 70 percent of 259 living HIV/AIDS cases diagnosed among MSM/IDU through 2003; African American men accounted for 24 percent of MSM/IDU cases; and Hispanic and American Indian men each accounted for 3 percent of cases (data not shown).

### ***Age at Diagnosis Among IDUs***

As depicted in Figure 24, the HIV/AIDS epidemic among IDUs primarily affects those aged 20-49 years. The largest percentage (47%) of cases among IDUs were diagnosed between the ages 30-39 followed by 25 percent in the 20-29 and 21 percent in the 40-49 year age groups. Youth (ages 13-19) only account for 1 percent of IDU HIV/AIDS cases.

### ***Geography of HIV Among IDUs***

Figure 25 demonstrates that the recent HIV/AIDS epidemic among IDUs is more likely to affect Greater Minnesota (24%) than the larger epidemic statewide in which only 10% of new cases reported living outside the Minneapolis-St. Paul metropolitan area. The percent in Greater Minnesota does not change if MSM/IDU and heterosexual contact with IDU is added.

<sup>51</sup> MDH, STD Prevalence Study, 1999-2001 (unpublished)

Figure 21. Living HIV/AIDS Cases by Mode of Exposure, Minnesota 2003

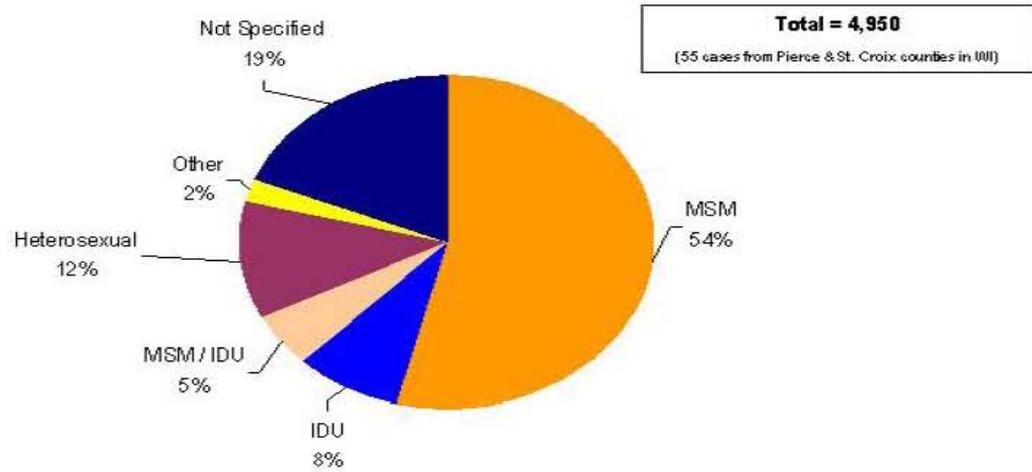


Figure 22. Living HIV/AIDS Cases Among Female IDU by Race/Ethnicity, Minnesota 2003

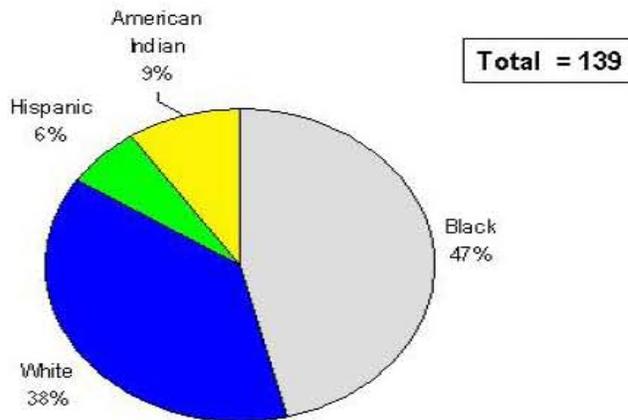


Figure 23. Living HIV/AIDS Cases Among Male IDU by Race/Ethnicity, Minnesota 2003

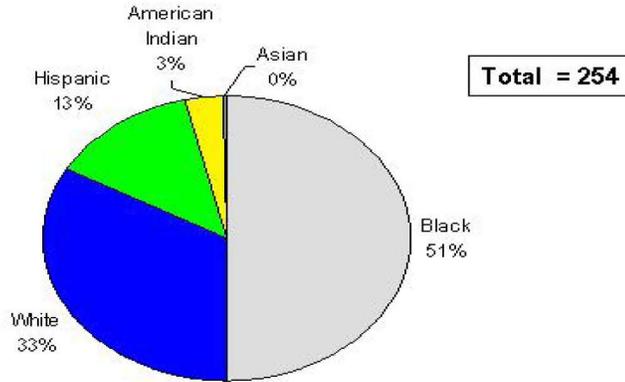
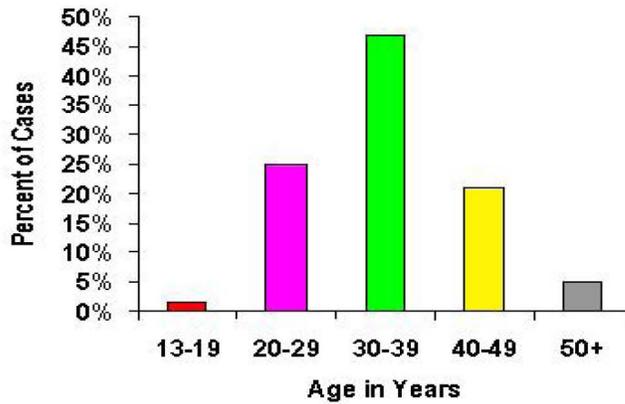
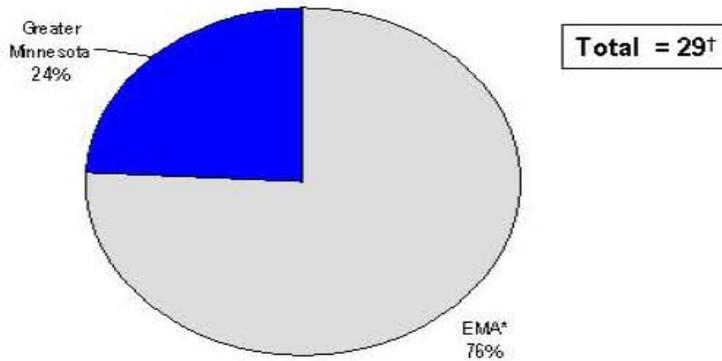


Figure 24. Persons Living with HIV/AIDS Attributed to IDU by Age at Time of HIV Diagnosis, Minnesota 2003



**Figure 25. New HIV Infections Diagnosed Among IDU by Region of Residence, Minnesota 2001-2003**



† Includes no cases from Pierce and St. Croix Counties.

### ***HIV Seroprevalence Data***

Clients of drug treatment centers receive a physical examination upon entry; that includes sera collected and tested for hepatitis serology. Between 1988 and 1995, the MDH conducted surveys at three clinics testing sera (when a sufficient quantity remained after hepatitis testing) in a blinded unlinked fashion for HIV antibody.

The seroprevalence among clients of drug treatment centers remained extremely low (<0.5% for injecting drug users) (data not shown). Injection drug users not in treatment may be more likely to be HIV-infected than those in treatment; however, even if they are two to three times as likely to be HIV-infected, the overall seroprevalence rate among IDU would still be expected to be low.

### **HIGH RISK HETEROSEXUAL CONTACT**

#### ***Establishing Heterosexual Contact as the Mode of HIV Exposure***

In order for a case of HIV or AIDS to be included in the heterosexual mode of exposure category, the case must have knowledge that his/her heterosexual partner has, or is at increased risk for, HIV infection (i.e. partner injects drugs, is a bisexual man (female cases), and/or has received blood, blood products, or an organ transplant). Oftentimes cases do not have this sort of knowledge about their partners.

Thirty-five percent (37% or 378/1,004) of female HIV/AIDS cases and 14 percent (552/3,891) of male cases living with HIV/AIDS in Minnesota have no specified mode of exposure. Although a similar study has not been conducted for men, results from a CDC study suggest that 80 percent of female cases with an unspecified mode of exposure can be attributed to heterosexual

exposure<sup>52</sup>. In Minnesota, this would increase the number of living female heterosexual HIV/AIDS cases from 444 to 746. For purposes of this analysis, only HIV/AIDS cases officially categorized as due to heterosexual exposure will be included.

### ***Estimates of High Risk Heterosexual Contact***

Quantifying the number of persons in Minnesota who engage in heterosexual contact that puts them at high risk of HIV exposure is difficult at best. In a broad manner, diagnosis of a sexually transmitted disease (STD) may be used as an indicator of risky heterosexual behavior. As stated previously, sexual behavior data are currently unavailable for chlamydia and gonorrhea cases and thus limit somewhat the generalizability of those data because cases due to homosexual contact are included as well. However, in 2004, MDH added gender of sexual partners to the STD case report form, which will provide some behavior information for STD cases. In 2003, 10,714 cases of chlamydia, 3,202 cases of gonorrhea, and 92 cases of early syphilis were reported in Minnesota. However in 2003, 77 percent (71) of early syphilis cases were associated with male-to-male sex. Rates of chlamydia and gonorrhea in 2003 were highest among those 15-24 years old followed by those 25-29 years old. Females accounted for a greater percentage of chlamydia cases than males (73% vs. 27%); the gender distribution for gonorrhea cases was more equal, 56 percent female and 44 percent male.

Rates of STDs were higher in more densely populated areas. For example, in 2003 rates of chlamydia were highest in Minneapolis (755 per 100,000), St. Paul (618 per 100,000) and their counties (Hennepin: 375 per 100,000 and Ramsey: 400 per 100,000). However, the counties in which Duluth, St. Cloud, Rochester, Mankato, and Moorhead cities are located had rates of STDs higher than other Greater Minnesota counties. A handful of other counties outside of the Twin Cities

metropolitan area (Mahnomen, Beltrami, Mower, Pennington and Wabasha) also had rates well above the average STD rate in Greater Minnesota.

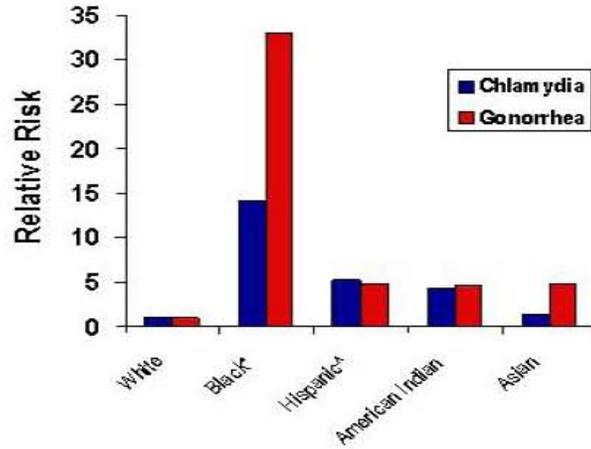
The most striking disparity is the continued high rates of STDs among Blacks compared to other racial/ethnic groups (Figure 26). Statewide in 2003, Blacks were 14 times more likely than Whites to be diagnosed with chlamydia and 33 times more likely to be diagnosed with gonorrhea. Persons of color, in general, were more likely to be diagnosed with an STD in Minnesota than were Whites.

### ***Proportion of Epidemic Among High Risk Heterosexuals***

Heterosexual transmission accounts for 12 percent (570 of 4,950 cases) of the HIV/AIDS epidemic in Minnesota (Figure 27), the majority of whom are women (78% or 444 cases). Of the 570 heterosexual cases, 46 percent of men and 45 percent of women had unsafe sexual contact with a partner they knew to be infected with HIV (Table 9).

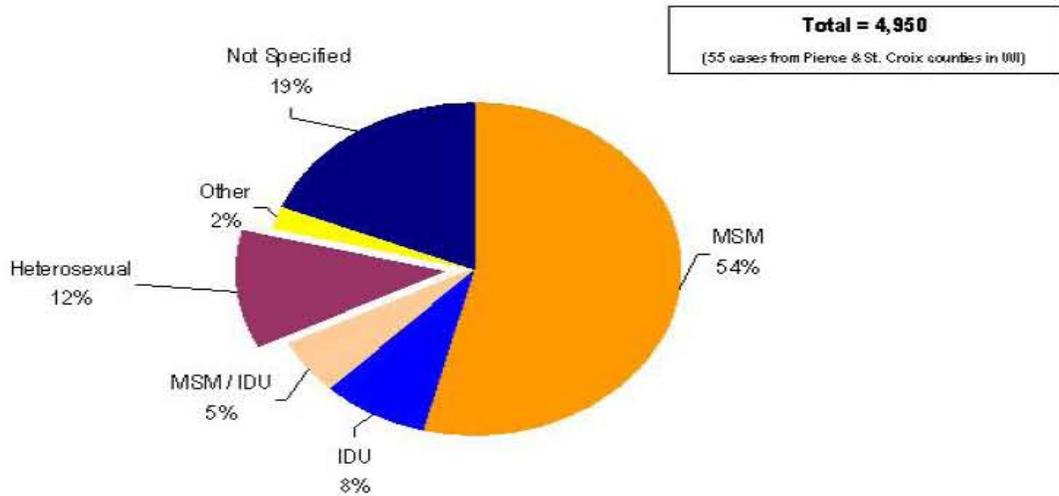
<sup>52</sup> Lansky et al, *MMWR*, 2001

Figure 26. Relative Rates of Chlamydia and Gonorrhea by Race/Ethnicity, Minnesota 2003



*\*Includes African Americans and African-born Blacks.  
 \*People of Hispanic origin may be of any race.*

Figure 27. Living HIV/AIDS Cases by Mode of Exposure, Minnesota 2003



**Table 9. Persons Living with HIV/AIDS Attributed to Heterosexual Transmission by Sexual Partner Type, Minnesota 2003**

Partner	Men		Women		Total	
	No.	%	No.	%	No.	%
HIV-infected (HIV or AIDS)	56	46%	198	45%	254	45%
Injection Drug User	63	52%	156	35%	219	39%
Bisexual Male	-	-	84	19%	84	15%
Hemophiliac	2	2%	6	1%	8	1%
Total	121	100%	444	100%	570*	100%

\* Includes 5 cases from WI, with unknown gender and partner status

### ***Racial/Ethnic Trends Among High Risk Heterosexuals***

Among females, African Americans make up the largest percentage of the 79 heterosexually acquired HIV infections that were diagnosed in the past three years (38%, Figure 28); African Americans, however, only make up 3 percent of the state population. Likewise for other women of color, African-born women account for 19 percent of the recent cases and less than 1 percent of the population, Hispanic women for 9 percent of cases and 3 percent of the population, American Indian women 5 percent of cases and 2 percent of the population, and Asian women 1 percent of cases and 1 percent of the population.

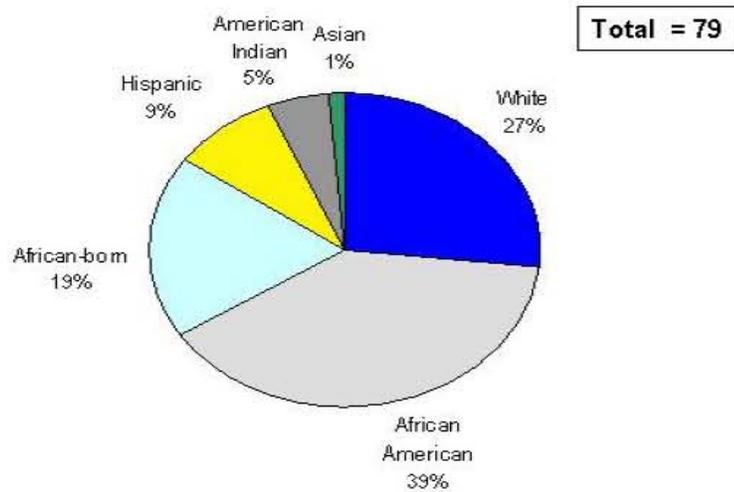
It should be noted that 81 percent of the 97 cases diagnosed among African-born women during the past years have an unspecified mode of exposure (compared to 41 percent in the next highest group). Due to language and cultural barriers, assessing risk behavior information among African-born cases has been difficult. However, given that heterosexual contact is the main mode of HIV transmission in their countries of origin and that the gender distribution of the cases residing in Minnesota reflects that of the African epidemic, heterosexual transmission is

likely for most of the unspecified cases among African-born persons.

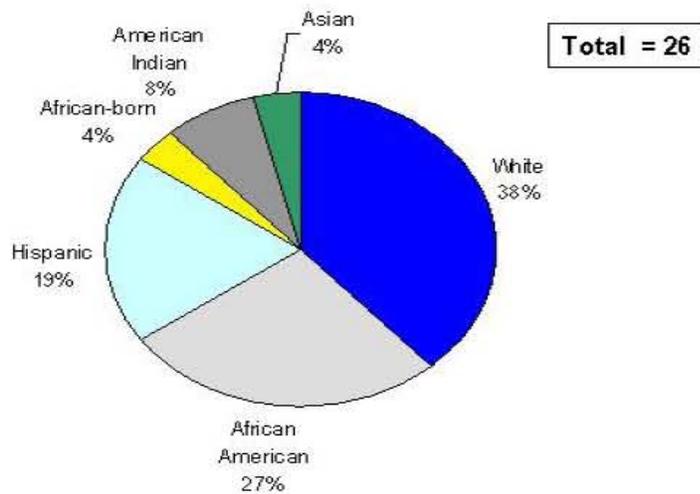
For males, Whites make up the largest proportion of heterosexually acquired HIV infections diagnosed in the past three years (38%, Figure 29). However, men of color are disproportionately represented when taking race-specific population size into account. Specifically, in the epidemic among high-risk heterosexuals, African Americans make up 27 percent and Hispanics 19 percent of new HIV infections diagnosed between 2001 and 2003, but only 3 percent of the state population in 2000. Similarly, African-born men represent 4 percent of cases and less than 1 percent of the population. Only 2 heterosexually exposed cases were diagnosed during 2001-2003 among American Indian men and 1 case among Asian men.

Figure 30 depicts the annual number of heterosexually acquired HIV infections diagnosed between 1990 and 2003 by race/ethnicity. A fair amount of fluctuation over time is exhibited, in part, due to relatively small numbers among race/ethnicity categories.

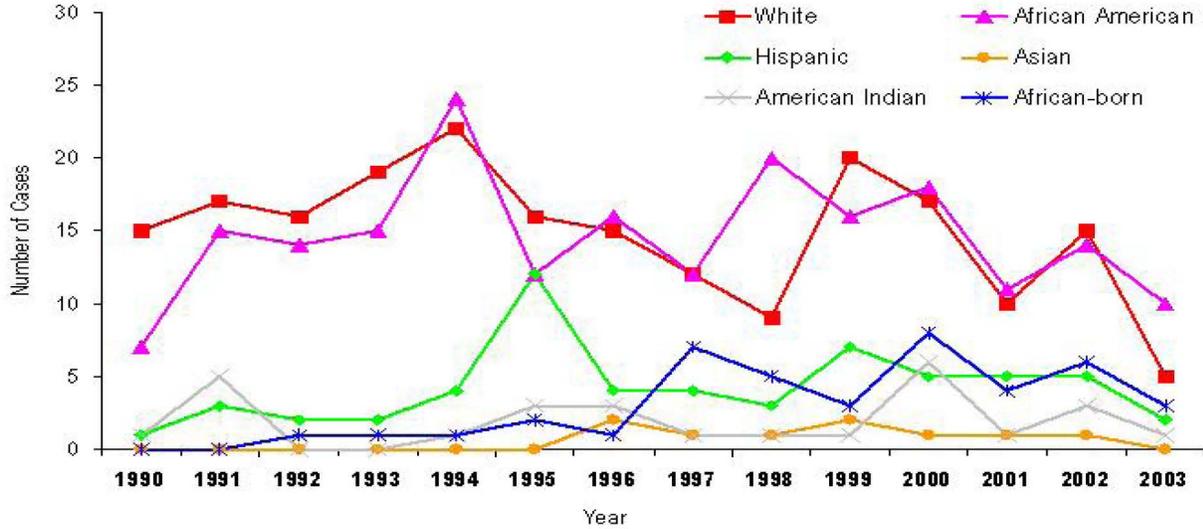
**Figure 28. Heterosexually-Acquired HIV Infections Diagnosed Among Females in 2001-2003 by Race/Ethnicity, Minnesota**



**Figure 29. Heterosexually-Acquired HIV Infections Diagnosed Among Males in 2001-2003 by Race/Ethnicity, Minnesota**



**Figure 30. Heterosexually-Acquired HIV Infections by Race/Ethnicity, Minnesota 1990-2003**

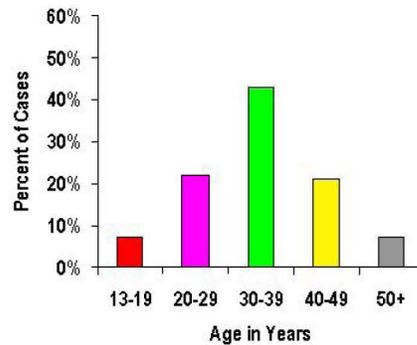


**Age Trends Among High Risk Heterosexuals**

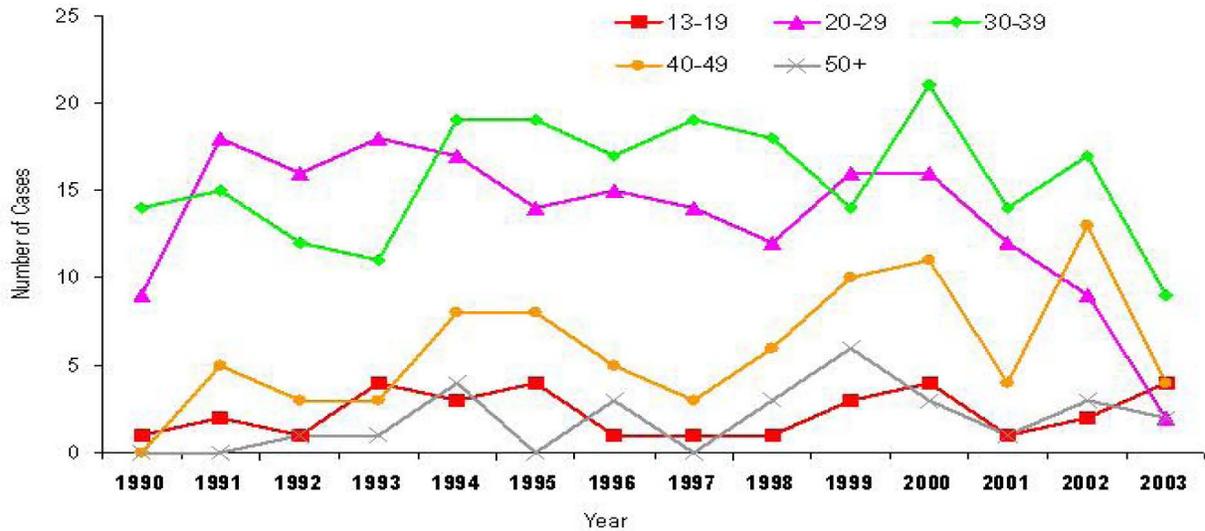
As depicted in Figure 31, the largest percentage of the recently diagnosed cases of HIV infection attributed to heterosexual contact occurred in the 30-39 year age group (43%) followed by 22 percent in the 20-29 year age group, and 21 percent in the 40-49 year age group. Teenagers comprise only 9 percent of newly diagnosed cases.

Figure 32 shows that age trends among heterosexual cases have been fairly consistent over the past decade. Most cases occurred in the 20-39 year age group.

**Figure 31. Heterosexually-Acquired HIV Infections Diagnosed in 2001-2003 by Age at Diagnosis, Minnesota**



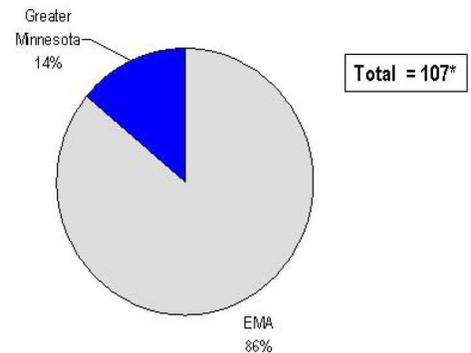
**Figure 32. Heterosexually-Acquired HIV Infections by Age at Diagnosis, Minnesota 1990-2003**



**Geography of HIV Among High Risk Heterosexuals**

Figure 33 demonstrates that the recent HIV/AIDS epidemic among high risk heterosexuals is more likely to affect Greater Minnesota (14%) than the larger epidemic statewide in which only 10 percent of new cases reported living outside the Minneapolis-St. Paul metropolitan area.

**Figure 33. Heterosexually-Acquired HIV Infections Diagnosed in 2001-2003 by Region of Residence, Minnesota**



\* Includes 2 cases from Pierce county, Ill

### **HIV Seroprevalence Studies**

HIV seroprevalence surveys were conducted at two sexually transmitted disease (STD) clinics in Minneapolis-St. Paul from 1988 through 1995. STD clinic patients are an ideal group to look at to determine the extent of HIV infection in the population, because, as evidenced by their attendance at an STD clinic, they are sexually active persons practicing unsafe sexual behaviors.

At the clinics, new patients routinely had blood drawn for syphilis serology. Specimens drawn on patients attending the clinic for an initial diagnosis or treatment of an STD during the study period (a pre-determined time of the year; same time for each successive survey) were tested in a blinded unlinked fashion for HIV antibodies. Overall, there was a remarkably low seroprevalence for all (presumably) heterosexual clients tested. For heterosexual men the seroprevalence rate was less than 1 percent, and for heterosexual women the rate was less than 0.4 percent (based on only 1-2 female cases per year) (data not shown).

The most recent survey conducted to measure the seroprevalence of HIV infection in women in Minnesota was completed in 1995. All newborns in Minnesota have blood collected by a heel-stick for testing for treatable metabolic and other disorders. Because HIV antibody is passively transferred across the placenta, testing of newborns allows an assessment of the prevalence of HIV infection among childbearing women. MDH began this blinded unlinked survey of childbearing women in July 1988. Initially only births from the Minneapolis-St. Paul area were included. This was expanded in 1989 to include all births statewide.

Results indicated a higher HIV infection level in the Twin Cities' metropolitan area compared to Greater Minnesota. This is consistent with surveillance data. Infection levels increased slightly over time from 1.5 per 10,000 in 1990 to 4.0 per 10,000 women delivering a live birth in 1995 statewide, although this increase is not statistically significant (data not shown). These results are

among the lowest reported in the U.S. for the 45 states (and District of Columbia and Puerto Rico) that conducted this survey. These seroprevalence surveys ceased in 1996.

### **Behavioral Data**

#### Drug use (other than injecting drug use) in Minneapolis

Drug use is discussed here because of the strong association between drug use and high-risk sexual activities. It should be noted that this association is not limited to heterosexuals even though these drug use data are presented in the section on high-risk heterosexuals.

Although accurate estimates of the magnitude of substance use in Minnesota are not available, data that reflect the relative increase or decrease in usage are. A 2004 report by Falkowski provides evidence that use of some illegal drugs in Minneapolis-St. Paul has increased over the past few years<sup>53</sup>. For example, methamphetamine-related (meth) deaths increased in Hennepin County, as did treatment admissions and the percentage of arrestees testing positive for meth<sup>54</sup>.

Telephone interviews were conducted with 7,508 randomly selected individuals in Minnesota between October 1996 and September 1997<sup>55</sup>. Illicit drug use patterns tended to be much lower than those reported nationwide (1996 National Household Survey on Drug Abuse) -- only 4.3 percent reported any illicit drug use in the past 12 months, compared to 10.1 percent of the United States, however, reported use of alcohol in the past 30 days was higher in Minnesota than in the U.S. as a whole (60.5% as compared to 54.8%). Alcohol use was highest among the 25 to 44 age group, and among White citizens. Binge drinking (defined as "typically drinking five drinks or more") was highest among Native Americans (28.1%) and

<sup>53</sup> Falkowski C, *Drug Abuse Trends*, June 2004

<sup>54</sup> Ibid

<sup>55</sup> Fulkerson JA, Minnesota Dept of Human Services, 1998

Hispanic populations (20.6%), and lowest among Blacks (5.9%).

In the fall of 1998, Minneapolis joined the National Institute of Justice's Drug Use Forecasting Program. Males and females who were arrested, but not convicted of misdemeanors and felonies in Hennepin County were recruited to participate in an interview and provide a urine sample. Seventy-five percent (75%) of eligible arrestees agreed to participate in the interview, and approximately 77 percent of these agreed to provide a urine sample. Sixty-five percent (65%) of males and 40 percent of females tested positive for at least one drug. Twenty-six percent (26%) of males and 30 percent of females tested positive for cocaine. Two thirds of females age 36 and older tested positive for cocaine. The study underscores that cocaine and crack are increasingly substances used by an aging cohort<sup>56</sup>.

More recently, data released in 2001 from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) indicate that marijuana continues to be a problem in the Twin Cities as Minneapolis experienced a 28 percent increase from 1999 to 2000 in mentions of marijuana or hashish during emergency room visits. One out of five (21.9%) people entering addiction treatment programs in 2001 reported marijuana as the primary drug of abuse, compared with only 8 percent in 1991.

Additionally, in a study conducted with adolescents and young adults in Minnesota by the MDH, 75 percent of participants reported ever using drugs and of those 34 percent reported current use.

### Sexual Risk Behavior

A 2001 MMWR article reported on the prevalence of sexual risk behaviors among states participating in the Behavioral Risk Factor Surveillance System in 1997<sup>57</sup>. Eighty-one percent (81%) of a random sample of Minnesotans older than 18 identified themselves as sexually active and 11.5 percent reported having multiple sex partners.

Of the persons reporting multiple sex partners only 54 percent reported using a condom during most recent intercourse. This data cannot be assumed to refer to only heterosexual persons.

In 2000, a needs assessment study was conducted among 129 self-identified sex workers (trade sex for money, drugs, etc.) recruited from various locations around the Minneapolis-St. Paul area. On average, across six risky sexual behaviors, 60 percent of sex workers reported that they used a condom half the time or less with their personal partners. The corresponding percentage for work partners was 42.5 percent<sup>58</sup>. Condom use with known HIV positive partners was sporadic depending on the sexual activity but typically was less than half the time. Note this data does not refer exclusively to heterosexual contact.

The majority of participants in the sex workers needs assessment also reported that they received counseling in the past for drug or alcohol use (72%), felt that their drug and/or alcohol use was a problem (67%), and believed that the use of drugs or alcohol affected their safe sex practices (71%).

Risk assessment data were collected from 1,367 women by the Catholic Charities Seton Program in Minneapolis, which performed outreach to women at risk on the streets of St. Paul, Minnesota in July 1998. Six percent (6%) of these women reported having more than four sexual partners in the last year, 13 percent reported trading unprotected sex for money, drugs, alcohol or favors. Forty-nine percent (49%) reported engaging in unprotected anal or vaginal sex at least once in the previous year, and 55 percent reported using condoms only sometimes or never when they had sex. Forty percent (40%) reported having sex while drunk or high in the previous year. The biggest reason given for not using condoms was "I am only having sex with one partner" (37%). Sixteen percent (16%) reported that they did not use condoms because "I use another form of birth control." Twenty-two percent (22%) reported ever having an STD. Nine percent (9%) reported using injectable drugs.

<sup>56</sup> Lenz S, *ADAM Program*, 1998

<sup>57</sup> CDC, *MMWR*, 2001

<sup>58</sup> Red Door Clinic, December 2000

In 1998, surveys were completed by 193 clients of battered women's shelters, family service agencies, women's correctional facilities, public health agencies, educational facilities, pregnancy centers, college student health centers, family planning agencies, and Gay/Lesbian/Bisexual/Transgender (GLBT) organizations in northwest Minnesota. Approximately 36 percent of women surveyed stated that they had had sex with two or more partners in the last year. Five percent (5%) of women surveyed had had sex with six or more partners. Only 19 percent of women said they always use condoms when they have sex, and 23 percent said they never used condoms when having sex. Twenty percent (20%) of respondents had ever been diagnosed with an STD. Only a slight majority of respondents stated that they trusted their partners to tell them if they acquired an STD (61%), or if they were having sex with other people (55%). Small minorities stated that their partners would not let them use condoms (5%), or that they did not dare ask their partners about HIV/STD (7%).

In a survey distributed between 1995 and 1997 in five cities in northeast Minnesota to people of color, 68 percent of respondents claimed to be sexually active, and 13 percent of these had had six or more sexual partners in the past year. Of the sexually active respondents, 68 percent never or only sometimes used condoms. Twelve percent (12%) reported that they have sex with multiple partners.

In a study with adolescents and young adults conducted in 2000 – 2001 in Minnesota by the MDH, participants were asked several questions about their sexual behavior. Fifty-five percent reported using protection half the time or less when having vaginal sex, 91 percent when having oral sex, 66 percent when having insertive anal sex and 77 percent when having receptive anal sex. The percent reporting never using protection was 17 percent, 41 percent, 2 percent and 2 percent for vaginal, oral, insertive anal and receptive anal, respectively. Additionally, 23 percent tested positive for an STD<sup>59</sup>.

<sup>59</sup> MDH, STD Prevalence Study, 1999-2001 (unpublished)

## Other High Risk Populations

### EMERGING HIGH RISK POPULATION: AFRICAN-BORN PERSONS

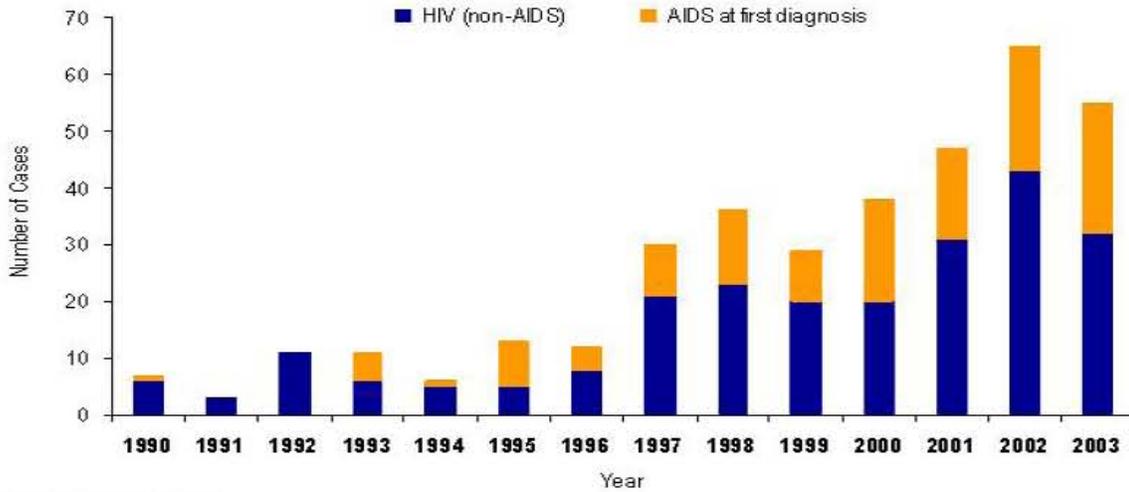
African immigration to Minnesota increased markedly during the mid-1990s; the current census estimate of African-born residents in the state is approximately 35,000<sup>60</sup>. However, many believe this to be an underestimate of the true African population in Minnesota. The number of new HIV infections diagnosed among African-born persons in Minnesota has been steadily increasing from 7 cases in 1990 to 55 cases in 2003 (Figure 34). Among new HIV infections diagnosed in 2003, African-born persons accounted for 21 percent of cases, but well under 1 percent of the statewide population. More cases of HIV infection were diagnosed among African-born females (28 cases) than any other female racial/ethnic group in 2003. The number of cases among African-born females has increased nine-fold between 1996 (3 cases) and 2003 (28 cases).

A notable difference in the local epidemic among African-born persons is the almost equal distribution of cases between males and females. In 2003, 51 percent of the new infections diagnosed among African-born persons were females compared to 18 percent among the remaining infections (Figure 35).

The sheer diversity of cultures (more than 25 different African countries are represented among Minnesota cases; many nations are home to tens of cultures within their borders), lack of education about HIV, and language and cultural barriers all pose significant challenges for HIV prevention efforts.

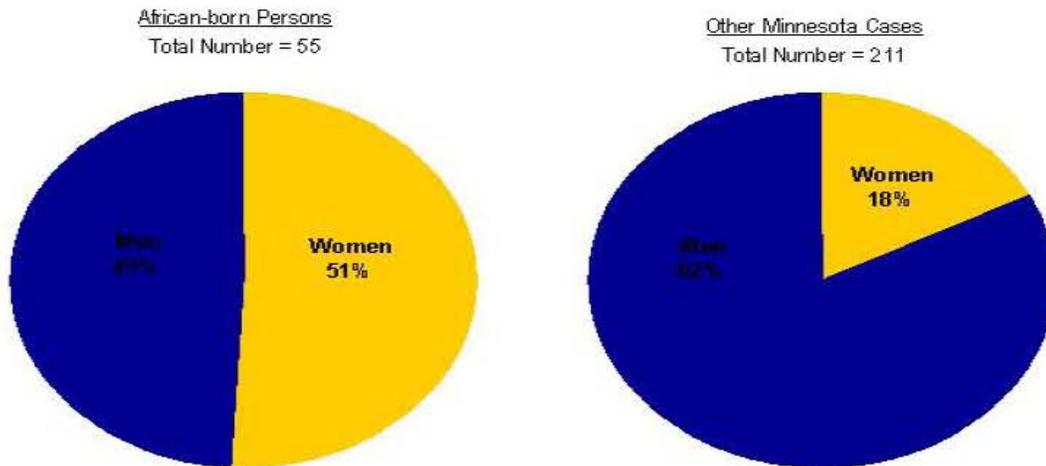
<sup>60</sup> Based on U.S. Census 2000 data, the U.S. Census Bureau estimates between 20,424 and 35,188 African-born persons are living in Minnesota out of a total population of 4,919,479. Because there are many reasons African-born persons may not be included in the census count (e.g. difficulties with verbal or written English), even 35,188 is likely an underestimate of the actual size of the African-born population living in Minnesota.

**Figure 34. New HIV Infections\* Among African-Born Persons† by Year of Diagnosis, 1990-2003**



\* HIV or AIDS at first diagnosis  
 † Includes 1 non-Black, African-born individual, but excludes persons arriving to Minnesota through the HIV+ Refugee Resettlement Program.

**Figure 35. New HIV Infections\* Among African-Born Persons† Compared to Other Minnesota Cases by Gender, 2003**



\* HIV or AIDS at first diagnosis

**EMERGING POPULATION: LATINO MEN**

Latino men accounted for 7 percent (275 cases) of the total number of men living with HIV/AIDS in Minnesota in 2003. While these numbers have remained relatively stable over the past few years, some of the characteristics of the epidemic among Latino men deserve further exploration. Below are some issues worth exploring for this population.

Latino men have a higher proportion of AIDS cases (50%), a higher proportion of cases who are less than 30 years of age (15%), and have had a higher proportion of new infections that were AIDS at first diagnosis (40%), than the total male population, 42, 6 and 30 percent, respectively.

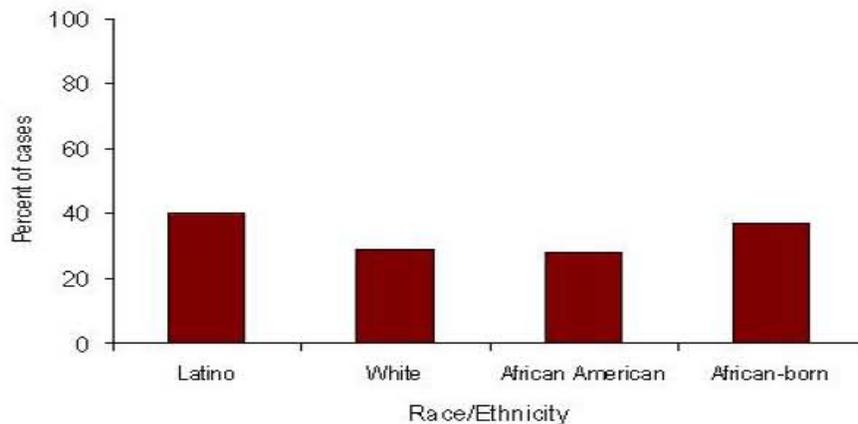
Additionally, Mexican-born men have both a higher proportion of AIDS cases (63%) and of cases who are less than 30 years of age (25%) compared to both the total male population (42

and 6 percent) and all Latino males (45 and 11 percent).

Figure 36 shows that Latino men have the highest proportion of new infections that were AIDS at first diagnosis (40%) then any other racial/ethnic group. The next closest is African-born men with 37%. Percents for Asian/Pacific Islanders and American Indians are not shown due to small numbers.

Fourteen (14) percent of all Latino men living with HIV/AIDS reside in Greater Minnesota (16 percent of Mexican-born men) compared to 10 percent of all male cases living with HIV/AIDS (10 percent of all cases). Incident and prevalent cases among Latino men are not equally distributed throughout Greater Minnesota; 60 percent of the cases are found in Southwest and Southern Minnesota. This is not surprising since Hispanics account for between 3.5 to 15 percent of the population in Southwest and Southern Minnesota counties compared to 3 percent for the state.

**Figure 36. Percent of New HIV Infections with AIDS at First Diagnosis Among Men by Race/Ethnicity\*, Minnesota 2001-2003**



\*Asian/Pacific Islander and American Indian not included due to small number of cases (15 or less)

## MIGRANT FARM WORKERS

Migrant workers, most of whom are Hispanic, are a mainstay of the agricultural workforce in Minnesota. Anywhere between 15,000 and 25,000 travel north, primarily from south Texas, each growing season<sup>61</sup>. Most migrant workers spend their time in Southern Minnesota, where sixty (60) percent of HIV/AIDS cases among Latino men reside.

While we lack epidemiological information on this population, research has shown that because of working and living conditions migrant workers are at high risk for becoming infected. Language and cultural barriers, as well as, poverty, sub-standard living conditions, and lack of access to health care and prevention services are some of the risk factors faced by migrant workers<sup>62</sup>. Furthermore, studies conducted in the migrant community have shown an overall low level of knowledge about HIV/AIDS<sup>63</sup>

Finally, some researchers have begun to assess HIV seroprevalence in migrant farm workers, and have identified rates that range from a low of 2.6 percent to a high of 13 percent<sup>64,65</sup>.

## TRANSGENDER PERSONS

Minnesota appears to attract a relatively large number of individuals who describe themselves as transgender due to the available treatment programs and access to hormonal and surgical sex reassignment. While the transgender population considers itself to be at elevated risk for transmission due to circumstances described in the needs assessment section of this plan, we lack comprehensive epidemiological data on this population.

Studies show that transgender individuals have elevated rates of HIV, particularly among transgender sex workers. These studies focus primarily on male to female transgender individuals. Possible reasons for the higher rates among transgender sex workers are more

frequent anal receptive sex, increased efficiency of HIV transmission by the neovagina, use of injectable hormones and sharing of needles, and a higher level of stigmatization, hopelessness, and social isolation.

Female to male transgender persons who identify as gay or bisexual may be having sexual intercourse with biological men who are gay or bisexual. Because the prevalence of HIV is higher among MSM, female to male transgender persons who identify as gay or bisexual are at greater risk for HIV than those who identify as heterosexual.

Studies by the University of Minnesota, Program in Human Sexuality show specific risk factors such as sexual identity conflict, shame and isolation, secrecy, search for affirmation, compulsive sexual behavior, prostitution, and that transgender identity complicates talking about sex.

## SENSORY DISABLED PERSONS

Written and/or verbal communication can be hindered for persons with a sensory disability(ies). Depending on the medium, general HIV awareness and prevention messages cannot be assumed to reach such populations. According to the Health Resources and Services Administration (HRSA), despite improved access to services – in large part through the Americans with Disabilities Act – the deaf and hard of hearing still do not have good access to the educational and social resources others take for granted<sup>66</sup>. Based on two limited studies, the CDC estimates that between 8,000 and 40,000 deaf and hard of hearing individuals are living with HIV/AIDS in the United States. There are few studies available in addressing HIV or its associated risk behaviors among persons with a sensory disability.

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals conducted a risk assessment evaluating HIV knowledge among 250 deaf or hard of hearing individuals. Only 15 percent of respondents from the community demonstrated knowledge of HIV transmission facts.

<sup>61</sup> Pioneer Press, March 2003

<sup>62</sup> <http://www.ncfh.org/newsline/03-0102.pdf>

<sup>63</sup> Organista et al, *Health and Social Work*, 1998

<sup>64</sup> Ibid

<sup>65</sup> CDC, *MMWR*, 1987

<sup>66</sup> HRSA, *HRSA Care Action*, April 2001

## Other Modes of Transmission

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### PERINATAL TRANSMISSION

HIV infected women are at risk of transmitting HIV to their children through perinatal exposure and/or breastfeeding. In Minnesota the rate of transmission is very low, two percent in 2001 - 2003. Additionally, in this time period no transmission occurred when the mother received appropriate therapy. However, women of color and foreign-born women were more likely to be diagnosed after the birth of their child indicating the need for efforts that will make universal HIV testing during pregnancy more acceptable to women of all races and cultures.

As a result of the Enhanced Perinatal Surveillance project undertaken in 2001, the MDH has added an active perinatal transmission component to its core HIV surveillance in order to obtain more accurate information both on perinatal HIV exposure and the exposed infants' serostatus.

### FEMALE-TO-FEMALE SEX

No cases of female-to-female sexual transmission have been documented. However, women who have sex with women (WSW) are at risk for HIV infection through other behaviors they may engage in. A study of lesbians and bisexual women in San Francisco found that 82 percent reported having sex with a man in the last 3 years. Of those women, 39 percent reported unprotected vaginal sex and 11 percent reported unprotected anal sex<sup>67</sup>. In another survey of lesbians and bisexual women in 16 small U.S. cities, among women who were currently sexually active with a male partner, 39 percent reported having sex with a gay/bisexual man, and 20 percent reported having sex with an IDU<sup>68</sup>.

## Summary of the HIV/AIDS Epidemic in Minnesota

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More people than ever are living with HIV/AIDS in Minnesota due to, both the introduction of new therapies that have slowed the progression of disease for many and, unfortunately, a consistent number of new infections diagnosed each year.

The epidemic in Minnesota is driven by sexual exposure, primarily among MSM, who represent the largest percentage of living (54%) and new cases (44% in 2003). Among females, heterosexual contact accounts for the vast majority of living (75% - adjusted<sup>69</sup>) and new cases (81% - adjusted<sup>70</sup>). Injection drug use directly or indirectly accounts for 18 percent of living cases and particularly impacts persons of color.

The HIV epidemic in Minnesota affects racial and ethnic minorities disproportionately, especially African Americans, who are over represented in every risk group. Additionally, the emerging epidemic among African-born persons shows no evidence of leveling off.

HIV/AIDS continues to be geographically centered in the Twin Cities metropolitan area, although injection drug users and heterosexual people living with HIV/AIDS appear to be more likely than other groups to live in Greater Minnesota than the EMA.

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<sup>67</sup> Lemp et al, *American Journal of Public Health*, 1995

<sup>68</sup> Norman et al, *Public Health Reports*, 1996

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<sup>69</sup> Lansky et al, *MMWR*, 2001

<sup>70</sup> Ibid

## Ryan White CARE Act Services in Minnesota

This section of the profile will describe those using the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act services in Minnesota, both within the EMA (Title I and Title II) and Greater Minnesota (Title II), and quantify the unmet need for primary medical care.

### DATA SOURCES

The data presented in this section will come primarily from two sources, the HIV/AIDS Reporting System (HARS) and the HIV Services Client-Level Reporting System (CLRS) used by all agencies providing Titles I and II services.

The CLRS System was first implemented in 1995, with the first full year of data collection occurring in 1996. This reporting system started out with 26 agencies, 15 programs and 1,771 clients, and has grown to 39 agencies, 25 programs and 3,121 clients. (*Note:* agencies that are funded to provide services that are not direct client services do not collect or submit this type of data.) Data is collected on every individual by each agency and submitted to the MDH two times a year. The MDH generates yearly reports by agency, programs and an overall summary.

To receive services, other than financial assistance and case management, an individual must have an income that is at or below 300 percent of the Federal Poverty Guideline (FPG). For financial assistance the cutoff is 175 percent of the FPG.

There is no income requirement for case management; however, clients must meet one of the following eligibility criteria in order to receive case management services:

- On or eligible for Medical Assistance
- English as a second language, Non-English speaking
- Less than 24 years old
- HIV positive and pregnant
- Mental illness or dementia
- Under 300 percent of the FPG
- Transmission issues
- Physically ill or disabled without adequate support system
- Unstable housing
- Visual or hearing impairment
- Caring for an HIV positive child

- Developmentally disabled
- Chemically dependent
- Other crisis situation without adequate support system

Due to data collection differences and eligibility considerations for CARE Act services and surveillance, caution should be taken when comparing the information. Differences in data collection will primarily affect the ability to compare the racial/ethnic distribution of people in services and surveillance. In 2002, the CLRS system began collecting race and ethnicity as two separate variables as well as allowing for a person to choose multiple race categories. That change was not made in HARS until January 1, 2003. For the purposes of this document, any instances when surveillance and services data are compared, Hispanics in services will be those that checked Hispanic ethnicity and no other race.

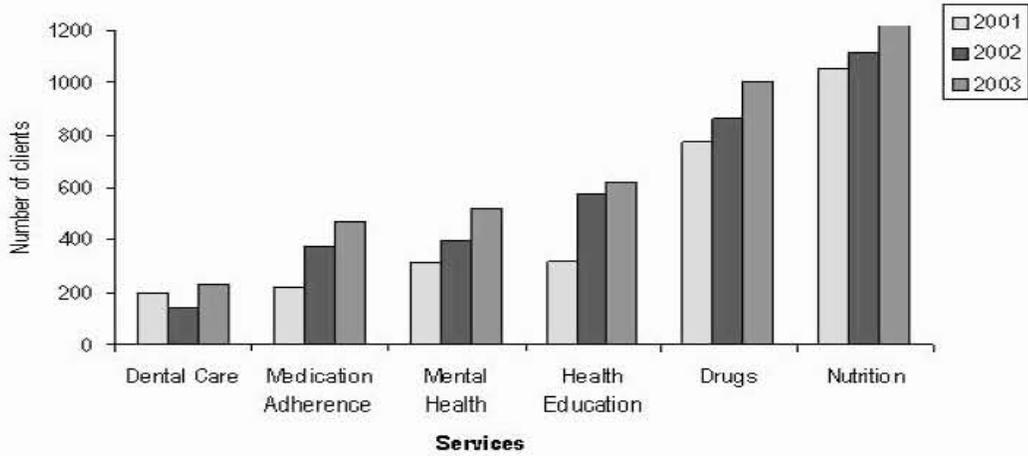
Additionally, since almost all Ryan White CARE Act services are dependent on financial eligibility, it should not be expected that everyone living with HIV/AIDS in Minnesota would be eligible and/or receiving Ryan White CARE Act services. Therefore, surveillance data should not be used as the standard by which services are measured, but as an additional piece of the puzzle in describing HIV/AIDS care in Minnesota.

### OVERVIEW OF RYAN WHITE CARE ACT SERVICES IN MINNESOTA

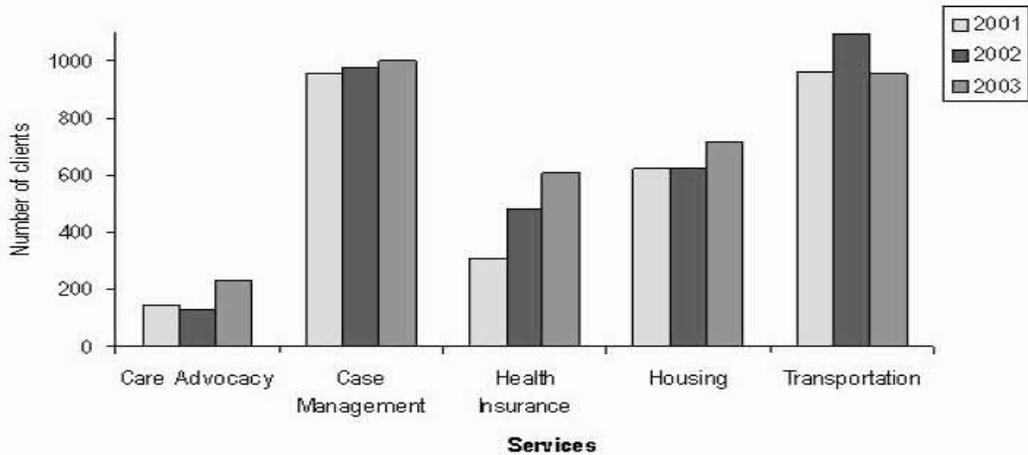
Since 1996 the number of clients utilizing CARE Act Services has steadily grown from 1,771 to 3,395 in 2003. Additionally, over the past three years, several of the funded services have seen large increases in the number of people being served. Figures 37 and 38 show the increase in some of the essential care and essential access services. Essential care services are those services considered necessary to address care needs, and essential access are services that help people get access to HIV care and support services.

The services experiencing the greatest increases were medication adherence and health education under essential care services, 118 and 97 percent increases respectively. Among the essential access services, health insurance and care advocacy saw the greatest increases, 96 and 60 percent respectively.

**Figure 37. Number of People Utilizing Ryan White CARE Act Essential Care Services, Minnesota 2001-2003**



**Figure 38. Number of People Utilizing Ryan White CARE Act Essential Access Services, Minnesota 2001-2003**



## COMPARISON OF EPI AND UTILIZATION DATA

As previously stated, while the center of the epidemic in Minnesota is the Minneapolis-St. Paul Metropolitan Area (EMA), there are people living with HIV/AIDS in over 80 percent of Minnesota counties.

In 2003, 3,395 people utilized Ryan White CARE Act Services in Minnesota, compared to 4,950 people living with HIV/AIDS in Minnesota.

### **Gender**

Males comprise the majority of those living with HIV/AIDS in Minnesota, accounting for 79 percent of all cases. A similar distribution is seen among those receiving services, with males accounting for 73 percent of clients and females accounting for 27 percent. Transgender persons make up less than 1 percent of those receiving services (data not shown).

### **Mode of Exposure**

There are also significant differences in the mode of exposure distribution of those living with HIV/AIDS in the EMA and Greater Minnesota. Figure 39 shows that while MSM account for 55 percent of those living with HIV/AIDS in the EMA, they only account for 42 percent in Greater Minnesota. Additionally, while IDU-associated (IDU, MSM/IDU) and heterosexual contact account for 18 and 17 percent in Greater Minnesota, they account for only 13 and 11 percent of people living with HIV/AIDS in the EMA, respectively.

Mode of exposure for those in services also differs for people residing in the EMA and those residing in Greater Minnesota. MSM account for 44 percent of those receiving services in the EMA compared to 33 percent in Greater Minnesota. IDU-associated (IDU and MSM/IDU) cases account for 12 percent of clients in the EMA compared to 16 percent in Greater Minnesota. Additionally, people who are not HIV-infected account for 4 percent of those receiving services in Greater Minnesota compared to 2 percent for the EMA (Figure 40).

Additionally, as with surveillance there are differences in mode of exposure by gender and race, especially among males. MSM account for

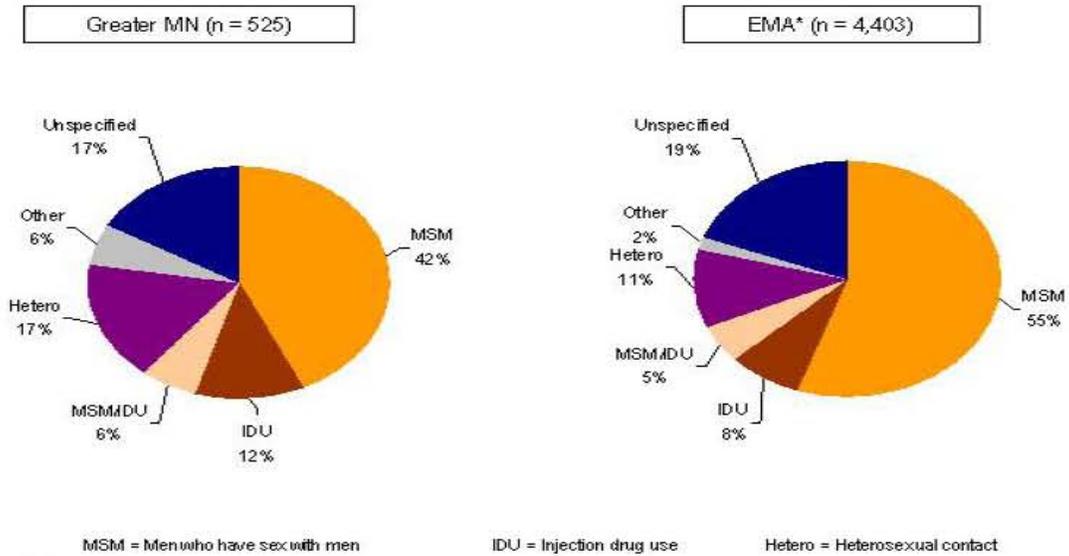
71 percent of White male clients compared to 39 percent of African American and 47 percent of Hispanic clients. IDU-associated (IDU and MSM/IDU) cases account for 9 percent of White male clients compared to 18 percent of African Americans and Hispanics (data not shown).

### **Race/Ethnicity**

There are significant differences in the racial/ethnic distribution between those living with HIV/AIDS in the EMA and Greater Minnesota. Figure 41 shows the racial breakdown for people living with HIV/AIDS (PLWHA) in Greater Minnesota and the EMA. While Whites account for the majority of cases in both areas, people of color make up 33 percent of cases in Greater Minnesota compared to 43 percent in the EMA.

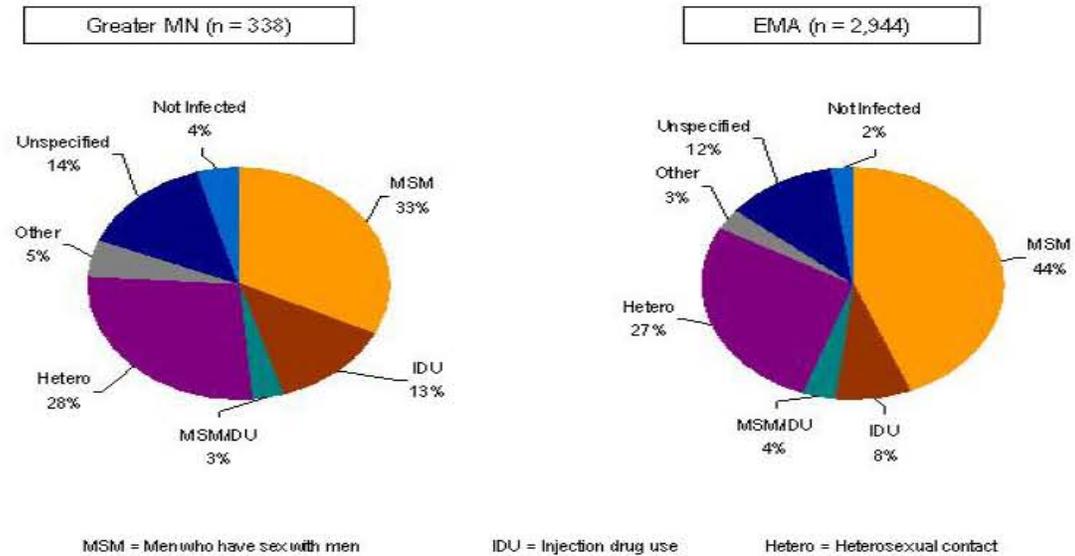
As with surveillance there are racial/ethnic differences between those receiving services in the EMA and Greater Minnesota. While Whites account for 48 percent of those receiving services in Minnesota, they account for 68 percent in Greater Minnesota compared to 45 percent in the EMA. Additionally, Blacks (includes African-born) account for 17 percent of those receiving services in Greater Minnesota compared to 33 percent in the EMA (Figure 42).

**Figure 39. Living HIV/AIDS Cases† By Mode of Exposure, Minnesota & EMA 2003**



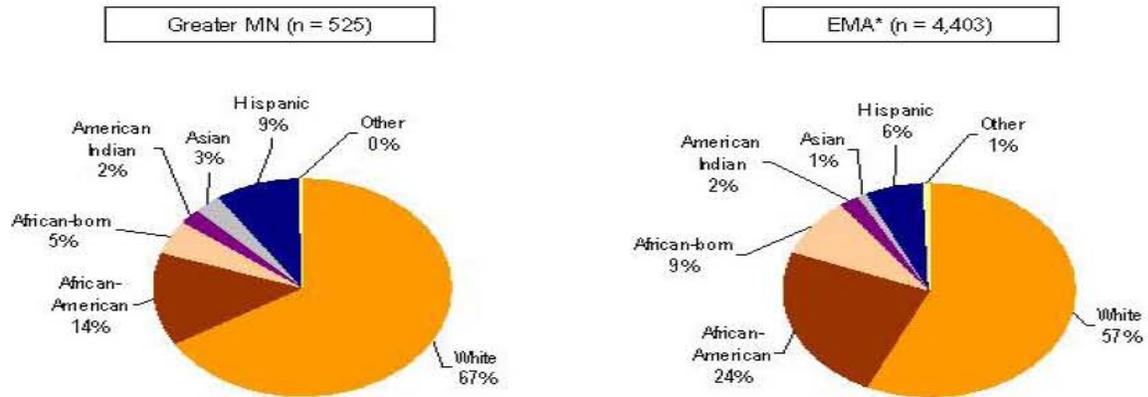
\*Includes 55 cases from Pierce and St. Croix Counties in WI  
 †Excludes 22 cases with missing residence

**Figure 40. People\* Receiving Ryan White CARE Act Services By Mode of Exposure, Minnesota & EMA 2003**



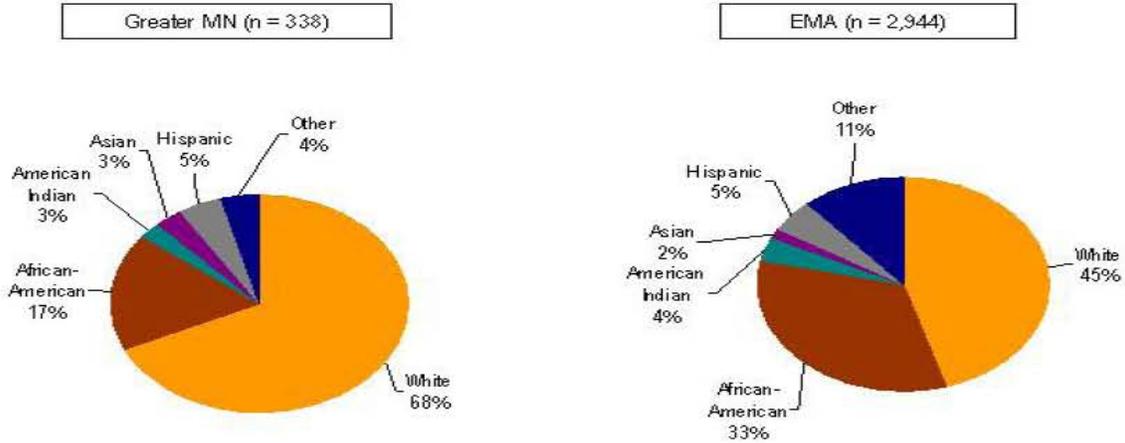
\*Does not include 17 out-of-state clients and 96 clients with unknown county of residence.

**Figure 41. Living HIV/AIDS Cases† By Race/Ethnicity, Minnesota & EMA 2003**



\*Includes 55 cases from Pierce and St. Croix counties in WI  
 †Excludes 22 cases with missing residence information  
 Other – Multi-racial persons or persons with unknown race

**Figure 42. People\* Receiving Ryan White CARE Act Services By Race/Ethnicity, Minnesota & EMA 2003**



\*Does not include 17 out-of-state clients and 96 clients with unknown county of residence.  
 Other – Multi-racial persons or persons with unknown race

**Geography**

Table 10, shows the proportion of people receiving services in Greater Minnesota and the EMA. Based on the numbers of people served, there appears not to be a difference between the percent served in the EMA (67 percent) and Greater Minnesota (64 percent). The map shown in the next page (Figure 41) shows the distribution of those living with HIV/AIDS as well

as the distribution of those receiving services by county. For a majority of the counties (73%), the number of people living with HIV/AIDS and the number of those being served are within the same range. For example, in Hennepin County there are 2,930 people living with HIV/AIDS and 2,071 people receiving services. Both of these numbers fall within the 1,001+ range in the map.

<b>Table 10. Number of People Receiving Ryan White CARE Act Services and Living Cases of HIV/AIDS, Minnesota 2003</b>			
	<b>Number Receiving Services*</b>	<b>Number in Surveillance<sup>†</sup></b>	<b>Ratio of Services to Surveillance</b>
Greater MN	338	525	64%
13-County EMA	2,944	4,403	67%

\*Does not include 3 out-of-state cases and 9 cases with unknown county of residence.

<sup>†</sup>Does not include 22 cases with unknown residence.

**Age**

Persons aged 30 – 49 account for the majority (72 percent) of those receiving services. Adolescents and young adults (13 – 24) account for 5 percent of those receiving services. The age distribution of those receiving services is similar to those living with HIV/AIDS. People aged 30 – 49 account for 72 percent of those living with HIV/AIDS and adolescents and young adults account for 4 percent (data not shown).

**SERVICES RECEIVED IN 2003**

In 2003, the service category of Meals was the most utilized, with 1,173 clients (34% of total clients) accessing meals programs. Meals programs include on-site meals, home delivered meals, and food shelf services. Transportation was the next most utilized service with 1,106 clients (33% of total clients), followed by Case Management with 1,037 clients (31% of total clients), and Drug Assistance with 1,007 clients (30% of total clients). The next most used services were Emergency Financial Assistance

and Emergency Housing Assistance, with 769 and 718 clients, respectively.

While in many states CARE Act funds are primarily used to pay for primary medical care for people living with HIV/AIDS, Minnesota has historically been fortunate enough to provide extensive access to health insurance through public programs. This has reduced the need to use CARE Act Title I and II funds to support primary medical care, and allowed the dollars to be used to create a comprehensive system of support services.

Because of the high rate of clients in the service system who are able to access health care-related services through their health insurance, the number of clients served through these types of CARE Act funded programs are rather low. For example, in 2003, the two Primary Care programs served 88 clients. Home Health Care served 24 clients and the Mental Health programs served 139 clients.



## CHARACTERIZING UNMET NEED FOR PRIMARY CARE AMONG HIV POSITIVE PEOPLE

Efforts to update the measure for unmet need for primary care in Minnesota among HIV-infected persons are currently in the planning stages. The estimate presented here was calculated using the same method used in the unmet care study conducted in Minnesota in 2002<sup>71</sup>.

The definition of unmet need for primary medical care is: “An individual with HIV or AIDS is considered to have an **unmet need for care** (or to be **out of care**) when there is no evidence that s/he has received any of the following three components of HIV primary medical care during a defined 12-month time frame: (1) viral load testing, (2) CD4+ count, or (3) provision of anti-retroviral therapy (ART).”<sup>72</sup>

The study conducted in 2002, used data from HARS<sup>73</sup>, and information from three additional clinical systems that do not report CD4 counts or viral loads. The clinics are Hennepin County Medical Center (HCMC), Veteran’s Administration (VA), and Allina Hospitals and Clinics (Clinic 42 and The Doctors). The investigators used HARS to obtain both the number of people living with HIV/AIDS in Minnesota as of December 31, 2001 and how many of those individuals had received a CD4 or viral load test in 2001. Additionally, for the clinical systems listed, investigators collected the total number of HIV-infected people that had received care in the past year. Using this information, the estimated percent of individuals who know their HIV-status and are not receiving medical care in Minnesota was 37 percent, compared to the national estimate of 33 percent<sup>74</sup>.

By December 31, 2003 there were 4,895 persons living with HIV/AIDS in Minnesota. This represents an increase of 6 percent from

the previous year. After obtaining the number served by the clinical centers mentioned above and the information from HARS, we are able to determine that the number of those not receiving primary medical care for their HIV is 2,015 or 41% of those living with HIV/AIDS in Minnesota (Table 11).

## Summary of Ryan White CARE Act Services in Minnesota

More people than ever are living with HIV/AIDS and utilizing Ryan White CARE Act services in Minnesota. The number of people utilizing services has steadily grown from 1,771 clients in 1996 to 3,395 in 2003 – a 92 percent increase. The system has also grown from 15 to 25 programs distributed over 39 different agencies.

As with the epidemic, in 2003, men accounted for the majority of those served (73%), whites accounted for 48 percent of all served, and the majority (90 percent) lived in the EMA.

There are racial/ethnic and mode of exposure differences among those being served in the EMA and in Greater Minnesota. While Whites account for 68 percent of those being served in Greater Minnesota, they account for 45 percent in the EMA. Similarly, while MSM account for 44 percent of those being served in the EMA, they account for only 33 percent in Greater Minnesota.

While the epidemic continues to be geographically centered in the EMA, there are people living with HIV/AIDS and utilizing Ryan White CARE Act services in 85 percent of Minnesota counties.

<sup>71</sup> Kroll et al, August 2002

<sup>72</sup> HRSA/HAB definition of unmet need

<sup>73</sup> Data from HARS spanned a 15-month period to allow for reporting delays

<sup>74</sup> Fleming et al, 2002

<b>Table 11. Out of Care Study Results, Minnesota 2002 and 2003</b>		
<b>DATA SOURCE</b>	<b>REPORTING PERIOD</b>	
	<b>7/1/2002 – 6/30/2003</b>	<b>1/1/2003 – 12/31/2003</b>
HARS:	1,355	1466
HCMC:	894	945
VA Hospital:	120	119
Allina Systems*:	988	350
<b>Total for all sources</b>	<b>3,357</b>	<b>2880</b>
<b>People living with HIV/AIDS in Minnesota</b>	<b>4,598</b>	<b>4895</b>
<b><i>Percent not in care</i></b>	<b><i>27%</i></b>	<b><i>41%</i></b>

\*In 2003 one of the clinics in the Allina System was not able to report the number of those in care, therefore it appears that a greater percentage of people are not in care. If we use the number reported in 2002 for 2003, then the percent not in care for 2003 would be 28 percent.

## Chapter Two

# Community Services Assessment

*This chapter describes the prevention needs of populations at risk for HIV infection (needs assessment), the prevention activities/interventions that have been implemented to address these needs (resource inventory), and what the unmet prevention needs are (gap analysis).*

### Community Services Assessment

---

**C**ommunity services assessment, or CSA, is a term that the CDC introduced in the new community planning guidance released in 2003. While it is a new term, the CSA is made up of components that the CCCHAP has been responsible for since its inception.

The first component is **needs assessment**, which is a process for getting and analyzing information to identify risk behaviors, co-factors related to increased risk for HIV, and prevention service needs of a specific population or geographic area. Needs assessment information is used, along with data from the epi profile, to identify the priority target populations most at risk for becoming infected with HIV. Needs assessment data is also used to help identify what types of prevention services are needed by each of the target populations. Information from local and national needs assessment studies are included in the first section of this chapter.

The second component is a **resource inventory**, which is a description of current HIV prevention activities and other education and prevention activities that are likely to contribute to HIV risk reduction in the state of Minnesota. The list of resources is comprehensive, including services funded through funding sources other than the CDC HIV prevention grant. The resource inventory is included in the second section of this chapter.

The third and final component is the **gap analysis**, which is a process used to compare

the needs of high risk populations, as determined by needs assessment, to existing services in the resource inventory. This comparison assists the CCCHAP and MDH in identifying what service needs are being met, and which types of services should be prioritized.

After the major prioritization process has occurred, the CCCHAP also conducts gap analysis by comparing the resource inventory, which includes prevention activities funded as a result of the prioritization process, to all of the priorities that were identified in this plan. This comparison again helps the CCCHAP in identifying what services needs are being met, and where there are still gaps in service as a result of priorities not being addressed. The results of the most recent gap analysis process are included in the third section of this chapter.

## Needs Assessment

*This section of the Community Services Assessment describes some of the environmental barriers and concerns experienced by target populations that may help to explain why they engage in behaviors that put them at high risk for HIV transmission.*

### Needs Assessment

**N**eeds assessment is a process for gathering and analyzing information about current needs in populations at risk for HIV infection identified through the epidemiological profile. This information is only one of the pieces that help the CCCHAP prioritize target populations and interventions.

In 2001-2002, the CCCHAP prioritized the following target populations in Minnesota as being at highest risk for becoming infected with HIV. They are broken into four broad categories with subpopulations identified within each category. The process used to prioritize them is explained in Chapter Three.

#### **Men Who Have Sex with Men (MSM)**

- Men of Color Who Have Sex with Men
- Young Men Who Have Sex with Men
- Adult Men Who Have Sex with Men
- HIV+ Men Who Have Sex with Men

#### **Heterosexual Women**

- Adult African American Women
- Young African American Women
- Young Women All Races
- Adult Women All Races

#### **Injecting Drug Users (IDUs)**

- African American Male IDUs
- African American Female IDUs
- Male IDUs All Races
- Female IDUs All Races
- Young IDUs

#### **Men Who Have Sex with Men and Are Injecting Drug Users (MSM/IDU)**

- No subpopulations

Some groups in Minnesota that are at risk for HIV may feel that they are not reflected in this list - for example, the transgendered, and

the deaf communities are not specifically identified. However, all individuals at risk for HIV should be able to find themselves in one or more categories, based on one or more of the following: their behavior (including who their sexual partners are), race, gender or age.

### RECENT NEEDS ASSESSMENTS

In 2003 the CCCHAP conducted some needs assessment activities within the Latino community, particularly targeting Latino men. The activities were focused on understanding whether Latinos have access to information about HIV, what the barriers are to getting tested for HIV, and what can be done to make it easier to get tested. A short survey was conducted at the Cinco de Mayo festival in St. Paul, and the survey was further distributed via providers to their clients.

In addition, five community forums were conducted during the summer and fall of 2003, focusing on knowledge of HIV and STDs and barriers to HIV testing. The community forums targeted the following subpopulations of Latinos: migrant workers, young men, MSM, HIV positive men, and women. Finally, a forum was held with providers serving the Latino community to share what was learned and to gather their recommendations. The results of the surveys and forums are included in this chapter.

In addition, some needs assessment dollars were used in 2003 to establish a one-year position at MDH that was responsible for developing a resource inventory of organizations in the various African communities residing in Minnesota, assessing and building capacity within those organizations to do HIV prevention work, and developing a network of individuals and

organizations in the communities that are interested in HIV prevention.

In 2002, a Request for Proposals (RFP) was released seeking consultants who were interested in performing needs assessment activities. Respondents to the RFP had the opportunity to propose conducting needs assessments in the following populations:

- MSM/IDU
- Young MSM of Color
- Non-Gay/Bi Identified MSM of Color
- Deaf and Hard of Hearing
- MSM Who Engage in Ongoing High Risk Behavior (barebacking)

Initially, as a result of the RFP process, a needs assessment was going to be funded for Young MSM of Color. However, due to state prevention budget cuts experienced in 2003, the needs assessment had to be cancelled.

**UPCOMING NEEDS ASSESSMENTS**

It is acknowledged that the data from a number of the local needs assessment efforts included in this chapter are now dated. The CCCHAP is hopeful that there will be opportunity in the near future to update this information. However, there are no further local needs assessment activities planned at this time due to budget constraints.

**INFORMATION IN THIS CHAPTER**

This chapter presents data that have been gathered through needs assessments and studies done within at-risk populations. The populations included in this chapter are not exactly the same as the target populations prioritized by the CCCHAP, although needs assessment information was used in considering which populations should be prioritized. Each report provides an overview of available national and local research about HIV risk behaviors and co-factors for HIV infection or transmission within that population.

It has been a priority of the CCCHAP to incorporate the HIV prevention needs as expressed by the target populations themselves into the planning process. Thus, many of the descriptions contain the words of individuals from the target population.

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## Needs Assessments Within At-Risk Populations

This section provides an overview of national and local research about HIV risk behaviors and co-factors that impact HIV infection or transmission within at-risk populations.

### HIV Positive Individuals

It is a national priority, as well as a priority identified within the Minnesota HIV prevention community planning process, to provide effective behavioral change interventions to HIV positive persons in order to assist them in maintaining their own health as well as in preventing further transmission of the virus. HIV positive individuals are therefore a priority within each of the risk groups described in the rest of this needs assessment.

#### NATIONAL STUDIES

With the advent of new antiretroviral drugs, many people living with HIV are living long and healthy lives, which include sexual activity. Recent studies have shown that most HIV positive individuals do their best to protect their sexual partners from HIV. For example, it has been found that knowledge of HIV infection makes it more likely that safer behaviors will be adopted that may decrease HIV transmission<sup>75</sup> suggesting that early HIV testing may reduce the subsequent spread of HIV.

#### DISCLOSURE OF HIV STATUS

A national study regarding disclosure of HIV status was conducted with 1,421 HIV positive adults in medical care.<sup>76</sup> Of this sample, 606 were gay or bisexual men, 287 were heterosexual men, and 504 were women. The study found that in the previous six months, 42 percent of the MSM, 19 percent of the heterosexual men, and 17 percent of the women had intercourse with either a casual or steady partner(s) without disclosure. Across groups, most people who didn't disclose their status reported only having protected anal or

oral intercourse, which pose less risk of transmission. This suggests that most people who don't disclose their status take steps to reduce the risk of transmission, or consider that disclosure is not necessary since they have taken these steps.

Thirty-five percent (35%) of MSM had intercourse without disclosure with casual partners. Of these, 42 percent engaged only in oral or receptive anal sex. A small percentage (3.2%) engaged in unprotected insertive anal sex to ejaculation. Nine percent (9%) of women and 9 percent of heterosexual men had intercourse without disclosure with casual partners.

The study found that in the previous six months, 58 percent of MSM, 48 percent of women, and 47 percent of heterosexual men had been with partners who were HIV negative or whose status was unknown. Across groups, 13 percent of serodiscordant partnerships involved unprotected anal or vaginal intercourse without disclosure. Also in each group, most unprotected intercourse involved nondisclosure on the part of both partners. More women (5%) did not disclose their status to serodiscordant exclusive partners compared to all men (1-2%).

The study suggests that since disclosure rates are lower among MSM, the norms around disclosure may be different in this community. As the HIV epidemic is older in the gay community and HIV prevalence is higher among MSM than heterosexuals, this may provide a basis for men to assume that their partners are aware of HIV transmission risk.

<sup>75</sup> Higgenbotham et al, *MMWR*, 2000

<sup>76</sup> Ciccarone et al, *American Journal of Public Health*, 2003

## RELATIONSHIP BETWEEN TREATMENT AND RISK BEHAVIOR

National and international studies draw varying conclusions regarding how the use of highly active antiretroviral treatment (HAART) affects risky behavior. Many studies indicate that individuals who are consistently adhering to medication regimens are less likely to engage in unprotected intercourse than those who are not adhering to treatment. However, studies also indicate that HIV positive individuals who are on ARV treatment and/or their partners are less concerned about the risk of HIV transmission with the use of treatment and consequently more likely to engage in risky behavior.

### **Men and Women**

In a study of 255 men and women living with HIV and receiving HAART, researchers found that people who were currently taking medications and missed at least one dose of their medications in the past week scored significantly higher on a hopelessness scale and reported more current use of marijuana. People who were not adherent to their medication regimen also reported having significantly more sex partners, greater rates of unprotected vaginal intercourse, and less protected sexual behaviors, including with partners who were HIV negative or whose HIV status was unknown.<sup>77</sup>

### **Heterosexual Men and Women**

Another study found that among 208 individuals (104 serodiscordant heterosexual couples), seropositive respondents taking protease inhibitors were 2.4 times less likely to report unprotected intercourse compared with those not taking protease inhibitors. However, up to 33 percent of seropositive partners and 40 percent of seronegative partners acknowledged being less concerned about transmission of HIV with the new treatments. Seronegative individuals were more likely than their seropositive partners to acknowledge increased risk taking and reduced HIV transmission concerns. The

study recommended that providers discuss the effect of HAART on the risk of sexual transmission of HIV with their clients, as well as with the serodiscordant partners.<sup>78</sup>

### **Heterosexual Women**

Between 1998 and 1999, data were collected from 766 HIV positive women about adherence to therapy and risk behavior. Seventy-six percent (76%) of women reported adherence rates equal to or greater than 95 percent. Among sexually active women, lower adherence rates were associated with an increased risk of inconsistent condom use. Women with lower adherence rates were also more likely to be younger, to have used drugs in the previous six months, to have lower scores for emotional well-being, and to have higher rates of detectable viral load. The study stated that counseling regarding sexual behavior and adherence to treatment regimens is usually done separately, and recommended that the relation between these two factors be discussed together.<sup>79</sup>

Of 80 HIV positive women enrolled in HIV care in 1999, only 5 percent believed that a reduction in viral load due to HAART means that it is safer to have intercourse. However, 15 percent indicated that they practice safer sex less often since the advent of new treatments, and 40 percent believed that AIDS is now a less serious threat.<sup>80</sup>

### **Men Who Have Sex with Men**

A study conducted in London, England among 420 HIV positive gay men found that all men reported high-risk sexual behavior. Twenty-two percent (22%) reported unprotected anal intercourse with one or more new partners in the last month. Men who were taking HAART had fewer sexual partners (median of 9) compared to those who were not on treatment (median of 20 partners), engaged in less unprotected anal sex (27% versus 36%), and were diagnosed with fewer

<sup>77</sup> Kalichman and Rompa, *Sexually Transmitted Infections*, 2003

<sup>78</sup> Van der Straten et al, *AIDS*, 2000

<sup>79</sup> Wilson et al, *Clinical Infectious Diseases*, 2002

<sup>80</sup> Catz et al, *AIDS Education and Prevention*, 2001

STDs in the previous 12 months (19% compared to 33%).<sup>81</sup>

Among MSM in San Francisco, a study found that the use of HAART had increased from 4 percent in 1995 to 54 percent in 1999. However, the percentage of MSM living with AIDS who reported unprotected anal intercourse and multiple sexual partners increased from 24 percent in 1994 to 45 percent in 1999.<sup>82</sup>

The perception of risk of HIV transmission on the part of gay and bisexual men was assessed among 472 HIV negative men attending a gay pride festival. The participants felt that having intercourse with an HIV positive man who is taking ARV therapy and has an undetectable viral load was no more risky than having intercourse with an HIV negative man or a man whose HIV status was unknown. They felt the greatest risk was having intercourse with an HIV positive man who was not taking ARV medications.<sup>83</sup>

A reduced concern about the consequences of having HIV due to improved treatment was the strongest predictor of taking sexual risk in another study among HIV positive gay men. Whether the participants' viral load was detectable or undetectable was not found to be a significant predictor of risk.<sup>84</sup>

### **Injection Drug Users**

There were some differences in risk behavior found in a study that compared HIV positive IDUs who were on HAART and those who were not. Of 316 IDUs, 133 were on HAART during the study. The full study group was 95 percent African American, 76 percent male, and had an average age of 34 years. The proportion who reported any sexual activity increased from 55 percent to 61 percent over a year and a half for those on HAART, and decreased from 67 percent to 63 percent in the untreated group. Unprotected

sex increased among those on treatment from 18 percent to 20 percent, and decreased for those not receiving treatment from 36 percent to 28 percent. In both groups, the proportion of participants injecting drugs declined and the proportion that reported sharing needles decreased marginally. However, the proportion of IDUs on HAART who used shooting galleries increased slightly (2.3% to 3%) while it decreased among those not on treatment (12% to 5%).<sup>85</sup>

## **SEXUAL RISK BEHAVIOR WITH SERODISCORDANT PARTNERS**

Although prevention interventions targeting HIV positive individuals were identified as a priority through the community planning process in Minnesota, there was not a specific focus on interventions working with serodiscordant couples. Research indicates that there is a need for interventions specifically designed for HIV positive persons with their HIV negative partners.

### **Risk Behaviors in Heterosexual Couples**

National data suggest that the majority of HIV positive heterosexual couples have unprotected intercourse. In the van der Straten study of 104 serodiscordant couples, more than two thirds of couples had unprotected vaginal and/or anal intercourse during the six months preceding the survey.<sup>86</sup>

### **Risk Behaviors with Regular and Non-regular Partners**

One study suggests that HIV positive individuals engage in greater transmission risk behaviors with regular partners compared to non-regular partners. The participants were 269 HIV positive men and 114 HIV positive women, of whom 53 percent identified as gay, 11 percent bisexual, and 36 percent heterosexual. Sixty-seven percent (67%) of participants were sexually active in the preceding three months, and 71 percent of the sexually active persons engaged in vaginal or anal intercourse with serodiscordant partners.

<sup>81</sup> Stephenson et al, *Sexually Transmitted Infections*, 2003

<sup>82</sup> Katz et al, *American Journal of Public Health*, 2002

<sup>83</sup> Suarez et al, *Journal of Acquired Immune Deficiency Syndromes*, 2001

<sup>84</sup> Vanable et al, *Journal of Psychosomatic Research*, 2003

<sup>85</sup> Vlahov et al, *AIDS*, 2001

<sup>86</sup> van der Straten et al, *AIDS*, 2000

Of those participants with regular partners who were not HIV positive, 22 percent had not told their partner that they were HIV positive. People who had not disclosed their HIV status to their regular partner were less likely to use condoms with their regular partner (68% of the time) than men and women who had disclosed their status to their regular partner (77%). People who had not disclosed their status to non-regular partners reported that they used condoms 72 percent of the times they had intercourse with non-regular partners, compared to 69 percent for people who had disclosed their status to non-regular partners. Participants were more likely to have unprotected intercourse with regular partners than with non-regular partners. Whether or not the HIV positive person had disclosed their status to their partner did not influence the results.<sup>87</sup>

### **Risk Behaviors among MSM**

A study was conducted to determine the potential for transmission of HIV among newly infected MSM during their HIV seroconversion period (defined as the interval between the time of their last negative HIV test and the time they received their first positive HIV test), and for the 12 months after learning that they were HIV positive.

Of 66 MSM who were diagnosed as being HIV infected, more than half reported unprotected anal intercourse with HIV negative or partners with unknown serostatus during the period of seroconversion. Unprotected anal sex with men who were HIV negative or whose status was unknown was significantly reduced immediately after participants received their HIV diagnosis. Self-reported risk behavior had increased by the 9 month and 12 month follow-up, although it did not reach the level reported during the seroconversion period.

Although a small minority, men who reported putting others at risk soon after receiving the positive HIV test results were more likely to continue doing so up to 9 months after. The study did not find evidence

that men sought out other HIV positive men or that they changed from insertive to receptive anal intercourse with HIV negative men or men whose status was unknown as risk reduction strategies. The study recommends that early testing is needed, and that effective risk reduction counseling should be provided to MSM during at least the first year after receipt of a positive test result.<sup>88</sup>

### **Impact on Serodiscordant Couples**

A qualitative study of 13 men and 15 women in serodiscordant relationships found that the differing serostatus often created feelings of alienation between the partners and made it difficult to communicate. Stigma related to HIV made it difficult to disclose mixed HIV serostatus to family, friends and the community. Many couples experienced a sense of sexual loss, and HIV positive individuals feared transmitting the virus to their partner. Participants felt that the HIV service community was not able to meet their needs as a couple, and was not prepared to work with seronegative partners.<sup>89</sup>

These studies point to the need for effective risk reduction interventions targeting HIV positive individuals, and interventions particularly targeting both the HIV positive and HIV negative partners in serodiscordant relationships. In addition to the risk reduction component, there is a need to integrate support for issues related to fear, loss, communication, stigma, and disclosure that serodiscordant couples face.

<sup>87</sup> Kalichman et al, *International Journal of STDs and AIDS*, 2002

<sup>88</sup> Colfax et al, *AIDS*, 2002

<sup>89</sup> van der Straten et al, *AIDS Care*, 1998

## RISK BEHAVIOR AMONG HIV POSITIVE IDUS

Many HIV positive IDUs continue to share needles after becoming aware of their HIV infection. An interview survey of 11,757 persons over 18 years of age with HIV or AIDS who were reported to 12 state or city health departments between June 1990 and August 1995 (the SHAS project), found that of the 1,527 people who had ever shared syringes and reported injecting in the five years before the interview, 51 percent had injected in the year before the interview. Of these, 50 percent had shared needles during that year. Researchers also found that IDUs who were aware of their HIV infection for more than one year were less likely to share (43%) than those who have been aware of their infection for one year or less (65%).<sup>90</sup>

The Seropositive Urban Drug Injectors Study (SUDIS) was conducted with 161 HIV positive IDUs in San Francisco and New York metropolitan areas.<sup>91</sup> The study found that study participants continued to inject drugs, often increasing their drug use right after finding out they were positive in order to escape reality. However, after this higher risk period, HIV served as a wake up call, motivating many HIV positive IDUs to access services and develop drug management strategies in order to maintain or improve their health. The drug management strategies included reducing the number of times they injected, drug substitution, not sharing needles, abstaining from alcohol and stimulants, and methadone maintenance. The study found that the majority of risk behavior occurring among HIV positive IDUs was sexual, and encouraged providers to emphasize sexual risk reduction in all HIV education and prevention efforts for HIV positive IDUs.

<sup>90</sup> Diaz et al, *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 1998

<sup>91</sup> UCSF AIDS Research Institute, 1999

## FACTORS INFLUENCING ONGOING RISKY BEHAVIOR AMONG HIV+ PERSONS

A national survey of studies<sup>92</sup> identified the following individual and social causes/needs related to continued high-risk sexual behaviors among HIV positive individuals:

- Desire for sexual intimacy and pleasure.
- Feeling by HIV + people that their physical appearance, preferred sexual activities, or nonverbal cues constitute disclosure.
- Disclosure is difficult - may stigmatize person, precipitate refusal to have sex.
- Question why they must shoulder the responsibility of protecting others - partners who are willing to forego condoms have accepted the risk of exposure.
- Anger, anxiety and tension promote escapist behaviors, including drug use.
- Optimism about new HIV therapies may be associated with sexual risk taking.
- Environmental factors encourage sexual risk taking - communities exhibit a powerful system of social rewards for practicing risky sex and having multiple partners.
- Social and legislative policies deter gay persons from forming permanent and monogamous relationships. Social and economic policies may have the same effect on poor and minority groups.
- Absence of strong campaigns to promote a norm of condom use.

### **Individual Level Interventions**

The same study<sup>93</sup> also identified different individual and environmental level interventions that are needed for HIV positive individuals:

- Establish psychosocial and behavioral support mechanisms for seropositive persons in HIV and STD clinics and ASOs.
- Promote safer sex norms through printed information, and communication from providers.

<sup>92</sup> Marks et al, *AIDS*, 1999

<sup>93</sup> Ibid

- Develop messages at counseling and testing sites that emphasize the need for HIV positive people to protect their own health, as well as the health of others.
- Use peer educators in social settings.
- Provide easily accessible client centered counseling (i.e., working with patients to establish achievable steps they can take to reduce their risk behavior).
- Strengthen link between HIV counseling, testing and referral for medical, psychosocial and behavioral intervention.
- Train health providers to communicate effectively and sensitively with HIV infected persons about the importance of safer sex.
- Disseminate information about transmission risks associated with specific sexual activities.
- Distribute condoms at facilities that serve HIV+ persons, and provide instructions on their use.

### **Environmental Interventions**

- Develop and reinforce norms for safer sex by displaying prominent visual cues.
- Promote norms of condom usage and other HIV prevention methods.
- Promote norms of responsibility and protection of others in sexual matters.
- Remove legal barriers to long-term committed gay relationship.
- Prohibit discrimination on the basis of HIV status or sexual orientation.
- Provide full access to high-quality health care and increase access to drug abuse treatment.

### **LOCAL STUDIES**

In 1997, the Minnesota HIV Services Planning Council funded a health education conference for Minnesotans living with HIV/AIDS. The purpose was to provide an opportunity for HIV positive individuals to learn about available services, get updated information about treatment, network with other HIV positive people, and be in a safe place. In all, 186 people attended the conference, and 106 (57%) completed an anonymous prevention survey.

The survey findings point to prevention needs of HIV positive persons:

- 55% lacked confidence in their ability to not infect others.
- 46% felt challenged in their ability to tell partners of their HIV status.
- 41% felt challenged in their ability to practice safer sex.
- 70% reported engaging in unsafe sex with an HIV positive person.
- 24% reported engaging in unsafe sex with people whose HIV status they did not know, or who were HIV negative.<sup>94</sup>

### **Routes of Transmission**

Through a long-term relationship: Forty-one percent (41%) of respondents reported seroconversion via a spouse, significant other, or long-standing friend. No one reported becoming positive through prostitution. Sixty percent (60%) stated they were able to identify the person who infected them. This finding is contrary to the stereotype that HIV is a disease associated with promiscuity, and emphasizes the need for HIV prevention education in the context of relationships.

Through heterosexual sex: Male/female sex was reported as the second most frequently cited behavior (17%) that participants believed led to their HIV acquisition. This finding indicates that heterosexual transmission reports contained in state and national surveillance systems may be under-estimates.

Through travel: Only 60 percent of respondents reported becoming infected in Minnesota. This finding indicates that travel may be a co-factor of HIV transmission. For Minnesotans and others from low-moderate prevalence areas, travel/vacation often brings them into contact with persons from high-prevalence areas. Anecdotal evidence suggests that assumptions about who engages in unprotected sex may vary by regional prevalence of HIV; thus travel and vacations appear to be particularly high-risk situations for sexually active persons from low-to-moderate risk areas like Minnesota.

<sup>94</sup> Rosser et al, *Journal of Sex Education and Therapy*, 1999

**Unknown:** Finally, 9 percent of the sample report not knowing how they became infected, or that route of infection was an insignificant issue for them. This is of concern if risk behaviors are repeated post-diagnosis.

### ***Reasons for Infection***

**Inconsistent safer sex practices:** By far the most common reason given for becoming infected was "not knowing the other person was infected" (53%), suggesting that respondents were selectively engaging in safer sex practices, based on assumptions they made about the HIV status of their partners. This finding emphasizes the continued need to promote messages around engaging in consistent safer sex practices.

**Psychosocial issues:** The next most cited reasons were all related to psychosocial issues, including depression and low self esteem (39%), needing to have sex (38%), and being drunk or high (36%). Trying to keep a partner and being sexually abused as a child were also ranked higher than some reasons more commonly discussed in prevention. Traditionally, HIV prevention programming focuses on addressing issues cited less often than these psychosocial issues, such as not liking condoms (25%), not having condoms available (24%), and not having assertiveness to insist on safer sex (20%). This survey indicates that prevention programming should explore ways to address psychosocial co-factors related to HIV transmission. In addition, half of the respondents felt dirty, contaminated or infected, and/or trapped, damned, or doomed by their diagnosis.

**Substance use:** Thirty-five percent (35%) reported needing help with alcohol and drug use.

## **NEEDS ASSESSMENT OF HIV POSITIVE MINNESOTANS**

In 2003, the Minnesota HIV Services Planning Council conducted a needs assessment of 242 HIV positive persons living

in Minnesota.<sup>95</sup> The sample was 64 percent male, 33 percent female, and 3 percent transgender. In terms of sexual orientation, 33 percent self-identified as gay or lesbian, 48 percent as heterosexual, 15 percent as bisexual, and 4 percent as other.

Thirty-six percent (36%) of respondents reported that they were European American, 34 percent African American or Black, 9 percent Latino, 7 percent Native American, 6 percent African-born, 5 percent biracial/ multi-racial or other, and 2 percent Asian or Pacific Islander.

The majority (59%) of respondents resided in the Minneapolis/St. Paul metro area. Another 22 percent were from suburban areas in Hennepin and Ramsey counties. Five percent (5%) were from additional counties in the seven county metropolitan area. Fourteen percent (14%) lived in Greater Minnesota.

### ***Factors in Becoming HIV Positive***

When asked about factors that may have contributed to becoming infected, 40 individuals (17%) felt that sexual abuse played a role in their becoming HIV positive, while 138 persons (57%) believed that drug or alcohol use or abuse had a role.

### ***Testing for HIV***

The most common answers that respondents gave as the main reason they got tested for HIV were: illness (30%), member of a risk group (16%), and sex partner was sick (15%). Other answers included blood donor (5%), pregnancy testing (4%), and test offered at clinic (4%).

When asked where they first tested positive, 36 percent of those interviewed stated that it was at an HIV counseling and testing site, such as Red Door or Room 111. The next most common type of facility was a hospital (18%), followed by private physician (13%), blood bank (6%), and other medical clinic (5%).

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<sup>95</sup> Kroll and Jackson, 2003

**Sexual Behavior**

Interviewees were asked questions about the number of sexual partners they had during the last year. A total of 45 persons (20%) reported not having sex in the previous year, with either men or women.

The findings from this study indicate that an individual's identity in terms of sexual orientation does not strictly define the gender of their sexual partners. Of 46 men who self-identified as heterosexual, 5 reported having sex with men in the previous year. Seventy-four (74) men identified as gay and 7 of these stated they had sexual relations with women. Of the 65 women who identified as heterosexual, 5 reported sexual relations with women in the past twelve months. Of the 3 women who identified as lesbian, 2 reported having sex with men.

Of those interviewed, 99 people (41%) reported that their most recent sexual partner was also HIV positive. Forty-five people (19%) stated that they did not know the serostatus of their most recent partner.

Necessity forces people at times to use sex as currency. Nearly twenty-six percent (25.8%) of those interviewed stated they had at some point exchanged sex for something they needed, such as a place to stay (5.8%), drugs (11.6%), money (5.8%), and food (1.7%).

One indicator of risky sexual behavior is STD infection. One hundred fifty-seven people (65%) reported having had an STD ever in the past. This would include STD infections that may have occurred prior to becoming HIV positive. Thirty-nine individuals (18%) had an STD in the past year. (Ten individuals out of the total interviewed were diagnosed with HIV in 2003. It is not possible from the report to determine whether they were among the respondents who reported an STD, and if so, whether it was prior to their HIV diagnosis.)

**Condom Use**

Of the 193 persons who indicated they engaged in sexual activity in the past year, a greater percentage reported using condoms all or almost all of the time with a non-steady partner (79%) than with a steady partner (61%). Only 3 percent reported never using condoms with a non-steady partner, while 11 percent reported they never use condoms with a steady partner.

<b>Reason for not using condom or barrier</b>	<b>#</b>	<b>%</b>
Don't like using condoms or barriers	63	26%
Partner doesn't like using condoms or barriers	53	22%
Just wanted to forget about HIV for a while	45	19%
In a monogamous relationship	40	17%
Sometimes high on drugs or alcohol during sex	38	16%
Condoms or barriers not always available	36	15%
Thought partner was HIV positive	34	14%
Partner would be upset if asked to use condoms or barriers	20	8%
It's not really sex with condoms or barriers	16	7%
Other	10	4%
Just don't care	9	4%
Don't know how to talk about condoms/barriers	8	3%
Want to have a baby	7	3%
Allergic reaction to condom	4	2%

**Information about Safer Sex**

The following were identified by those interviewed as very useful sources of information about safer sex: physicians (54%), written materials (41%), other HIV positive people (41%), case manager (38%), educational program (33%), prevention with positives program (33%), nurse or other health professional (29%), and partner/spouse/lover (25%). Only 12 percent identified the Internet as a very useful source

of information, and 9 percent identified the AIDSLine.

More than half (63%) of all those interviewed stated that they would be interested in participating in an HIV prevention program (such as a workshop, seminar or conference) designed for people who are HIV positive.

**Drug and Alcohol Use**

Nearly 30 percent of respondents reported they never used alcohol, while 8 percent reported daily use in the past six months, 33 percent used alcohol once or twice a week, and 19 percent used once or twice a month.

Marijuana was the drug most commonly used. During the previous six months, 15 percent (15%) used it daily, 13 percent used it weekly, and 9 percent monthly. The next most commonly used drug was crack, with 4 percent reporting daily use, 2 percent weekly use, 5 percent monthly use, and 4 percent having used it once in the last six months.

Ninety percent (90%) of those interviewed reported never having used crystal meth. Two individuals (<1%) reported using crystal meth daily, 2 persons used it weekly, 7 (3%) used it monthly, and 7 (3%) had used it during the last six months.

Of all respondents, 55 (23%) had ever injected drugs. Of those, only 5 persons were currently injecting drugs. Of everyone who had ever injected, 16 had participated in needle exchange at some point. Thirty people stated they knew where they could go to exchange needles.

Questions were also asked related to the respondents' perception of their alcohol and/or drug use. The findings are summarized in the table below for those who responded yes to the questions.

Question	Yes Responses	
	#	%
Do you think your drug or alcohol use is a problem?	57	24%
Do others tell you that your drug or alcohol use is a problem?	75	31%
During the past 5 years, have you ever been enrolled in a drug or alcohol treatment program?	74	31%
At this point, do you consider yourself clean and sober?	85	35%
Do you think your alcohol/drug use affects your health?	119	49%
Do you think your alcohol/drug use affects your safe sex practices?	98	41%
Does your partner use drugs/alcohol?	47	19%
Do you think his/her use is a problem?	26	11%

**SUMMARY**

***HIV prevention needs of HIV positive individuals:***

- Support to engage in safer sex, including the provision of training in assertiveness and negotiation skills, condom utilization.
- Programs must address alcohol and substance use and abuse, depression, self-esteem and disclosure issues.
- For serodiscordant couples, prevention programs must address risk reduction strategies, as well as provide support for issues related to fear and loss, stigma, communication, and disclosure.
- For HIV positive IDUs, barriers to acquiring and possessing sterile needles and syringes must be eliminated.
- Prevention efforts for HIV positive IDUs must also include sexual risk reduction education.

## Men Who Have Sex with Men

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### TRENDS IN THE NATIONAL EPIDEMIC

As elsewhere in the US, the HIV epidemic in Minnesota began in the gay community. Although we have seen a decrease in the annual number of cases among MSM over the past ten years, most people living with HIV/AIDS in Minnesota, and most new cases of HIV in Minnesota, are still found among men who have sex with men.

More recently, epidemiologists in several major cities have documented an increase sexual risk taking among MSM, as well as a rise in STDs such as syphilis, gonorrhea, and chlamydia. In 2002, we saw a similar phenomenon in Minnesota, with 56 cases of syphilis being diagnosed among MSM. Forty-five percent (45%) of the MSM were co-infected with HIV. This trend continued in 2003. At the end of 2003, there were 70 total early syphilis cases diagnosed among MSM. Of these cases, 30 (43%) were co-infected with HIV.

In San Francisco there has been an increase in HIV incidence among MSM.<sup>96</sup> Health officials attribute some of the risk to the use of antiretroviral drugs that have reduced deaths from AIDS, and therefore increased the pool of infected persons in San Francisco. In addition, optimism about these new therapies, and the fact that HIV positive people are living longer and healthier lives has created a false perception that HIV is no longer a major health threat, and has helped to create a sense among some MSM that the "crisis" of HIV is over. Some also believe, incorrectly, that a reduced viral load brought about by antiretroviral drugs means that a person is no longer infectious, and has made some MSM less vigilant about maintaining safer sexual practices.<sup>97</sup>

Focus groups conducted in five California cities with 113 racially and ethnically diverse MSM found three factors associated with an

increase in risky behavior: 1) more effective therapies have led to the perception that HIV is not as much of a threat as it was in the past; 2) MSM are communicating less about HIV, and there is less social support for safer sex; and 3) there has been a shift in community norms with unsafe sex becoming more acceptable.<sup>98</sup>

### SEXUAL ORIENTATION AND SEXUAL BEHAVIOR

Although a number of studies, including some referenced later in this chapter, have pointed to greater variance between sexual identity and sexual behavior in African American and Latino men, a recent study conducted in Houston found slightly different results.<sup>99</sup>

A survey of 1,494 African American, Asian, White and Latino men and women approached in public congregation sites such as parks, mass transit locations and malls, found the greatest lack of concordance in African American and White men.

Of 206 African American total men interviewed, 49 percent who self-identified as heterosexual reported having sex with both men and women during the previous three months. Of 200 White men, 47 percent of those who identified as heterosexual had sex with men and women. The percentages were much lower among Asian and Latino men, with only 17 percent of heterosexually identified Asians, and 18 percent of heterosexually identified Latinos reporting sex with both genders.

This study points to the need for prevention programs and clinical practices to ask questions about sexual behavior. Assumptions about behavior should not be made based on how an individual identifies their sexual orientation.

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<sup>96</sup> Denning et al, San Francisco Department of Health, 2000

<sup>97</sup> CDC, 2001

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<sup>98</sup> Morin et al, *AIDS & Behavior*, 2003

<sup>99</sup> Ross et al, *Sexually Transmitted Diseases*, 2003

## EXPLORE STUDY

From January 1999 to February 2001, 4,295 HIV negative MSM were recruited from 6 cities: Boston, Chicago, Denver, New York, San Francisco, and Seattle to participate in a study to test the efficacy of a behavioral intervention in preventing HIV by using HIV infection as the endpoint.<sup>100</sup>

Of the men enrolled in the study, 72.5 percent were White, 15.2 percent were Latino, 6.5 percent were Black, and 5.8 percent were of another or mixed race. The average age of the participants was 34 years.

The average number of male sex partners during the six months before the study was 7, with 42 percent reporting 10 or more partners. About half of the men reported being in a primary relationship. Forty-five percent (45%) reported engaging in unprotected receptive anal sex with ejaculation, 48 percent reported engaging in unprotected receptive anal sex, and 55 percent reported engaging in unprotected insertive anal sex. Although the men with HIV positive partners reported less unprotected sex, 21 percent of men with HIV positive partners reported unprotected receptive anal intercourse, and 37 percent reported unprotected insertive anal sex.

Regardless of the serostatus of partners, men were significantly more likely to report engaging in unprotected anal sex with one primary partner than with one non-primary partner. Men who had multiple partners were significantly more likely to report sexual risk behaviors than men who had a single primary partner. Almost 25 percent of men with multiple partners who were HIV positive reported engaging in unprotected receptive anal sex; however, they were more likely to engage in unprotected insertive sex. Most researchers have found that riskier behavior is associated with one primary partner. However, the baseline data from this study indicate that men with multiple partners of unknown and HIV positive status were having as much unprotected sex as men with one primary partner.

Almost 13 percent of the men reported having a specific STD during the six months prior to enrollment in the study, with chlamydia being the most common (4.2%), followed by gonorrhea (3.3%), genital or rectal warts (3.1%), and anogenital herpes 2.6%).

Drinking alcohol at least 3 times a week was reported by 26 percent of the men, and 11 percent were heavy drinkers. Marijuana was the non-injection drug most likely to be used (46%); followed by poppers (37%), hallucinogens, including ecstasy (24%); cocaine (19%); and amphetamines (13%). Ten percent (10%) of men reported injection drug use within the previous six months. Men who reported having used drugs were significantly more likely than men who had not to report unprotected anal sex, regardless of the HIV serostatus of their partners. Heavy alcohol use was significantly associated with unprotected receptive anal sex with partners of unknown status and HIV positive partners, as well as with unprotected insertive anal sex with partners of unknown status.

The EXPLORE study points to the need for prevention programs to understand relationship status, and known or perceived serostatus of potential partners before counseling MSM. It also points to the need to address alcohol and drug use in prevention programs targeting MSM.

## RISK BEHAVIORS AMONG OLDER MSM

Although MSM account for the greatest proportion of HIV and AIDS cases in the country, there have been few studies focused on MSM who are 50 years or older. In San Francisco, Los Angeles, New York and Chicago, a phone survey was conducted with 2,881 MSM, of which 507 were 50 years or older. HIV status was determined based on self report and confirmed through oral HIV tests for 67 percent of participants who said they were HIV positive.<sup>101</sup>

The data from the survey suggests that HIV prevalence among older MSM is very high, at 19 percent among men in their 50s and 3

<sup>100</sup> Koblin BA, *American Journal of Public Health*, 2003

<sup>101</sup> Dolcini et al, *Journal of Acquired Immune Deficiency Syndromes*, 2003

percent for men in their 60s. No men in their 70s were HIV positive. A similar pattern is found in Minnesota. Of the 2,908 total living cases of HIV/AIDS among MSM and MSM/IDU in Minnesota in 2003, men in their 50s accounted for 487 cases (17%), men in their 60s accounted for 67 cases (2%), and men over 70 accounted for 20 cases (<1%).

The study found high prevalence of HIV among older Black MSM (30%), moderate substance users (35%), less closeted men (21%), and MSM who are injection drug users (21%).

Participants' responses also indicate that high-risk sex between serodiscordant partners remained relatively constant among men older than 30 years of age (4% - 5%) and decreased among men in their 70s.

Before HAART was introduced in 1996, many HIV positive MSM died, accounting for the lower prevalence among men in their 60s and 70s. However, with the availability of treatment, and the continuance of high-risk activity among older MSM, it is expected that older MSM will make up a larger proportion of the epidemic in the future.

## BAREBACKING

Within the gay community, the term "barebacking" refers to intentionally not using condoms during anal intercourse. A brief street intercept survey was conducted with 518 gay and bisexual men in New York City.<sup>102</sup> Of the 448 men who were familiar with the term, 204 (46%) reported engaging in bareback sex during the previous three months. HIV positive men were significantly more likely to report this behavior than men who were HIV negative. Participants were significantly more likely to engage in bareback sex with persons of the same HIV status than to bareback with persons of a different HIV status.

From an emotional standpoint, the men associated barebacking with feelings of intimacy, connectedness, and masculinity.

Reasons commonly given for engaging in bareback sex included:

- The Internet and availability of sexually oriented chat rooms
- Advances in HIV treatment
- Emotional fatigue related to HIV
- Popularity of "club drugs"

Another study by the same authors focused on the barebacking among HIV positive gay men who use the Internet to find sexual partners.<sup>103</sup> A sample of 112 HIV positive gay men were recruited from Internet sites used by men who identify as being HIV positive and seeking male sex partners.

The majority of participants (84%) reported bareback sex in the past three months. Forty-three percent (43%) had engaged in barebacking with a partner whose HIV status was unknown. The study found a significant correlation between men who defined masculinity as sexual prowess and those who intentionally have unprotected anal sex.

## SUBSTANCE USE

### Alcohol Use

The Urban Men's Health Study conducted a phone survey of 2,172 men who identified as gay, bisexual, or reported sex with another man in the last five years. The sample was gathered from selected zip codes in the cities of San Francisco, Los Angeles, New York and Chicago.<sup>104</sup>

Eighty-seven percent (87%) of the total sample reported some alcohol use during the previous six months. Twelve percent (12%) of the sample reported three or more alcohol-related problems, and 8 percent reported frequent/heavy alcohol use.

Multivariate analyses indicated that men whose parents abused substances, who attended bars or clubs more frequently, and who read local gay media less frequently were significantly more likely to report drinking frequently or heavily, and/or experiencing three or more alcohol-related problems.

<sup>102</sup> Halkitis et al, *Archives of Sexual Behavior*, 2003

<sup>103</sup> Halkitis and Parsons, *AIDS Care*, 2003

<sup>104</sup> Stall et al, *Addiction*, 2001

## **Drug Use**

The Urban Men's Health Study<sup>105</sup> also found that drug use was less common than alcohol use, with 52 percent of the sample reporting any drug use during the previous six months. Only 1.3 percent reported injection drug use in the past year. Marijuana was the most commonly used drug (42%), followed by poppers (20%), cocaine (15%), ecstasy (12%), and speed (10%). There were regional differences in drug use, with marijuana being more common in San Francisco, and cocaine more common in New York.

When combining all stimulant drugs together (cocaine, crack cocaine, methamphetamines, other amphetamines, and ecstasy), the study found that 23 percent of the total sample across regions reported any use of these drugs in the past six months.

Men who lived in San Francisco or New York, were HIV positive, were depressed, frequented bars more often, and had a greater number of one-time sexual partners were more likely to be frequent drug users or to use multiple drugs.

More participation in public sex environments, such as bathhouses and sex clubs, was associated with fewer alcohol problems but with greater multiple drug use.

### **MDMA (Ecstasy) Use**

An anonymous survey was conducted of 169 gay and bisexual men entering three gay dance clubs in New York City on three successive Saturday nights.<sup>106</sup> Fifty-six percent (56%) of respondents described themselves as White, 20 percent as Latino, 4 percent as Black, 3 percent as Asian/Pacific Islander, and 17 percent as Other/No Answer.

Thirty-four percent (34%) of respondents reported frequent use (at least once a month) of 3,4 methylenedioxymethamphetamine (MDMA, or "ecstasy"). MDMA use exceeded that of all other illicit drugs except for marijuana.

The study found a strong association between frequent MDMA use and high-risk sexual behavior. Neither frequent alcohol use nor frequent use of other drugs was significantly associated with high-risk sexual behaviors, suggesting that the association between frequent MDMA use and high-risk behavior was not influenced by other substance use.

### **Crystal Methamphetamine Use**

Crystal methamphetamine, commonly known as "crystal meth," "meth," or "Tina," is a stimulant drug used by gay and bisexual men to initiate, intensify and prolong sexual encounters. The drug is commonly used in environments where sexual contact among gay men is promoted, such as sex clubs or circuit parties. Crystal meth is, of course, also used by heterosexual teens and adults, but research indicates that meth use is strongly associated with risky sexual behaviors that may transmit HIV among MSM, and that crystal meth use is on the rise among gay men.<sup>107</sup>

People using crystal meth experience a variety of sensations, such as hypersexuality, euphoria, lowered sexual inhibitions, and an increased self-esteem and confidence. Meth also appears to increase anal sensation, while high doses of the drug make it more difficult to obtain a full erection. This phenomenon leads to the creation of "instant bottoms," or meth users who take on the receptive anal role during sex. The use of crystal meth is also linked to longer periods of continuous sexual intercourse.<sup>108</sup>

A study of 1,263 MSM seeking STD clinic services in San Francisco in 2002 and 2003 found that 17 percent reported using crystal meth during the previous four weeks. When compared to nonusers, those who used meth were more than 2 times as likely to be living with HIV, 4.9 times as likely to be diagnosed with syphilis, and 1.7 times as likely to be diagnosed with gonorrhea.<sup>109</sup>

<sup>105</sup> Ibid

<sup>106</sup> Klitzman et al, *American Journal of Psychiatry*, 2000

<sup>107</sup> Halkitis et al, *Journal of Homosexuality*, 2001

<sup>108</sup> Ibid

<sup>109</sup> Mitchell, 2004 National STD Prevention Conference

## TWIN CITIES MEN'S HEALTH STUDY

The CDC and MDH teamed up, along with some volunteers from the community, to conduct a men's health survey at the Twin Cities Gay Pride celebration in June 2004. Three hundred and seventy-nine (379) men ages 18 and older were interviewed over the weekend.<sup>110</sup>

The majority of the participants were White (81%), with 6 percent identifying as Black, 4 percent Latino, 7 percent multiracial, and 6 percent other. Ninety-three percent (93%) were born in the United States. The age breakdown was as follows: ages 18 or 19 (5%), ages 20 - 29 (32%), ages 30 - 39 (27%), ages 40 - 49 (26%), and age 50 or older (11%).

### **Sexual Behavior and HIV/STD Testing**

Of all men interviewed, 300 (79%) said they had sex with men during the last year, and of these, 189 men (50%) had had multiple sexual partners in the previous 12 months. Additionally of those engaging in anal sex in the past 12 months, 47 percent overall reported having unprotected sex (72% of men with single partners, 42% of men with multiple partners). For men with multiple partners, the most common places to meet their partners were over the Internet (52%) and at a bar or club (47%).

In relation to HIV testing, 335 out of 379 men interviewed (88%) said they had ever been tested; and of those, 137 (41%) had an HIV test in 2004. Of those who had been tested, 8 percent were HIV positive. Additionally, 5 percent of those interviewed reported having an STD diagnosis in the previous 12 months.

### **Substance Use**

One hundred and forty-five (145, 38%) participants reported using non-injecting drugs during the last 12 months, with 31 percent using once a week or more. The most common drug was marijuana (80%), followed by poppers (34%). Other drugs used included

Viagra (16%), mushrooms (14%), cocaine (13%), crystal meth (12%), pain killers (10%), ecstasy (9%), and crack (7%). Twenty-six (26) men reported ever injecting drugs, and of those, only 4 had injected during the past year. Thirty-two percent (32%) of men who had multiple partners and 15 percent of men with one partner reported using drugs or alcohol before or during the last time they had sex.

### **Prevention Services**

Participants reported having received the following types of prevention services in the past 12 months: free condoms (71%), HIV/STD prevention literature (70%), referral for HIV testing (14%), referral for STD testing (11%), participated in an individual level intervention (30%), and participated in a group level intervention (14%).

## **SUMMARY**

### ***HIV prevention needs of MSM:***

- Address homophobia.
- Address societal taboos around sexuality.
- Address sexual behavior separately from sexual orientation.
- Develop a cultural norm of consistent condom use.
- Ensure that there are a variety of safe environments for MSM to meet and socialize.
- Address HIV prevention burnout.
- Develop negotiation and coping skills.
- Provide long-term positive reinforcement.
- Address alcohol and drug use, and its relationship to unprotected sex.
- Consider issues related to relationship status, and serostatus of partners in the context of a risk reduction intervention.

<sup>110</sup> MDH, Twin Cities Men's Health Survey, 2004 (unpublished)

## Men Of Color Who Have Sex With Men

The changing face of the HIV epidemic has had a disproportionate impact on racial/ethnic minority MSM, especially African Americans and Latinos. In Minnesota, while African Americans make up only 4 percent of the population, they account for 13 percent of new cases among MSM from 2001 through 2003. Similarly, Latino men make up only 3 percent of the state's population, and account for 10 percent of newly diagnosed cases among MSM during the same time period.

### ISSUES FACED BY MEN OF COLOR

Race/ethnicity itself is not a risk factor for HIV infection; however it may act as a marker for other social and economic factors that are more prevalent within those communities, including homophobia, high rates of poverty and unemployment, and lack of access to prevention services and health care. Such factors may serve as barriers to receiving HIV prevention information or accessing HIV testing, diagnosis, and treatment.<sup>111</sup>

#### *Living in Two Worlds*

Gay men of color often have to face both issues of racism and homophobia. Some cultures believe that same sex orientation does not exist within their culture; others are not accepting of homosexuality, or believe it to be deviant or sinful. Gay men of color often have to separate their life as a gay man from family and friends of their racial or ethnically defined culture.

Men of color may also feel isolated and marginalized by the gay community. They may encounter such discrimination from white gay men; however, there are also stereotypes and prejudices between gay men of color from different racial or ethnic backgrounds. Overall, images and issues pertaining to people of color are often ignored in major gay media.<sup>112</sup>

### ***Non-gay Identified Men of Color Who Have Sex with Men***

Because the lack of acceptance of same sex orientation is so strong within some cultures, notably within the African American and Latino cultures, there are a number of men of color who engage in sexual behavior with other men, but do not identify themselves as being either gay or bisexual. Often they are in relationships, or also have sexual intercourse, with women. This poses an HIV prevention issue not only for men who have sex with men, but also for the women with whom they are having sex with, as well. It is difficult to reach these men with targeted prevention messages because they do not frequent gay clubs or other hangouts, and do not read gay-oriented media.

A recent needs assessment was conducted in Chicago targeting Black and Latino men 50 years and older who have sex with men. Of the 110 men who completed the survey, over 90 percent reported having sex with other men. Most reported using drugs before having sex, and 20 percent said they had unprotected receptive anal sex. Forty-five percent (45%) of the men identified as either bisexual, or mostly or completely straight. Thirty-six percent (36%) reported having sex with women. A large percentage said that they were relatively secret about their same sex behavior. Most of the men (74%) felt that they were at low risk for contracting HIV.<sup>113</sup>

### **TWIN CITIES MEN'S HEALTH STUDY**

In June 2004, MDH collaborated with CDC and some community partners to conduct the Men's Health Study at the Twin Cities Pride festival.<sup>114</sup> Of the 379 men surveyed, 71 (19%) self-identified as being men of color. Twenty-two men (6%) identified as Black, 25 (7%) as multi-racial, and 24 (6%) as other.

<sup>111</sup> CDC, 2001

<sup>112</sup> Safe Zone Ally Program

<sup>113</sup> Jimenez AD, *Journal of Acquired Immune Deficiency Syndromes*, 2003

<sup>114</sup> MDH, Twin Cities Men's Health Study, 2004 (unpublished)

Included in these numbers are 10 persons who identified their ethnicity as Latino. There were also 7 individuals who identified their ethnicity as Latino and their race as White. For the purposes of these analyses, these men have been counted as White. Because the numbers of men who identified a race other than White are quite small, they are grouped together as men of color.

Men of color who participated in the survey were significantly less likely to identify as gay or bisexual compared to White males (75% vs. 91%), and were significantly less likely to have had a male sexual partner in the past 12 months (18% vs. 31%).

**Substance Use**

There were no significant differences related to drug use found between White men and men of color. Eight percent (8%) of men of color and 7 percent of White males reported ever injecting drugs. Forty-two percent (42%) of men of color and 38 percent of White men had ever used non-injecting drugs.

**Sexual Behavior**

Of men who reported having a male sex partner in the last 12 months, 51 percent of men of color and 41 percent of White males had insertive anal intercourse during their last sexual encounter. Condom use during this encounter was as follows:

Condom Use	Men of Color	White Men
None of the time	33%	43%
Part of the time	16%	5%
All of the time	54%	60%

Thirty-one percent (31%) of men of color and 37 percent of White men had receptive anal intercourse during their last sexual encounter. Condom use during this encounter was as follows:

Condom Use	Men of Color	White Men
None of the time	33%	43%
Part of the time	6%	9%
All of the time	61%	47%

There were no significant differences in the type of partner during the last sexual encounter. Fifty-nine percent (59%) of White males stated that their last sexual encounter was with their steady partner compared to 52 percent of men of color. The remainder stated that they were with a casual partner (40% White males vs. 48% men of color).

There were no significant differences in HIV testing behavior, either. Eighty-six percent (86%) of men of color and 90 percent of White men had previously been tested for HIV.

**POPULATION SPECIFIC INFORMATION**

The remainder of this section on Men of Color who Have Sex with Men provides population specific information from various studies regarding African American, Asian Pacific Islander, Latino, and Native American MSM.

## AFRICAN AMERICAN COMMUNITY

### *Homophobia*

As noted earlier in this section, African American men face a great deal of homophobia in their community. A survey conducted by the CDC found that almost a quarter of African American HIV positive men who have sex with men consider themselves to be heterosexual.<sup>115</sup> This makes it difficult to reach them with prevention information and programs targeting gay men.

A recent study indicates the need to expand prevention programs to reach African American men who self-identify as straight but engage in same sex behavior. Of 90 HIV infected and 272 HIV negative African American men who self-identified as heterosexual, 31 percent of the HIV positive men and 16 percent of the HIV negative men reported having anal intercourse with other men. Among those who said they had sex with men, all of the HIV positive and 67 percent of the HIV negative men said they inconsistently used condoms during anal intercourse. In addition, 46 percent of the HIV positive men and 37 percent of the HIV negative men reported having anal intercourse with women without consistently using a condom.<sup>116</sup>

### *Black Pride Survey 2000*

Over 2,500 participants at Black Pride celebrations in nine cities were interviewed in 2000.<sup>117</sup> When asked their sexual orientation, 42 percent self-identified as gay, 24 percent as lesbian, 11 percent as bisexual, and 8 percent as “same gender loving.” Four percent (4%) self identified as “in the life,” and 3 percent as straight/heterosexual. Labels that received little support included “queer” (1%), “two-spirit” (1%), “one of the children” (1%), and “in the family” (1%).

Of men who identified as gay, 72 percent reported sex exclusively with men. Of the

overall sample, 66 percent of men said they had sex only with men.

Survey participants were asked to rank the importance of their identities in terms of race, sexual orientation and sex/gender or gender identity. They were able to rank each independently, allowing them the option to rank the three facets of their identity as having the same importance.

Almost half of the sample did not answer the question. Of those who did, 77 percent felt that their racial identity was most important. Forty-three percent (43%) ranked sexual orientation as most important, and 38 percent rated their sex/gender or gender identity as most important. Women and transgender respondents were more likely than men to rank their sex/gender or gender identity and sexual orientation as most important. Many respondents ranked two or more characteristics as most important, with over a quarter of all participants indicating that all three were equally important. This highlights the experience of many Black GLBT people that these identities are not separable.

### *Substance Use*

A study conducted in San Francisco looked at risk behavior among African American MSM living in the Tenderloin neighborhood, which is one of the poorest areas of the city.<sup>118</sup> Of the 238 men recruited, 43% self-identified as gay, 42% as bisexual, 10% as heterosexual, and 5% as other. Approximately half of the participants reported having sex only with men in the previous six months, while the other half reported having sex with both men and women, or with men, women and transgender persons.

Eighty percent (80%) of the men reported drinking alcohol in the past six months, with 20 percent frequently having five or more drinks at one sitting more than once a week. Eighty-four percent (84%) reported using recreational drugs, with 69 percent using weekly. Thirty-six percent (36%) reported a history of injecting drug use. The most

<sup>115</sup> CDC, 2001

<sup>116</sup> Wohl et al, *Journal of Acquired Immune Deficiency Syndromes*, 2002

<sup>117</sup> The Policy Institute of the National Gay and Lesbian Task Force, 2000

<sup>118</sup> UCSF AIDS Research Center, 2001

commonly used drugs were marijuana (60%), crack (54%), and crystal meth (22%).

Of the 45 study participants who were identified as being at higher risk (reporting unprotected anal intercourse with an HIV serodiscordant partner or one whose serostatus was unknown) 82 percent had anal intercourse while under the influence of alcohol or drugs. The study also found that HIV positive men were more likely than HIV negative men to engage in unprotected anal intercourse with partners of unknown or different serostatus.

The study recommends the need for programs particularly targeting HIV positive men who engage in unprotected sex while under the influence. It also notes the need for interventions to acknowledge and address the difference in how African American men may identify their sexual orientation and the sexual behavior they engage in.

### **ASIAN/PACIFIC ISLANDER COMMUNITY**

Data about the number and mode of transmission of HIV/AIDS cases among Asian/Pacific Islanders (APIs) may be undercounted because of misclassification of race or ethnicity in medical records, which may not reflect patients' self identification. An analysis of APIs with AIDS found a 12 percent discrepancy between the race listed on the AIDS case report and that listed on the death certificate. There was also a 33 percent discrepancy between the race listed on the AIDS case report and that provided by self reports.<sup>119</sup>

#### **Factors Related to HIV Risk Behavior**

There are a number of cultural factors that influence API MSMs' risk for HIV. Family expectations that men will marry and carry on the family line cause feelings of guilt and anxiety regarding sexual identity. Additionally, API cultures do not discuss issues of sexuality in general, and homosexuality in particular.<sup>120</sup>

The Center for AIDS Prevention Studies at the University of California San Francisco conducted five focus groups with 38 Asian/Pacific Islanders who self-identify as gay, bisexual or MSM. Seven were HIV positive and 21 were HIV negative. Forty-seven percent (47%) were Filipino, and the others were Chinese, Vietnamese, Hawaiian, Taiwanese, Japanese, and mixed API ethnicity. Fifty-nine percent (59%) were born outside of the United States, and the average length of time living in the U.S. was 15 years.

Six basic themes related to HIV risk and protection were identified:

Dual identity as gay and API: Participants experienced homophobia in their API social networks and racism in their gay social networks. Many felt that they had to deny their sexual identity to their family and friends. Racism was experienced in subtle forms, such as there being low visibility of APIs in gay media, White standards of attractiveness, and being considered sexual objects by White gay men.

Coming out and disclosure issues: The primary fear about coming out was fear of rejection from family and friends. Several felt that they had to hide their sexual orientation because they were dependent on their family for housing and finances. The men who had disclosed that they were HIV positive spoke of the support they received from their families.

Relationships and dating: The gay community stereotypes API men as being submissive, non-confrontational, and willing to engage in receptive anal sex. A number of participants, particularly younger men, admitted that they internalized and adopted the stereotyped roles. Over time, however, many were able to develop a stronger sense of self-identity and power. Many of these men preferred to exclusively date other API men, and enjoyed more equitable relationships.

Substance use: High levels of alcohol and drug use (speed, ecstasy, gamma-hydroxybutyrate) were reported by the participants as a way to lose inhibitions and feel more confident.

<sup>119</sup> Kelly et al, *Ethnicity and Health*, 1996

<sup>120</sup> Nemoto et al, *AIDS Education and Prevention*, 2003

**Sexual risk reduction strategies:** In general, the participants said that they were educated about risk behaviors for HIV infection and transmission. Their personal risk reduction strategies included not having anal sex, not having anonymous sex, limiting the number of sex partners, and not having sex outside of a relationship. Some participants expressed the need for prevention programs that address STDs, sexual negotiation skills, and substance use, in addition to HIV.

**Culturally competent services:** Participants felt that culturally competent prevention services were essential. They felt that necessary components of such a program include API gay men as peer counselors and role models, and social support groups. Many men were not comfortable with programs that seemed overtly sexual in nature or that were only focused on HIV and sex. They stressed the importance of outreach to hard to reach parts of the API MSM community, such as recent immigrants, less acculturated men, men who are not comfortable with their sexuality, and men who don't voluntarily enroll in social service programs.

### **Sexual Health Among API MSM**

A model was developed to provide greater understanding of sexual health issues among API MSM.<sup>121</sup> The model is based on the premise that API MSM develop their sense of self in an environment marked by racism, homophobia and immigration status. The model first takes into consideration the prevailing cultural norms of the home country, the migration/immigration experience, and how norms, beliefs and practices are influenced by acculturation as men adjust to life in the United States

Home country patterns influence gender roles, sexual mores, sexual practices, drug use, and cultural conceptions of shame. These cultural norms and values can make HIV prevention very difficult in the API community. The reluctance to talk openly about sex can result in API MSM not being assertive in negotiating safer sex with their partners. The cultural need to maintain social harmony can also lead to API MSM placing more value on protecting their partners from

an uncomfortable discussion than on protecting themselves from HIV.

In many API cultures, talking about sexuality with strangers is not acceptable. Since HIV is associated with sexuality, HIV educational materials are usually rejected. However, if they are presented as health materials, they are more likely to be accepted.

Family is the cornerstone of API culture, and sometimes MSM are forced to choose between remaining closeted to be with their families or living openly without family support or acceptance. Men may choose to have wives and children, and have anonymous sexual encounters with other men.

Immigration can also play a role in HIV risk behavior. Newer immigrants are often forced to work low-paying jobs in the service industry that do not offer health insurance. Persons in this situation have concerns that are more pressing than HIV, such as housing, food, etc. API MSM immigrants who do not have marketable skills may resort to trading sex in exchange for things they need.

Three distinct groups of API MSM have been identified in terms of how they are affected by acculturation. One group self-identifies as both API and gay. They are the least closeted, most politically active, and most likely to be involved in gay API groups.

The second group identifies more with the gay community than the API community. These men often date only White partners, and demonstrate internalized racism. Many experience lower self-esteem because they don't physically match the ideal of male beauty established by the gay White community. Many API MSM in this category have indicated that they engage in unsafe sex as a result of low self-esteem and negative self-image. The third group self-identify as API, but not as gay. This group is the hardest to reach with prevention messages.

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<sup>121</sup> Chng et al, *AIDS Education and Prevention*, 2003

## LATINO COMMUNITY

### ***National Research***

A person's state of mental health can play a large role in their ability to engage in safer behaviors. A study of 912 gay and bisexual Latino men was done to look at the effects of homophobia, racism and poverty on their mental health.<sup>122</sup> The study was conducted with a sample of men from New York City, Miami, and Los Angeles. The majority of the men (72%) were immigrants, and about half (53%) had been in the United States for 10 years or less. More than a third used Spanish exclusively or most of the time when talking with friends. Almost a quarter (22%) of the participants were HIV positive, 67 percent were HIV negative, and the remaining 11 percent did not know their status. The population had a high level of education, with 64 percent having completed at least some college education or more. However, the rate of unemployment was surprisingly high, at 27 percent.

A majority of participants had experienced homophobia, both as a child and in adulthood. Sixty-four percent (64%) of men said that they have had to pretend they were straight at some point during their adult life, 29 percent reported that they had to move away from family or friends in order to live their gay lives, and 20 percent had experienced some sort of police harassment in relation to being gay.

Racism was reported less frequently than homophobia, and tended to occur more often when they were adults. However, it is important to note that a majority of the men were immigrants and many did not grow up as a member of an ethnic minority in the United States. Thirty-one percent (31%) experienced verbal harassment as a child, and over a third (35%) had been treated rudely as an adult because of their ethnicity. Many of the men reported experiencing racism in the gay community, with 62 percent stating that they had felt sexually objectified. Twenty-six percent (26%) were uncomfortable going to places where there were mostly White gay men.

Many of the participants had experienced financial problems in the past year. Sixty-one percent (61%) hadn't had enough money for basic necessities sometime during the last 12 months, and 54 percent had needed to borrow money in order to get by.

The study found that 80 percent of the men had experienced feelings of sadness and depression at least once during the last 6 months, with 22 percent experiencing these symptoms much more often. Sixty-one percent (61%) had problems sleeping once or twice in the last six months, with 20 percent with frequent sleep problems. About 50 percent had feelings of anxiety (fear or panic without an apparent reason) at least once or twice in the past six months. Most seriously, 17 percent of the men had thought about committing suicide once or twice during the last six months, and 6 percent had thought about it "a few times" or more.

There was a statistically significant relationship between having experienced social discrimination, in both childhood and adulthood, and having thoughts of suicide in the last six months. In addition, experiences of homophobia, racism, and low income were strong predictors of being socially isolated and having low self-esteem. All of these mental and emotional health issues impact personal risk reduction efforts.

The study recommends that prevention efforts targeting Latino gay/bisexual men should address social isolation and low self-esteem in relation to experiences of discrimination.

### ***Observations from UMOS, Inc. Program***

In a program implemented by UMOS Inc., targeting young men of color who have sex with men in Wisconsin, the following observations of male sexual behaviors within the Latino community were made:

- One must distinguish between sexual behavior and sexual identity within the Latino community. How Latino males self-label their behavior has little to do with their sexual behavior. Within many Latino cultures, many males who publicly self-label as heterosexual males manifest private bisexual behavior.

<sup>122</sup> Díaz et al, *American Journal of Public Health*, 2001

- Discussing sexuality is considered socially improper, and there is little to no appropriate direct verbal language available in Spanish to discuss these issues. Indirect and non-verbal (often crude) expressions are used.
- Sex is a necessary function; with either a male or a female; male to male sex is just an expression of masculinity.
- Male to male sexual encounters when one is young are often perceived as a way for a young man to practice his sexual skills and are not considered relationships. Young men often have older partners, and there is risk of engaging in coercive or abusive relationships where their ability to negotiate safe sex is often compromised.
- Most Latinas know or suspect that their male partners are engaging in same gender sexual activities, but there is a significant difference between knowing this and discussing it in or outside the family. Introducing condoms into an ongoing existing relationship is almost impossible without indicating the reasons.
- Latino men who do not identify as being gay or bisexual will not respond to the same prevention messages as the White gay community.
- Often prevention programs promote a philosophy that asks Latino men to choose being gay over being Latino. There are few programs that target Latino MSM who choose not to disclose.

### **Local Community Forum**

As part of the needs assessment project conducted by the CCCHAP in the Latino community, a community forum was held with a group of eight Latino MSM in the fall of 2003. Two women were also participants in the forum. The purpose of the forum was to learn more about their level of knowledge of HIV and STDs, the barriers to HIV testing for Latino men, and what could be done to make it easier for Latino men to get tested.

Overall, the group demonstrated a high level of knowledge about HIV and how it is

transmitted, but some did not know as much about other STDS.

The participants noted that there is a general lack of communication and education about sex in the Latino community. Additionally, they felt that religion has a strong influence on the culture.

Participants were asked whether there is a difference in the level of awareness about HIV between gay men, heterosexual men and bisexual men. Several participants stated that they have noticed a belief in the community that only gay people can get AIDS. The group as a whole agreed that it is important to not address sexual orientation in HIV/AIDS communications. The focus of the message should be on risk behaviors.

The group identified the following reasons they believe that Latino men do not get tested. Many of these reasons were also cited by individuals who participated in other community forums or completed a survey as part of this needs assessment effort within the Latino community (refer to page 115).

- Embarrassment
- Machismo
- Ignorance
- Culture
- Lack of communication in the home.
- Lack of education.
- Lack of information, and lack of information in Spanish.
- Fear of being told the results are positive.
- Fear of being rejected if the results are positive.
- Not wanting to be seen getting the test.
- Not engaging in risk behavior (e.g., only having one sexual partner).

The group also provided the following ideas for what could be done so that more Latino men will get tested:

- Providers need to help Latinos or let them know that they want to help them.
- Do not ask for name and address. Just use a number.
- Do not ask for a social security number.
- Go to places like bars and laundry mats to find people to test.
- Testing could be provided in a rented room because Latinos are not going to search for a clinic.
- Testing should be provided in areas where Latinos live.
- Have health educators working at night.
- Media efforts (magazines, newspapers, radio, signs) with information about HIV and STDs, testing, and the message that if Latinos test positive, they will not die tomorrow, there is treatment available.

## **NATIVE AMERICAN COMMUNITY**

There is a great lack of published research related to HIV prevention needs of Native Americans in general, and Native American MSM specifically.

There are 11 Indian reservations in Minnesota, seven of which are Ojibwa and four are Lakota/Dakota. While there are tribal differences between the Ojibwa and the Lakota, differences between reservations are more pronounced. There are urban concentrations of Native Americans in Duluth, Bemidji, and the Twin Cities.

### **Factors Contributing to HIV Risk**

There are a number of factors that contribute to HIV risk in the Native American community. The health of this community is worse than that of the general population, with high levels of alcohol abuse and injecting drug use, which impede an individual's ability to make wise decisions in relation to safer sex or needle use. The level of acceptance and tolerance of gay and bisexual men varies, but

discrimination is faced by many MSM. There is a great distrust of the government based on historical experience of colonization and broken treaties. This distrust extends to the Indian Health Service (IHS), particularly in small communities, based on issues of confidentiality and quality of care.<sup>123</sup>

Native Americans are unique in terms of the oppression and forced relocation they suffered as this country was being settled by European immigrants. This population has experienced historical trauma, which is defined as "cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences." Responses to historical trauma include depression, self-destructive behaviors, suicidal ideation and acts, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions.<sup>124</sup> All of these responses can contribute to HIV risk behaviors.

### **Underreporting of HIV/AIDS Cases**

There are several factors that contribute to the probable undercounting of cases in the Native American community. Firstly, although the IHS is authorized to participate in communicable disease surveillance activities mandated by state or local regulation, they are not required to report HIV and AIDS cases to the state health department.<sup>125</sup> It is unknown what proportion of cases have not been reported to the Minnesota Department of Health.

Misidentification of race is another factor that may lead to an underestimation of cases. Studies of state disease surveillance systems have demonstrated undercounting of Native American cases due to misclassification of race. It is likely that most misclassification occurs among Native American persons who seek health care from non-IHS or non-tribal facilities.<sup>126</sup>

<sup>123</sup> Vernon et al, *Public Health Reports*, 2002

<sup>124</sup> Management Sciences for Health and HRSA, 2003

<sup>125</sup> Bertolli et al, *AIDS Education and Prevention*, 2004

<sup>126</sup> Ibid

**Summary of HIV prevention needs of men of color who have sex with men (MCSM):**

- MCSM need to feel that it is safe to identify as gay/bisexual within their communities. Many men of color who have sex with men do not identify as gay or bisexual. This is shown by the large numbers of men who were not out publicly about their sexuality, as well as the general reluctance to learn information about HIV prevention from friends, or from gay/lesbian organizations. This may be due in part to the difficulties men of color have in identifying themselves as GLBT. It may also explain to some degree why Minnesota lacks agencies that specifically target GLBT people in communities of color.
- Provision of culturally competent, language specific, non-gay focused messages targeting a broad audience, and provided by indigenous, nonjudgmental, trusted and respected trained staff.
- Access to condoms and the ability to carry them. Men who have sex with men seem to engage in same day sexual encounters fairly frequently.
- Repeated risk reduction messages targeting behavioral change are provided.
- Questioning of the assumption that negotiation skills are required. Much prevention work emphasizes the need to develop and use negotiation skills. This work is based on the assumption that men know their partners - many men do not.
- Targeting non-gay specific venues with non-gay specific messages about how to reduce risky sexual behavior in order to reach men who have sex with men but do not identify as gay.
- For Latino and African American men particularly, it is important for prevention messages to be targeted at all males and to address risk behaviors.
- Provision of consistent prevention messages - especially regarding the relatively low risk of transmission related to oral sex.
- Targeted outreach that is focused on site, time, and short, face-to-face contacts. Existing Minnesota HIV/AIDS organizations should evaluate their existing marketing strategies and devise ways to market their names and services specifically to gay/bisexual men of color.
- Promotion of peer education related to STD risk reduction as a best way to start informal conversations about HIV within the 'cliques' that most men belong to. This is also a way to build capacity within communities.
- HIV risk reduction case management is made available to men of color that is frequent, accessible, and quick.
- Promotion of HIV antibody testing in HIV prevention literature.
- Safer sex and health sexuality become a cultural norm. Many communities of color consider discussion of sexual health to be "taboo".

## Young Men Who Have Sex With Men

### NATIONAL RESEARCH

#### *Findings from Young Men's Survey*

Recently, the Young Men's Survey (YMS), a study measuring HIV incidence among young men who have sex with men, found a high prevalence and incidence of HIV and associated risks among MSM aged 15-22 years old.<sup>127</sup> The survey was conducted in Baltimore, Dallas, Los Angeles, Miami, New York City, and Seattle from 1994 – 2000.

The prevalence of HIV infection was 7.2 percent, increased with age, and was higher among Blacks, Hispanics, and men of mixed race than among Whites or Asians/Pacific Islanders. These findings and the high prevalence of unprotected anal intercourse during the preceding six months (41%), suggest that HIV incidence was high among these young men. The estimate of HIV incidence was 2.6 percent overall, 4 percent among Blacks and 5.4 percent among men of mixed race. Among young MSM aged 23-29, prevalence was 7 percent for Whites, 14 percent among Hispanics, and 34 percent among Blacks. Incidence was 4.4 percent overall, 2.5 percent among Whites, 3.5 percent among Hispanics, and 14.7 percent among Blacks.

These researchers decline to speculate why prevalence and incidence is so high among young MSM of color. Perhaps the combination of socio-economic barriers that adults from communities of color face, the homophobia that adult MSM face, along with the increased vulnerability that youth face in all areas of society can help to explain these high rates.

#### ***Young Black Men Who Have Sex with Men***

Further analysis was conducted on the data gathered from 920 young Black MSM who participated in the Young Men's Survey in order to evaluate the prevalence of unknown

HIV infection, barriers to testing, and reasons for not using condoms.<sup>128</sup>

Sixteen percent (16%) of the 920 young Black MSM were HIV positive, and almost all of those who tested positive (93%) were unaware of their infection. Of those who had not known they were infected, 71 percent had stated prior to knowing the results that there was no chance, or it was very unlikely or unlikely that they were infected with HIV. Forty-two percent (42%) perceived that they were at low risk of ever becoming infected.

During the six months before the time the Young Men's Survey was administered, 37 percent of the 920 young Black MSM reported unprotected anal intercourse. There were 79 individuals who were unknowingly HIV positive and had engaged in unprotected anal intercourse in the previous six months. Of those 79 men, 52 percent said they didn't use a condom for the following reasons:

- They knew they were HIV negative (24%).
- They knew their partners were HIV negative (20%).
- They thought their partners were at low risk (35%).
- There were no condoms available (43%).

Of the 920 men, 64 percent had previously tested for HIV, but not many tested frequently. Of the 336 men who had never had an HIV test before, the reasons they gave for not testing were (more than one reason could be given): they thought they were at low risk for HIV (45%), fear of learning the results (41%), and fear of needles (21%).

As a result of the study, the CDC recommends the following strategies for reaching young Black MSM:

- Address concerns about testing by talking about benefits of early diagnosis and treatment.
- Market availability of oral and finger prick HIV tests.

<sup>127</sup> CDC, *MMWR*, 2001

<sup>128</sup> CDC, *MMWR*, 2002

- Provide testing in non-clinical settings frequented by young Black MSM.
- Testing should include quality, in-depth, and personalized risk reduction counseling.
- Providers should address drugs, alcohol, and partner influences on condom use.

### **Young Latino Men Who Have Sex with Men**

Having ties to ethnic community appears to be very important in reducing risk among young Latino MSM. A study of 475 young Latino MSM, ages 15 to 25, in New York City showed that young men who were attached to their ethnic community were 40 percent less likely to engage in any unprotected anal intercourse in the 3 months prior to the survey. Even more dramatic was the finding that young men who have ties to their ethnic community were 60 percent less likely to engage in unprotected anal intercourse with a non-primary partner. The study recommends further research into how the community can best provide support risk reduction efforts of young Latino MSM.<sup>129</sup>

### **Young Asian and Pacific Islander Men Who Have Sex with Men**

Rates of HIV infection are very low among Asian and Pacific Islander (API) MSM, in Minnesota and nationwide, which has created the perception that API MSM practice less risky sex. It may also lead the community to believe that the disease does not affect them. However, one study indicates that young API men who have sex with men are just as likely as other young MSM to engage in risky behavior.<sup>130</sup>

This study interviewed 253 API MSM between the ages of 15 and 25 in Seattle and San Diego. Although all were English-speaking, 55 percent of participants were foreign-born. Overall, 33 percent of participants reported unprotected anal intercourse in the previous three months. They were more likely to engage in unsafe sex with main partners (49%) than with non-

main partners (25%). The factors that were found to predict unsafe sex were: having multiple sex partners in the last three months, having been tested for HIV, feeling that peers don't endorse safer sex, and self-identifying as gay or bisexual.

The authors felt that one possible explanation for why men who self-identify as gay or bisexual are more likely to engage in risky behavior is that they feel more relationship with the mainstream gay community where they can enjoy more sexual freedom than in the general API community. However, they may not receive adequate prevention messages from the gay community because the messages are not culturally sensitive to the API community and API men don't appear in visual materials.

The study recommends that prevention programs targeting young API MSM should look at steady relationships as a possible source of HIV transmission and promote discussion of sexual risk with main partners and joint testing of couples. The promotion of peer norms to practice safe sex is also important as participants who felt that their peers engaged in safer sex were more likely to do so.

## **FACTORS AFFECTING RISK**

### ***Establishment of Identity***

Developmentally, adolescence is a time when people are more likely to experiment with sex and drugs, take risks, and believe themselves to be invulnerable. Youth are also struggling to develop and integrate their adult identities. In addition to all of the challenges faced by adolescents, young gay and bisexual men also have to deal with exploring a sexuality identity that involves feelings and behaviors that are not generally accepted by the society at large.<sup>131</sup>

Unlike many of their heterosexual counterparts, gay youth often don't have built-in support systems or assurances that they will not be rejected by family and friends.

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<sup>129</sup> O'Donnell et al, *AIDS Education and Prevention*, 2002

<sup>130</sup> Choi et al, *AIDS Education and Prevention*, 2002

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<sup>131</sup> Ryan and Futterman, *Adolescent Medicine: State of the Art Reviews*, 1997

Additionally, gay and bisexual youth have been confronted since childhood with negative attitudes towards homosexuality through the media and social institutions.<sup>132</sup>

**Stigma, Discrimination and Violence**

Young MSM are more likely to be at risk for HIV than their heterosexual counterparts because they often experience stigma and acts of violence and discrimination.

Due to the constant exposure to heterosexist messages in the media and social institutions, some gay and bisexual young men question the “normality” of their attraction and feelings for members of the same sex.<sup>133</sup> This stigma is reinforced as they learn about discriminatory laws that deny them the same rights as heterosexuals, such as the right to serve in the military and to marry.<sup>134</sup>

A random sample was conducted of 3,647 high school students in Massachusetts. Four percent of the sample was considered to be gay, lesbian or bisexual (GLB) based on self-identification of sexual orientation and/or self-report of same-sex behavior. The study found that GLB youth were significantly more likely than their heterosexual classmates to have missed school for personal safety reasons (20% vs. 5%), have been threatened or injured with a weapon (28% vs. 7%), and to have had property damaged or stolen (52% vs. 28%).<sup>135</sup>

**Lack of Appropriate Prevention Education**

In many communities, sexuality education targeting gay and bisexual youth is often perceived as advocating for the homosexual (and in this context, immoral) "lifestyle." Consequently, there is a lack of support, lack of self-esteem, and a lack of counseling for gay youth around emotional, physical and spiritual health. There is a clear heterosexual bias in education. Failing even to find

information and answers in school and/or public libraries, students reported “deadening their anxieties” by turning to self-destructive behavior.

**Use of Alcohol and Drugs**

The sample of Massachusetts high school students, found that GLB students were significantly more likely than their heterosexual peers to have used drugs in the past 30 days, and in their lifetime. In the past 30 days, 58 percent of GLB students had used marijuana and 19 percent had used cocaine compared to 32 percent and 3 percent of heterosexual students, respectively. In their lifetime, GLB students were more likely to have used miscellaneous drugs (61%) and to have injected drugs (24%) compared to heterosexual students (27% and 2%, respectively). While alcohol use during the last 30 days was greater among GLB youth (70% vs. 54%), the difference was not statistically significant.<sup>136</sup>

Being high on drugs or alcohol was found to be associated with risky sexual behavior among young MSM, particularly with non-primary partners. During the summer of 2000, the Community Intervention Trial for Youth (CITY) Project interviewed 3,075 young MSM ages 15 to 25 from 13 urban areas in the United States, including Minneapolis.<sup>137</sup> Nearly one third of the young MSM interviewed reported being high on drugs or alcohol the last time they had sex with a non-main partner. Those who were high were 60 percent more likely to have engaged in unprotected receptive anal sex with a non-main partner. This did not vary based on race/ethnicity, age, or self-identification of sexual orientation.

The CITY Project also pointed to some differences in use of substances. Men in their 20s were more likely than adolescents to report being high during intercourse. Young MSM born in the United States were also more likely to use substances than immigrants. Young MSM who had sex with both men and women were more likely to be

<sup>132</sup> Ibid

<sup>133</sup> Harper and Schneider, *American Journal of Community Psychology*, 2003

<sup>134</sup> Harper and Wilson, *The Community Psychologist*, 2003

<sup>135</sup> Blake et al, *American Journal of Public Health*, 2001

<sup>136</sup> Ibid

<sup>137</sup> Stueve et al, *AIDS Education and Prevention*, 2002

high during sex than men who only had sex with men. However, self-identification as bisexual, straight, or questioning was not related to being high during sex.

The CITY Project found that the use of substances was also associated with other risk behaviors such as having multiple male sex partners, trading sex, and weaker peer support of condom use.

Between 1989 and 1997, trends in drug use and their impact on unprotected anal intercourse were monitored in Minneapolis through a study of 9 annual cross-sectional cohorts. The entire sample included 877 men ages 13 to 21 who self-identified as gay, bisexual or men who have sex with men. The racial/ethnic composition of the sample was 79 percent White, 8 percent African American, 3 percent Latino, 3 percent Asian, 2 percent Native American, and 5 percent multiracial. Overall, 34 percent of respondents reported unprotected anal intercourse with any of their last 3 sexual partners during the previous year.<sup>138</sup>

The study found an increase in amphetamine use among young MSM between 1994 and 1997. From 1989 to 1993, between 3 and 8 percent of the sample used amphetamines in the three months prior to the interview. Between 1994 and 1997, when the study ended, use increased to between 12 and 15 percent of the sample. In 1997, the use of marijuana (47%) and cocaine (10%) was also significantly greater in 1997 compared to 1994 (37% and 3%, respectively).

There were several differences found in substance use patterns across racial/ethnic groups. Whites drank more alcohol in the three months prior to the interview than people of color (85% vs. 78%), and African Americans (85% vs. 73%). Whites also used more alcohol before or during sex than people of color (61% vs. 53%).

Univariate analyses revealed that 10 substances (alcohol, marijuana, cocaine,

amphetamines, barbiturates, heroin, LSD, volatile nitrates, tranquilizers, and methaqualone) were associated with unprotected anal intercourse. However, multivariate analyses to control for the use of multiple drugs and the severity of drug use indicated that only cocaine use before or during sex was independently associated with unprotected anal intercourse.

### **Homelessness**

A recent Minnesota study found that 12 percent of homeless youth and young adults identified as lesbian, gay or bisexual. An additional 3 percent identified as questioning.<sup>139</sup>

A study of 168 homeless youth aged 13 to 21 in Seattle found that GLBT youth left home for reasons similar to their heterosexual peers (family conflict, desire for freedom, difficulties with a family member). Twelve (12) GLBT youth left due to conflict with their parents over their sexual orientation. GLBT youth left home more often than heterosexuals (average of 12.38 times vs. 6.69, respectively).<sup>140</sup>

The Seattle study found that young gay/bisexual males experienced higher levels of physical victimization (average of 1.67 times) in the last three months than heterosexual males (1.39 times), and reported being sexually victimized by an average of 6.74 people since leaving home compared to an average of 0.17 perpetrators against heterosexual males.

When considering the use of 12 types of drugs, GLBT youth used all except marijuana more frequently in the previous six months than their heterosexual counterparts. The difference was significant for cocaine/crack, crank, and speed or crystal meth. GLBT youth also reported higher levels of depressive symptoms.

Finally, although 94 percent of the total sample reported engaging in voluntary sex at least one time, GLBT youth had a higher number of lifetime sexual partners (average of

<sup>138</sup> McNall and Remafedi, *Archives of Pediatrics and Adolescent Medicine*, 1999

<sup>139</sup> Wilder Research Center, 2001

<sup>140</sup> Cochran et al, *American Journal of Public Health*, 2002

24.19 and 12.49 respectively). More than twice as many GLBT youth reported not always using protection during intercourse.

## INDICATORS OF RISK

A study was conducted of 569 young men ages 17 to 28 from New York City who reported having sex with a man at least once during the last six months. Forty percent (40%) were Latino, 23 percent African American, 27 percent White, and 10 percent biracial or other. Twenty-one percent (21%) were currently homeless or in an unstable living situation. Almost half (47%) were formally employed, and 15 percent currently made money on the street (i.e., sex work or drug dealing). Sixty-four percent (64%) self-identified as gay, 24 percent as bisexual, 7 percent as heterosexual, and 9 percent as transgender.<sup>141</sup>

Of the total sample, 200 (35%) had ever engaged in sex work; 26 percent had ever been homeless; and 47 percent had been detained by the police, arrested or jailed. Twenty percent (20%) used substances daily (most commonly marijuana), and 19 percent were out of school or unemployed.

The study found that having a fearful attachment style (fear that others may not be available and discomfort with closeness) is a significant predictor of the risks examined here: sex work, daily substance use, involvement in criminal justice system, homelessness, and being out of work or school.

The study also found that youth who identified as heterosexual were at considerable risk for all five outcomes. Those at greatest risk were youth who identified as heterosexual and reported a fearful attachment style. Most of these young men had been involved in sex work, had been homeless, or both.

Bisexual youth were more likely to use substances daily, be homeless, and to be out of work or school. Transgender youth were more likely to be involved in sex work,

homeless, not in school or work, and if they experienced victimization, to use substances daily.

## SEXUAL RISK BEHAVIOR

The previously referenced study of high school students in Massachusetts found that GLB students were significantly more likely than heterosexual students to report lifetime (86% vs. 48%) and recent (69% vs. 34%) sexual intercourse, and to report using drugs or alcohol before last sexual intercourse (44% vs. 28%). Among sexually active youth, GLB students reported an earlier age of first intercourse (13.7 vs. 14.3), more lifetime (3.6 vs. 2.7) and recent (2.1 vs. 1.1) sexual partners, and a higher frequency of either being or getting someone pregnant (30% vs. 11%) in comparison to heterosexual students.<sup>142</sup>

Data from six sites included in the CITY Project were reviewed in order to identify trends in sexual behavior from different geographic regions and racial/ethnic groups. Sites included in this analysis were Jackson Heights (Queens - New York City); San Gabriel Valley, CA; Atlanta, GA; San Diego, CA; Detroit, MI; and Minneapolis/St. Paul, MN. Participants were between 15 and 25 years old, and reported having sexual contact leading to an orgasm with a male in the past year.<sup>143</sup>

The study found a significant reduction in unprotected anal intercourse across all four years (1999 – 2002) in New York City and San Gabriel Valley, where only Latinos were interviewed.

A highly significant increase in unprotected anal intercourse was found in Detroit between 1999 and 2000, followed by a significant decrease from 2000 to 2002. A non-significant increase was observed in the Twin cities. These cities interviewed primarily White participants.

There were no significant trends noted in Atlanta or San Diego. Only African Americans

<sup>141</sup> Gwadz et al, *Journal of Adolescent Health*, 2004

<sup>142</sup> Blake et al, *American Journal of Public Health*, 2001

<sup>143</sup> Guenther-Grey et al, submitted for publication, 2004

were interviewed in Atlanta, and the incidence of unprotected anal sex remained fairly constant over time. In San Diego, where only Asian and Pacific Islanders were interviewed, there was a non-significant increase observed between 2000 and 2001, and a decrease between 2001 and 2002.

In 2001, 420 of 1,396 (30%) total participants (and 30% of Twin Cities sample) reported unprotected anal intercourse in the previous three months. In 2002, 31 percent of total participants (and 34% of Twin Cities participants) reported unprotected anal intercourse. Approximately one third to one half of all men who had unprotected anal intercourse reported having at least one sex partner who was serodiscordant or of unknown HIV status in 2001 (range across sites: 30% to 56%) and 2002 (range across sites: 31% to 60%).

**Young MSM Tell Us What They Need**

The CITY research team from Milwaukee conducted interviews with 72 young MSM to get their recommendations about the types of HIV prevention programs that would best meet their needs.<sup>144</sup> The participants said they need comprehensive prevention programs that address the following issues:

- Dating and intimacy
- Sexuality and arousal
- Drugs and alcohol
- Self-esteem and self-worth
- Abuse and coercion
- Sexual identity

They felt it was important for prevention programs to be confidential, fun, comfortable, accepting and open to all young MSM regardless of sexual identity. They also identified resources within the community that could be used to strengthen safe behaviors:

- Safe places for youth to hang out.
- More peer educators.
- Older MSM to act as mentors.
- Increased school-based sexuality education.
- Greater support from the general society, as well as from the gay community, communities of color, and churches.

**SUMMARY**

***HIV prevention needs of young MSM:***

- Promotion of consistent use of condoms.
- Opportunities for friendship and positive role models.
- Access to intensive mental health and social services.
- Access to age and culturally appropriate HIV counseling and testing.
- Peer education and older MSM who act in the role of mentors.
- Increased knowledge about HIV/AIDS and safer sex guidelines.
- Effective HIV risk reduction programs that eroticize safer sex practices.
- Training in communication skills for negotiating safer sex practices.
- Support around coming out, chemical dependency recovery, and leaving prostitution.
- Training to adult providers about GLBT youth experiences, appropriate sex education, risk assessments, referrals.
- Access services related to housing, health care, education assistance and employment training.
- Street outreach and drop in centers.
- Prevention programs that address dating and intimacy, sexuality and arousal, drugs and alcohol, self-esteem and self-worth, abuse and coercion, and sexual identity.

<sup>144</sup> Seal et al, *AIDS Care*, 2000

## Heterosexuals

*Subpopulations include: Adult African American Women, Young African American Women, Young Women All Races, and Adult Women All Races*

In 2000-2001, the CCCHAP prioritized heterosexual women as a target population due to the fact that the majority of heterosexually contracted HIV infections in Minnesota are among women (women accounted for 78% of heterosexually contracted living cases and 90% of new infections in 2003). Heterosexual women were selected as a priority target population in recognition of the fact that HIV transmission rates are increasing among women (particularly African women) who acquire HIV through unprotected sex with HIV positive men. These men are likely to have acquired HIV through injecting drug use, or through unprotected sex with other men.

Most of the information contained in this section is about heterosexual women, but because the heterosexual transmission of HIV requires the involvement of a man as well, and because some studies do not break out data by gender, some data included here are about women and men, or men only.

### **FACTORS THAT PUT HETEROSEXUAL WOMEN AT RISK FOR HIV TRANSMISSION**

#### **Poverty**

Approximately 50 women at a Minneapolis community forum in 1995 talked about how the experience of poverty contributes to HIV. Participants described women in poverty as experiencing racism, internal oppression, intimidation, and lack of respect. Women who experience poverty lack assertiveness and negotiating skills.

*“Poor women must meet basic needs before they begin to value HIV/STD prevention. Lack of food, shelter, safety and separation from loved ones are more immediate problems than the risk of a chronic infection that may result in death in the future.”*

Women in poverty experience financial, transportation, and child care barriers in accessing health care and testing. Their first priority is to take children to health care providers.

Testing sites are often inconveniently located, and the women are often distrustful of Western medical procedures. Barriers to accessing health care increase the justification for a person to not learn their HIV status, especially when there is no cure. Women test for HIV or other STDs when they are feeling sick, when they are having a baby, when they are giving blood, or when at the clinic for another reason (routine health promotion, annual exam), not usually because of a specific concern around HIV infection.

Many women in poverty are not accessing behavioral interventions and are not sure how to access them. Although information is plentiful, it is often not understood because those delivering it do not take into account the context of poverty; for instance, literacy levels are often inappropriate, or materials are not culturally specific. Health providers are also perceived as not taking into account subcultures within cultures. Many women don't care about TV or media messages, so personal contact is key. There is a lack of knowledge about condoms. Condoms are perceived as not fitting, liable to break, and not fun. Some believe that needles are safe to share with family members or loved ones.

Within communities of poverty, service agencies are over worked and under funded. However, the area of HIV/STD prevention requires personal effort, time commitment, hope, and a vision for a better future. Staff are usually not adequately trained, particularly around sexuality issues.

#### **Chemical Dependency**

Studies have shown that there are relationships between non-injecting drug use and HIV prevalence. While rates of HIV in the general population are estimated to be less than 1 percent, the rate of HIV among alcohol abusers and non-injecting drug users ranges

from 3 percent to more than 30 percent.<sup>145</sup> Nationally, 75 percent of new HIV cases each year are among people who are using legal and illicit substance.

According to the Minnesota HIV Services Planning Council's Needs Assessment of HIV Positive Minnesotans, 57 percent of all persons interviewed (n=242), and 56 percent of the women (n=87), believe that substance use/abuse played a role in their becoming HIV positive. Fifty percent (50%) of all persons interviewed acknowledged that their drug and alcohol use affects their safe sex practices.<sup>146</sup>

It is clear that chemically dependent individuals are much more likely to engage in high-risk behaviors for HIV transmission, and/or find themselves in environments that encourage high-risk behaviors. An analysis of a subset of data taken from the Black HIV/AIDS Services Needs Assessment, originally conducted in 1998, pointed to some links between having been in chemical dependency treatment and risky behaviors.

It was found that HIV positive individuals who had been in chemical dependency treatment in the last five years were significantly more likely to:

- Have been in prison, jail or the workhouse.
- Have unstable housing.
- Use crack cocaine, alcohol.
- Have been drinking before having sex/high on crack when having sex.
- Have traded sex for crack.
- Have known their last sexual partner a week or less.

Individuals were also more likely to report that the following statements were true for them when they became HIV positive.

- Likely that neither partner had condoms.
- Didn't have access to clean needles.
- Likely to have been in prison.
- Likely to have been depressed, lonely, not care about self, and/or have low self-esteem.<sup>147</sup>

### ***Sexual Contact with Men Who Have Sex with Other Men***

Women, and particularly African American women, are at risk of contracting HIV through heterosexual sex with a man who has also engaged in sex with men. There is a much greater stigma associated with being homosexual in the African American community than among Whites, so African American men may choose to lead double lives, which puts themselves and their partners at risk<sup>148</sup>.

Research from the University of California San Francisco shows that many African American women, especially adolescent women, are at high risk for heterosexually acquired HIV. They may not want to or be able to negotiate condom use with their partner. There are several reasons for this: they may think it would interfere with physical and emotional intimacy, imply infidelity by themselves or their partner, or result in physical abuse. Over one third (35%) of AIDS cases reported nationally among African American women in 1998 were classified as "risk not reported or identified." It is thought that a majority of these women were infected through heterosexual sex with IDUs and/or gay or bisexual partners.<sup>149</sup>

### ***Crack Cocaine***

In a study of men and women addicted to crack cocaine, researchers found high rates of HIV infection, particularly among women. Crack smokers were more likely to have had more sexual partners than nonsmokers, and to have had a history of STD infection. The researchers explain that the epidemic of crack is also associated with the exploitation of addicted women, who are often induced to provide sex in exchange for crack, or money to buy crack. Crack-smoking women who exchange sex for money or drugs often lack control over their working conditions and suffer severe degradation. There is often an increased threat of violence in situations where substances are involved if a woman

<sup>145</sup> Center on Addiction and Substance Abuse, 1999

<sup>146</sup> Kroll and Jackson, 2003

<sup>147</sup> Jackson, 2001

<sup>148</sup> Kaiser Family Foundation, 2001

<sup>149</sup> Center for AIDS Prevention Studies, 1999

suggests the use of condoms. Often women are involved in short or long-term relationships with male injecting drug users (IDUs), and often there may be denial about the drug using status of their partners.

**Substance Use Causes Barriers to HIV Prevention Messages and Care**

Not only are chemically dependent women more likely to engage in high-risk behaviors for HIV transmission than women who are not chemically dependent, they are also more likely to encounter barriers to HIV prevention education and health care services. Access to chemical dependency treatment itself is limited, often because treatment centers are unable to serve women with their children.

**Local Studies Identify Barriers**

The Overview of HIV Service Needs of Women and Children in Minnesota, conducted by the Minnesota AIDS Project in 2000, identified the following barriers to reaching chemically dependent women:

- Reluctance of substance abuse treatment programs to address sexual risk behaviors of clients.
- Reluctance of treatment programs to provide safer sex education and materials.
- Counselors are not always comfortable discussing their clients' risk taking behaviors. Many counselors believe they don't receive adequate training.
- State law directs the Minnesota Department of Human Services (DHS) to provide standards for HIV education, but there is no oversight mechanism in place to screen and review HIV information being presented to staff and clients of Minnesota treatment programs.
- Stigma associated with chemical dependency, high-risk sexual behaviors, and HIV/STDs, as well as the denial that is a common element of substance abuse, prevents many substance abusers from acknowledging and addressing their own high-risk behaviors.

- Substance abuse treatment centers do not routinely test patients for HIV/STDs.
- People with a history of IDU who are seeking treatment take on average 19 months longer to enter care than those without a history of IDU.<sup>150</sup>

A survey of chemical health providers conducted by Shanti of Minnesota in 1998 found that:

- Almost half did not offer safer sex instruction to their treatment clients.
- Only 20% provide safer sex materials to clients.
- Only 28% allowed clients to keep condoms during treatment.
- Only 19% informed clients about safer injecting drug using techniques, or how to access sterile needles.
- One third did not believe that discussions around safer injection activities and needle access and exchange were relevant to their work.

**Sexual Abuse**

Because of the relationships between drug and alcohol use, and high-risk sexual behaviors for HIV transmission, it may be helpful to begin to think about causes of drug and alcohol abuse. Several studies have shown a close relationship between sexual abuse, and subsequent drug and alcohol abuse.

As part of a national survey on drinking, 1,099 women were asked about sexual experiences that happened before age 18. Women who reported childhood sexual experiences that were abusive were significantly more likely to report recent alcohol use, intoxication, drinking related problems and alcohol dependence symptoms, lifetime use of prescribed psychoactive drugs and illegal drugs, depression and anxiety, pain

<sup>150</sup> Pearce Ruch, 2000

that prevented intercourse, and consensual sexual intercourse before the age of 15.<sup>151</sup>

The following statistics are taken from a presentation given by Sarah Kashmir at a conference titled AIDS on the Frontline, which was held on March 31, and April 1, 1997 in Orange County, California:

- Women who are survivors of sexual abuse report higher rates of problems with alcohol and drug use than women without a history of sexual abuse.
- Women in drug treatment who reported being survivors of sexual abuse ranged from 34 to 75 percent of total women in the programs.
- Women and men with a history of sexual abuse are 3-9 times more likely to use drugs and 10-15 more times more likely to share syringes (Beth Israel study).
- Women and men with a history of sexual abuse are 3-9 times more likely to participate in sex work (summary of several studies cited in Beth Israel study).
- Substance use can be and is an effective form of pain management for those with a history of trauma. Being high may be the only way for someone with a history of sexual trauma to have sex, or if someone is currently experiencing sexual trauma (either in their personal life or through sex work), substance use may be the only way to get through it.
- For those without access to professional support and prescription medication to address the pain of sexual trauma, drug use is an alternative.

## SEX WORKERS

In 2000-2001 the CCCHAP commissioned needs assessments activities among prostituted women and other sex workers. One assessment was performed among 129 self-identified sex workers recruited from the Red Door Clinic (STD clinic in Hennepin County), as well as from nude modeling clubs, strip dance clubs, and through street

outreach. Seventy-five percent (75%) of this sample was female, 23 percent male, and 3 percent transgender. Racially, the group was diverse, 36 percent African American, 31 percent White, and the remainder identifying as biracial, American Indian, and other racial and ethnic groups.<sup>152</sup>

The second assessment was through face-to-face individual surveys with 145 prostitutes, as well as three focus groups with prostituted women. In this assessment, 65 percent of respondents were African American, and only 7 percent were male.<sup>153</sup>

Despite the differences in race and gender in these two populations, the survey groups were quite similar. Both samples saw extremes in monthly income (ranging from \$0 to \$300,000), and a fair degree of stability in terms of housing (approximately 75 percent in both samples were in stable housing situations). Participants also seemed to have relatively good access to health care - with 73 percent in the Hennepin County sample having health insurance, and between 82 percent and 92 percent of participants in both samples accessing medical care within the previous year.

### **HIV Risk Behaviors**

Unprotected sex with HIV positive individuals: Both samples measured extensive risk behaviors for HIV transmission. In both samples, 11 percent of individuals identified as HIV positive, and in both samples individuals admitted to having sex with individuals they knew to be HIV positive. In the Hennepin County sample, 16 of the sex workers had personal partners who were HIV positive, and 10 (8%) had work partners who they knew were HIV positive. In the Breaking Free sample, 3 individuals admitted to having unprotected intercourse with partners they knew to be HIV infected. In both studies, researchers found that sex workers use condoms inconsistently, and were less likely to use condoms with their personal sexual partners than with their work partners.

<sup>151</sup> Wilsnack et al, *Journal of Studies on Alcohol*, 1997

<sup>152</sup> Persell and Fritz, 2000

<sup>153</sup> Breaking Free, 2000

**High rates of STDs:** Both samples showed high rates of STDs. In the Breaking Free sample, participants averaged one STD in the previous year, and 100 percent of participants had received testing and treatment for an STD during the last year.

**High rates of drug use:** Both samples showed high rates of drug use. In the Hennepin County sample, for example, 33 percent used crack/cocaine daily, and 21 percent had injected drugs at some point in their lives. Seventy-one percent (71%) stated that drugs or alcohol had affected their safe sex practices.

In the Breaking Free sample, 19 percent reported injecting street drugs during the last year, and 25 individuals reported sharing needles while shooting up. In the focus groups performed by Breaking Free, drug use was described as almost universal. Eighty-three percent (83%) reported being high on drugs or alcohol while turning tricks. Sex for drugs was common, and desire for drugs was described as contributing to HIV transmission risk in two ways - firstly, by making women willing to accede to demands for unsafe sex, and secondly, in that being high makes them not think about safer sex.

*"It's the drug, crack, that prevents women from being safer."  
 "That drug has power that makes you do things you would never normally do."  
 "A woman who is prostituting will not use a condom if she is offered more money, especially when she is high and needs more drugs."  
 "There was nothing you could do to stop unsafe behavior with such powerful addiction."*

**Levels of HIV Knowledge**

Levels of HIV knowledge were high in both samples, and in both groups individuals overwhelmingly knew where to access condoms, free HIV and STD testing, and HIV/STD prevention and care services. The majority of individuals in both groups had been tested for HIV/STDs at some time in their lives. Most sex workers received

information about HIV through the health care setting, through brochures and TV and from friends and family, and also felt that these were the best ways in which to reach them. In the Hennepin County sample, 90 percent of sex workers said that prevention messages did influence them to practice or maintain safer sexual behaviors, but that they needed daily messages or at least occasional messages.

There is obviously, therefore, a disconnect between the HIV/STD knowledge and access to services that sex workers have, and their overall continued engagement in high-risk behaviors. Participants suggested that barriers to safer sex activities include: 1) the influence of drugs and money; 2) messages have been heard too many times; 3) messages are provided in the wrong places and at the wrong times; 4) lack of transportation; 5) lack of time; 6) lack of incentives; and 6) fears about HIV testing and/or feeling embarrassed or uncomfortable.

Recommendations for HIV prevention interventions within the population of sex workers included:

- Targeted street outreach utilizing appropriately trained former prostitutes or survivors of prostitution. Women felt a peer who is also HIV positive would be most effective. Provide outreach during late afternoon, evening, and early morning.
- Mobile outreach van, providing HIV testing and counseling that makes scheduled stops at outreach sites to distribute condoms, prevention messages, as well as clothes, food, etc.
- Group HIV prevention discussions at hotels and strip clubs, including HIV testing and education.
- Condom distribution to sex workers on the streets, in businesses, or any other location they frequent.
- Work with sex workers to find prevention methods that are compatible with their lifestyle.

- Address sexual risk behaviors with personal partners.
- Media – billboards, posters, flyers in strategic locations.
- Drop-in center in the prostitution zone.

### **The Johns Study**

The Breaking Free study also interviewed 117 johns, or men who use prostitutes. They were predominantly White, employed, higher income and had more stable living circumstances than the prostituted individuals.

The johns averaged two unprotected sexual encounters per week. Most carried condoms on them more than half the time. Sixty percent (60%) reported never having oral sex without a condom, and up to 92 percent reported never having insertive anal intercourse without a condom. Only 32 percent reported being high on drugs or alcohol when having sex with a prostitute. Only 5.5 percent reported injecting street drugs during the last year. Three johns reported unprotected intercourse with a known HIV positive individual. Reasons given for soliciting prostitutes included "just for fun," "for sexual variety," "sexual addiction," and "not in a relationship."

The johns recommended that HIV prevention messages reach them through prevention education at john's schools (65%), through churches (45%), TV/radio (41%), and outreach (41%).

### **HEALTH CARE PROVIDERS' RESPONSE TO HIV**

In 1996, members of the Women and Families Community Advisory Workgroup performed an informal survey of some major health care providers for women in the metro area. They asked some providers whether they provided HIV/AIDS prevention education to women, whether they performed risk assessments, and whether pre- and post-test counseling was provided.

In summary, community health and family planning clinics were most cooperative, and provided minimal risk assessments and staff education, but often depended on "experts" to

perform the work (for example, referring out to social workers from an HIV clinic to perform post-test counseling). In the opinion of the workgroup, provision for HIV/AIDS prevention at private physicians and women health care clinics in public hospitals ranged from inconsistent to appalling. The members encountered resistance or refusal to answer questions, no education and prevention in place, no risk screening, nor pre- or post-test counseling, and some clinics informed their clients of HIV test results by telephone.

The workgroup noted that many of the prevention efforts that have taken place in Minnesota have not targeted women currently being seen in area clinics. Education and prevention about HIV is not happening in women's health care, but there is a tradition of treatment and not of prevention in medical practice. Most efforts at a national level are geared toward identifying HIV positive women and children and very little toward education and prevention.

### **BARRIERS WOMEN EXPERIENCE IN ACCESS TO CARE AND TESTING**

Poverty, substance use, and sexual abuse create barriers that make it difficult for women to access care and/or HIV testing. If a woman is able to access care, or testing, there are many additional barriers. There are barriers presented by the system. For instance, there are assumptions that the medical system has about females, chemical use and HIV status. Institutional barriers exist at testing sites evidenced by the length of wait to get an appointment to be tested, and the length of wait to get results, especially for the transient populations, although this is changing in sites where OraQuick tests are offered, facilitating the delivery of same day results. Location of testing sites and hours of operation also present barriers.

There are also barriers due to assumptions on the part of the women of how the system works. A woman may fail to request an HIV test, under the assumption that STD testing includes HIV testing. A woman may also assume that if she is not notified of HIV test results at an STD exam, the results are HIV

negative. Women have voiced concerns around confidentiality.

## **OROMO AND SOMALI COMMUNITIES**

In 2002, Rainbow Research, Inc. conducted an assessment of the level of understanding and cultural attitudes towards HIV/AIDS among the Oromo and Somali communities in Minnesota.<sup>154</sup> They conducted four simulation focus groups and four actual focus groups with 40 total participants: two groups with Oromo women, two with Oromo men, two with Somali women, and two with Somali men. Facilitators and record keepers were of the same gender and ethnic group as the participants.

Data from both the simulation and actual focus groups were included in the report. From the report, it was not possible to separate out the responses of the women, so the information reported here includes findings from focus groups of both men and women.

The International Institute of Minnesota reviewed records of refugees who arrived in Minnesota between 1999 and 2002 and were between the ages of 19 and 35. Participants were chosen from this roster based on their availability and their comfort participating in focus groups about HIV and AIDS.

The focus groups were designed to gather information on the following five topics:

- Understanding of HIV/AIDS and how it is contracted
- How the Oromo and Somali communities get messages about HIV/AIDS, and the most effective medium and person to deliver the messages
- Access to and understanding of HIV/AIDS messages
- Appropriateness and relevance of the messages to the Somali and Oromo cultures/communities
- Awareness of HIV/AIDS services to the Somali and Oromo populations in the Twin Cities

## ***Understanding of HIV and AIDS***

The participants acknowledged that they did not know much about HIV/AIDS, although they had heard about it. They noted that both the Oromo and Somali communities are not comfortable talking about HIV. They use phrases such as, “the dangerous disease,” “the disease,” “the slimming disease,” and “the disease with no medicine” to refer to HIV/AIDS. The Somali community in particular felt that people are not comfortable talking about HIV because it is associated with sexually-related issues such as immorality, unacceptable premarital sex, dishonesty of a spouse, and adultery. If they acknowledge that HIV and AIDS exists in their culture, they are also admitting that there are people who are not living according to Islam.

Participants stated that HIV is transmitted by sex, blood transfusion, contaminated blood, touching, sharing toothbrushes, and living with someone who has HIV or AIDS. Some of the Somali participants felt that the disease is contracted according to God’s will.

Some of the participants said that they didn’t know how to protect themselves. The most common responses were: spouses need to be faithful, abstinence until marriage, and use of condoms. Other responses included being careful about sharing combs and toothbrushes. Some of the Somali participants felt they could protect themselves by following God’s rules.

## ***Communication, Access, and Understanding of HIV/AIDS Messages***

Most participants first heard about HIV/AIDS from the radio or television. Others had read about it in the newspaper, or seen billboards in Kenya, Somalia or Oromia. They remember the messages as being frightening, because they said there was no cure and they should be careful about what they eat or share. They felt the messages were confusing and stressed the importance of communicating factual statements.

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<sup>154</sup> Othieno and Smith, 2003

### ***Appropriateness and Relevance of HIV/AIDS Messages***

All of the participants felt it is important for everyone to know about HIV/AIDS. They agreed that the focus of prevention messages should be on the young people who are not as religious as other members of these communities and are sexually active.

The Somali felt that religious leaders, Sheikh and Imam, would be the most effective in communicating information about HIV/AIDS since they are well respected. The Somali also suggested that women would be effective, since they are considered the best teachers and messages relayed by them are more likely to be passed on to others. The Somali participants also mentioned that messages should be culturally appropriate and tied to religion in the sense that religious morals such as remaining with one partner and abstinence can assist in prevention efforts.

The participants agreed that women should educate women, and that youth would benefit from peer training. Using the arts, such as music and drama by popular Oromo and Somali musicians and actors, was recommended as a strategy for communicating informational and prevention messages. Group discussions and radio program in their own languages were other suggestions. Open forums, with speakers that include medical professionals and people who are living with HIV and AIDS, would be very effective.

All of the participants felt that messages should relay that HIV/AIDS knows no boundaries, and that everyone, Muslim or not, can become infected. They should be positive instead of instilling fear.

### ***Awareness of HIV/AIDS Services***

The participants were not aware of any HIV/AIDS services available to the Oromo and Somali communities in the Twin Cities metro area. They noted again that people are not comfortable talking about HIV, although if the communities were more aware of the disease, they would be more likely to talk about it. The Somali participants agreed that it would be difficult to have a discussion in their community about HIV/AIDS because of the close tie to Islam.

Summary of prevention needs in the Oromo and Somali communities:

- Increased knowledge of HIV, how it is transmitted, and how to protect oneself from becoming infected
- Increased communication about HIV
- Culturally appropriate messages

Suggested strategies for HIV prevention:

- Use religious leaders to provide information about HIV in the Somali community
- Women should educate women
- Peer training for youth
- Use the arts, such as music and drama, to communicate information
- Group discussions and radio programs in their own languages
- Forums with medical professionals and people living with HIV

## **AFRICAN AMERICAN/AFRICAN WOMEN**

In 2000, the CCCHAP commissioned a study on the knowledge, behavior and attitudes of Black women in Minnesota.<sup>155</sup> A total of 247 women were interviewed, with 85 percent self-identifying as African American, 7 percent as African, and 5 percent as biracial. Three percent (3%) also identified as Latina. Seventeen percent (17%) of the sample were living with HIV/AIDS.

The average age of respondents was 36, with a quarter of interviewees under the age of 25. Almost all lived in the 11 county metropolitan area.

### ***Sexual Risk Behavior***

One of every five women reported going to other cities just to meet men, most commonly to Chicago and Atlanta. Nearly all of these women reported engaging in sexual intercourse with the men in those cities.

Twenty-five percent (25%) of women first had sex when they were under the age of 14. Fifty percent (50%) were 16 years of age or younger.

Half of the women reported that they regularly carry condoms, and 40 percent had condoms with them at the time of the interview. Only 27 percent of women reported using a condom all of the time with their steady partner. Thirty-eight percent (38%) reported using a condom when having sex with an unsteady partner. Fifty percent (50%) of the women engaged in unprotected vaginal intercourse in the previous two months, while 11 percent of women reported unprotected anal intercourse during the same time period. The most common reasons giving for engaging in unprotected sex were: being with their main partner, believing that their partner was only engaging in unsafe sex with them, being in love, and not having a condom.

Only 11 percent of the respondents reported having sex with a bisexual male in the last five years, and 44 percent of the women stated they could tell if a man was bisexual. Fifteen percent (15%) reported having sex with an

injecting drug user in the last five years, and 50 percent felt that they could tell if a man injects drugs or not.

Thirty-five percent (35%) did not know the HIV status of their last sexual partner. Nine percent (9%) knew that their last partner was HIV positive, and 50 percent stated that their last partner was HIV negative.

Thirty percent (30%) reported knowing their last three sexual partners a week or less before having sex with them. A little more than 15 percent had sex on the same day they met their partners; however, this is about the same percentage of women who self-reported as prostitutes.

### ***Sexually Transmitted Diseases***

Half of the sample reported having been tested 2 or more times for an STD in the last ten years, with 37 percent being diagnosed with one or more STDs during that same time period. One quarter of the interviewees reported having an STD two or more times. Chlamydia and gonorrhea were the most common STDs.

Nearly a third (32%) had asked a partner at least once to get an STD test before having sex with him. Twenty-four percent (24%) of these women waited for the results to come back before having sex. An equal proportion did not wait for the results, and 16 percent of those who did not wait engaged in unprotected intercourse with their partner.

### ***Substance Use***

Thirty-four percent (34%) of women reported using alcohol weekly or daily. Twenty-one percent used marijuana daily, and 29 percent used crack cocaine in the last six months. Nine percent (9%) had injected one or more drugs in the previous six months, and all of these women reported participating in a needle exchange program. One third of the women felt that alcohol or drug use affected their safer sex practices.

<sup>155</sup> Jackson, 2000

**Physical and Sexual Abuse**

Approximately one third of the respondents had been physically abused by a male partner. Seven percent (7%) had stayed in a domestic violence shelter. Eleven percent of women reported having been sexually abused by a partner. Forty percent (40%) stated that at least once or more, they had not used a condom because their partner was abusive.

**Perception of HIV Risk**

Eighty-one percent (81%) reported having at least one HIV test. Twenty-six percent (26%) thought that it was likely or very likely that they were HIV positive, while 21 percent thought it was likely they would get HIV in the future. Half of the women (51%) said that they think about HIV almost all of the time or a lot of the time.

**Prevention Services**

The women were asked about prevention services and what would work best for them.

Summary of recommendations regarding prevention services:

- 50% said they needed to be reached face to face with prevention messages.
- 40 percent reported needing to be reached daily or weekly.
- 58% said that the gender, race, or age of the person giving the prevention message did not matter.
- 92% said the prevention media ads are important.
- The author of the study (Juan Jackson) recommends particularly targeting prostitutes, women who abuse alcohol/drugs, and younger women.

Most useful sources of information in descending order:

- Printed materials
- Outreach workers
- AIDS service organizations
- Physicians/nurses (77% were comfortable speaking to a physician about HIV/STDs; however, 50 percent said their doctor rarely or never asks about them.)

**LATINO COMMUNITY**

**Survey of Community**

In 2003, a community advisory group assisted the CCCHAP and MDH by developing and conducting a survey in the Latino community to learn more about access to HIV information, barriers to HIV testing, and what could be done to make it easier for Latinos to get tested. The survey was conducted at the Cinco de Mayo celebration in St. Paul, and was subsequently distributed by providers to their clients.

The needs assessment project was focused on Latino men because of the concerning epidemiological trends that were identified among men. In 2002, Latino men had a higher proportion of AIDS cases (49%) compared to all males (42%). Mexican-born men had an even higher proportion of AIDS cases (62%). Latino men also had a higher proportion of living HIV/AIDS cases that were less than 30 years of age (14%) than the total male population (6%). Additionally, from 2000 through 2002, Latino men experienced a higher proportion of new infections that were AIDS at first diagnosis (47%) compared with all men (34%). These trends were not observed among Latina women. The survey, however, was completed by both men and women.

Because there was a concern on the part of the community advisory committee that respondents would not truthfully answer questions related to sexual orientation, there were no questions included about sexual orientation or gender of sexual partners.

The survey was available in English and Spanish. The great majority were completed in Spanish. Of the 119 surveys completed, 54 percent of respondents were men and 44 percent were women. One person self-identified as transgender, and two people did not answer the question. The majority of respondents (71%) were between 20 and 39 years old. Almost half (49%) completed less than 12 years of education, while 19 percent completed 12 years, and 36 percent completed more. Seventy percent (70%) lived

in Minneapolis or St. Paul, 10 percent were from the suburban metro area, and 12 percent were from Greater Minnesota.

Questions related to country of birth and time living in Minnesota were added after the Cinco de Mayo celebration, resulting in 71 surveys with responses to those questions. The majority of these 71 respondents (63%) were born in Mexico, followed by persons born in the United States (11%). Almost half (49%) had lived in Minnesota between one and five years, with another 34 percent living here between five and ten years. Thirteen percent (13%) had lived in Minnesota for less than one year.

**Access to Information**

Overall, 61 percent of respondents received information about HIV/AIDS in the past year. Seventy-nine percent (79%) of the women received information compared to 48 percent of the men. Only 16 percent of women felt that it was difficult to get information about HIV/AIDS compared to 28 percent of men. The most common reason given across genders for the difficulty was not knowing where to look for information.

The proportion of all respondents who received information specifically about testing for HIV in the past year was somewhat less (53%). However, women again were more likely to have received the information (63% of women) compared to men (48% of men).

Respondents were asked to identify 1) the most common sources of information about HIV/AIDS, 2) the best ways of getting information about HIV/AIDS, and 3) the most common sources of information about HIV testing. Four sources of information were listed among the top five in response to all three questions:

- Clinic/hospital
- Brochure in Spanish
- Outreach worker (Spanish-speaking)
- TV in Spanish

Spanish-speaking doctor or nurse was mentioned among the top five answers in response to two out of the three questions.

For women, clinic/hospital, brochure in Spanish, and Spanish-speaking outreach workers were included in the top five responses to all three questions. Spanish-speaking doctor/nurse was mentioned among the top five in response to two of the three questions.

For men, TV in Spanish and Spanish-speaking outreach workers were mentioned among the top 5 sources of information in response to all three questions. Clinic/hospital was mentioned in response to two of the three questions.

**Barriers to Testing**

Fifty-one percent (51%) of all participants had never been tested for HIV. Thirty percent (30%) had ever tested, and 18 percent of respondents did not answer the question. Women were much more likely to have been tested (51% of women) compared to men (25% of men).

Participants were asked to identify what would prevent them from testing for HIV. They were allowed to choose as many options as applied. The most common reasons given by men and women were similar, although the frequency with which the answers were chosen varied by gender. The most common responses are summarized in the following table:

Reason	Women		Men	
	#	%	#	%
Don't think I'm at risk	12	24	10	17
I feel healthy	11	22	10	17
Don't have money to pay for test	7	14	9	16
Don't know where to go	6	12	20	34
Don't have transportation	6	12	9	16
Don't know what I would do if I had HIV	6	12	9	16

The second most common response given by men (22%) as a barrier to testing was not knowing of a Spanish-speaking place to get

tested. This reason did not appear among the most common responses given by women.

***What Would Make it Easier to Test***

Responses regarding what would make it easier to get tested were related to three basic concerns: confidentiality, access to testing, and information.

Confidentiality

- Knowing that nobody will recognize me when I go to get tested (29%)
- Having a guarantee that my test results will not be reported to anybody (25%)
- Having a guarantee that my test results will not be reported to the INS (15%)

Access to Testing

- Information about where I can get a free test (28%)
- Information in Spanish about Spanish-speaking places I can get tested (23%)
- Information about where I can get tested (22%)

Information

- Knowing more about HIV/AIDS (19%)
- Information about where I can go for help if I have HIV/AIDS (18%)
- Information about how the test is done (18%)
- Having my doctor or nurse talk to me about getting tested (18%)

Additionally, 13 percent of all respondents stated that nothing would make it easier to test since they did not think it was difficult. Three percent (3%) said that nothing would make it easier to test because they did not want to get tested.

***Community Forums***

Five community forums with 41 total participants were also held as part of the needs assessment project in the Latino community. Each forum was targeted to a different audience: young men ages 17 – 25 (Mankato), women (Minneapolis), HIV positive men (Minneapolis), men who have sex with men (Minneapolis), and male migrant farm workers (Montgomery).

The purpose of the community forums was to gather further information regarding knowledge of STDs and HIV, barriers to testing, and how to make testing easier. The forums were focused on gathering information from Latino men. The advisory group recommended holding a forum with women because they would be able to provide valuable insight into the men in their lives, as well as to raise awareness of the issue since it also directly impacts women.

***Knowledge of HIV and STDs***

Across the various groups, the community forum participants were able to provide some accurate information about the various types of diseases, how they are transmitted, symptoms and effects of HIV and STDs, and treatment. Some misconceptions also existed in relation to how HIV can be transmitted, that only specific groups (gays and injection drug users) can get the disease, and that married people cannot.

Throughout the discussions, all groups mentioned the lack of education about HIV, STDs and sexuality in Latin American schools, as well as the lack of communication related to these issues in the general Latino community.

***Barriers to Testing***

There were a number of cultural themes mentioned as barriers to testing:

- Fear of rejection by family and friends.
- Machismo.
- *Pena* (being ashamed or embarrassed) to talk about HIV/AIDS, STDs, and sex and sexuality.
- Religious beliefs.
- Pattern of seeking medical care only when sick.
- Stigma associated with HIV/AIDS.

There were also a number of general and personal themes that emerged as barriers to testing:

- Lack of information about HIV/AIDS, testing and testing locations, treatment options, and where to go for help.

- Feeling healthy.
- Not engaging in risky behaviors such as injecting drugs or having sex with multiple partners.
- It is better not to know if one is positive.
- Fear of screening tests/blood tests.
- Belief that nothing can be done if one tests positive (not aware of treatment advances, do not have health insurance, do not have legal immigration status).
- Lack of confidentiality (do not want to provide name, address and social security number; do not want to be recognized at clinic; fear that friends, family and government will learn the test results).
- Lack of time to get tested.

Community forum participants provided the following recommendations for how to increase testing among Latino men:

- Address cultural issues.
- Improve communication within Latino families about sex and sexuality, HIV, oral sex.
- Provide more communication and education in Spanish through media targeting the Latino community.
- Focus education on risk behaviors and not on sexual orientation.
- Fund more health educators to provide information and services in the evening.
- Provide mobile testing in places such as laundry mats, mobile clinics, and soccer games.
- Normalize testing so that it is not seen as something to be afraid of.
- Provide free or reduced cost tests, or pay people to get tested.
- Provide anonymous testing.
- Provide testing at work.
- Provide self-testing kits online.
- Provide test results more quickly with the option to receive results over the phone.
- Provide testing as the “cover” or entrance fee to dances and/or clubs.

### **Provider Forum**

The final step in the Latino needs assessment project was to hold a forum with providers serving the community. The findings from the survey and community forums were shared, and the providers were asked for their recommendations for how to increase testing in the Latino community, and particularly among men.

The providers placed the most emphasis on having enough human resources to do prevention work. They identified the need for in-depth outreach interventions that allow the workers the opportunity to build a trusting relationship with the clients, and the need for workers to be available in the evening. They felt that it was important to include testing as a component of outreach programs.

The providers did not feel that funds should be spent on media efforts to encourage testing without having an infrastructure in place to offer culturally and linguistically appropriate testing services. They did encourage the MDH and providers serving the Latino community to collaborate with community media outlets in order to get free space/time to provide information about HIV/AIDS.

Finally, the providers identified the need to use local and national capacity building providers to increase the capacity of social service and medical providers to: 1) serve the Latino community; 2) conduct effective risk assessments (particularly with MSM); and 3) to access other resources.

## **NATIVE AMERICAN COMMUNITY**

There is a lack of published information related to the HIV prevention needs of Native Americans in general, and Native American women in particular.

American Indian women are affected by the same issues experienced by the general Native American population: high rates of poverty, STDs and other health problems, as well as alcohol and drug use. Nationwide, death rates among American Indians and Alaska Natives due to alcoholism are seven times higher than in the general population.<sup>156</sup>

### **Alcohol Use**

A study of enrolled members of four tribes on reservations in the Northern Plains and Rocky Mountain states found that most drinkers in the study were binge drinkers.<sup>157</sup> Binge drinking in social groups and gatherings is common, particularly among Plains Indians, on weekends and special occasions.

Women begin regular drinking at a slightly later age (18) than men (17). In the year prior to the study, 60 percent of women and 71 percent of men had consumed at least one drink, which is very close to male and female consumption rates of the overall U.S. population.

The average numbers of drinking days per month was 2.1 for women and 4.7 for males. On the days when drinking occurs, women consume an average of 3.1 drinks, while men have an average of 5.7. People under the age of 40 consume more drinks, with men having an average of 9 to 10 drinks per drinking day, and women having 5 to 6 drinks.

The authors of this study note that risk factors present in particular tribes or regions cannot be generalized to other Native Americans or Alaska Natives (AI/AN).

## **Sexual Abuse**

The National Center on Child Abuse and Neglect reported that 80 percent of Native American girls had experienced sexual abuse, compared to 23 percent for Native American boys.<sup>158</sup> Another study of 13, 923 American Indian girls in grades 7 – 12, mostly residing on reservations, found that 19 percent reported a history of childhood sexual abuse and 17 percent had experienced physical abuse.<sup>159</sup>

### **Other Co-factors Affecting HIV Risk**

A summary document created by the Health Resources and Services Administration (HRSA) and Management Sciences for Health identifies a number of co-factors that can influence HIV risk in AI/AN communities.<sup>160</sup>

Confidentiality can be difficult to maintain, particularly in rural areas where relatives or friends may be employed at the local clinic. This can be a barrier for persons who wish to seek counseling and testing, treatment for alcohol or drug use, or buy condoms at the local store.

There are a number of issues related to health care that affect the Native American community. All AI/AN who are members of federally recognized tribes are eligible for health care through Indian Health Service (IHS). Even so, 44 percent of AI/AN in the country do not have access to IHS. For those that do have access, services are provided at no cost as funds are available. However, this means that sometimes services must be rationed. As a result, patients with less urgent medical issues often have their care postponed or never provided. There is also a shortage of health care professionals working in Native American communities, with fewer than 90 doctors for every 100,000 AI/AN, compared to 229 per 100,000 nationwide.

Of the more than 2 million Native Americans and Alaska Natives living in the United States, 1.3 million live in urban areas. Indians living in urban areas share the same health

<sup>156</sup> Indian Health Services, 2001

<sup>157</sup> May and Gossage, 2001

<sup>158</sup> National Center on Child Abuse and Neglect, 1999

<sup>159</sup> Pharris et al, *Journal of Adolescent Health*, 1997

<sup>160</sup> Management Sciences for Health and HRSA, 2003

problems as the general Native American community, but may face more difficulties emotionally due to lack of family and traditional cultural support. Many AI/AN who live on reservations or in rural areas migrate daily, weekly or several times a year back and forth to urban areas. This may mean that HIV is being carried from urban areas to reservations, or vice versa.

### **Native American Women in Urban Areas**

A mail survey was conducted of 155 Native American women who were members of an American Indian community center in the New York metropolitan area.<sup>161</sup> The women ranged in age from 18 to 87. The individual blood quantum across all tribes was: 1-25% (21%), 26-50% (40%), 51-75% (16%), 76-99% (12%), and 100% (12%).

Thirteen percent (13%) of the sample had been adopted or in foster care, with 95 percent of these being with non-Native families. Six percent (6%) had attended an American Indian boarding school, and 11 percent had lived on a reservation or tribal lands within the last year.

### **Sexual and Physical Abuse**

Twenty percent (20%) of the women reported being abused sexually by a sexual partner, 34 percent by a non-partner, and 15 percent by both. Thirty-one percent (31%) reported any physical abuse during their lifetime by a sexual partner, 20 percent by a non-partner, and 14 percent by both. When combining type of abuse, over half (52%) had experienced some type of abuse in their life.

### **Substance Use**

Alcohol use was more common among this sample than drug use. Sixty-two percent (62%) reported drinking alcohol in the last year. However, 70 percent reported never having more six or more drinks at one time. Only 2 percent reported heavy drinking once a month, almost daily or daily. Only 1 percent had injected an illegal drug during the last year, while 13 percent had used some other illegal drug.

### **HIV Knowledge, Testing, and Status**

The women demonstrated a high level of knowledge about HIV. They were also supportive of providing safer sex information to Native Americans and teaching youth how to use condoms. A little more than half (58%) of the sample had been tested for HIV, but only 7 percent said they did not know their HIV status.

### **Sexual Risk Behaviors**

Of the full sample, 105 women reported being sexually active during the previous year. Most had less than four partners, and 10 percent had sex with a woman.

Sixty percent (60%) of the total sample reported engaging in vaginal intercourse. Of these, 46 percent never used condoms, while 24 percent reported always using them. Eighteen percent (18%) of the total sample reported engaging in anal intercourse. Of these women, 82 percent reported never using a condom, while only 11 percent always used them. Forty-eight percent (48%) of the total sample engaged in unprotected vaginal or anal intercourse during the last twelve months.

The study found an association between having a higher blood quantum and engaging in fewer lifetime high-risk sexual behaviors. The authors suspect that higher blood quantum may indicate a greater level of involvement in and identification with the Native American community, which may in turn be a protective factor against HIV risk behavior.

Any prevention efforts targeting the Native American community must be culturally appropriate, and take into consideration the unique history and trauma of this population, as well as its diversity in terms of language, culture, and urban, rural or reservation residence.

<sup>161</sup> Simoni et al, *AIDS Behavior*, 2004

## ASIAN PACIFIC ISLANDER COMMUNITY

There is also a lack of published research related to the HIV prevention needs of Asian Pacific Islander (API) women.

Management Sciences for Health and HRSA created a document that summarizes many of the issues facing the API community in general, and women specifically<sup>162</sup>:

- Immigration laws exclude most HIV positive individuals from obtaining permanent status, which may scare API immigrants away from counseling and testing services.
- The disqualification of many immigrants from Medicaid, Social Security, and other public benefits prevents some APIs from receiving health care.
- Because the incidence and prevalence of HIV in the general API community is low, people may believe that they are not at risk.
- API communities may view HIV/AIDS as a disease that only affects Westerners.
- Many APIs associate shame and stigma with issues related to sex, sexuality, and drug use. Many are unaware of HIV risk factors and are uncomfortable talking about how to protect themselves.
- An alarming number of API women (the highest percentage of all racial or ethnic groups) could not identify what puts them at risk for HIV infection.
- Some immigrant API women who work in massage parlors engage in activities that put them at risk for HIV. For many of these women, immediate survival needs take precedence over protecting themselves from HIV.

A qualitative study of risk in Asian Pacific Islander women in California identified three cultural norms/values that directly impact API women's ability to engage in an open conversation with their partners about HIV and/or to request the use of a condom:

- Discomfort with open discussion about issues related to sex and sexuality.
- Priority placed upon making others feel comfortable.
- Traditional romantic ideal.<sup>163</sup>

The study found that instead of directly talking with their partner about risk, API women tend to make inferential assessments of their partners' risk, which may lead to a false sense of control and safety.

Recommendations for HIV prevention efforts in API communities:

- It is important to implement interventions that incorporate the entire family or community, when possible, instead of only focusing on individual change.
- Peer based programs, and interventions that include the development of nonverbal and other indirect communication skills, are more culturally appropriate.
- Education materials that describe how HIV is transmitted, as well as emphasize the gradual increase in HIV in the API population [nationally].
- Providers should establish a relationship with a client/patient before asking intimate questions related to sexual orientation, sexual behavior, contraception, and family planning.<sup>164</sup>

<sup>162</sup> Management Sciences for Health and HRSA, 2003

<sup>163</sup> Chin D, *Social Science and Medicine*, 1999

<sup>164</sup> Management Sciences for Health and HRSA, 2003

## **SUMMARY**

### ***HIV prevention needs of heterosexual women:***

- Consistent provision by health care providers of HIV/STD testing, risk assessment, and prevention education.
- Services to increase assertiveness and negotiation skills for women of poverty.
- Transportation and child care for women of poverty attempting to access HIV/STD prevention is provided.
- Increased outreach, which is shown to be effective in reducing HIV risk behaviors of IDUs.
- Harm reduction approach to reach substance abusers that are unwilling or unable to seek chemical dependency treatment.
- Increase access to HIV testing (and hepatitis B, C, and other STDs) within substance abuse treatment centers.
- Enhance consumer empowerment services to address issues of stigma and denial.
- Improve referral to HIV prevention case management and to early intervention for HIV positive IDUs.
- Increase capacity of all programs and services that interact with substance abusers (substance abuse treatment, primary and emergency medical care, STD test sites, community outreach, corrections, etc.) to conduct HIV risk assessments, provide basic HIV education, and provide access to HIV testing.
- Increase capacity of substance abuse treatment programs to provide HIV prevention education.
- Continue work with DHS to ensure that HIV and STD education and training in chemical dependency programs is current and consistent.
- Address internalized and societal homophobia. The stigma attached to being gay or bisexual can result in low self-esteem, and leads to some men remaining closeted and continuing to engage in high-risk heterosexual sex.
- Provide culturally and linguistically appropriate HIV prevention messages and interventions within the African, Latino, Native American, and Asian/Pacific Islander communities.
- In the Oromo and Somali communities, use women and religious leaders to provide education about HIV and AIDS.
- Use cultural events, drama, and music to communicate HIV messages to the Somali and Oromo communities.
- Media efforts in Spanish are needed in the Latino community to raise awareness of HIV.
- Provide anonymous, mobile testing in the Latino community.
- Increased research of HIV prevention needs in the Native American community in general, and among women specifically.
- Increased research of HIV prevention needs of Asian/Pacific Islander women.
- Educational materials in a variety of API languages that describe HIV and how it is transmitted.

## Injecting Drug Users

*Subpopulations include: African American Male IDUs, African American Female IDUs, Male IDUs All Races, Female IDUs All Races, Young IDUs, MSM/IDU*

In Minnesota, the impact of injecting drug use on HIV infection rates in women is of particular concern. Thirty-seven percent (37%) of all female AIDS cases and 25 percent of all HIV cases are the result of injection drug use or heterosexual sex with an IDU.

Overall, however, new cases of HIV infection through injecting drug use have been relatively low in Minnesota over the last decade. In 2003, only 9 new cases in male IDUs and 2 new cases in female IDUs were diagnosed. There were an additional 10 new cases among MSM/IDU. Planning for needle exchange in Minnesota was begun in 1993, with the very first needle exchange program being implemented in 1995. Other needle exchange programs soon followed, and several are still in existence today.

### LOCAL IDUS IDENTIFY FACTORS THAT IMPACT THEIR RISK FOR HIV

In 2000, two community forums were held with 30 injection drug users at Access Works in order to gather input on their needs, as well as their thoughts about effective interventions with this population.

#### **Risk Factors**

It is not only the risky sexual activity and sharing of needles that puts this community at risk; poverty and homelessness go hand in hand with drug addiction, leaving individuals (especially women) open to sexual exploitation, including the imperative to engage in prostitution to survive.

#### **Knowledge of HIV and Risk**

Participants emphasized that HIV prevention was important to them, and many talked about how fortunate they felt to have escaped infection before information was available to them about how to remain safe from HIV.

They felt, however, that access to information about cleaning of needles is limited. Some believe that exchanging parts of needles, or cookers is safe. Some believe that if they cannot see blood in the works, the works are clean. However, participants also noted that sharing of needles is in no way a universal behavior within the community. Some feel that if they ask to share needles they must also share their drugs. More individuals seem to be going out of their way to clean their needles.

#### **Syringe Access**

Participants emphasized that bleach kits and condoms are not readily available to this community. Since 1999, it has been legal in Minnesota to purchase up to 10 syringes without a prescription. Paraphernalia laws have also been changed to support this legislation, so that carrying of unused needles is no longer illegal.

Many participants viewed this syringe access initiative as a very positive step, but they continued to express fear of being apprehended, even with clean needles. Many users talked about the need to expand needle exchange programs, and the need for documentation that prohibits the prosecution of people trying to access needle exchange programs while carrying used syringes. *"People should not be prosecuted for doing the right thing!"*

However, while increasing availability of clean syringes promotes HIV risk reduction among injecting drug users, the continued lack of readily apparent and available syringe disposal methods weakens the effectiveness of this intervention.

#### **Harm Reduction**

Participants echoed Ernie Drucker (Harm Reduction: A Public Health Strategy), "Although addiction and prevention interventions such as needle exchange programs play a crucial role in reducing harms associated with drug use under prohibitory regimes, changes in drug policy per se offer the best chance for primary

prevention. By reducing the association of drug use with criminal prosecution - a system that drives drug use and the drug user to the most dangerous margins of society - the reform of punitive legal policies can produce clear benefits in the realm of public health and social order."

### ***Perception of Social Services***

In addition, a proportion of participants stated they would not access social service agencies due to the belief that social service agencies are a part of a genocidal conspiracy on the part of the government to wipe out communities of color, low-income communities, and drug users. This is not so far-fetched a belief when one considers that many addicted women who are pregnant will not seek prenatal care or HIV testing because of the fear that child protection will take their children from them. Participants reported that medical providers exhibit prejudice and racism by more frequently ordering drug tests for women of color.

### ***Societal Denial***

While denial may be a barrier to HIV prevention education within the IDU community, denial within society at large around the prevalence and impact of substance abuse was also identified as a barrier to reducing transmission in the drug using community. As a result, this community found the lack of basic services like childcare, transportation, and health insurance to be barriers to HIV prevention.

## **NATIONAL RESEARCH**

Project Access was a qualitative study conducted in three San Francisco Bay Area counties for the purpose of understanding barriers to counseling and testing, and personal prevention strategies among IDUs.<sup>165</sup>

The study involved 187 low income IDUs, with men and women similarly represented. The majority of the sample (62%) identified as African American, 31 percent identified as White, 11 percent as Latino, and 7 percent as

Native American (some participants identified as belonging to more than one race/ethnic group). Just over one fourth of the sample was homeless at the time of the study.

The most common sources of income among participants were a job or business (58%), friends or family (54%), and governmental assistance programs (53%). Drug-related income and panhandling were both mentioned by 28 percent of the sample. Shoplifting and sex work were each mentioned by more than 10 percent of the participants. Alcohol was the most commonly used substance, reported by 42 percent of the participants. Thirty-three percent (33%) of the sample reported that they used crack cocaine, and 33 percent reported using heroine.

### ***Risk behaviors***

Seventy-two percent (72%) of the sample was sexually active, with no difference being seen between men and women. However, women tended to have more sex partners. Twenty-five percent (25%) of women reported trading sex.

Among the entire sample, unprotected intercourse was a greater risk than injection related behaviors. More than half (58%) reported engaging in risky sexual behavior, while 28% stated that they had engaged in risky injecting behaviors, such as sharing needles, cookers, cottons and/or water; and/or frontloading; backloading; piggy-backing; or using more than one syringe to mix or divide drugs. However, the participants felt that their greatest risk was drug use.

### ***Utilization of Counseling and Testing***

The number of HIV tests throughout a lifetime varied from 40 tests to zero. The average number was 4 tests. There was no difference in the frequency of testing based on risk behavior. The participants that had tested 6 or more times included people with both high and low behavioral risks. Similarly, the low frequency testers also included both people at high and low risk of HIV.

Women were more likely to test out of concern for family or significant others, while

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<sup>165</sup> UCSF AIDS Research Institute, 2001

men were more likely to be motivated to test for incentives or compensation.

The participants saw HIV as being random and unpredictable because although many IDUs have similar risk behaviors, only some become infected. In addition, the participants believed that HIV can be dormant and remain undetectable to tests for up to 10 years, so that it may just appear suddenly, after previous negative test results. Routine HIV testing was accepted as a normal part of self-care, regardless of current risk behavior.

### **Perceptions of HIV**

Low income African American IDUs saw HIV as part of greater problems that affect their communities, such as the lack of societal concern for poor urban areas and the cutting of programs serving poor communities. Low income drug users are scared of HIV and want to protect themselves from the disease, but also have the sense that it is just one more threat among many others related to chronic health conditions and violence that could affect them.

### **Gender Differences in HIV Risk**

Injection drug use places women at risk for HIV both through their own risky injection practices and risky sexual behavior with men who also inject drugs. Research has consistently shown that female IDUs are more likely than males to have IDU sexual partners.<sup>166</sup>

A study conducted with 531 syringe exchange program clients (175 women and 356 men) in California looked at gender differences in sexual partners' injection drug use, injecting risk behavior, sexual risk behavior, and secondary syringe exchange, or exchanging syringes used by other people.<sup>167</sup>

The study found that more women (43%) than men (27%) had steady sexual partners who injected drugs. More women (43%) than men (33%) reported injecting 90 or more times in the previous month. There were no gender differences in terms of using needles

and then giving them to others to inject with (distributive syringe sharing), with 29 percent of women and 30 percent of men reporting this behavior in the past 30 days. Twenty-nine percent (29%) of women and 23 percent of men reported shooting up with used needles received from others (receptive syringe sharing).

Women attended syringe exchange programs only slightly more often than men (3.8 times vs. 3.2 times) in the previous month. Women were more likely to exchange needles for others (47%) than men (33%), although men primarily engage in secondary syringe exchange for their sexual partners, while women do it for other members their social network in addition to sexual partners.

Sixty-five percent (65%) of women and 60 percent of men engaged in unprotected anal or vaginal sex during the previous six months. Nearly a quarter (23%) of women had exchanged sex for money or drugs in the last 30 days, compared to only 4 percent of men.

### **YOUNG IDUS**

An article reviewing recent studies related to injecting drug use highlights some of the trends in drugs of choice, as well as concerns related to HIV risk for young IDUs, particularly those who are just beginning to inject.<sup>168</sup>

### **Drugs of Choice**

Heroin use has increased dramatically over the last decade, and this trend has been particularly pronounced among young adults. Some studies suggest that heroin is more likely to be the first drug injected by new injectors. In some areas of the country, the purity of the heroin has improved and the cost has decreased, making it an attractive drug for young people. While much of the heroin use over the last three decades was concentrated among low-income African American and Latino men in urban areas, recent data suggest that new heroin users now include working and middle class young White men and women.

<sup>166</sup> Riehman et al, *Journal of Urban Health*, 2004

<sup>167</sup> Ibid

<sup>168</sup> Clatts et al, *Journal of Urban Health*, 2003

Other drugs that are injected by youth are crack cocaine and methamphetamine. The injection of ketamine, one of the new “club drugs” is becoming increasingly popular among high-risk youth.

**Factors Contributing to Risk**

New IDUs may not have the information or skills needed to purchase drugs, and may look for the drugs in high-risk settings and from groups of experienced injectors. New injectors may often be the last in line as the drugs are being divided and injected, thus sharing needles or cookers that have been previously used.

The process for preparing and injecting drugs is complex, and varies depending on the type of drug. New injectors will need to depend on more experienced, and often older, IDUs, at least during their first few times. The experienced IDU is likely to control the preparation and injection process, which could put the inexperienced IDU at risk.

**MEN WHO HAVE SEX WITH MEN AND ARE INJECTING DRUGS USERS**

Because there is a scarcity of research that focuses on MSM/IDU, the CCCHAP identified a needs assessment as the priority intervention for this population. The purpose of this needs assessment will be to better help us understand the risk behaviors and prevention service needs of this population. Due to funding cuts, however, the study was not implemented.

**SUMMARY**

***HIV prevention needs of injecting drug users:***

- Eliminate barriers to acquiring and possessing sterile needles and syringes.
- Providers must understand and address the primacy of the drug in the lives of users.
- HIV prevention education and risk reduction planning specifically focused on sexual risk behaviors.
- Address poverty and homelessness that lead to high-risk survival behaviors (e.g., unprotected sex for drugs or housing).
- Decrease denial of need for HIV prevention education and resources.
- Accessible, supportive, culturally competent health and social services.
- Increase the general community’s concern for substance abusers.

## Youth and Young Adults at Risk

*Subpopulations include: Young African American Women, and Young Women of all Races*

### NATIONAL RESEARCH

In February 1997, a report was released by the Harvard AIDS Institute and the Center for AIDS Prevention Studies that clearly and simply described the factors that put youth at risk for HIV in America today. It said, “*Simply counseling abstinence or rational sexual behavior won’t stop the epidemic. Those most at risk (YMSM, young women, young people of color, and homeless and runaway youth) - must confront an array of personal and external social factors in order to protect themselves.*”

To a large extent youth who are most at risk are those most marginalized in society. They experience:

- Socially based vulnerability, including homophobia, sexism, poverty, and homelessness.
- The need to find acceptance, respect and love through sex.
- The discovery phase of sex, gay and straight.
- Power dynamics with older partners.
- Coercion and force.
- Difficulty in communicating personal needs.
- Sex work.

### ***Vulnerability Increases HIV Risk***

Research related to adolescent sexual behavior has shown that youth experiencing vulnerable lives are more likely to initiate sexual intercourse at early ages. Early sexual intercourse is associated with high risk factors for HIV at a later age, including more partners, multiple concurrent partners, and more frequent sex.

For example, living in a single parent household, using alcohol or drugs, and having sexually active siblings and friends are associated with earlier onset of intercourse,

while frequent church attendance, supportive family relationships, educated parents and good grades are associated with later onset of intercourse.

In one study, consistency between teens’ values and parents’ values and the closeness of family ties were found to be important factors in delaying a teen’s sexual behavior. Parental control of dating (supervision and control over hours, locations, and partners) was a strong inhibitor of adolescent sexual activity and pregnancy. Lowest rates of sexual experience were associated with parents perceived to be moderately strict, as opposed to parents with “traditional” values.

Similarly, factors related to contraceptive use at first intercourse include living in an intact family, having a better educated mother and having discussed birth control with the partner prior to intercourse, being of older age at first intercourse, and living in a neighborhood with better labor force opportunities for women. Teens who engage in other risk behaviors, such as drug use, are less likely to use contraception at first intercourse, and to live in a neighborhood with a higher proportion of women who are divorced.

### ***Underlying Factors Influencing Risk Behavior***

Risky sexual behaviors tend to be just one element in an array of risky behaviors that vulnerable youth engage in, which suggests that it is important to address underlying causal factors of all of these behaviors. For example, use of alcohol, tobacco, marijuana, dating violence, physical violence, and carrying weapons are all associated with an increased number of sexual intercourse partners among youth.<sup>169,170</sup> Studies of alcohol use among adolescents show correlates with sexual activity, increased number of partners, and early sexual initiation.<sup>171</sup>

<sup>169</sup> Valois, *Journal of Adolescent Health*, 1999

<sup>170</sup> Moore et al, *Child Trends, Inc.*, 1999

<sup>171</sup> Bailey, *Journal of Adolescent Health*, 1999

Data from the 2001 Youth Risk Behavior Surveillance System (YRBSS) provides insight into behaviors and experiences of students in grades 9 through 12 across the nation.<sup>172</sup> The table below summarizes types of behaviors or experiences and the percentage of students nationwide that reported them.

Behavior/Experience	Percentage
Been hit, slapped or physically hurt by girlfriend or boyfriend	9.5%
Forced to have sexual intercourse	7.7%
Attempted suicide $\geq$ 1 times in last 12 months	8.8%
Had $\geq$ 5 alcoholic drinks $\geq$ 1 times during last 30 days	29.9%
Used marijuana $\geq$ 1 times during last 30 days	23.9%
Used methamphetamines during lifetime	9.8%
Had injected illegal drugs during lifetime	2.3%
Had sexual intercourse during lifetime	45.6%
Initiated sexual intercourse before 13 years of age	6.6%
Had sexual intercourse with $\geq$ 4 partners in lifetime	14.2%
Had sexual intercourse in last 3 months (currently sexually active)	33.4%
Used condom during last sexual intercourse (of currently sexually active students only)	57.9%
Used alcohol or drugs at last sexual intercourse (of currently sexually active students only)	25.6%
Had been pregnant or gotten someone else pregnant	4.7%
Were taught about HIV in school	89%

<sup>172</sup> Grunbaum et al, *MMWR*, 2002

### Self-Efficacy

One of the factors underlying high-risk behaviors among youth is self-efficacy, or their confidence in their ability to do things. This confidence can be eroded by an unsupportive environment. For example, one study showed that condom use self-efficacy emerged as the strongest predictor of change in sexual risk behavior over time among girls: girls with highest levels of condom use self-efficacy at the beginning of the study were engaged in the lowest level of STD risk behavior at the end of the study.<sup>173</sup>

Similarly, studies have shown that adolescents with more positive attitudes toward delaying sexual intercourse, and who believed that their friends thought persons their age should delay intercourse were less likely to engage in intercourse.<sup>174</sup>

### HIV POSITIVE YOUTH

A study of 350 HIV positive youth (252 males and 98 females) ages 13 – 23 from New York, Los Angeles, San Francisco, and Miami was conducted to evaluate lifetime and current risk behaviors.<sup>175</sup> Ninety-five percent (95%) of males self-identified as gay or bisexual, and 96 percent of females identified as heterosexual. The average age of the respondents was 20. Fifty-five percent (55%) of the sample had graduated from high school. Most of the young people had tested positive for HIV more than two years earlier.

Emotional distress and the number of counseling visits were significantly higher among the youth who had an AIDS diagnosis or were symptomatic.

### Sexual Risk Behavior

For all participants, the average age at time of first sexual activity was 14. Overall, 51 percent reported having no unprotected intercourse since receiving their HIV diagnosis. Thirty-nine percent (39%) of all

<sup>173</sup> Sieving et al, *Archives of Pediatrics and Adolescent Medicine*, 1997

<sup>174</sup> Carvajal et al, *Health Psychology*, 1999

<sup>175</sup> Rotheram-Borus et al, *AIDS Education and Prevention*, 2001

respondents had ever exchanged sex for something they needed (34% of males and 22% of females); this was more common among youth with an AIDS diagnosis.

When considering sexual activity in the past three months, 19 percent reported abstinence. Among those who were sexually active, 31 percent reported using condoms all the time during those three months. Males had significantly more partners than females and used condoms less often. However, overall, most (89%) vaginal and anal intercourse was protected. Fifty-four percent (54%) disclosed their serostatus to their partners.

### **Substance Use**

Throughout their lifetime, almost all of the youth had smoked cigarettes, used alcohol, marijuana and hard drugs. When comparing lifetime use to current use, about a quarter of those who had at some point used each of the substances above reported not using in the past three months. Fifteen percent (15%) had ever injected drugs, and 6 percent of these had not injected in the past three months. However, 17 percent reported using alcohol or some drug on a daily basis.

The results of this study indicate that a good proportion of youth who are living with HIV or AIDS take steps to reduce risk after learning of their diagnosis.

## **LOCAL RESEARCH ON HOMELESS YOUTH AND YOUNG ADULTS**

Researchers have shown a relationship between risk for HIV infection and homelessness. For example, a 1991 study conducted by the University of Minnesota Youth and AIDS Projects shows that over 80 percent of HIV infected youth are or have been homeless in the past five years.<sup>176</sup>

A study conducted by the Wilder Research Center in 2000 estimates that approximately 660 unaccompanied youth (persons aged 17 or younger) are without shelter on any given night in Minnesota, and in one year, nearly

10,000 Minnesota youth experience at least one episode of homelessness.<sup>177</sup>

The Wilder Research Center study includes interviews of 209 homeless youth (ages 10 to 17) and 285 homeless young adults (ages 18 to 20) conducted on one night in October 2000.

### **Reasons for Leaving Home**

The youth and young adults cited many reasons for leaving home:

- Conflict with parents.
- An adult in the household won't tolerate them being around.
- Alcohol or drug use by a parent or other household member.
- Adults don't attend to the basic needs of the youth.
- Not enough space for everyone in the household to live.
- To escape physical, sexual and emotional abuse.
- Families are unable to provide for their children because of economic problems or psychological instability.
- Families throw them out for identifying as gay, lesbian, bisexual, or transgender.
- Some leave inappropriate foster/institutional care settings.

### **Demographics of Homeless Youth**

Homeless youth are much more likely than youth in the general population of Minnesota to be persons of color. While only 8 percent of all youth in the metro area are African American, 44 percent of homeless youth in the Twin Cities area are African American. In Greater Minnesota, Native Americans account for only 2% of all youth, while they make up 32 percent of homeless youth in Greater Minnesota.

The homeless youth population includes members of minority groups who have immigrated unaccompanied to the U.S. and are attempting to make themselves inconspicuous. Because they have no legal status and may face deportation if identified, they try to avoid service providers.

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<sup>176</sup> Remafedi, 1991

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<sup>177</sup> Wilder Research Center, 2001

Eighty-five percent (85%) of homeless youth and young adults in the Wilder Research Center sample self-identified as heterosexual. Seven percent (7%) identified themselves as bisexual, 5 percent as gay or lesbian, and 3 percent reported being unsure of their sexual orientation. Three participants identified as transgender.

The study found that homeless youth who stay with friends or on the street are more likely than those in shelters or transitional programs:

- To be female (59% vs. 49%)
- To have left home at a later age (average of 13.7 years vs. 12.9 years)
- To be gay, lesbian or bisexual (14% vs. 8%)
- To feel unsafe in their current housing situation (17% vs. 3%)
- To have homeless relatives (37% vs. 27%)

Homeless youth that stay in shelters and transitional housing programs are more likely than those who stay with friends or on the street:

- To be attending school this year (81% vs. 71%)
- To have higher average monthly income (\$312 vs. \$260)

**Risk Factors of Homeless Youth**

Homeless youth are routinely unable to secure housing due to their age, lack of affordable housing, lack of rental history, the cost of application fees, and having a criminal background. Homeless young adults mentioned similar reasons, but also cited problems with their credit rating.

Beyond not having a stable place to live, a number of homeless youth are dealing with multiple additional issues that can help place them at risk for HIV infection. Nearly one-third (31%) of the total sample had been diagnosed within the previous two years with a serious mental health problem. The most common diagnoses were major depression (21%), alcohol abuse disorder (11%), and drug abuse disorder (11%). Over 43 percent of the homeless youth and young adults had

considered suicide, and over one fourth had actually attempted suicide (28%).

Almost half (45%) of the homeless youth and young adults reported having been physically abused, and 33 percent having been sexually abused. More homeless women than men reported being assaulted or threatened with violence in a relationship during the last year. Twenty percent (20%) stated that they have stayed in an abusive situation because they had no other housing options.

As is seen in other vulnerable populations, sex is a commodity that can be traded for things that are needed to survive. Seven percent (7%) of homeless youth reported trading sex for shelter, clothing, food or other things (2% of males and 12% of females interviewed). Ten percent (10%) of homeless young adults also reported trading sex (7% of males and 11% of females).

Almost the entire sample (94%) reported that they have learned about safer sex practices and 89 percent stated that they use safer sex practices sometimes or almost always. Ten percent (10%) reported that they have had an STD in the past 12 months.

Frequently homeless youth are not involved in formal settings where HIV/STD prevention education is available, and reaching these youth is a major challenge for HIV prevention service providers. Homeless youth are at risk for HIV by virtue of their circumstances and the behaviors in which they may engage in order to survive.

## MINNEAPOLIS STD PREVENTION STUDY OF BLACK YOUTH

In 1999, the MDH commissioned the STD Prevention Study of Black Youth Living in the 55404 and 55411 neighborhoods of Minneapolis.<sup>178</sup> The zip codes were chosen because they have the highest incidence of gonorrhea and syphilis in the state.

The primary goal of this study was to find out what youth think are the most effective means of reducing sexually transmitted diseases.

Eighty-five (85) youth were interviewed, recruited through a snowball sampling method, and referred through alternative schools, Boys and Girls Club staff, and the Minneapolis Urban League HIPPHOPP program.

The study found that nearly every youth reported using condoms with non-steady partners most of the time, or when they first met their partner. Youth are aware that condoms can protect them from STDs and prevent pregnancy, and almost 90 percent of the youth knew how to use a condom correctly. But, more than a third of interviewees had had an STD in the past.

Participants stated four main reasons for not using condoms consistently:

- With long-term partner.
- No condom available.
- I don't think s/he has anything.
- I don't know why, I just chose not to.

The youth who participated in the survey recommended four interventions to solve the STD problem among their peers:

- Early parent education of young children.
- People publicly speaking about having an STD - especially other youth.
- Street outreach.
- Peer education.

The Minneapolis STD Prevention Study recommends that prevention programs:

- Address the specific reasons youth give for not consistently using condoms, recognizing that the reasons are not the same for every youth, or even for an individual youth all the time.
- Build from the experience and knowledge base that youth already have. In particular, programs should try to increase how often youth use a condom.
- Make condoms available where youth have sex; i.e., parks, cars, houses of friends and relatives, by making condoms available late at night, and through local corner stores.
- Address misinformation about STDs – particularly, “you can tell if someone is infected.”
- Target youth who have had an STD in the past -- these youth reported needing to hear weekly prevention messages.
- Target high school dropouts and those doing poorly in school. Consistent with other studies, individuals who reported frequently engaging in unprotected sex were more likely not to have finished high school, or to be getting poor grades.
- Continue to target youth who have children, youth with multiple partners, and youth who are chemically dependent or buy/sell drugs. A lot of youth have sold drugs at one time or another. Male youth who sell drugs also have a higher STD risk. They frequently reported being the recipients of oral sex from female “customers.” And most of the time they do not use condoms.

<sup>178</sup> Jackson, 1999

## MINNESOTA YOUTH TALK ABOUT THEIR RISK

Two community meetings were held in 1994 to collect recommendations and discussion from youth. At one of these meetings participants included gay and bisexual youth; at the other, youth peer educators from a program targeting street youth and from a program targeting youth in alternative schools participated. While most youth experience similar barriers to learning about HIV, some of the issues surrounding HIV prevention were different for the two groups of youth.

### **The Environment**

The youth discussed the ways in which their environment places them at risk. All youth receive mixed messages from school, parents, and society about how to be safe, whether to be abstinent, how to live without being sexual. Youth are unsure of who they can trust to provide definitive and accurate information about HIV. While safer sex strategies are minimally taught in schools, the focus is on heterosexuals. Gay and bisexual youth lack acknowledgement of their orientation or information on gay safer-sex behavior. The youth said that they need clarification about what is safe and also about exactly how transmission occurs (e.g., is condom use mandatory during oral sex?). Not only do youth not know the specifics of sexual activity, some do not even know how to date, or how to have a date. However, many educators also feel trapped by society that will not allow them to disburse the information they would like to.

### **Social Expectations**

Adolescent women experience potentially harmful expectations from society around the way they are supposed to behave. There is a myth and assumption that relationships are, and/or should be, characterized by monogamy and romantic love, and that love will protect a person from STDs and HIV. Such dynamics in a relationship are disturbed by prevention issues.

In addition, adolescent women are expected to be placating; they may be expected to date

older men; both of these expectations result in an imbalance or lack of control over condom use. The Adolescent Risk Behavior Study examined HIV risk behavior among minority female and male adolescents in 1993 and 1994. The study found that, compared with teenagers whose first partner had been about their own age, female adolescents with older first sex partners were less likely to use a condom at first intercourse, last intercourse, or to use condoms consistently over their lifetime or in the previous six months.<sup>179</sup>

High rates of sexually transmitted diseases may result in part from expectations of young men to prove their worth and of young women who make gifts of themselves to men. Our society is also characterized by a lack of female mentors for women, and a lack of respect for youth. Youth often become the victims of a society (and parents) that lacks knowledge of human development and are unwilling to comprehend human sexuality or support sex education. This lack of knowledge often translates to a stigmatizing of sexually active youth by parents and society, and into inaccurate knowledge being acquired from peers.

Finally, our society values providing for our children over nurturing our children, so that possessions are more valued than communication. Youth learn from adults and society around them: *"If their society is out of control, they act out."* These social morals are all compounded by promotion through the media. *"There are more SPRITE commercials than there are HIV prevention commercials."*

### **Developmental Issues**

The youth discussed developmental issues including peer pressure. Youth are in a stage of development that is characterized by a crisis orientation around health issues; a sense of invincibility (denial of individual risk); a wariness of institutions and a tendency to resist authority; peer pressure; a desire to experiment and take risks; a general lack of life experience/wisdom, coping/negotiation skills, assertiveness; and a lack of anatomical

<sup>179</sup> Miller et al, *Family Planning Perspectives*, 1997

education. As with many other communities, many youth have knowledge about HIV and about how to protect themselves, but are in denial about their personal risk. *“If they don’t see a peer who is sick, they don’t believe it is a problem for them.”*

### **Peer Pressure**

Meanwhile, youth experience many to engage in sexual activity. Youth, like adults, experience many positive reinforcements for engaging in sexual activity. There is peer pressure to not remain a virgin. Youth are curious and they see sex as a way to get love and attention. Many youth experience a sense of fatalism about their lives, and they express a desire to have children before they die.

In addition, youth face negative pressures if they do try and use a condom. There is a belief that a partner does not care for a person if they use a condom; condoms don’t feel good; and while girls tend to take more responsibility for condoms than boys, the youth felt that a boy could talk a girl into not using them. In some instances, girls won’t use condoms or birth control, because they want to get pregnant. For some boys, there is a desire to prove their manhood by having multiple partners who have their children. Youth tend not to explore their partner’s sexual history before engaging in intercourse with them and seem to not think at all of inquiring into drug using habits. However, the youth all agreed that alcohol and chemical use is extremely widespread among their peers.

The youth peer educators felt that there is pressure among youth to have sex at younger ages (10 - 14 years old). They believe these children are emulating their older siblings and blame lack of family bonds, lack of role models, and lack of education for not preventing such behavior, *“They don’t get taught, there is no one to tell you not to.”*

Examples of beliefs generally held by adolescent women are that you can’t get pregnant the first time, that withdrawal prevents pregnancy, and that oral and anal sex is not a high-risk sexual activity and indeed is protective against pregnancy. The group felt that there is a general burnout

among youth on “AIDS 101,” but even so, knowledge retention is low among adolescent women. Further, there seems to be a lack of connection between what knowledge youth do have and the behaviors they engage in.

### **Barriers to Testing**

The youth discussed the availability of services. It seems that many counseling and testing services are inadequate, as well as being developmentally inappropriate for adolescents. Some adolescents see testing as prevention, which means that counseling is inadequate.

There is a general lack of understanding of the health care process. Many adolescents assume that HIV or STD testing automatically takes place during pap and pelvic exams, or regular physicals. Many adolescents will go for testing if there are symptoms, but a woman’s body masks STD infection. Simultaneously, there is a general lack of knowledge of the significance of symptoms of sexually transmitted diseases. There is also a lack of understanding of the connection between STDs and HIV.

Many adolescents don’t return for test results. Many are concerned over the lack of anonymity. There tends to be limited access to testing for youth. Many clinic hours are not good for youth in school. Many health care settings don’t educate or offer testing. There is too long a wait for an appointment and to receive the results. There is a lack of childcare and a lack of transportation. Too many sites are not local or accessible. Youth are often dependent upon their parents for health care. Transportation and confidentiality can be a barrier for youth trying to access health care without their parents’ knowledge.

In 1999, focus group surveys of 87 high-risk youth were conducted. Of these youth, 15 were homeless. The average age of participants was 17. Forty percent (40%) were from communities of color.

The results of the surveys showed the following:

- 55% were sexually active. The average number of sexual partners was 8, with a range of 1-40 partners. 45% used condoms every time, or most of the time.
- 17% had been pregnant or gotten someone pregnant.
- 14% had ever had an STD.
- 11% traded sex for drugs, money, and food.
- 9% had ever injected drugs.
- 68% thought that their risk of getting a STD was moderate to none.

### ***Parent Interviews***

In 1999, interviews and surveys were conducted with 25 parents approached in Minneapolis parks.

Parents recognized their own role in providing honest, open, education, support and example to their teens around STDs. They wanted training that covered both information and communication skills. They seemed to need confidence in their own abilities.

Overwhelmingly, they want support from the community as a whole for their teens. Parents seemed to feel that the institutions and people necessary to deliver these messages are already present in the community. Support should come through more media messages and through messages from family, friends, youth workers, church leaders and schools. A very strong need for affordable, alternative activities for youth was expressed.

## **SUMMARY**

### ***HIV prevention needs of youth and young adults:***

- Skills training in condom use, and negotiation and communication skills, in addition to provision of basic HIV prevention information.
- Peer education approaches.
- Proper “dosing” (length or duration of the intervention) is an important factor in delivering effective prevention.
- Initiation of prevention interventions early in life before high-risk patterns are established.
- Address factors that cause homelessness among youth.
- Address substance abuse among youth.
- Tailored interventions for specific groups, including programs for gay youth, African American and Latino/a youth, and homeless and runaway youth.
- HIV programs that are part of a broader effort to address youths’ and young adults’ hierarchy of needs.
- Successful school-based HIV prevention interventions have common characteristics, which should be useful to guide programming.
- Building understanding of significance of condom use in preventing HIV and STDs.
- Building confidence in ability to use condoms.
- Having a true sense of susceptibility to HIV/STD infection.
- Accessible and developmentally appropriate STD/HIV prevention services.
- Training to assist young people to “decode” portrayals of sexuality in the media in order to better understand their social environment.
- Address contradictory social norms that simultaneously promote, and condemn sexuality.
- Availability of accurate HIV/STD prevention information.
- Address HIV/STD prevention "burnout" among youth.
- Consistent provision by health care providers of HIV/STD testing, risk assessment, and education.

## Factors That Impact HIV Transmission Within the Priority Target Populations

*This section of Chapter Two describes factors other than risk behaviors that impact HIV transmission among the populations that are most at risk.*

### Factors Impacting HIV Transmission

There are many ways in which to categorize and define target populations for HIV interventions. An ongoing complexity in this process is a tension between categorizing communities according to high risk behaviors, (allowing us to target individuals most at risk for HIV), and categorizing communities according to culture, race and ethnicity (which is how communities define themselves). The following is a description of cultural and other factors/issues that impact HIV transmission among all of the risk groups described previously in this chapter.

### Racism, Discrimination and Cultural Factors

Key findings of two Minnesota reports on health disparities in populations of color show that racism and discrimination play a crucial role in explaining health status.

#### ***A Call to Action (MDH, 2001)***

- People with a higher income generally enjoy better health and longer lives than people with a lower income. However, the health of people of color and American Indians, at every level of income, is worse than that of their White peers.
- Racism and discrimination play a crucial role in explaining health status and health disparities through factors such as restricted socioeconomic opportunities and mobility, limited access to and bias in medical care, residential segregation (which can limit access to social goods and services), and chronic stress.

#### ***Minnesota Metro Minority Health Assessment Project Report***

- Populations of color are growing dramatically in all metro area counties.
- People of color in the seven-county area are more likely to die at younger ages than Whites.
- Adolescents of color have higher rates of sexually transmitted infections than White adolescents. For example, the gonorrhea rate among Black adolescents is about 70 times higher than that of Whites.

#### **THE AFRICAN AMERICAN EXPERIENCE**

##### ***Feedback From Minnesota Community forums***

African American community members identified barriers they experienced in accessing effective HIV prevention at a series of three community forums held in 1994. Many of the same barriers were identified at all three meetings.

The context for African Americans' experiences of HIV issues is a mixture of cultural norms integral to the community and cultural norms imposed on the community by the larger society, including the experience of racism and poverty.

##### ***Social Conditions***

African Americans are at increased risk for HIV due to environmental forces that make prevention programming and education hard to access, place prevention activities as a low priority, and support high-risk behaviors.

Disparities in socioeconomic status, as well as in health status between the African American community, and the majority White community are vast in Minnesota. Many

African Americans experience the double burden of poverty and racism. Individuals at the community forums described their community as experiencing this burden as an overwhelming sense of depression, apathy and hopelessness. Priorities of survival take precedence over healthy behaviors. HIV is just one of the many problems that African Americans encounter.

Not all African Americans are poor, however, and in this community, as in all communities, there are divisions based on class. Community participants described middle class African Americans as feeling exempt from HIV infection and deny that anyone they know will be infected. Leaders in the community (especially church leaders) were seen as not taking an interest in HIV prevention efforts.

A taboo against open discussion of sexual issues, including homosexuality, presents a barrier to discussion of HIV risk behaviors in public settings such as churches, and promotes discrimination against HIV infected individuals. Parents aren't comfortable talking to their children, or to their peers, about sexuality issues and drug use.

### **Knowledge of HIV**

Many African Americans don't distinguish between HIV and AIDS. Many fear casual contact as a possible mode of transmission. There is also misinformation about transmission of HIV, with a fairly widespread belief in HIV as a government plot to rid society of people of color, homosexuals, and injecting drug users. Myths about sexuality were cited, including *"if you love someone it won't happen to you (going steady is protection),"* and *"heterosexuals can't get it."* Lack of knowledge of transmission was attributed to people not understanding their risks.

Lack of knowledge was also attributed to illiteracy and to the fact that many school-aged and high-risk youth are not in school. Even for those individuals who receive education, there is a barrier or gap between knowledge and behavior change.

*When kids talk of getting burned, they're thinking of syphilis or gonorrhea, not HIV, it is not a lack of knowledge, but denial.*

HIV infection is still seen as a White, gay male disease, or an injecting drug user's disease, and this is coupled with homophobia. HIV is associated with a fear of discrimination and stigma, which keeps homosexual and HIV infected individuals silent about their orientation and/or their disease. The community does not want to accept that it has gays, IDUs, mentally retarded, or alcoholics among its members.

### **Young African Americans**

Young teens are very sexually active, engaging in unprotected and experimental sex, and have multiple partners (short span monogamy). Participants also cited the risks associated with chemical use which leads to unprotected sex and multiple partners, gang initiations involving sex, and survival sex.

### **Barriers to HIV Prevention**

Barriers to HIV prevention associated with quality or comprehensiveness of existing programs include a lack of comprehensive, culturally appropriate services for African Americans, especially gay men, and transportation and child care for those wishing to access programs in the community. There also was a fairly widespread lack of trust of health care providers, especially around disclosure of HIV status and confidentiality issues. Others felt unwanted or unaccepted by existing service agencies. Other concerns included power struggles within the community over funding, and burnout of providers who have to attend *"too many meetings, not enough time to devote to the program."*

### ***Prevention Needs of African Americans***

Participants identified the following HIV prevention needs in the African American community:

- Church and other community leaders prioritize HIV prevention.
- Comprehensive culturally appropriate HIV prevention programming that includes transportation and childcare.
- Attitudes and beliefs of youth regarding violence, sexual promiscuity, and chemical use are addressed.
- Poverty and racism are addressed.
- Consistent condom use becomes a cultural norm.
- Health care providers consistently provide HIV/STD prevention information, and are perceived as trustworthy and confidential.
- Training to assist parents with skills and motivation to discuss HIV/STD prevention issues with their children.

### **THE ASIAN PACIFIC ISLANDER EXPERIENCE**

Asian Pacific Islanders (API) are at increased risk for HIV due to environmental factors, including language, culture, poverty, and racism which make resources and education hard to access. Asians Pacific Islanders described their experiences around HIV prevention during a community forum held in 1994.

#### ***Diverse Community in Minnesota***

The API community in Minnesota is very diverse. Vietnamese, Chinese and Hmong attended a community meeting; however, there are also significant communities of Korean, Japanese, and Lao in Minnesota. The degree of acculturation, language acquisition, and maintenance of traditional ways differs from one community to the next. However, what these communities do share in common is increasing poverty and a degree of illiteracy among some adults, even in their own language, as well as in English. Youth who have been born here or have grown up in the

United States do not always speak the language of their parents very well.

#### ***Poverty***

Poverty rates are evidenced by increased utilization of food lines, shelters, and prostitution for survival. Effects of resettlement and the struggle to adapt to a new lifestyle are apparent in the Hmong community as it suffers from negative self-image, high levels of spousal abuse, divorce, child abuse, gambling, and chemical dependency. There is a rising involvement of youth in gangs.

#### ***Traditional Medical Models vs. Western Medical Model***

There is a difference between traditional and Western explanations of how diseases are spread, and thus confusion about how HIV is transmitted. For example, there is a belief that HIV can be transmitted casually, through food, or that it is airborne and contagious like TB or pneumonia. There is a lack of knowledge around the meaning of the terms HIV and AIDS. Discussion of illness and death is often seen as a self-fulfilling prophecy, and is taboo. There is a cultural norm of self-care or self-treatment. Individuals will only seek care if they are sick, and/or until traditional medicines have been tried and have failed.

#### ***Reluctance to Discuss Sexuality***

Participants at the community workgroup described reluctance among APIs to discuss HIV or sexuality with each other, and particularly with members of the opposite sex. The reluctance to discuss sexuality translated to communication barriers between parents and youth, and parental denial of sexual activity among youth, an influence from traditional Asian culture.

Homosexuality is a taboo issue. There is denial and homophobia. There is a lack of institutionalization of homosexuality, (i.e., no homosexual community within the Asian Pacific Islander population), and therefore, a lack of disclosure by gays.

#### ***Barriers to Service***

Providers have a myth that Asians are sexually conservative, particularly the youth.

Providers also tend to lack an understanding of the diversity within the Asian Pacific Islander communities, so that one interpreter is expected to speak all languages, or understand all cultural norms. As with the Latino community, there is a general lack of integration of culturally specific services into the mainstream because, “the size of the community does not justify it.” Thus interpreters and providers from within the community are often lacking.

### **Response to Discrimination and Relationship to Risk**

A recent study points to a link between how API MSM respond to discrimination and the HIV risk behaviors they engage in.<sup>180</sup> Interviews were conducted with 23 Chinese, Korean, Filipino, and South Asian (Indian or Pakistani) MSM in New York City. The men ranged in age from 23 to 46, and were highly educated. Ninety-one percent (91%) of the sample was born outside of the United States, and the average number of years living in this country was 13.

There were four basic types of discrimination experienced by the sample:

- Racism (45% of episodes)
- Homophobia (16% of episodes)
- Discrimination based on stereotypes of passivity and submission (16% of episodes).
- Anti-immigrant discrimination (11% of episodes)

Respondents most often encountered discrimination within the gay community (27% of episodes) and in public settings, such as the street or subway (21% of episodes). They also experienced discrimination within their families (14% of episodes), and at work or school (11% of episodes).

### **Types of Responses to Discrimination**

The men reported using five basic types of responses to acts of discrimination. *Confront* responses include confronting, insulting, and/or educating the person who was being discriminatory. *Self-attributed* responses are when people believe they are the reason for the discrimination (i.e., because of the way they look or speak) and/or try to change themselves to avoid further discrimination.

*External attribution* responses are when people attribute the discrimination to the source (i.e., that person doesn't know any better), or to factors outside of themselves (i.e., the event happened in an area with a lot of Section 8 housing). *Social network* responses are when people talk with friend or family about the experience. Finally, *avoidance* responses are when people actively avoid the experience by not talking about it, and/or engage in an activity to take their mind off it.

### **Relationship to Risk**

The study found that confrontational and social network responses to discrimination may be associated with less risk behavior. Levels of self-empowerment may be higher among API men who engage in confrontational responses, which may also reflect a greater ability to negotiate safer sex. Social networks provide social support and may promote greater mental health.

The study also found that avoidance responses were associated with lower HIV risk behavior among the API men. This may be a reflection of some aspects of Asian culture, which is characterized by regulating or avoiding emotions.

The response type most associated with high-risk behaviors was the self-attributed response. API MSM who respond in this way may not feel empowered to reduce their risk. Some of the men in the sample engaged in HIV risk behaviors in an effort to be more attractive to non-Asian, non-immigrant sexual partners.

<sup>180</sup> Wilson and Yoshikawa, *AIDS Education and Prevention*, 2004

**SUMMARY**

***HIV prevention needs of Asian Pacific Islander communities:***

- Acknowledgement of cultural taboos around sexuality and homosexuality.
- Comprehensive culturally and linguistically appropriate HIV prevention programming that includes transportation and childcare.
- Poverty and racism are addressed.
- Consistent condom use becomes a cultural norm.
- Health care providers consistently provide HIV/STD prevention information, and are perceived as trustworthy.
- Training to assist parents with skills and motivation to discuss HIV/STD prevention issues with their children.
- Interventions that challenge or reject stereotypes within the gay community that affect API MSM's sense of self-worth.
- Interventions that foster discussion about discrimination within social networks or peer groups.
- Individual interventions that assist APIs in expanding the type of responses they employ to deal with discrimination.

undocumented and/or migrant workers. There were no women at these meetings. Social service and health professionals who provide education and services for the Latino community attended the third meeting. Comments provided by the both Latino men and women from Northwest Minnesota in 1996 are also included in the discussion, as well as feedback gathered through the survey and community forums conducted in 2003.

***Barriers to Prevention***

Community professionals say that lack of access to medical care, lack of availability of bilingual and bicultural health professionals and health education materials, a reluctance to be tested for HIV, and mobility of the population contribute to under-reporting of actual cases, and high rates of STDs and HIV. There is an ongoing need for basic information as new arrivals to the country arrive daily in substantial numbers.

The Latino community is small enough in Minnesota that many providers are also friends or acquaintances of potential clients. This creates a barrier in terms of confidentiality and exacerbates the stigma associated with seeking out HIV related care. It seems that the size of the population creates barriers to service development, since the community at large does not consider the size of the population large enough to justify intervention. For example, there is a chronic lack of bilingual providers or interpreters at major service programs or providers.

Access to care and education around HIV is seen as a form of control by the government, a way of keeping people out of the United States. Many people don't access education or services in Minnesota because they think they have to pay for it.

One agency described the need to reach Latino youth, particularly the newer immigrants who are at higher risk for acquiring HIV and STDs. Many youth are homeless, or at least so constantly mobile that they could be classified as homeless, coming from migrant families who move to find work. There is also a relatively high proportion of youth who have either dropped out of school due to

**THE LATINO EXPERIENCE**

According to the 2000 Census, there are an estimated 143,000 Latinos living in Minnesota; a 104 percent increase over previous estimates. Of these, the greatest majority (95,600) identify themselves as Mexican.

Latinos are at increased risk for HIV due to environmental factors, including language, culture, poverty, and racism which make resources and education hard to access.

***Feedback From Community Forums***

The following discussion is synthesized from three community forums held in Minneapolis and St. Paul in October and November of 1994. Two of the forums were held at drop-in centers and attended by

lack of English skills, or cultural insensitivity. Some simply never entered school upon arrival to the United States.

There appears to be a good deal of misinformation within the community around HIV transmission. Community members have questions about the relationship between STDs, such as syphilis and HIV, and about the nature of sexual transmission; for example, does it include kissing, or sharing a living space? Participants of the 2003 forums demonstrated accurate knowledge about HIV/AIDS and how it is transmitted, but some people had misconceptions, such as the disease being transmitted by mosquitoes.

Language and culture also present communication barriers between youth and parents. Parents and youth find it hard to communicate about sex, sexuality and drug use. The 2003 forum participants agreed that there is a lack of communication about sex and sexuality in families, and in the Latino community in general. They noted a lack of education, particularly in Latin American schools. Language also presents barriers in terms of accessing and understanding educational materials, media and HIV prevention programs.

### **Cultural Norms**

Cultural prejudices against the discussion of sexuality, against homosexuality, and cultural support for males to have multiple sex partners must be challenged.

For many undocumented workers or migrants, loneliness is a large problem. For many, a relationship for even one day is more important than HIV prevention. There seems to be a fatalistic attitude towards life, *“if God wills it, it will happen.”* *“Everyone knows what they need to know, people who are going to get it, are going to get it, whatever, (God willing)”*. A similar attitude can be seen in the approach to accessing care; one doesn't go to the hospital until the day of death. There is a cultural imperative to cope and endure.

There is a contradictory network of attitudes and beliefs within the Latino community around homosexuality that implies that

individuals may engage in high-risk behavior while they and the community are in denial around that behavior. Homosexuality is seen as a sin and sickness. It is considered important to keep youth away from homosexuals, since there is a feeling that it may be catching, or at least that homosexuals are child abusers. Men believe that HIV is a homosexual disease and they are not at risk if they are in a heterosexual relationship.

However, there is a lack of understanding of the distinction between risk behavior and risk group. There is a belief that being gay puts one at risk for HIV, and not the act of engaging in a high-risk sexual activity such as anal intercourse. Some participants in the 2003 forums also felt that HIV is a disease that only affects gay men and people who inject drugs.

Many men who have sex with men do not consider themselves to be gay and believe, therefore, they are not at risk. One person's response to the question "what is your sexual orientation?" was "I'm a man." There does seem to be a significant number of such men in the community. Many Latino males (usually undocumented males) exchange sex for money and some older Latino males habitually have sex with males while they continue to classify themselves as heterosexual. A male is not gay if he engages in insertive (rather than receptive) anal sex with another male.

Traditionally women do not have control over sex; the male holds the reins in the relationship. Women often do not have the power to choose to use condoms or contraceptives. A woman is supposed to remain virginal, however, it is acceptable or expected that a man will have more than one partner. The majority of Latino men do not use condoms, they are not used to them, and they do not feel good. *“Latino people don't talk about having sex and don't ask about HIV.”* *“We are machos, we talk about ourselves.”*

There appears to be a cultural connection in Minnesota between young Latino males and Native American women. The relationships appear to be characterized by

alcohol and marijuana use, and language can present communication problems. Often the men are migrants and are married, or have relationships in their native country. Both Native American and Latino community members described this dynamic, and expressed concern around the likelihood of STD transmission in such situations.

Self-medication is common, with medical supplies readily available from Mexico. A pharmacist, or respected community member, may take on the role of providing injectable drugs for sick people in the community. Sometime reuse of needles is associated with this practice, but since street drugs are not involved, individuals do not consider themselves to be at risk.

### **Stigma of HIV**

Men are more likely to refuse to be tested than women, who are more open to discussing HIV and undergoing HIV antibody testing, especially in relation to prenatal care. Of the 119 survey respondents in 2003, only 30 percent had ever been tested. Women were twice as likely to have been tested; 51 percent of the women in the sample had been tested compared to 25 percent of the men.

This reluctance to be tested may be related to a fear that one's reputation is at risk in the community if one is seen or known to have been tested. The 2003 survey indicated that 29 percent of respondents thought it would be easier to test if nobody would recognize them when they went to get tested. Similarly, people will not attend forums on HIV prevention, because of the stigma associated with being present.

Some undocumented Latinos will not go for testing because they are afraid of being deported. *"There are a great deal of Latinos living on the streets in fear. They are so afraid of deportation that they won't interact with any organization that can help them. 'La Migra' (the INS) is the biggest barrier for many Latinos' access of medical care and social services."* Twenty-five percent (25%) of 2003 survey respondents reported that it would be easier to get tested if they knew their results would not be reported to anybody, and 15

percent thought it would be easier to test if they knew their results would not be reported to the INS.

### **Racism, Poverty and Risk Behavior**

A recent study was done on social discrimination experienced by Latino gay men and its effect on risk behavior.<sup>181</sup> The findings were based on a qualitative study of 300 Latino gay men in the context of 26 focus groups in three cities. The findings from the focus groups were used to develop the survey for a probability study of 912 Latino gay men entering Latino gay venues in New York, Miami, and Los Angeles.

The majority (72%) of the probability sample were immigrants, with 53 percent of the immigrants having been in the country 10 years or less, and over one third mostly speaking Spanish with their peers.

The focus group participants reported many instances of racism, verbal and physical violence, police harassment, and decreased opportunities for social and sexual interaction because of being Latino, immigrant and/or having a darker skin color. A great deal of racism was experienced in the gay community and in gay venues. Men reported not feeling comfortable or welcomed, and some even reported being escorted out of venues because of the way they looked or their accents. Some men felt sexually objectified by White lovers, who paid more attention to their skin color or Spanish accents than to who they are as a person.

The quantitative survey found that 31 percent had been verbally harassed in childhood because of ethnicity, and 35 percent were treated rudely as an adult because of ethnicity. Twenty-six percent (26%) experienced discomfort in gay White spaces due to ethnicity, 22 percent had been harassed by police, and 62 percent had been sexually objectified.

Men in the probability sample who reported engaging in high-risk behavior (unprotected

<sup>181</sup> Díaz and Ayala, Policy Institute of the National Gay and Lesbian Task Force, 2001

anal sex with a non-monogamous recent partner) also reported more experiences of racism than those who fell into the low risk group.

### **SUMMARY**

#### ***HIV prevention needs of Latino communities:***

- Culturally appropriate chemical dependency services.
- Acknowledgement of cultural taboos and norms around sexuality and homosexuality.
- Comprehensive culturally and linguistically appropriate HIV prevention programming that include transportation and childcare.
- Poverty and racism need to be addressed.
- Consistent condom use becomes a cultural norm for men and women.
- Health care providers consistently provide HIV/STD prevention information, and are perceived as trustworthy - and specifically will not report clients to the INS.
- Training to assist parents with skills and motivation to discuss HIV/STD prevention issues with their children.
- Brief programs targeting migrant farm workers which take into consideration factors such as mobility, level of acculturation, and generational differences in beliefs and knowledge.

## **THE NATIVE AMERICAN EXPERIENCE**

### ***History of Oppression***

Although not the only population to experience oppression in the United States, Native Americans have been subjected to a unique history. They were the original residents of this country, but were forcibly removed from their tribal lands. The U.S. government ordered the extermination of many Native people during the colonialization process. Children were sent away to boarding schools, and Native languages and spiritual practices were outlawed for years. Treaties made with Native peoples were broken many times by the U.S. government.

Tribal leaders across the country believe that little progress will be made in addressing the many issues facing the American Indian community without recognizing and accepting that many of the problems are related to cultural genocide, and are the effects of unresolved grief experienced and passed down through generations.<sup>182</sup>

This history of oppression has led to Native Americans being disproportionately impacted by social, behavioral and economic factors associated with HIV risk. According to 2000 Census data, 30 percent of Native Americans in Minnesota are living at or below poverty level, compared to 6 percent of Whites. Native Americans also experience high rates of alcohol and drug use. American Indian males ages 18 and 19 have suicide rates six times higher than in any other age or population group.

### ***Responses from Community Forums and Surveys***

In 1994, three community forums were held for Native Americans, one in inner city Minneapolis, one at a retreat for Native Americans living with HIV, and one in Bemidji at the headquarters of the area Indian Health Service.

In 1996 and 1997, Fond du Lac Human Services performed needs assessment activities among four reservations in Northeast

<sup>182</sup> Minnesota Department of Human Services, 2001

Minnesota. In the following year, Clay County Public Health worked closely with Fond du Lac to perform needs assessment activities among Native Americans living in Northwest Minnesota. A total of seven focus groups were held and 630 surveys were completed.

**Resources**

All Tribal Health programs either offer HIV/STD counseling, testing, and treatment or make referrals for such services. Native Americans living on reservations also have access to public health programs, social service programs, spiritual leaders, chemical dependency programs, community health representatives, reservation tribal councils, Pow Wows, health fairs, education workshops, brochures, videos, speakers, local clinics, and peer education.

There is honesty and comfort among small and large group settings in discussing the need for HIV/STD prevention, and there is a high level of knowledge of basic AIDS information, at least among community members under the age of 30. However, there seems to be a widespread lack of basic knowledge of other STDs. Community members want more information and education regarding HIV/STD prevention and indicate a willingness to participate in such activities. This attitude of support is mirrored by the Tribal Health programs and extends to some Tribal Councils, which have passed resolutions in support of HIV/AIDS education.

**Racism Has Weakened Social Mores of the Community**

Barriers presented by the Native American communities to HIV prevention arise out of internal cultural morals and external societal pressures including racism. Racism has also determined attitudes about body image, *“Many Native people don’t feel good about their bodies. These shame-based attitudes are a result of the boarding schools. You can see the difference in those who went and those who didn’t. The assimilation process brought shame-based attitudes.”*

*“Without good food, clothes, transportation, health and things to make people feel good, education isn’t going to grip a person’s mind.”*

*“White values are materialism.”*

*“The greed, the ‘me first’ attitudes have especially devastated ethnic communities.”*

*“People don’t share the same values anymore.”*

**Sexual Behavior and Drug Use**

- Over 70% of respondents had their first sexual experience before the age of 18, and 40% before the age of 15.
- 23% had become pregnant or gotten someone pregnant before the age of 18.
- 35% of those surveyed indicated two or more sexual partners in the last year.
- 64% of survey respondents felt that it was very likely, or somewhat likely, that someone they know could get HIV.
- Only 25% felt it was likely they could get HIV.
- 10% indicated that their past sexual history gave them reason to believe that they may be infected with HIV.
- 7% of those surveyed said they had ever injected drugs.
- 37% had been diagnosed with at least one STD.
- There was little knowledge regarding STDs.
- Community members who are in their late 20s or older have little information regarding HIV and little knowledge of how to access prevention resources.
- Drug and alcohol use/abuse is an identified high-risk behavior practiced in all communities.

Native Americans who participated in the 1994 community forums saw that Native people use alcohol or drugs as a license to engage in behavior they may not normally

engage in. There are those who are chemically dependent and infected, placing themselves and others at risk through sexual intercourse. *“Sexually, we are looking at a population who changes partners frequently, and engage in serial monogamy.”*

Many Native American women want to have children without being tied down to a man. If they wear condoms, they can't get pregnant. *“Women love large families, it is not irresponsible.” “Native people are dying, women have a sense of responsibility to replace the population.” “But for teens, they see that women are treated nice when they are pregnant so their behavior is reinforced.”*

Many people are in denial; they don't feel they are at risk. The attitude is to sweep HIV under the rug. *“If they are over 25, their attitude is that they are not at risk.”* Adults are learning the information for their children, not themselves. *“Youth are not listening to the words of the adults, but are listening to the attitude of the adults (I'm not gay, I'm not a drug user).”*

### **Barriers to Prevention Education for Rural Native American People**

- Lack of financial resources to provide HIV/STD prevention education on reservations. Often the person designated as the HIV Resource Person for each Tribal Health program has many other responsibilities.
- Denial, fear, and shame are barriers to prevention education, to the extent that some staff are unwilling to provide prevention, schools are scared to provide information on a controversial topic, and there is a lack of support from the governing bodies.
- Community members lack confidence in confidentiality of local HIV/STD testing.
- Lack of knowledge of existing services.
- Limited clinic hours and clients' fear of test results.
- Lack of culturally sensitive providers and educational materials.

Many people don't trust that HIV testing services are confidential. *“The oral tradition is that a person must speak the whole truth, and not to speak all the truth is a lie. Gossip is a bastardization of old tradition. Now, people put people down to make themselves feel better.”* Fear and shame are prevalent; people may know a person has AIDS but do not talk about it.

There is also a lack of trust in Anglo service providers. HIV and medical systems are set up in a non-Native way. *“Management is a White cultural concept.”* Some Indian programs are “for” Indians, but are not planned or staffed by Indians. This presents barriers to providing education to the community and increases the mistrust of the Anglo community. More Indian organizations could be doing HIV related work but confidentiality is a problem, the Indian community is small, and everyone knows what others are doing. Access to 4H and other “traditional” youth programs are limited for Native American youth.

## **SUMMARY**

### ***HIV prevention needs of Native American communities:***

- Culturally and linguistically appropriate programs that acknowledge and address the history of Native peoples.
- Comprehensive culturally and linguistically appropriate HIV prevention programming that includes transportation and childcare. *“Native American people prefer to receive care and education from Native people; sometimes this preference extends to providers who are from the same Native American community.”*
- Culturally appropriate chemical dependency services that include HIV prevention education.
- Condoms provided at accessible locations such as health and community centers.
- Incorporation of skills building education into existing Tribal Health educational programs.
- Health care providers consistently provide HIV/STD prevention information, and are perceived as trustworthy.
- Improved access to and understanding of HIV/STD prevention information through Tribal Council resolutions to endorse community education efforts, notifying Tribal Health programs of the need, publicizing information in community newspapers at casinos and at community gatherings, providing prevention information at health fairs, bingo games, etc., notifying local schools of the need for education, utilizing peer education, using incentives to promote community participation in community meetings to discuss HIV/STD prevention needs, and promoting television as a medium for the distribution of HIV prevention. Parents have skills and motivation to discuss HIV/STD prevention issues with their children.
- Poverty and racism are addressed.
- Acknowledgement of cultural taboos and norms around sexuality and homosexuality

## **Homophobia and Heterosexism**

Homophobia and heterosexism have been identified as factors by men who have sex with men that contribute to engaging in high-risk behavior.

### ***Homophobia and Discrimination***

Participants attended a community forum in Minneapolis to give feedback about their HIV prevention risk behaviors and needs. They identified additional factors that over time have contributed to high-risk sexual behaviors. Men who have sex with men are derided and condemned by society because of their sexual orientation. Some participants said that societal homophobia limits the range of environments available to the community to socialize and meet. Environments that are available, such as bars or beaches, are often ones that promote casual and anonymous sexual encounters. In some of these environments, MSM encounter police harassment that additionally forces MSM “underground” in their sexual activity. There is a lack of positive, social alternatives to bars, especially for those aged between 18 and 25.

Needs assessment data from earlier in this chapter indicate that MSM of Color face an even stronger stigma against homosexuality within their respective cultures than is experienced within the dominant White culture.

A study of 912 Latino gay men found that 71 percent were told as a child that gays would grow old alone, 70 percent felt that homosexuality hurt or embarrassed their family. Sixty-four percent (64%) were verbally harassed as a child for being gay or effeminate, 64 percent had pretended to be straight in order to be accepted, and 29 percent had to move away from their family because of their homosexuality. Members of this sample who reported high-risk behavior also reported more experiences of homophobia.<sup>183</sup>

<sup>183</sup> Díaz and Ayala, Policy Institute of the National Gay and Lesbian Task Force, 2001

The fear of being identified as gay or bisexual, or the fear of not being accepted as such, results in some men maintaining a public identity as heterosexual, while also engaging in sexual relationships with men. This double life puts the men and their partners, both men and women, at risk for HIV infection.

### ***Internalized Homophobia***

Homophobia from society at large can also be internalized to a degree, and forum participants reported that men who have sex with men often see sex as shameful and secret, and sexual relationships are not acknowledged.

A quote from a focus group participant of the qualitative portion of the study of Latino gay men portrays the sense of shame experienced by some gay men, as well as the link to substance use, “*We do it [sex with men] because it’s pleasurable, but then there’s this big guilt trip that comes afterwards. It’s like you do it, you feel guilty and then you don’t do it for a while, then you do it again, you feel guilty again....I see a lot of men get drunk or get high in order to have sex, because they can’t say – a lot of Latino men can’t say, ‘I want to have sex because I want to enjoy sex with another man.’ So no, the excuse is, ‘well, you know, I’m kind of drunk, I’m kind of high.’*”<sup>184</sup>

In a study performed by Rosser et al,<sup>185</sup> a complex relationship between internalized homophobia was found. Homophobia can be protective (men avoid sex and relationships), but it is also a risk factor (more casual sex, and more unprotected sex). Hiding sexuality from oneself can also mean hiding the consequences of sex, such as HIV and STDs from oneself.

There seem to be many ways in which this denial is expressed; the myth or justification that asking about one’s partners HIV status is protection against infection; the myth that romance or true love will protect you from HIV; the myth that if you are young, or have sex

<sup>184</sup> Ibid

<sup>185</sup> Rosser et al, 1999

with young people you are protected against infection; that having sex in bed is riskier than having sex standing up; that men into leather are more at risk; or that if you are engaging in insertive intercourse, if you do not identify as gay, or do not go to the beach, you are safe from infection. Substance abuse, sexual compulsivity, abuse, and low self-esteem stemming from homophobia and heterosexism, were also mentioned in relation to high-risk behavior.

**SUMMARY**

***HIV prevention needs of men who have sex with men:***

- Address homophobia and heterosexism, both in the broader culture and within communities of color.
- Address co-factors influenced by homophobia, such as low self-esteem, substance use and abuse, sexual compulsivity, and abuse.

**The Greater Minnesota Experience**

Minnesota is somewhat unique in that while a fairly large state (84,363 square miles), it has only one major metropolis. Fifty-four percent (54%) of the state's approximately 5 million residents live in the seven county metropolitan region of the Twin Cities of Minneapolis and St. Paul. While there are other moderately sized population centers in Minnesota, culturally there tends to be a divide between the metro area and Greater Minnesota. Attitudes and beliefs around HIV, as well as access to HIV testing, prevention activities, and care services in Greater Minnesota are different than in the metro area.

Eleven percent (30 cases) of the 262 new cases of HIV reported to MDH in 2003 were located in Greater Minnesota. Twelve percent (577 cases) of total living cases of HIV/AIDS reside outside of the seven county metro area.

Greater Minnesota is defined as all counties outside of the seven-county Minneapolis-St.

Paul metropolitan area. Rural areas refer to non-urban areas in Greater Minnesota.

**FEEDBACK FROM COMMUNITY FORUMS**

A series of nine community meetings were held throughout Greater Minnesota in 1994. The prevalent theme was denial about HIV in Greater Minnesota. Contributing to this denial is homophobia, and an overall reluctance to discuss sexuality. *"We don't perceive that our counties have a problem with HIV when we don't see the numbers."* *"There are not enough cases or high-risk populations in the area to justify funding."* *"It is hard to keep talking about something that never happens and then when it does happen, it is only once."* *"Our communities met regularly for the first few years. But it is hard to maintain when we don't have any cases and we have so many other problems."* *"The truth is AIDS is not a real problem and there are many, much more pressing issues."*

***Low Incidence Supports Denial of Risk Behaviors***

There is a prevailing notion that *"people should know better anyway, why are we spending so much time and energy on education and prevention?"* There is denial about teen pregnancy, STDs, and other sexual issues and problems as well as HIV. *"We don't have sex."* Explicit brochures are unacceptable in the community and there is an association of HIV information with homosexuality, which is seen as "immoral" or as "recruitment to the homosexual lifestyle." *"The community won't accept anything explicit. We have only been able to say anal intercourse for the past few years."*

***Lack of Specific and Consistent HIV Prevention Education***

Adults who are not affiliated with secondary education lack access to HIV prevention education. Youth receive information in schools, but the extent and quality of education varies from school district to school district. School board policies and teachers' fears (due to personal prejudices, etc., as well as fear of parental outcry) present barriers to

providing comprehensive school-based sex education. A vocal minority has a disproportionate affect on the curriculum. There is a clear heterosexual bias in education.

### **Concerns about Confidentiality**

Individuals fear identification and harassment if they seek out HIV testing and counseling. *“Confidentiality is breached here regularly so it is a real fear. People are all related, small town issues that you really cannot avoid.”* Homophobia on the part of providers, and lack of training among family practice doctors, were also identified as barriers to testing and education. Some physicians won’t test even if a client requests, while others test without asking. In addition, some people assume that they will receive an HIV test and be informed of positive results during routine health care. In many areas, Planned Parenthood is the most accessible testing site, but this organization experiences prejudice from the community. In July 2002, the Planned Parenthood sites in Brainerd and Grand Rapids were both fired at with gunshots, resulting in damage to the buildings.

### **Alcohol abuse is a problem**

Abuse of alcohol is prevalent, and culturally acceptable, particularly among youth in many rural communities. Parents model and cover up this behavior. However, communities often fail to connect alcohol abuse with high-risk behaviors and HIV/STD transmission.

## **SPECIFIC TARGET POPULATIONS IN GREATER MINNESOTA**

In 1995, MDH provided funding to four agencies in four regions of Greater Minnesota to perform community needs assessment activities for the purpose of HIV/STD prevention community planning. Each region identified one target population with which they worked. The following describes the results of their needs assessments.

## **MEN WHO HAVE SEX WITH MEN IN SOUTHERN MINNESOTA**

### **Background**

Ten focus groups were held with men who have sex with men. In addition, 136 surveys were completed and returned. The typical participant in the needs assessment was Caucasian, between 30 and 49 years old, single or divorced or separated, did not have children, and self identified as a man who has sex with men. He was out about his sexuality only to close friends, travels more than fifty miles to meet sexual partners, and had had two or more sexual partners in the past year.

### **Risk Factors for Greater MN MSM**

- 56% of respondents had two or more sexual partners in the last year, and 17% of respondents had more than ten sexual partners in the past year.
- Those men who had between six and ten sexual partners in the last year reported the lowest personal perception of risk for HIV/STDs.
- 51% of respondents did not always use condoms in the last year - 14% reported that they never used condoms. Only 50% of the individuals that reported having more than 10 partners in the last year reported that they always used condoms.

### **Barriers MSM Experience in Accessing HIV/STD Prevention Education**

- The primary reported barrier to accessing education is a lack of time. This may be due to low personal priorities for HIV/STD prevention education, or because prevention education services are difficult to access.
- Fear of being perceived to have HIV or an STD, and fear of being considered gay.
- Lack of confidence in the confidentiality of local HIV/STD testing, counseling, and treatment services.
- Homophobia - rural communities tend to be “closed” - where everyone knows everyone else, and anyone who is different from community norm is considered to be a “stranger.”

### ***What Greater Minnesota MSM Need to Prevent HIV/STDs***

- Informal, peer-led, one-to-one community outreach to supplement formal services.
- Social marketing to address misinformation and ignorance about homosexuality and HIV/AIDS.
- Additional providers and/or increased efforts to cross-refer clients to appropriate agencies.
- Develop and distribute educational materials that include a variety of formats and topics (e.g., explicit safer sex messages, eroticization of safer sex), and that are rural sensitive.
- Increase accessibility of formal prevention services by taking into account the need of rural MSM to maintain their personal degree of “closetedness”.
- Provide comprehensive prevention education, through peer led small group counseling sessions that incorporate safer sex negotiation skills, chemical use issues, and the eroticization of safer sex behaviors.
- Most respondents reported a preference for discussing HIV/STD prevention issues, and being tested for HIV/STDs with their local doctor - however, physicians are generally not well versed in the counseling needs of MSM. There is a need for physician education.
- Social and emotional support from peers in informal or social settings.
- Targeted peer outreach (including condom distribution) to local public sex areas. An understanding of the dynamics of such areas is crucial. For example, in one rural town, participants reported that the local public sex area was visited by different types of MSM at different times of the day. Professional men would stop between 5:00 and 7:00 p.m. on their way home from work. Between 8:00 and 9:00, young men would cruise before visiting bars, and youth exploring their sexuality would be out before parent or community curfews.

From 10:00 p.m. to midnight, blue collar workers on their way home from local factories would stop. Later in the evening, after the bars closed, the younger crowd would be out “cruising” again.

- Targeted outreach (including condom distribution) at bars, clubs and parties, where the majority of respondents say they meet their sexual partners.
- Increase availability of condoms at multiple locations including schools, medical facilities, community action programs, the Salvation Army, farmers’ coops/elevators, etc.
- Increase availability of rural sensitive print media materials at multiple locations, including public libraries, grocery stores, and other locations where information can be made generally and anonymously available.

### **IMMIGRANTS IN SOUTHWEST AND NORTHWEST MINNESOTA**

The immigrant groups that were studied through this needs assessment were Lao, Latino, and Somali.

#### ***Perceptions of HIV***

- Over 50% of the respondents thought they could acquire HIV through insect bites.
- Only 16% of respondents knew HIV was spread by sharing needles for injecting drugs.

#### ***Lack of Trust in Western Medical System***

Immigrants do not readily trust representatives of government agencies, and tend not to access services in public health clinics. This presented barriers to those performing the needs assessment; participants felt the survey was being used to identify carriers of HIV disease. It was hard to assess the prevalence of high-risk behavior, as only 8 percent of respondents chose to answer these questions on the survey. This reluctance to reveal personal information about sexual and drug using habits is itself an indication of the need to proceed with

sensitivity and creativity in providing information and performing risk assessments.

### **Access to HIV Prevention Education**

Mobility of migrant workers presents a barrier to contacting and discussing availability and accessibility of education as they often work 16 hours a day. However, immigrants are often involved in several community institutions, including churches, and the workplace; most usually work in processing plants that could provide opportunities and venues for HIV prevention education activities.

### **Language Barriers**

Language barriers exist for most newly arrived immigrants. Most immigrants learn English as a second language after they arrive in the United States. Many do not read or write in their own native language. This is especially true of Somali immigrants because their language has only been a written language for twenty years.

## **MIGRANT FARM WORKERS**

Although this study with migrant farm workers was conducted in Michigan, the findings are still helpful as Minnesota is part of the same central stream of migrant farm workers, made up of mostly Mexicans and Mexican Americans. In 1998 and 1999, the researchers looked at knowledge of HIV/AIDS and risk behaviors among 109 adult and adolescent Midwest migrant farm workers, both men and women, most of whom (87%) were Mexican or Mexican American. Seventy percent (70%) were born in Mexico, although this was not as common with the younger participants. Most of the group spent the winter months in Texas, Florida, or Mexico. Overall, the group had a low level of acculturation, indicating extensive use of Spanish in their everyday life, although the younger women were more acculturated than younger men or adults of both genders. Younger women also had more education.<sup>186</sup>

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<sup>186</sup> Ford et al, *AIDS Education and Prevention*, 2001

## **Knowledge of HIV and Condoms**

Most of the respondents knew that HIV could be transmitted through vaginal, oral and anal sex. However, a number of people thought that it could be transmitted through casual contact (30%) or through kissing (62%). About one third of the respondents thought that a person with HIV/AIDS would look sick, and around half thought that there was a cure for AIDS. The level of acculturation was not significantly related to the level of knowledge about HIV.

Almost everybody said that they knew what a condom was, but only 51 percent reported that they knew friends that used them. About one third of men and women had ever used a condom, and about the same proportion had used a condom the last time they had sex.

Only 7 percent thought that condoms were a good way to prevent pregnancy, and 10 percent believed that condoms could protect against HIV. Fifty-four percent (54%) thought that condoms were only for gay men, while one third reported that it was only necessary to use condoms with prostitutes.

## **Views of Premarital Sex**

Three fourths of the women reported that they had only had one partner in their lifetime, while the men reported an average of 6 partners. Only two males reported same sex behavior. Gender and age made a difference in the way the participants viewed premarital sex. Seventy-six percent (76%) of males under the age of 21 felt that premarital sex was acceptable, compared with 38 percent of young women. Fifty-seven percent (57%) of men and 50 percent of women over the age of 21 thought that premarital sex was acceptable.

## **Comparison to Data of Urban Latino Youth**

Data from this study was compared to an earlier study from 1991 with urban Latino youth from Detroit. The comparison, while based on data from two different time periods, did find some differences in knowledge that probably would have been even greater if the Detroit study had been done during the same time period.

The comparison found that the level of acculturation was much lower among the migrant population. Although sexual experiences were similar for both groups, the Detroit population had more accurate knowledge about HIV and condoms. Another difference that was noted was that over 40 percent of the migrant workers reported that condoms were too expensive, while only 15 percent of the youth from Detroit had the same concern.

**Recommendations of Study**

The study recommends that HIV prevention programs targeting migrant farm workers must take into consideration the mobility, lower level of acculturation, and generational differences. Interventions should be brief so that they can be delivered during the short months of an agricultural season. Effective prevention programs must also be culturally and linguistically appropriate.

**Women at Greater Risk**

Another study done among migrant farm workers in southern Florida found that women were at greater risk for HIV infection.<sup>187</sup> The study reported the following for a sample of 121 male and 123 female Latino migrant and seasonal farm workers:

- 55% had unprotected vaginal or anal sex during past three months.
- 66% reported not using condoms in the last year.
- 66% perceived no partner risk for HIV.
- 21% had been ever been tested for HIV.
- 22% had never heard of HIV.
- 70% reported having some or a lot of knowledge of HIV.
- 15% of women had been paid for sex.
- 33% of men had paid for sex and 5% had been paid for sex.
- Women were 4 times more likely to be at risk for sexually acquiring HIV than men.

<sup>187</sup> Fernández et al, *AIDS and Behavior*, 2004

**Local Community Forum**

In the fall of 2003, a community forum was held with 9 Latino male migrant farm workers in Montgomery. The forum was focused on knowledge of HIV/STDs, barriers to testing for HIV, and what can be done to make it easier to test.

Overall, the group knew what HIV is and how it can be transmitted. One person stated, *“people who are heterosexual and who have a matrimonial relationship we see that there is no need to get tested. Now here in our case most of us got here and are alone. That is an issue that is against one’s own self, in that one searches for companionship, whether it be masculine or feminine, even the heterosexuals. We often do not think about taking care of ourselves, rather we think about taking care of our kids.”*

**Barriers to Testing**

Participants identified the following barriers to being tested:

- Ignorance – not knowing why to take the test
- Fear of getting any kind of test
- Custom of not going to the doctor unless sick
- Denial
- Perception that an HIV test is very expensive
- Most of the migrant workers do not have health insurance

**How to Increase Testing**

Participants also provided their recommendations about what could be done to get more Latino men to test:

- Have pamphlets available that explain HIV and the test, especially for newly arrived immigrants.
- More education about HIV and why it is important to test in the workplace and with families.
- Have the tests available during hours migrant workers are not working (they work 6 a.m. – 6 p.m.).

- Testing campaign with mobile clinics.
- If the tests are expensive, allow for payment plans.

One person noted that there used to be workers that went from house to house distributing condoms and talking to the migrant farm workers about HIV. This does not happen anymore. It was also noted that an effective location for providing information or having talks about HIV would be at the factories or in a park in front of the factory.

### **COLLEGE-AGE YOUTH (18-24 YEARS) IN NORTHWEST MINNESOTA**

Information on this population was collected through a series of community forums at technical colleges and university campuses at five cities in the region. A sixth forum was held in a town where large numbers of 19-24 year old persons worked in local industries. Surveys were also distributed through bar outreach and community events and completed by 134 individuals.

#### ***Norms and Behaviors that College Aged Youth Think Put Them at Risk***

Common norms and values within this population included experimenting with many new things. It is the first time away from home for many of these youth. Media messages around sexuality are everywhere - youth grow up desensitized to sex. Perhaps as a result, there is confusion between sex and intimacy. Sex before marriage is perfectly acceptable. Serial monogamy is very common; however, people are not honest about the number of partners they have had.

Prevalent attitudes are *"I don't care,"* and, *"It won't happen to me."* Low self-esteem is prevalent. Family values and expectations are often missing. Many youth do not feel responsible for their actions. Common risk behaviors include drug and alcohol use, casual sex, multiple sexual partners, experimenting with injectable drugs including steroids, inconsistent condom use, and waiting for a crisis to occur before seeking services.

### ***Barriers to HIV/STD Prevention***

Many barriers to utilizing prevention services were identified. Many youth choose to continue their education. This decision often prompts them to relocate, creating a need to learn where and how services are provided in this new community. Most colleges or technical schools provide student orientation, but this does not include information on services provided in the community. The portion of youth who choose not to attend college or technical school are hard to reach, because they are often employed in many different types of jobs.

Many 18-24 year old persons are no longer covered under a parent's insurance policy and this means they will incur the expense of HIV/STD testing and treatment.

Testing in rural areas is a barrier in itself. The nearest testing site may be at least 90 miles away, and they may not have transportation. While there is testing available at local clinics, many feel confidentiality is lost in small towns. Many public health clinics do not offer HIV testing, but refer the client to their local provider. Common feelings expressed were being fearful of test results and embarrassment about being tested.

### ***What Greater Minnesota College-Aged Youth Need to Prevent HIV/STDs***

- Access to condoms.
- Access to testing services, such as a mobile unit that provides a range of health related screenings at set locations and times, including evening hours.
- Parent Education addressing child and adolescent sexuality and training on communication skills. Parent teacher conferences, preschool screenings, and community education classes could be effective venues.
- School based education that integrates behavior change messages into all school health programs.
- School based clinics, which provide actual STD testing or referrals to testing.
- Physician education to train physicians and other health care workers to

proactively perform HIV/STD risk assessments, and provide risk reduction education for 18-24 year olds. Physicians should not assume clients of this age will ask appropriate questions.

- Promote linkages between chemical dependency, mental health, STD/HIV prevention, and pregnancy prevention programming.
- Media to publicize existing resources (e.g. toll free information lines, and free HIV test sites) more widely.

### **YOUTH (AGED 13 – 21) AT RISK**

Approximately 400 surveys, 14 key informant interviews, and 14 focus groups were completed among youth who were or had been in foster care, mental health and/or chemical dependency programs, alternative learning centers, and juvenile detention centers across the state. In addition, two focus groups of youth-serving professionals were also held.

#### ***Behavior that Puts Youth at Risk***

- 85% have ever had sex.
- 43% say they have sex one or more times a week.
- 58% said they had had three or more partners since the first time they had ever had sex.
- 17% say they have ever been, or ever gotten someone pregnant.
- 31% did not use any kind of protection the last time they had sex.
- 60% only sometimes, or never used condoms during sex. Only 26% said they always used condoms. (The rest said they had not had sex).
- 25% said they drank alcohol one or more times a week, and 9% said they drank every day (12% said they never drank).
- 22% had tried illegal non-injecting drugs (marijuana, cocaine, inhalants), and nearly 37% said they used one or more times a week.
- 81% said they had never injected drugs, but 3% said they injected one or more times a week, and 3% said they injected every day.

- 60% have some form of body piercing and/or tattoos, and two thirds of those did not use a professional service.

#### ***Attitudes and Norms that Contribute to HIV/STD Risk***

Youth listed the following factors that they felt placed them at risk for HIV: devaluation of youth by society, fatalism, anonymous exploration of sexuality, peer expectations regarding sexual activity, lack of relationship skills, sexuality labels, sexual identity, isolation, feelings of invincibility, a desire to feel loved, rejection, chemical use, lack of skills integration, and lack of sex education.

Barriers to HIV/STD prevention include fear, embarrassment, and denial; concerns about confidentiality; lack of funds, the need for parental approval prior to receipt of services or participation in educational activities; societal and peer expectations regarding sexual activity; and prejudiced attitudes on the part of providers based on youth appearance. These barriers are complicated by geographic distance, and lack of transportation.

#### ***What Greater Minnesota Youth Need to Prevent HIV/STDs***

- Comprehensive services including medical care, emotional support, counseling, support from volunteers, housing options, local case management, or compassionate networks.
- Condom distribution in schools, at teen centers, and in street outreach.
- Access to clean needles.
- Education offered in group discussions, one-to-one counseling, lectures, seminars, in schools through comprehensive health education, community centers, and through street outreach.
- Education should address discrimination, high-risk behaviors, condom use, how to change behavior, test site locations, signs and symptoms of STDs, access to condoms, help with chemical dependency issues, access to support from other youth, and help with negotiation and decision making skills.

- Promotion of HIV/STD prevention messages through the mass media, including magazines, newspapers, and print mass media. Also electronic mass media - messages via the Internet.
- Alternative activities including skateboard parks, dance halls, teen centers. Parents' perception that because youth know the information they will act upon it is inaccurate. Youth are risk takers and they need to be provided with non-deadly risk taking opportunities."

### **NATIVE AMERICANS**

The responses from the community forums and needs assessment surveys conducted with Native Americans from various regions of Minnesota was included earlier in this chapter, so the findings are not repeated here.

### **COMMUNITIES OF COLOR IN NORTHEAST MINNESOTA**

In 1995-1996, Fond du Lac Human Services performed needs assessment activities among people of color living in five towns in Northeast Minnesota - Bemidji, Duluth, Grand Rapids, International Falls, and Virginia.

A total of 263 individuals completed the needs assessment surveys. Fifty-four percent (54%) of the participants were Native American, 15 percent were Asian, 14 percent were multiracial, 11 percent were African American, and 6 percent were Latino. In addition, 4 focus groups were held, and 3 interviews were done with key informants.

#### ***Risk Factors Among Rural People of Color***

- 13% of respondents had six or more sexual partners in the last year.
- Of sexually active respondents, 32% said they never used condoms, and 36% said they only sometimes use condoms.
- 12% of respondents reported having sex with multiple partners.
- Alcohol and drug abuse were most frequently mentioned as high-risk behaviors, followed by multiple sex partners and unprotected sexual activity.

- Ignorance, denial, lack of communication skills, and low self esteem were mentioned as co-factors for risky behaviors.

#### ***Barriers to HIV/STD Prevention Education***

Respondents identified the following barriers to accessing HIV/STD prevention education: leaders in communities of color in Greater Minnesota tend to be stretched very thin and HIV/STD prevention cannot always be a priority, lack of transportation, lack of child care, inconvenient hours that services are available, lack of linguistically appropriate services, and community members lack confidence in the confidentiality of local HIV/STD testing, counseling, and treatment services.

#### ***What Greater Minnesota People of Color Need to Prevent HIV/STDs***

- Distribution of free condoms at STD clinics and other sites.
- One-on-one counseling regarding use of condoms, negotiation skills, communication skills, and self-esteem.
- Educational community forums led by HIV/STD infected peers.
- Promote HIV/STD comprehensive prevention education and condom distribution in schools.
- Promote comprehensive HIV/STD prevention education at the workplace.
- Provide continuing education for existing agencies.
- Promote collaboration between agencies, and within the community.
- Build community.

**WOMEN AT RISK IN NORTHWEST MINNESOTA**

In 1998, 193 surveys and 21 key informant interviews were completed by clients of battered women’s shelters, family service agencies, women’s correctional facilities, public health agencies, educational facilities, pregnancy centers, college student health centers, GLBT organizations, and family planning agencies. Five focus groups were also held, of which one was with women who were or had been sexual partners of men who have sex with men, or of persons living with HIV/AIDS, or who had been diagnosed with HIV.

**Risk Factors among Women**

Approximately 36 percent of the women surveyed stated that they had had sex with 2 or more partners in the last year. Five percent (5%) had had sex with 6 or more partners. Only 19 percent of women said they always use condoms when they have sex, and 23 percent said they never used condoms when having sex. Twenty percent (20%) of respondents had ever been diagnosed with an STD. Only a slight majority of respondents stated that they trusted their partners to tell them if they acquired an STD (61%), or they were having sex with other people (55%). Small minorities stated that their partners would not let them use condoms (5%), or that they did not dare ask their partners about HIV/STDs (7%).

**Barriers to HIV Prevention Education**

Women stated that they lack confidence in the confidentiality of local HIV/STD testing, counseling, and treatment services, and that while they would visit private health providers for HIV/STD testing and counseling, such providers are often uncomfortable discussing sexual issues.

There is significant denial in rural communities that HIV/STD transmission is even an issue for women. Over 30 percent of women said they lacked motivation to access education about HIV/STDs. Given that significant travel is required for many rural women to access health clinics, libraries or

public health facilities, this is understandable. Women also said that obvious places to find information, like AIDS service organizations, “are never open.” Other reasons women gave for not accessing HIV/STD prevention education were lack of time, and fear the people will think they have HIV.

- What Greater Minnesota Women Need to Prevent HIV/STDs**
- Informal peer support and education groups to address reluctance to talk about sexual behaviors, sexuality issues, and self-esteem.
  - Information about discrimination, high-risk behaviors, bisexuality and implications for female sexual partners, where to get support from other women, and one-to-one counseling.
  - Integration of HIV and STD education into health education provided at doctors visits.
  - Training of providers to increase their comfort level when discussing or teaching sexual topics.
  - Educational outreach and social marketing by peers and key influential people in the community.
  - More publicizing of hotlines.
  - More publicity about, and access to testing and counseling locations.
  - HIV/STD prevention information made available at worksites, day care centers, fitness centers, community health fairs etc.
  - Use mass media to provide HIV/STD prevention education – “small town Minnesota watches a lot of TV.”

## **HIV POSITIVE INDIVIDUALS IN GREATER MINNESOTA**

In 1997 and 1998, the Rural AIDS Action Network conducted one focus group with people living with HIV/AIDS and in addition, they received 7 completed surveys.

### ***Barriers to Prevention Education***

There continues to be a perception among rural Minnesotans that HIV does not occur in Greater Minnesota. Consequently, HIV infected people in Greater Minnesota experience an immense sense of isolation. The lack of peer connections in Greater Minnesota for persons living with HIV is the most significant barrier to providing HIV/STD prevention education to this population.

The long distances required to travel to access health care and support services is challenging, especially when a person does not have transportation or is not feeling well. Difficulty in accessing basic health care and HIV treatment is also a barrier, since this is a primary source of information for prevention education for HIV infected people. As with other communities living in Greater Minnesota, HIV positive individuals lack confidence that confidentiality will be respected by local health care services.

### ***What Greater Minnesota HIV Positive Individuals Need to Prevent HIV/STDs***

- Peer led community outreach programs.
- Local providers need to increase collaborative and networking efforts, and cross-refer to appropriate agencies.
- Local HIV positive role models who are "out" about their status. Messages should include information about family and religious community to begin to break down the misperceptions that HIV and STDs destroy these crucial support components of the lives of HIV positive people.

## **IDUs IN GREATER MINNESOTA**

As noted in Chapter One, 24 percent of new HIV cases diagnosed among IDUs between 2001 and 2003 were reported as living outside of the metropolitan area. This percentage is high considering that 11 percent of new cases overall reported living in Greater Minnesota.

No specific needs assessment activities have been done with IDUs living in Greater Minnesota, but we do know that they are a difficult population to reach. They are not a population that is concentrated in any one area, and they are likely to be more undercover about their injecting drug use than their counterparts in the metropolitan area. They are also probably less likely to be aware of the Syringe Access Initiative. In addition, there are fewer pharmacies in Greater Minnesota that participate in the Syringe Access Initiative.

**SUMMARY**

***HIV prevention needs in Greater Minnesota:***

- Change community norms that support taboos against discussing or accepting HIV, STDs, sexuality, and homosexuality.
- Change community norms that support excessive use of alcohol.
- Provision of comprehensive and accurate HIV/STD prevention information in schools and other public institutions.
- Access to HIV/STD testing and risk assessments through local health providers.
- Local health providers are deemed trustworthy and confidential.
- Availability of culturally competent and bilingual health and HIV/STD prevention services for people of color.
- Address divergent cultural norms that promote sexual activity through the media, and simultaneously create a taboo against discussion and education around sexuality.
- Address geographic barriers to accessing HIV/STD prevention education and services.
- Intentions to change behavior are strengthened.
- Change social norms to foster safer sex.
- Greater efforts to expand the Syringe Access Initiative in Greater Minnesota, and to reach a growing IDU population.

**Physical and Mental Disabilities**

**DEAF AND HARD OF HEARING**

The CDC estimates that between 8,000 and 40,000 deaf and hard of hearing individuals are HIV positive in the United States. While the numbers are an estimate, there is little doubt that seroprevalence among the deaf and hard of hearing community is higher than in the general population.<sup>188</sup>

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals conducted a risk assessment of 250 individuals, of which 22 percent were program participants and the remainder were from the community at large. Only 15 percent of respondents from the community demonstrated knowledge about how HIV is transmitted.<sup>189</sup>

***Barriers to Prevention***

A primary reason for the ignorance about HIV is that information has not been developed in a way that is understandable to deaf people. Deaf people often have difficulty understanding written material. Deaf and hard of hearing people largely communicate through American Sign Language (ASL). The average deaf person reads at a fourth- or fifth-grade level, partly because ASL sign language is so structurally and grammatically different from written English. As opposed to the hearing community, deaf people don't have the opportunity to gather information by listening to news or prevention messages on the radio or TV.<sup>190</sup> There is also very little HIV or sexuality education in schools for the deaf, especially for teenagers. As a result, deaf children have less awareness about HIV.<sup>191</sup>

There are certain issues that have traditionally been taboo in the deaf community which make it difficult to address HIV

<sup>188</sup> HRSA, *HRSA Care Action*, 2001

<sup>189</sup> Ibid

<sup>190</sup> Sleek S, *The APA Monitor Online*, 1998

<sup>191</sup> Center for AIDS Prevention Studies, 1999

prevention: alcohol and drug abuse, childhood sexual abuse, and homophobia.<sup>192</sup>

While accurate information about HIV has been lacking, the mainstream misinformation, stigma and prejudice about, and towards people with AIDS and gay people, is present within the community. Many members are afraid to access mainstream services for fear of having their confidentiality violated, particularly when they need to communicate with service providers through an interpreter.

### **Risk Behaviors**

A focus group for the deaf and hard of hearing was held at a 1994 conference in Minneapolis convened by the community to increase awareness of HIV and AIDS.

Many members of the community put themselves at risk through alcohol and drug use, and through the unsafe sexual behavior that occurs when partners have difficulty communicating with each other. Self-esteem issues, related to stereotyping of gay men and of deaf people, from both within and from outside the community compound the likelihood of high-risk behavior.

### **What Deaf and Hard of Hearing People Need to Prevent HIV**

In two community forums held in 2001, deaf individuals said that the following interventions are important in their community for preventing HIV:

- HIV education in programs with deaf children.
- Strong visuals and graphics should be used in brochures and other media.
- Simple language should be used in prevention materials.
- TTY Hotline
- Develop an MSM video about safe sex using deaf actors and captioning. Develop a series of videos on substance use and HIV, MSM and HIV, people who don't identify as gay and HIV.

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<sup>192</sup> Ibid

- Easy access to condoms and dental dams in deaf clubs, Minnesota Rainbow Alliance for the Deaf (MNRAD) meetings, at Communication Services for the Deaf (CSD), gyms, and at gay bars.
- Have a brochure to hand out with condoms that explains how to use them in simple language and with pictures.
- Have an advocate to accompany people to testing. Have the advocate arrange for an interpreter.
- Testing and counseling should be done along with outreach. Do outreach in bars, coffee shops, deaf clubs, MNRAD events.
- Doctors should speak to patients about sexual behaviors and risks. They think deaf people don't have sex.
- Support group for people who are infected.
- Prevention case management should be provided by someone who is culturally competent instead of using an interpreter.
- Have HIV prevention workshops for deaf people only.

The Center for AIDS Prevention Studies (CAPS) at the University of California San Francisco (UCSF) developed a report that recommends a better understanding of the strengths of the deaf community. Because the deaf community is close, there is a greater degree of physical and emotional intimacy. Because ASL is a visual language, sexual and drug issues must be addressed openly. Deaf persons often have more comfort discussing sexuality and drug use, which can help in understanding and negotiating safer behaviors.<sup>193</sup>

Prevention programs and materials for deaf people should be as clear and as visual as possible. Presentations should incorporate opportunities for longer discussions, physical activities, pictures, dolls, graphic manuals in ASL, and captioned videos. Interactive video and the Internet also provide opportunity to reach the deaf community. Programs for the deaf should also address issues such as

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<sup>193</sup> Ibid

negotiating safer sex with a hearing partner, and breaking down barriers about sexual and substance abuse among deaf persons.<sup>194</sup>

### **MENTALLY RETARDED OR DEVELOPMENTALLY DELAYED**

The Women's Community Workgroup described the following risk factors and/or barriers to prevention messages:

- Developmentally delayed individuals do not understand many prevention messages or are viewed as not understanding.
- They are often sexually abused.
- They experience inability to advocate for themselves around condom use.
- They are vulnerable.
- They don't know how to get their sexual affection needs met.

The Governor's Task Force on Gay and Lesbian Minnesotans produced a report in August of 1995. In the report, the Governor's Task Force discussed discrimination faced by Minnesotans with Disabilities who are Gay/Lesbian/Bisexual/Transgender. They face discrimination from society for their sexuality and for their disability, from the GLBT community for their disabilities, and from the disabled community for their sexuality. Often perceived as unattractive, or asexual, people with disabilities are often overlooked in prevention efforts. Many disabled persons have spent long periods of time institutionalized, and often have had no sex education or counseling.

## **Gender Identity**

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The Governor's Task Force on Gay and Lesbian Minnesotans estimates that 1 to 5 percent of the population are transgender or have these feelings, but only a fraction have learned to accept this special part of their lives. Male to female transgender people are usually more visible than female to male, because society has developed certain standards of acceptance, and because of taboos that exist against men wearing clothing usually reserved for women.

Studies show that transgender individuals have elevated rates of HIV, particularly among transgender sex workers. These studies focus primarily on male to female transgender individuals. Possible reasons for the higher rates among transgender sex workers are more frequent anal receptive sex, increased efficiency of HIV transmission by the neovagina, use of injectable hormones and sharing of needles, and a higher level of stigmatization, hopelessness, and social isolation.

Female to male transgender persons who identify as gay or bisexual may be having sexual intercourse with biological men who are gay or bisexual. Because the prevalence of HIV is higher among MSM, female to male transgender persons who identify as gay or bisexual are at greater risk for HIV than those who identify as heterosexual.

### **Definitions and Terms**

*Transsexuals* are people who feel that they are not the correct gender for their physical body. Most desire to change their body so that it physically matches their gender through hormonal treatment and/or gender reassignment surgery. *Cross Living People (transgenderist)*, choose to live and function in the role of the opposite gender full time, yet may not seek gender reassignment surgery. *Crossdressers (transvestites)* are people who dress in the clothing usually reserved for the opposite sex; some dress flamboyantly, but most crossdressers do not. Crossdressers are by far the overwhelming majority of

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<sup>194</sup> Ibid

transgender people, but are often the most invisible and the most closeted.

### ***Negative Stereotypes and Public Ignorance***

Transgender persons experience negative stereotypes and public ignorance. Transgender persons living in Greater Minnesota face significantly greater isolation and lack of support and resources than those persons living in the metro areas. Gender identity counseling is available at the University of Minnesota, and other private clinics in the metro area. Social organizations and support groups also exist. The community is active in trying to educate the public on transgender issues. However, most counselors and human service workers have little knowledge or experience with gender identity issues, and many transgender people are damaged, rather than helped, in their therapy by mental health professionals.

## **NEEDS ASSESSMENT OF TRANSGENDER PEOPLE IN MINNESOTA**

A needs assessment was performed with 59 transgender individuals who participated in an HIV prevention education workshop held by the University of Minnesota Program in Human Sexuality in collaboration with City of Lakes Crossgender Community, Minnesota Freedom of Gender Expression, Minnesota AIDS Project, and the Aliveness Project.<sup>195</sup>

### ***Focus Groups***

In the development of that program, a needs assessment of transgender persons at risk for HIV infection was performed. Four research focus groups were conducted, consisting of:

1. Compulsive crossdressers,
2. Transgender persons living with HIV/AIDS,
3. Mixed group comprised of individuals representing a spectrum of transgender identities, and
4. Transgender hustlers/prostitutes.

In that study the following behaviors and situations that help to explain elevated HIV

transmission risk were described as being prevalent in the transgender community.

### ***Compulsive Sexual Behavior***

Shame, isolation, and fear of rejection contribute to a compulsive sexual acting out pattern, often associated with alcohol and drug use.

### ***Secrecy***

Many transgender persons, especially crossdressers, are afraid of being found out. Secretive activities may include sexual encounters that are kept secret from their primary partners. Associated guilt, shame, and low self-esteem further amplify the risk for unsafe sexual acting out.

### ***Sexual Identity Conflict or Confusion***

The search for one's true self is often accompanied by sexual experimentation and risk behavior. In addition, being considered attractive as a sexual partner is very affirming to one's crossgender identity. This affirmation may interfere with setting limits and assertiveness during sexual encounters.

### ***Unique Identity Status***

Sexual negotiation is complicated by the unique physical situation (e.g., women with breasts and penises, men with vaginas). Shame and fear of discovery/rejection may prevent open and clear communication.

### ***Prostitution***

Some seek sexual encounters in the crossgender role, and resort to prostitutes to avoid the extra effort involved in finding a sexual partner otherwise, to ensure anonymity, prevent rejection, or to act out a fantasy. Others work as hustlers/prostitutes to supplement income that might enable them to pay for sex reassignment, or to compensate for lack of employment due to discrimination. The objectification of the transgender hustler/prostitute by the customer reduces the likelihood of safer sex.

### ***Vulnerability to Assault***

Male to female transgender participants reported experiences of not being prepared

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<sup>195</sup> Bockting et al, *AIDS Care*, 1998

for increased vulnerability in the role of a woman as opposed to the role of a man. In the crossgender role, they experienced lack of safety in situations in which they normally would not have felt threatened. Limitations in padding in the crossgender role, and being "read", further increased the likelihood of assault.

### **Sharing Needles While Sharing Hormones**

Transsexuals may experiment with or acquire hormones through informal networks. Silicon is also sometimes injected to feminize the body.

### **Focus Group Recommendations**

Focus group participants confirmed the need for targeted interventions to address the specific needs of the subgroups of the transgender population they represented, and made the following recommendations:

- Support for actualization of one's crossgender identity and role as a way to enhance self-esteem and increase responsible behavior.
- Peer education.
- Community involvement.
- Education should respond to specific risk factors, including sexual compulsivity, and risk for assault.
- Provide clear instructions for safe sex.
- Education of health professionals about transgenders to increase their sensitivity and make it safer for transgender clients to discuss issues with their health care providers.

### **NATIONAL RESEARCH**

Participants in a study conducted in San Francisco reported many of the same issues as the individuals who participated in the local needs assessment. The study sample consisted of 392 male to female and 123 female to male individuals who participated in an interview, were given an HIV test, and two

weeks later were given their test results and provided counseling and referral.<sup>196</sup>

### **Sociodemographic Differences**

There were many sociodemographic differences between the male to female participants and the female to male participants. While 67 percent of female to male individuals identified as White, only 27 percent of male to female individuals were White. The remainder identified as African American (27%), Latino/a (27%), Asian/Pacific Islander (13%), and Native American (6%).

Male to female transgender persons were more likely than female to male individuals to identify as heterosexual, to have previously been incarcerated, to be in an unstable living condition, have low education, and low monthly income. Thirty-two percent (32%) of male to female persons reported having done sex work in the last six months. Eighty-one percent (81%) of female to male persons were employed.

Fifty-two percent (52%) of male to female participants did not have health insurance compared to 41 percent of female to male. Of those who were insured, male to female individuals were more likely to be on public health care programs (34%) while female to male participants more often had private insurance (47%).

### **HIV Infection**

Of the 392 male to female participants, 137 individuals (35%) tested positive for HIV, of whom 65 percent already knew their status. Twenty-one (21) persons did not know their status and did not return for their results. Sixty-three percent (63%) of the African American male to female participants were HIV positive. Of the persons who knew they were infected, 78 percent were receiving medical care, and 58 percent were receiving antiretroviral therapy. Only 2 of the female to male had positive HIV test results, and both already knew and were in care.

<sup>196</sup> Clements-Nolle et al, *American Journal of Public Health*, 2001

**HIV Risk Behaviors Among Male to Female Transgender Participants**

Sixty-five percent (65%) of male to female participants reported injecting hormonal drugs. Approximately one fifth had injected non-hormonal (street) drugs in the past six months, and this behavior was more common among those who were HIV positive. Almost half of the people who injected street drugs shared needles and backloaded, and 29 percent shared cookers.

The following sexual risk behaviors occurred during the preceding six months among male to female transgender persons:

- 37% had more than 10 partners
- 75% had sex with males, 6% with females, 8% with other transgender persons
- 62% engaged in unprotected receptive anal sex with main partner, 44% with casual partners, and 28% with partners with whom they exchanged sex for things needed (money, drugs, shelter, food)
- Only 7% had undergone vaginal reconstruction surgery so unprotected receptive vaginal sex was rare (2%).

**HIV Risk Behaviors Among Female to Male Transgender Participants**

There was less risky behavior reported by female to male transgender participants. Eighteen percent (18%) of the female to male participants had a history of injecting street drugs in their lifetime, and 54 percent had injected hormones. Most participants in the study (both male to female and female to male) obtained their hormone syringes from a medical provider and only 3 people reported that they had shared hormone syringes in the past six months. Only 5 persons had injected street drugs in the last six months, although 4 of them had shared needles and cookers, and backloaded.

Female to male transgender persons reported that following sexual risk behaviors during the last six months:

- 20% had not had anal, vaginal or oral sex in the last 6 months.

- 58% had sex with females, 18% with males, and 15% with transgender persons.
- 46% had only 1 partner, 32% had 2 to 10 partners, and 2% had more than 10 partners.
- 10% had receptive vaginal sex with a male or transgender person, of whom 67% did not always use condoms.
- 7% had receptive anal sex with a male or transgender person, of whom 56% did not always use condoms.
- Only 2% had undergone penis reconstructive surgery, so insertive vaginal and anal sex was rare.
- 31% had a history of sex work or survival sex.
- 59% had been forced to have sex or were raped.

**Study Recommendations**

The study made several recommendations regarding prevention interventions with transgender individuals:

- Street outreach and more intensive HIV prevention interventions, such as prevention case management, are needed for sex workers and should include education, job training, and job placement.
- Jails and prisons may be good settings for HIV prevention interventions for sex workers given the high rates of incarceration of this population.
- Public health providers need to ask transgender clients about hormonal and non-hormonal drug practices, and refer them to harm reduction and treatment interventions.
- Health care providers should assess the potential for depression and suicide.
- Needle exchange programs should reach out to transgender persons and provide both hormone needles and non-hormone needles.

## Incarceration

Incarceration presents its own set of challenges to HIV prevention, both for individuals who are in prison, and those who have been released. In 2002, the Council on Crime and Justice conducted an assessment of the HIV/STD needs of African American ex-offenders, which also provides some information on needs within the prison system.<sup>197</sup> The study focused on the needs of African Americans because they are disproportionately represented in prisons, both locally and nationally.

Focus groups and individual interviews were held with 20 service providers in the HIV/STD field, and with approximately 15 male African American ex-offenders. The ex-offender focus group was attended by some men who were HIV positive and some who were HIV negative.

None of the service providers currently had services specifically targeting ex-offenders, but all stated that their programs were open to ex-offenders. One agency said they were in the process of developing a program to provide housing and employment related services for ex-offenders.

### ***Service Gaps Identified by Providers***

Housing was identified as the most important service gap facing African American ex-offenders. Landlords are legally allowed to discriminate against people who have a felony conviction, so ex-offenders are in a particularly precarious situation. Maintaining safe behavior, as well as accessing health care for those who are HIV positive, becomes more difficult when basic needs are not being met.

The second highest priority was the need to evaluate the effectiveness of prevention education. They want to know what works and what doesn't. They also want to learn which interventions change behavior as well as increase knowledge of HIV.

As with housing, many providers noted ex-offenders need assistance finding employment with a decent salary in order to be able to meet their basic needs.

Health insurance coverage is a significant service gap for many African American ex-offenders. In prison, offenders receive care and treatment without having to pay for it. They need assistance finding affordable health care coverage that will be effective the day they are released.

Finally, service providers noted a need for mental health services. One provider indicated a need for family counseling sessions to support the entire family during release. Chemical dependency treatment was also identified as a need by some.

### ***Service Gaps in Prison Identified by Ex-Offenders***

About two-thirds of ex-offenders felt that HIV and STDs are a problem in prison, and most of them felt it was a serious problem. Most believed that more education is needed in prison in order to increase knowledge and reduce stigma. Education about HIV treatment options was identified as a need for individuals who are HIV positive so that they can make informed decisions about their care.

Several participants stated that condoms should be made available in prison. They noted that it is not enough to educate prisoners about prevention if they aren't also given the tools to protect themselves and others.

### ***Service Gaps Outside of Prison Identified by Ex-Offenders***

All participants agreed that more prevention education about HIV/STDs is needed by ex-offenders, as well as education that encourages people to get tested for HIV.

Respondents felt that HIV positive ex-offenders needed more education about treatment options, and education about prevention in order to protect others from their infection and to protect themselves from becoming infected with another strain of the

<sup>197</sup> Council on Crime and Justice, 2002

virus. HIV positive individuals often need help teaching their families about HIV.

Case management immediately upon release was identified as a need for HIV positive ex-offenders. An appointment with a case manager should be set up before release to occur right after release.

Ex-offenders provided some ideas for prevention efforts to reach them:

- Outreach conducted by HIV positive individuals would be the most effective in providing motivation for protecting oneself.
- Prevention efforts should be focused on the couple rather than the individual.
- Outreach efforts should be targeted within African American communities.
- African Americans need to be reached by other African Americans.

There were some differences in the priorities identified by service providers and by ex-offenders. However, there were two areas where they strongly agreed. The first is that case management is needed for HIV positive African American offenders, both in preparation for their release and after their release. Ex-offenders spoke more about health-related case management, while providers also mentioned housing and employment services. Secondly, they both agreed that more effective education about HIV/STDs is needed.

## HIV Resource Inventory

*This section of the Community Services Assessment describes programs and initiatives in Minnesota that are involved in preventing the spread of HIV. Some programs are based at the Minnesota Department of Health; others receive funds from the MDH and are based in the community, while others are independent initiatives.*

### Resource Inventory

The resource inventory lists HIV prevention programs currently being operated in the state of Minnesota. It is not a comprehensive inventory, but is inclusive of programs that are funded through the CDC and state funds administered through the Minnesota Department of Health (MDH), as well as some programs in the community that are funded through other sources. The resource inventory in this chapter includes the prevention programs that were granted awards through the Request for Proposals (RFP) released in the spring of 2002. The programs were implemented in January 2003.

### Department of Health Prevention Programs

#### COUNSELING, TESTING & REFERRAL

##### *Historical Perspective*

HIV counseling, testing and referral (CTR) sites funded through MDH have provided CTR services to over 100,000 people throughout Minnesota since 1985. In 1997, the CCCHAP identified two goals of the CTR system. The primary purpose of CTR was to identify individuals who are HIV positive; in order to refer them to needed services, including medical care, social support, and behavioral change programs. This has primarily been accomplished through CTR services provided at the two STD clinics in the state (Red Door and Room 111), which have been funded since 1985. More recently, community based organizations have also been contracted with to provide OraSure testing on-site or through outreach activities.

The secondary purpose of the MDH-funded CTR testing sites as identified by the CCCHAP was to provide HIV testing to individuals who may not have any other access. Until 2003, this was accomplished through paying the lab costs associated with HIV tests conducted by 32 clinics located throughout the state. In 2003, when faced with state budget cuts, MDH was forced to eliminate funding for sites with the lowest positivity rates, which included the statewide clinics.

##### **Community Advisory Process**

In the spring of 2003, MDH staff convened an ad hoc community advisory group to assist in developing a philosophy to shape the CTR system in the future, to agree on and prioritize goals that reflect the philosophy, and to provide guidance on activities to support the goals.

There were several guiding principles that the advisory group identified. The first is that anonymous testing should consistently be promoted and available as an option to individuals who want to test. The group also felt very strongly that counseling should continue to be a component of all HIV testing encounters. Additionally, the group valued referral and follow-up. They felt that CTR providers should have the capacity to make referrals to culturally appropriate prevention, mental health, substance use, support services, and medical care. The group suggested that CTR sites may want to consider developing on-site partnerships with mental health, substance use, and prevention with positive programs in order to facilitate access and assure follow through.

The group identified five possible goals for the CTR system, and then based on research,

experience, and discussion as a group, engaged in a process to prioritize the top three.

**In rank order, the top three goals for CTR:**

- 1) To prevent infection by:
  - a. Identifying persons at increased risk for HIV;
  - b. Creating a client centered, risk reducing, sexual health promoting behavioral strategy during the CTR session(s); and
  - c. Providing referrals to ongoing prevention programs.
- 2) To prevent transmission by:
  - a. Identifying and notifying individuals who are infected with HIV;
  - b. Creating a client centered, risk reducing, sexual health promoting behavioral strategy during the CTR session(s); and
  - c. Providing referrals to ongoing prevention programs.
- 3) To identify HIV infected persons in order to get them into care and support services.

While funding CTR sites solely for the purpose of identifying HIV infected individuals outside of the context of a prevention strategy will not be priority of the MDH CTR system, it will be a priority to link individuals who are found to be positive into medical care and support services, as they have both a primary and secondary prevention outcome. Antiretroviral medications can reduce viral load, making the risk of transmission less likely. Some Ryan White CARE Act funded support services, such as case management and health education and risk reduction, also provide information on reducing the risk of transmission to others. In addition, medical care and support services provide information and support for improving and maintaining one's health.

Because the focus of CTR is not primarily on identifying HIV positive individuals, MDH funds will not be used to support testing in point of entry sites unless such sites can demonstrate a connection between HIV testing and a broader comprehensive HIV prevention program. Point of entry sites are places where people who are at high risk for HIV are likely to show up, such as substance use and mental health treatment centers, homeless shelters, emergency rooms, etc. CTR sites that are funded through MDH would be able to partner with point of entry sites if they feel that these organizations would be an effective environment in which to recruit participants or deliver interventions.

***Plan for MDH-funded CTR System***

After the community advisory group finished its process, MDH used their input to develop a plan for the implementation of CTR services funded through the health department. The overarching philosophy of the plan is that CTR activities funded through MDH with HIV prevention dollars must be a component of broader HIV prevention strategies. While there are many possible HIV testing providers and opportunities, the priority for MDH will be to provide funding and technical assistance to programs that have the capacity to provide a client centered, risk reducing, sexual health promoting behavioral strategy as a component of CTR. The emphasis of MDH-funded CTR will be to provide a behavioral intervention for both high-risk and HIV positive individuals as part of the testing encounter, and to provide referral into ongoing prevention services.

***Protocols for Behavior Intervention***

Protocols for delivering a client centered, risk reducing, sexual health promoting behavioral strategy will be developed, keeping in mind the constraints related to doing testing in different environments. The goals of such a behavioral strategy (counseling) are to:

- Engage the individual in an initial exploration of his/her HIV risk behavior;
- Facilitate the individual's understanding of issues and circumstances that contribute to his/her risk behavior;
- Identify constructive risk reduction attempts and explore barriers to behavior change;

- Develop a specific, concrete and incremental HIV/STD risk reduction plan;
- Identify resources that will enhance the individual's ability to reduce risk;
- Link individuals with medical and behavioral resources; and
- Elicit the names of partners from individuals receiving a positive test result.

### **Referrals**

CTR sites will be expected to provide referrals to culturally appropriate health education and risk reduction, mental health, substance use, and medical care services in the context of an HIV testing encounter. These referrals may also include programs that address the economic, cultural, emotional, and spiritual needs of individuals. In order to assure follow through and facilitate access, CTR sites may want to consider on-site partnerships.

### **Venues for Providing CTR**

Because the goals of CTR in Minnesota are to reach at-risk or HIV infected individuals, resources will be focused in geographic areas of the state with high HIV prevalence and incidence rates. CTR activities will be implemented through several venues that reach populations with the highest positivity rates. The Partner Counseling and Referral Services (PCRS) program will offer OraSure testing to individuals who have been identified as being sexual or needle-sharing partners of a person infected with HIV. This program has historically had the highest positivity rate because they are working with a population that has had a suspected exposure to HIV.

In addition, the two STD clinics (Red Door and Room 111) will continue to be funded. They are serving a population that has reason to believe that they have been exposed to or infected with a sexually transmitted disease, and the two clinics have historically accounted for testing over 30 percent of new HIV cases in the state.

Finally, community based organizations and clinics, including MDH-funded prevention grantees, will have the opportunity to compete for funds to provide CTR services. Priority will

be given to applicants that can link the CTR program with behavioral interventions. These behavioral interventions can be delivered by the applicant agency or through relationships with other agencies. Applications will also be evaluated for evidence of one or more of the following: past experience with HIV testing, historical positivity rates, and the demonstrated ability to reach at-risk and emerging populations.

### **Testing Technologies**

For most MDH-funded outreach programs, OraSure testing will continue to be the predominant technology used. However, MDH recognizes the value of new rapid testing technologies. Using free test kits available from CDC, rapid testing has been implemented in two clinic settings, which have the laboratory infrastructure to support it. MDH will also pilot rapid testing with community based organizations that are able to meet necessary criteria. The effective use of rapid testing technologies will continue to be assessed.

### **Timeline for Implementation**

In 2004, MDH hired a CTR coordinator who is responsible for developing trainings, continuing education curriculum, and protocol guidelines for counseling to be delivered in the context of CTR. During 2004, the coordinator has delivered training on counseling, and worked with existing STD clinic-based CTR programs to implement rapid testing. She has also been evaluating and updating the current quality assurance plan, and will be working on implementing the plan with funded agencies.

In 2004 and 2005, rapid testing pilot projects will be implemented with a limited number of community based organizations. The CTR coordinator will continue to develop protocols, trainings and continuing education curriculum, and continue to deliver the counseling training for new employees. The coordinator will also identify and address CTR system gaps and capacity building needs, develop the HIV testing site evaluation criteria and evaluation plan for the CTR system. If funding is available, MDH will develop media campaigns designed to reduce stigma related

to HIV and the behaviors that put individuals at risk for HIV. The goal of media will be to encourage testing and knowledge of HIV status.

In 2005, MDH will release an RFP for CTR, evaluate the proposals, and select CTR sites for 2006 through 2008. This RFP will be closely tied to the funding decisions for health education and risk reduction programs, but will occur after that process.

**Perinatal HIV Prevention**

Minnesota experiences a very low rate of perinatal transmission of HIV. Between 2000 and 2003, the overall rate of transmission among all HIV positive pregnant women who gave birth was 2 percent, and only 3 cases of perinatal HIV have been reported to MDH during that time period. MDH continues to monitor rates of perinatal transmission but, unless an increase is noted, will not undertake any specific efforts with health care providers to promote universal HIV screening of pregnant women.

**HIV/STD PARTNER COUNSELING AND REFERRAL SERVICES**

HIV Partner Counseling and Referral Services (PCRS) are designed to facilitate primary prevention of HIV transmission and secondary prevention of diseases and conditions that may ultimately threaten the lives of infected persons.

**Intervention strategies for HIV include:**

- 1) Counseling infected patients about how they can prevent transmitting HIV to others.
- 2) Referring patients for a medical evaluation and other services as appropriate.
- 3) Locating sexual and/or needle sharing partners identified by the patient and notifying them of their risk for infection.
- 4) Referring partners for HIV antibody testing, further counseling and medical evaluation, when appropriate.
- 5) Offering OraSure testing to partners, and providing it when partners agree.
- 6) Counseling uninfected partners about how to reduce their risk of exposure to HIV.
- 7) If partners are infected, counseling partners about how to prevent transmitting HIV to others.

The PCRS program also provides similar services related to the STDs that are reportable in Minnesota: syphilis, gonorrhea, chlamydia, and chancroid.

**Intervention strategies for STDs include:**

- 1) Identification of infected patients through disease surveillance and at STD clinics.
- 2) Ensuring that patients receive and follow appropriate antibiotic therapy.
- 3) Counseling patients about how to prevent re-infection.
- 4) Identification and notification of sexual partners who may be the patient's source of infection or may have been infected by the patient.
- 5) Ensuring that partners receive medical evaluation and treatment as appropriate.

**HEALTH THREAT INVESTIGATION**

The purpose of investigation activities is to interrupt and prevent the spread of HIV and other serious communicable diseases such as tuberculosis, that cause serious illness, serious disability, or death. While efforts undertaken by MDH, local health departments, the private medical sector, and community-based organizations are successful in working with most communicable disease carriers to prevent the further spread of disease, there remain a small number of carriers who are unwilling or unable to conduct themselves in such a manner as to not place others at risk of exposure to their infections. Investigative activities intervene with such clients to maintain community protection.

**INFECTED HEALTH CARE WORKERS PROGRAM**

In 2004, the Infected Health Care Workers Program was moved into the STD and HIV Section from another area of MDH.

In 1992 the HIV/HBV "Infected Healthcare Worker Program" was mandated by the Minnesota legislature. The addition of HCV in 2000 as a condition to report is the first major change to the program since its inception.

This program is intended to promote the health and safety of patients and regulated persons by reducing the risk of transmission of HIV/HBV/HCV during the provision of healthcare through the use of Standard Precautions and other infection control measures. A regulated person is defined as a licensed dental hygienist, a registered dental assistant, a dentist, physician, nurse who is currently registered as a registered nurse or licensed practical nurse, podiatrist, physician's assistant or chiropractor.

The law mandates that any information that is provided to MDH as part of the evaluation process is confidential. This includes information from a healthcare provider and employer.

When the evaluation is complete, MDH establishes a written monitoring plan for the regulated person. The monitoring plan will address the regulated person's scope of practice and any other pertinent issues, as well as establish a process for obtaining periodic reports on the health status of the regulated person. In some situations it may be necessary for MDH to refer the regulated person back to their licensing board for evaluation and monitoring.

## **MASS MEDIA OUTREACH**

MDH utilizes mass media channels as a supplemental strategy to help increase awareness about HIV prevention and promote existing resources. Due to current budget limitations, MDH will primarily rely on obtaining message placements as a public service. Indoor/outdoor, print, electronic and web media channels will be used whenever the opportunities present themselves.

Public service campaigns will be organized around specific state and national health observances: National Black HIV/AIDS Awareness Day, National STD Awareness Month, National Hepatitis Month, GLBT Pride Month, National HIV Testing Day, Black GLBT Pride Month, National Latino AIDS Awareness Day, and World AIDS Day. Whenever possible, existing community planning groups and coalitions are used to help develop and

distribute campaign messages and materials to audiences disproportionately affected by HIV. Existing campaign materials are also pursued and adapted from other national organizations, agencies, companies, and coalitions as a cost-saving strategy.

In 2004, there was paid media campaign about syphilis, which was targeted at MSM during GLBT Pride Month. Strategies implemented during this campaign included print, restroom, bus shelter, and chat room media ads. It also included posters and outreach at events.

At times there are specialized campaigns to release new information to release new information or address disproportionate disease occurrences or outbreaks within specific communities. Examples of these campaigns include the release of the annual HIV and STD surveillance reports, syphilis and the MSM community, HIV and the African immigrant community, and resistance gonorrhea and MSM.

Technical assistance is offered to MDH funded HIV testing sites, community-based prevention agencies and city/county public health departments so they can implement their own campaigns to promote HIV related programs and services.

## **COMMUNITY-BASED PREVENTION PROGRAMS**

These programs provide communities with the opportunity to work intensively with their own members to provide information and build prevention and risk reduction skills. With the new grants that began January 2003, MDH provides programmatic funding and technical assistance for 20 community-based and governmental organizations. MDH funded programs to provide targeted outreach, individual counseling, group counseling, prevention case management, and community awareness interventions to at-risk and HIV positive individuals. Many of these organizations use innovative educational strategies that build skills needed to follow and maintain risk reduction behaviors. The

programs are targeted at youth and adults most at risk of acquiring or transmitting HIV or STDs.

A detailed resource inventory of MDH funded programs that started January 2003 is included at the end of this chapter. The resource inventory also includes CDC directly funded CBOs, programs funded through the MDH Eliminating Health Disparities Initiative, and through Titles I, II, III, IV and Part F of the Ryan White CARE Act.

## **HIV Prevention Programs Within Governmental Agencies**

### ***Community Health Boards***

There are 49 local Community Health Boards that plan, coordinate, and deliver public health and disease prevention services in Minnesota. HIV prevention services provided by these boards include: community presentations, one-on-one disease intervention, and risk reduction counseling and referral. MDH provides technical support to the Community Health Boards through monthly informational mailings, periodic district trainings, and technical assistance with media campaign efforts.

### ***Minnesota Department of Corrections***

The Department of Corrections (DOC) provides HIV testing and counseling for inmates of state correctional facilities. Testing is offered to inmates when they arrive at the facilities. Testing is also available throughout their stay, although it becomes more difficult to request testing after having been in prison. Inmates are required to explain why they think they need to be tested, which may mean admitting to behavior that is illegal in prison.

### ***Minnesota Department of Education***

Coordinated School Health Approach, a collaboration between the Minnesota Department of Education (MDE) and MDH, addresses school-related health policy development, instruction, counseling, support, and community education. Staff assist school districts to implement comprehensive

curriculum and programs to prevent and reduce the risk of HIV/AIDS and remain in compliance with the state STD statute.

Coordinated School Health Approach provides Minnesota school, community and public health educators with a variety of resources and technical assistance, including:

- HIV prevention as a component of comprehensive school health.
- HIV training in Greater Minnesota and smaller school districts.
- HIV prevention with youth at highest risk.
- HIV-related resource development.
- Teacher in-service training.

### ***Minnesota Department of Human Services***

The Minnesota Department of Human Services (DHS) is the Ryan White Title II grantee and directly administers the AIDS Drugs Assistance Program (ADAP) for Minnesota, which provides drugs and health insurance for HIV positive individuals. In addition, they directly administer the dental and nutritional supplement programs. DHS also administers HIV case management programs and other services for HIV positive individuals made available through the federal Ryan White CARE Act Title II funds.

DHS has developed and implemented mandatory guidelines for all licensed chemical dependency treatment programs around HIV prevention education. The guidelines were woefully outdated, and recently DHS worked closely with the Minnesota AIDS Project and the AIDS Substance Abuse Partnership to update the guidelines and bring them in line with protocol developed by the Substance Abuse Mental Health Services Administration (SAMHSA).

Through Office of Refugee Resettlement (ORR) funds, DHS funded three African organizations in 2003 to provide HIV/AIDS awareness and education, and referral into care for those who are HIV positive, in the Oromo, Somali, and Ethiopian communities.

The DHS chemical dependency guidelines address:

- Essential components of AIDS education efforts.
- Elements of AIDS risk assessment counseling.
- Infection control.
- Advisability and implications of both on-site and off-site HIV antibody testing and disease prevention counseling.
- Care and treatment of HIV-infected persons receiving chemical dependency services.

## Capacity Building and Technical Assistance

### MINNESOTA DEPARTMENT OF HEALTH

MDH is becoming increasingly committed to a long term HIV prevention philosophy that encourages integration of HIV prevention activities into existing services and that enables grantees to become self-sufficient. Thus, training and capacity building activities must be made available to agencies and individuals beyond those currently receiving federal or state funds to implement HIV prevention activities.

Recent changes in the organizational structure of the STD and HIV Section facilitate the provision of broader and more in-depth technical assistance to community based agencies. MDH contract managers have always had responsibility for developing the capacity of providers to ensure that the desired services are delivered in an effective and efficient manner. Contract managers work with individual providers to assess and address organizational and programmatic needs. Under the new organizational structure, more emphasis is being placed on providing on-site technical assistance. MDH contract manager staff are expected to have a working knowledge of current scientifically evaluated behavioral interventions and the expertise to assist partner agencies in adapting core intervention philosophies to meet the needs of their target population(s).

### Ongoing Capacity Building Opportunities

MDH routinely provides capacity building and technical assistance opportunities to funded prevention and CTR providers. These opportunities are also available to community health service agencies, community clinics and CARE Act funded providers. The following trainings are designed to strengthen the capacity of these agencies to deliver, design, implement and sustain effective HIV prevention interventions:

*HIV/STD/Hepatitis Update* provides agencies with an annual epidemiological overview of HIV, STDs, and Hepatitis A, B, and C in Minnesota. The update highlights recent trends and disproportionate impact of these diseases.

*Using Research Findings and Information in Program Planning and Design* assists providers in learning how to use research to develop HIV prevention programs that are effective and appropriate.

*Strategies for Planning, Designing and Implementing Outreach Activities* is an ongoing collaborative effort with a network of grantees providing outreach services to MSM that assists these agencies in the development and implementation of outreach services to this population.

*Basics of HIV and STDs* is offered to non-clinical prevention workers who are new to the HIV/STD field or those who wish to have a refresher course. The content includes basic descriptions of HIV and viral, bacterial and parasitic STDs, basic treatment information, and prevention information.

*The Fundamentals of HIV Prevention Counseling* enhances the HIV prevention counseling skills of prevention workers in a variety of settings. The content includes information on counseling skills and concepts and the six steps of HIV prevention counseling.

*Counseling Skills* is designed to enhance the skills of prevention workers in providing positive test results to clients. The content includes the early tasks of living with HIV, and

the appropriate counseling skills and strategies to assist and support clients through this time.

*Administration and Provision of OraSure Testing* is provided to agencies conducting OraSure testing. As rapid testing is piloted with selected community based organizations over the next year, training on the administration and provision of rapid testing will also be developed.

*Joint Prevention and Care Provider Meetings* are held semi-annually and are designed to increase the knowledge among providers of available care and prevention services, and to provide networking opportunities for the providers.

#### **Other MDH Capacity Building Efforts**

A one-year syphilis control and prevention coordinator position was established at MDH in 2004. This position is responsible for assessing the skills and capacity of prevention providers, MDH disease intervention specialists, and clinicians to deliver state of the art syphilis screening, diagnosis and prevention interventions. This position is also responsible for developing and/or coordinating trainings and other activities to address gaps in capacity.

An additional one-year community outreach coordinator position was established at MDH in 2004. This position is responsible for providing guidance to health care providers and other organizations related to addressing and eliminating barriers to HIV testing for Latinos, particularly MSM, immigrants and migrant workers, who are at risk for HIV infection. This individual is responsible for also identifying and/or assisting in the development of culturally and linguistically appropriate HIV testing services in communities where large Latino populations reside permanently or temporarily. This individual will work with community leaders to increase awareness in the Latino community about HIV and to promote testing

MDH maintains a contract with Educational Operations Concepts (EOC), Inc., which provides direct technical assistance and

training to prevention providers in relation to process and outcome monitoring. Assistance is provided in the areas of client-level data collection and reporting, and designing and implementing outcome monitoring activities.

MDH has a contract with a technical assistance provider to design and deliver a project training and technical assistance curriculum for African American agencies funded to implement peer outreach, networking and education activities. In addition, MDH has a contract with an individual to assist the MDH CTR coordinator with the provision of OraSure training to grantees, and to provide technical assistance to grantees related to implementation plans and the selection of sites/activities for providing OraSure testing.

#### **Future Capacity Building Efforts**

In 2004, MDH will conduct an assessment of capacity building needs of prevention providers. One phase of this has already occurred through a survey that was distributed to both prevention and care providers asking them to identify areas of desired technical assistance. MDH will undertake further activities to identify needs specific to implementing prevention programs.

A new training coordinator was hired at MDH in the summer of 2004. The coordinator will be developing a schedule of training opportunities for the upcoming year, in part considering opportunities for national capacity building assistance organizations to assist local providers in strengthening infrastructure in order to build greater capacity to provide quality prevention programs.

### **OTHER CAPACITY BUILDING OPPORTUNITIES**

The agencies and programs described here also provide opportunities for capacity building, training, and technical assistance.

#### **African HIV Collaborative**

The mission of the African HIV Collaborative is to build the capacity of, and coordinate efforts between, existing organizations serving

African immigrants in the area of HIV, and increase participation of African immigrant community members in HIV decision-making entities. The goals of the African HIV Collaborative are to: 1) build the capacity of the African immigrant community to decrease the stigma of HIV through community building and leadership; 2) bring African immigrant communities together around the common problem of HIV, while recognizing cultural differences; 3) strengthen and make the system of services more available to African immigrants with HIV; and 4) provide support, education, and networking for HIV organizations that serve African immigrants.

### ***American Red Cross***

The American Red Cross is a humanitarian organization, led by volunteers, that provides relief to victims of disasters and helps people prevent, prepare for, and respond to emergencies. In response to HIV/AIDS, the Red Cross program provides effective community education about how to prevent the spread of HIV infection; reduce unreasonable fear about HIV and AIDS; and foster a compassionate and humane response toward those living with HIV infection and AIDS. The American Red Cross currently offers general HIV/AIDS certification classes, African American culturally specific HIV/AIDS certification classes, Latino culturally specific HIV/AIDS certification classes, and a culturally specific American Sign Language class. In addition, MDH currently has a contract with the Red Cross to develop a culturally and linguistically appropriate HIV education curriculum for Africans, and to provide the training to grantees funded to implement community awareness activities in African communities.

### ***Hennepin County Human Services Department***

The Hennepin County Human Services Department (HSD) is the grantee for the CARE Act Title I funds used to provide medical care and support services to people living with HIV/AIDS in the metropolitan area. HSD staff routinely offer capacity building opportunities to CARE Act funded providers,

and have been very generous in inviting prevention providers to attend. Trainings have included the following topics: grant writing, recruiting and maintaining staff, program development and evaluation, and cultural competency.

### ***MDH Office of Minority and Multicultural Health***

The Office of Minority and Multicultural Health (OMMH) received funding to build the capacity of minority community based organizations to implement HIV interventions. The OMMH is currently focused on assessing capacity building needs in the African and Latino communities. Results from these assessments will be used to design capacity building interventions. The information will also be used by the STD and HIV Section to inform capacity building efforts within these communities.

### ***Midwest AIDS Training and Education Center***

The Midwest AIDS Training and Education Center (MATEC) is a center at the University of Minnesota that provides education about HIV for health professionals. MDH and MATEC worked jointly to develop a physician and dental consultation program through which physicians and dentists who are HIV experts provide educational consultation services to other physicians and dentists in the state who do not serve a large number of patients with HIV.

### ***United Migrant Opportunity Service, Inc.***

The United Migrant Opportunity Service (UMOS), Inc. offers training and technical assistance to organizations to assist them in learning about HIV/STDs in the migrant community, HIV prevention education, and the development of HIV-related training programs. In addition, UMOS, Inc. provides capacity building and technical assistance on migrant cultural competency, HIV and migrants, behavior change and other risk reduction related areas.

### ***Women and Families Network***

The mission of the Women and Families Network is to address the needs of Minnesota women and families affected by HIV through collaboration, advocacy, training and resource sharing. The network is coordinated by West Side Community Health Services, the Ryan White CARE Act Title IV grantee, in collaboration with the Woman and Families Systems Advocate at the Minnesota AIDS Project (MAP).

The network is comprised of consumers and providers that address the multiple needs of people living with HIV and their families. The network creates the opportunity for formal and informal partnerships to facilitate referrals, avoid duplication of services, and to provide cross-training and support. In order to ensure that services are meeting the needs of consumers, feedback and input is gathered from consumer network members and Consumer Advisory Boards.

In 2003, the Women and Families Network held an HIV Women's Health Retreat focused on gynecological issues for women with HIV, and learning how to talk with providers and each other about these issues.

The Title IV grant recently funded a new position, the Perinatal HIV Nurse Coordinator. This position is responsible for creating and distributing user-friendly tools that explain the recommendations for care of HIV-infected pregnant women, and offer support and education to OB/GYN providers. The nurse coordinator also provides education and support directly to HIV positive pregnant women, or works closely with their case manager. The nurse coordinator is working to develop a system to help ensure that HIV positive women receive care during and after their pregnancy and their children receive ongoing HIV-related care after birth.

### ***Resource Inventory***

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The resource inventory starting on page 177 includes information about HIV prevention services funded by CDC and state funds through MDH. In addition, information is provided about CDC directly funded community based organizations, and efforts supported through MDH's Office of Minority and Multicultural Health Eliminating Health Disparities Initiative. Medical care and support services funded through Titles I, II, III, IV, and Part F of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act are also included.

For each organization providing services, the resource inventory describes the target population, the services provided, and the target area. Under target area, definitions for the metro area vary somewhat for prevention programs and care programs. For prevention programs, it refers to the 7 county Minneapolis - St. Paul metropolitan area. Some programs target clients in a particular portion of the metro area. For CARE Act services, the metro area refers to the 13 county Minneapolis-St. Paul emergency metropolitan area (EMA). In both cases, Greater Minnesota refers to all counties not included in the metro area. Most services in Greater Minnesota are targeted to a specific region. In addition, there are statewide programs that serve clients from the entire state.

#### ***Types of Interventions***

The most detailed information is provided in relation to the health education and risk reduction (HERR) programs funded through MDH, including the type of intervention and numbers of people proposed to be served by each agency.

**Outreach interventions** are generally conducted by peer or para-professional educators and are designed to identify individuals who are at risk for becoming infected with HIV. The outreach activities take place in neighborhoods and other places that high-risk individuals usually congregate. Outreach workers hand out condoms, sexual

responsibility kits, bleach and educational materials about how to reduce risk. They also provide referrals to services that can help people reduce or change their risk behaviors.

**Individual level interventions (ILI)** assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. They include a skills building component. **Group level interventions (GLI)** also contain skills building exercises, as well as education, information and support, and are provided to groups of varying sizes. **Prevention case management (PCM)** provides intensive, ongoing and individualized prevention counseling, as well as support and assistance in accessing other services.

**Community awareness interventions** are designed to provide information and change the way a community *thinks* about something. These interventions are not necessarily designed to make individual people or communities change the way they *behave*. Community awareness interventions are those that the CDC defines as Health Communication/Public Information or Other.

Community awareness activities involve the delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences in order to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk of infection how to obtain specific services.

Examples of mediums used to provide community awareness interventions include: electronic media, print media, hotlines, clearinghouses, presentations or lectures, community events, and websites and chat rooms.

### **Target Populations**

Please note in defining target populations, MDH only required that 50 percent of the clients served be from the target population. For this reason, you will see, for example, that agencies targeting MSM have also proposed to reach women.

During the last priority setting process, the only HIV positive population to be named as a priority target population was HIV positive MSM. However, in the RFP released as a result of that prioritization process, applicants were encouraged to serve HIV positive individuals within the other target populations, as well. Through the RFP process, prevention with positive programs were proposed for heterosexual women and IDUs, as well. As part of the process to address the unallotment of funds in 2003, three prevention with positive programs were funded. One is specifically targeted at HIV positive MSM. The other two programs have group interventions for HIV positive MSM, but also serve HIV positive heterosexuals and IDUs. One group particularly targets HIV/HCV co-infected persons.

## RESOURCE INVENTORY

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
<b><i>MDH Funded Health Education and Risk Reduction (HERR) Programs</i></b>			
Chicanos Latinos Unidos en Servicio (CLUES)	MSM of Color (Latinos)	<p><i>Outreach and OraSure Testing</i></p> <ul style="list-style-type: none"> <li>– Outreach and OraSure testing in night clubs, bars, restaurants, coffee shops</li> <li>– 200 Latinos</li> </ul> <p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, risk reduction counseling about HIV/STDs, substance use, safer sex and building self esteem</li> <li>– 25 Latinos</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Four group sessions focusing on HIV/STDs, substance use, safer sex, self esteem</li> <li>– 35 Latinos</li> </ul>	Metro
Indigenous Peoples Task Force	MSM of Color (Native Americans)	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>– Outreach in public sex places, bars, street, community centers</li> <li>– 100 Native American men</li> </ul> <p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, risk reduction counseling, skill building</li> <li>– 25 Native American men</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Four group sessions on relationship between self, psychosocial issues, and HIV/STD risk; build self-worth</li> <li>– 5 Native American men</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– Small group presentations on gender issues; homosexual behavior; and emotional, physical and sexual abuse</li> <li>– 40 Native Americans</li> <li>– Presentations at Pow Wows on sexuality, sexual practices. Will reach community leaders who will continue to pass on messages</li> <li>– 500 Native Americans</li> <li>– Two Spirit socials to build community, find commonality, and learn about risk reduction</li> <li>– 15 Native Americans</li> </ul>	Metro and on reservations in Greater MN

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
Minneapolis Urban League (MUL)	MSM of Color (African American)	<p><i>Outreach and OraSure Testing</i></p> <ul style="list-style-type: none"> <li>– Outreach and OraSure testing in bars, parks, neighborhoods, community events</li> <li>– 350 African American men</li> </ul> <p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, risk reduction counseling</li> <li>– 100 African American men</li> </ul>	Minneapolis
Pillsbury United Communities	MSM of Color (primarily African American and Latino)	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>– Outreach in bars, streets, shelters, parks, events</li> <li>– 5200 persons</li> </ul> <p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, risk reduction counseling, individual prevention goals</li> <li>– 36 men</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Men’s brunch focused on sexual responsibility, condom use, relationships, HIV/STDs, spirituality, racism, coming out, substance use, etc. Chemical health classes offered during brunch four times a year</li> <li>– 200 men</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– Presentations in group homes on HIV, risk reduction</li> <li>– Theatre presentations exploring myths/prejudices about HIV/STD</li> <li>– 300 men</li> </ul>	Minneapolis
The City, Inc.	Young MSM (African American)	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>– Outreach in schools, buses/ bus stops, concerts, fast food restaurants, schools, barber shops</li> <li>– 50 young African American men and transgender</li> </ul> <p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, skills building and practice, individual prevention plan</li> <li>– 15 young African American men and transgender</li> </ul>	Minneapolis

<b>AGENCY</b>	<b>TARGET POPULATION</b>	<b>INTERVENTIONS</b>	<b>TARGET AREA</b>
Face to Face Health and Counseling Service	Young MSM	<p><i>Individual Level &amp; OraSure Testing</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, HIV education, risk reduction counseling, psychosocial evaluation. OraSure testing at drop-in site</li> <li>– 20 young men</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Support and educational group focused on HIV education, risk reduction, safer sex negotiations, psychosocial evaluation</li> <li>– 20 young men</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– Health information booths at Pride and World AIDS Day to reach 50 youth</li> <li>– Presentations to 200 youth-serving providers about GLBT issues affecting youth</li> </ul>	St. Paul metro area
Youth and AIDS Projects (YAP)	Young MSM	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>– Outreach in bars, parks, beaches, restaurants, entertainment venues, and institutions (shelters, drop-in sites, correctional facilities, support groups)</li> <li>– 250 youth</li> </ul> <p><i>Individual Level &amp; OraSure Testing</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, risk reduction counseling, OraSure testing, monitoring change in knowledge and behavior</li> <li>– 50 young men</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Peer education group session on safer sex, condom use, risk associated with sex and drug use, role plays</li> <li>– 35 young men</li> </ul> <p><i>Prevention Case Management &amp; OraSure Testing</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, behavior change counseling, individual prevention plan, OraSure testing</li> <li>– 50 young men</li> </ul> <p><i>continued on next page</i></p>	Metro

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
Youth and AIDS Projects (YAP), <i>continued</i>	Young MSM	<p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>- Information on HIV and risk reduction provided at community events and through educational presentations in bars, beaches, parks, shelters (1000 youth)</li> </ul>	Metro
Hennepin County Red Door Clinic	Adult MSM of All Races	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>- Outreach at public sex locations, bars and cafes</li> <li>- 975 men</li> </ul> <p><i>Individual Level &amp; OraSure/OraQuick</i></p> <ul style="list-style-type: none"> <li>- Risk assessment, risk reduction counseling, sexual negotiation, communication, maintenance of safer sex behavior, testing</li> <li>- 132 men</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>- 8-session group focuses on increasing condom use and decreasing internalized homophobia (24 men)</li> <li>- Monthly support group for married men who are also attracted to men (96 men)</li> <li>- Chemical/sexual health educational and skills building group for MSM in treatment programs (120 men)</li> <li>- Ongoing discussion group for sexually active gay/bi men on sexual health and other issues (40 men)</li> </ul> <p><i>Prevention Case Management</i></p> <ul style="list-style-type: none"> <li>- Risk assessment, behavior change counseling, individual prevention plan</li> <li>- 6 men</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>- Website with program and testing info, postings to chat rooms</li> <li>- Articles on HIV/STDs, sexual health, program info in gay press</li> <li>- Educational presentations to HIV+ /high-risk MSM (60 men)</li> <li>- Information, referral and recruitment into program at events (1500 people)</li> </ul>	Metro

<b>AGENCY</b>	<b>TARGET POPULATION</b>	<b>INTERVENTIONS</b>	<b>TARGET AREA</b>
Minnesota AIDS Project (MAP)	Adult MSM of All Races	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>- Outreach at bars and public sex places. Offer OraSure through ILI in a van at outreach site</li> <li>- 650 men</li> <li>- Outreach on Internet/chat rooms</li> <li>- 250 men</li> </ul> <p><i>Individual Level &amp; OraSure Testing</i></p> <ul style="list-style-type: none"> <li>- Risk assessment, risk reduction counseling, individual prevention plan, counseling and testing</li> <li>- 300 persons (mostly men)</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>- Group intervention on sexual health, condom use, risk reduction. Leadership and skills training on providing prevention messages to peers/community</li> <li>- 40 men</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>- Distribution of safer sex kits and health promotion messages (8000 people)</li> <li>- Peer facilitated discussions on how HIV/STDs relate to reality for gay/bi men (275 men)</li> <li>- Ads with prevention messages developed by participants</li> </ul>	Metro
Rural AIDS Action Network (RAAN)	Adult MSM of All Races	<p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>- Risk assessment, risk reduction counseling, mental and chemical health screening</li> <li>- 30 men</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>- 10-session peer led groups on homophobia, coming out in Greater MN, HIV in rural areas, religion and GLBT community, safer sex, domestic violence</li> <li>- 15 men</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>- HIV 101 presentations at rural network meetings and campus health fairs, and information at Pride events in Greater MN</li> <li>- 900 persons</li> </ul>	Greater MN

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
Program in Human Sexuality	Adult MSM of All Races	<p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Man to Man Seminar on sexual health, condom use, risk reduction</li> <li>– 60 men</li> <li>– Our Sexual Health Seminar</li> <li>– 40 persons</li> <li>– All Gender Health Seminar</li> <li>– 30 persons</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– Information booth promoting group level events at GLBT Pride</li> </ul>	Metro
Minnesota AIDS Project (MAP)	HIV+ MSM	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>– Outreach at social events</li> <li>– 155 men</li> <li>– Internet outreach through chat rooms and list serves</li> <li>– 20 men</li> </ul> <p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>– Face to face risk assessment, individual prevention strategies, self care and health promotion</li> <li>– 7 newly diagnosed HIV+ men</li> <li>– Internet risk assessment, self care and health promotion</li> <li>– 3 newly diagnosed HIV+ men</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Group training and discussions about risk reduction and self care. Leadership and skills training to provide prevention messages to peers and community. Some participants will be recruited to volunteer for outreach activities</li> <li>– 25 HIV+ persons</li> </ul>	Metro

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
Clinic 42 – Abbott Northwestern Hospital	HIV+ Adults	<p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, develop behavioral goals, supports and barriers</li> <li>– 125 HIV+ persons</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Three groups targeting HIV+ MSM, HIV+ Heterosexuals, and HIV/HCV co-infected persons. Sexual health, dating and disclosure, sexual and mental/chemical health, body image, safer sex skills</li> <li>– 58 HIV+ persons</li> </ul> <p><i>Prevention Case Management</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, behavior change counseling, individual prevention plan</li> <li>– 5 HIV+ persons</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– Coasters with STD information</li> <li>– Website with health information, resources, message board, live chats targeting HIV+ persons and/or negative sexual partners</li> <li>– 100 persons</li> </ul>	Metro
The Aliveness Project	HIV+ Adults	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>– On-site outreach with short prevention messages, safer sex and bleach kits</li> <li>– 500 HIV+ persons</li> </ul> <p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>– Staff and peer-led risk assessment, risk reduction counseling. May include partners sometimes</li> <li>– 100 HIV+ persons</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Group sessions (one for MSM, another for other HIV+ adults) with opportunity for peer modeling of risk reduction skills. Partners may be included sometimes</li> <li>– 125 HIV+ persons</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– Brief on-site individual encounters to give out safer sex and bleach kits, and referrals</li> <li>– 1500 persons</li> </ul>	Metro

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
Breaking Free	Adult African American Heterosexual Women (prostituted)	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>– Outreach targeting prostituted women in areas of high prostitution, bars, hair salons</li> <li>– 1000 persons</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Peer group led by ex-prostitutes and/or ex-addicts. Discussion, role plays, negotiation skills</li> <li>– 15 African American women</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– HIV/STD presentations at treatment centers, halfway houses, Johns school, shelters, churches, community centers, health fairs (4500 persons)</li> </ul>	Metro
Wake Up We're Affected (WUWA)	Adult African American Heterosexual Women	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>– Outreach by peer educators in bars and community events</li> <li>– 840 African American women</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– Presentations and lectures at community events to increase awareness of HIV/STD and empower women to teach others</li> <li>– Forums in clubs, churches, community settings</li> <li>– 1660 African American women</li> </ul>	Metro
The City, Inc	Young African American Heterosexual Women	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>– Outreach at schools, hangouts, bus/bus stops, beauty shops, fast food restaurants, concerts, special events</li> <li>– 150 African American youth</li> </ul> <p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, risk reduction counseling, skills building and practice, individual prevention plan, encourage testing</li> <li>– 15 African American youth</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Staff and peer educator led group with HIV/STD info, risk reduction, sexual violence, skills building</li> <li>– 30 African American youth</li> </ul> <p><i>continued on next page</i></p>	Minneapolis

<b>AGENCY</b>	<b>TARGET POPULATION</b>	<b>INTERVENTIONS</b>	<b>TARGET AREA</b>
The City, Inc. <i>continued</i>	Young African American Heterosexual Women	<p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– Presentations at City Inc, alternative schools, group homes, churches, “hang-out, condom house,” special events, community events, community organizations, community radio.</li> </ul>	Minneapolis
Hennepin County Red Door Clinic	Young African American Heterosexual Women	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>– Outreach at strip clubs that have primarily African American dancers and sex businesses</li> <li>– 200 youth</li> </ul> <p><i>Individual Level &amp; OraSure/OraQuick</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, risk reduction counseling, information about HIV/STD testing, pre- and post-test counseling if test requested during Teen Clinic at Red Door</li> <li>– 100 young women and sexual partners</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Group workshops and skills building for youth in sex businesses, alternative schools, youth shelters, substance use programs</li> <li>– 180 youth</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– Info, safer sex strategies at health fairs, community events, parades, etc.</li> <li>– 350 young African American women and their partners</li> <li>– Website with information, e-mail response with information and referrals</li> </ul>	Metro

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
Face to Face Health and Counseling Services	Young Heterosexual Women of All Races	<p><i>Individual Level &amp; OraSure Testing</i></p> <ul style="list-style-type: none"> <li>- Risk assessment, risk reduction counseling, psycho-social evaluation. OraSure testing offered at drop-in center</li> <li>- 50 young women</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>- Educational presentations on HIV and risk reduction at schools, other agencies, community health fairs (500 young women)</li> <li>- Information on HIV, risk reduction at health fairs, community events (100 young women)</li> </ul>	St. Paul area
Hennepin County Red Door Clinic	Young Heterosexual Women of All Races	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>- Outreach at strip clubs, sex businesses</li> <li>- 150 youth</li> </ul> <p><i>Individual Level &amp; OraSure/OraQuick</i></p> <ul style="list-style-type: none"> <li>- Risk assessment, risk reduction counseling, information about HIV/STD testing, pre- and post-test counseling if test requested during Teen Clinic at Red Door</li> <li>- 120 young women and sexual partners</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>- Group workshops and skills building for youth in sex businesses, alternative schools, youth shelters, substance use programs</li> <li>- 300 youth</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>- Info, safer sex strategies at health fairs, community events, parades, etc. (240 young women and their partners)</li> <li>- Website with information, e-mail information and referrals</li> <li>- Staff training about HIV and how to work with young women regarding sexual health (80 professionals at youth agencies)</li> </ul>	Metro

<b>AGENCY</b>	<b>TARGET POPULATION</b>	<b>INTERVENTIONS</b>	<b>TARGET AREA</b>
Neighborhood House	Young Heterosexual Women of All Races (Latina)	<p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, risk reduction counseling, individual prevention plan, accompany to appointments</li> <li>– 30 young women</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Small group discussions on HIV/STDs, risk reduction, family communication, cultural barriers, skills building, held in community settings or homes</li> <li>– 50 young women</li> </ul>	Metro
Africa Solutions	Adult Heterosexual Women of All Races (African-born)	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>– Outreach in places Africans congregate</li> <li>– 1800 African adults</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– Presentations on HIV and prevention skills in service organizations and at community events</li> <li>– 200 African women and 40 male sexual partners</li> <li>– Community forum at which an HIV/STD specialist provides accurate and current information about HIV/STDs</li> </ul>	Metro
Minnesota AIDS Project (MAP)	African American Male IDUs	<p><i>Outreach and OraSure Testing</i></p> <ul style="list-style-type: none"> <li>– Outreach in van to street locations and fixed sites. Offer OraSure which is provided through ILI</li> <li>– 230 persons</li> </ul> <p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>– Risk reduction and skill building, harm reduction, negotiation and communication, OraSure testing, Rule 25 assessments</li> <li>– 141 persons</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– Small group HIV/STD/HCV and risk reduction presentations (275 persons)</li> <li>– Briefer outreach contact (2200 persons)</li> </ul>	Metro

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
Turning Point, Inc.	African American Male IDUs	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>– Outreach in shooting galleries, bars, where drug dealers congregate, shelters, substance use treatment centers</li> <li>– 250 African American men</li> </ul> <p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, risk reduction and harm reduction counseling</li> <li>– 35 African American men</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>– Group sessions at treatment center on condom use, cleaning needles, vein care, HCV symptoms, harm reduction</li> <li>– 200 African American men</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– Presentations on HIV prevention, condom use, harm reduction at shelters and organizations</li> <li>– Community outreach including safer sex and injection information at events</li> </ul>	Minneapolis
Turning Point, Inc.	African American Female IDUs	<p><i>Outreach</i></p> <ul style="list-style-type: none"> <li>– Outreach in shooting galleries, bars, where drug dealers congregate, shelters, substance use treatment centers</li> <li>– 250 African American women</li> </ul> <p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>– Risk assessment, risk reduction and harm reduction counseling</li> <li>– 26 African American women</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>– Presentations on HIV prevention, condom use, harm reduction in shelters and organizations</li> <li>– Community outreach including safer sex and injection information at events</li> </ul>	Minneapolis area

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
Access Works	Male and Female IDUs of All Races	<p><i>Individual Level &amp; OraSure</i></p> <ul style="list-style-type: none"> <li>- Risk assessment, HIV/HCV risk reduction counseling related to substance use and sexual health, harm reduction. OraSure testing provided. Referrals to HAV/HBV vaccinations and HCV testing and treatment</li> <li>- 180 persons</li> </ul> <p><i>Group Level</i></p> <ul style="list-style-type: none"> <li>- 6-session educational group for HCV infected and HIV/HCV co-infected persons providing information on HIV/HCV and risk reduction</li> <li>- 60 persons</li> <li>- Weekly group for users providing HIV and hepatitis education, risk reduction support, nutritional info, needle cleaning info, and skills building and role plays</li> <li>- 12 persons</li> <li>- Monthly HIV/hepatitis educational group providing risk and harm reduction information, testing and treatment information</li> </ul> <p><i>Prevention Case Management</i></p> <ul style="list-style-type: none"> <li>- Risk assessment; counseling on harm reduction sexual health and substance use; individual prevention plan; accompany to appointments</li> <li>- 15 persons</li> </ul>	Minneapolis area
Leech Lake Band of Ojibwe	Female IDUs of All Races (Native American)	<p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>- Risk assessment, safer sex and safer drug use counseling</li> <li>- 25 Native American women</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>- Educational presentations at women's outpatient treatment program, methadone program, and community events on reservations focused on HIV/STD/Hepatitis, safer sex and drug use</li> <li>- 50 Native American persons</li> </ul>	Leech Lake Reservation and surrounding area

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
Leech Lake Band of Ojibwe	Young IDUs (Native American)	<p><i>Individual Level</i></p> <ul style="list-style-type: none"> <li>- Risk assessment, risk reduction counseling, HIV/STD/Hepatitis info, adolescent health issues, health decision making</li> <li>- 12 young Native American</li> </ul> <p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>- Educational presentations at local schools, Alternative Learning Center, and to employees at casinos, focused on HIV/STD/Hepatitis, safer sex and drug use</li> <li>- 50 Native American youth</li> </ul>	Leech Lake Reservation and surrounding area
Minnesota AIDS Project (MAP)	All target populations, as well as any individual or community in the state concerned about HIV	<p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>- Phone hotline and website that provides information about HIV, and referrals to testing, prevention and care services (2200 phone and e-mail contacts)</li> <li>- Quick Connect provides face-to-face information about services for HIV+ individuals</li> <li>- OraSure counseling and testing provided. Risk assessment to determine need for testing is done on phone calls to the AIDSLine</li> </ul>	Statewide
The Family Tree, Inc	Individuals at risk of STD infection, individuals concerned about STDs	<p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>- Phone hotline that provides information about STDs (including HIV), and referral to appropriate services</li> <li>- Media campaign promoting hotline targeted at African Americans</li> </ul>	Statewide
MDH	Latino community	<p><i>Community Awareness</i></p> <ul style="list-style-type: none"> <li>- Build awareness of HIV and the benefits of testing through community events, health fairs, media</li> </ul> <p><i>Capacity Building</i></p> <ul style="list-style-type: none"> <li>- Build capacity of organizations serving Latinos to provide culturally competent HIV testing, or be able to refer people to testing</li> <li>- Build capacity of organizations to conduct risk assessments</li> </ul>	Statewide

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
<b><i>MDH Funded Short-term HERR Programs in African Communities</i></b>			
African and American Friendship Association for Cooperation and Development, Inc (AAFACD)	African communities from Liberia, Nigeria, Kenya, Uganda, Tanzania, Sierra Leone, Côte d'Ivoire, Ghana	<i>Community Awareness</i> – Educational presentations at churches, soccer matches, women's retreat, festivals	Metro
African Assistance Program, Inc (AAP)	Nigerian community	<i>Community Awareness</i> – Community awareness ads on African cable TV – Educational TV shows for men, women, youth, children – All tribal TV forum	Metro
Ethiopian Community in Minnesota	Ethiopian community	<i>Community Awareness</i> – Educational presentations in churches – Recruit volunteers for Red Cross training and empower them to take on individual community outreach	Metro
Liberian Human Rights and Refugee Welfare Organization (LIHRRWO)	Liberian community	<i>Community Awareness</i> – Educational presentation at sports events (girls and boys), and with community members of various Liberian counties – HIV/AIDS awareness activities for African Liberation and Awareness Month	Metro
Mestawet Ethiopian Newspaper	Ethiopian community	<i>Community Awareness</i> – Educational presentations in churches, with Muslim community and at community gatherings – HIV facts and information in newspaper – Recruit volunteers for Red Cross training and empower them to take on individual community outreach	Metro
Minnesota African Women's Association (MAWA)	African communities from Somalia, Liberia, Ethiopia, Cameroon, Kenya, Sudan,	<i>Community Awareness</i> – Educational presentations to gender and age-based groups (women, men, youth) to educate about HIV and stigma – Educational programs on African cable TV	Metro

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
New American Community Services (NACS)	African communities from Kenya, Somalia, Oromia	<i>Community Awareness</i> <ul style="list-style-type: none"> <li>– Educational presentations in the community. Some are to general community. Several specifically target youth, two target Kenyan community, one targets Somali men, and one targets Oromo elders</li> </ul>	Metro
Oromo Community of Minnesota, Inc (OCM)	Oromo community	<i>Community Awareness</i> <ul style="list-style-type: none"> <li>– Peer group education for girls and boys</li> <li>– Group education for women, men, church members, mosque members</li> <li>– Oromo TV and radio presentations</li> <li>– Presentation at annual Oromo community picnic</li> </ul>	Metro
Project Valentine	Cameroon community	<i>Community Awareness</i> <ul style="list-style-type: none"> <li>– Drama performance for general Cameroon community, and for church group</li> </ul>	Metro
Somali Community Resettlement Services, Inc (SCRS)	Somali community	<i>Community Awareness</i> <ul style="list-style-type: none"> <li>– Educational presentations for general Somali population, youth, women, men, elders,</li> <li>– HIV/AIDS awareness announcements on Somali TV</li> </ul>	Rochester
Somali Health Project (SHP)	Somali community	<i>Community Awareness</i> <ul style="list-style-type: none"> <li>– Educational presentations for community members, women, and at national annual Somali gathering</li> <li>– All events will be broadcast on Somali radio and TV</li> </ul>	Metro
Somali Mai Community of Minnesota, Inc (SOMCOM)	Somali community	<i>Community Awareness</i> <ul style="list-style-type: none"> <li>– Public service announcements and prevention education on Somali Mai TV</li> <li>– Peer group education for women and youth</li> <li>– Prevention articles in Somali Mai newsletter</li> <li>– Presentations at community events</li> </ul>	Metro

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
Sub-Saharan African Youth and Family Services in Minnesota (SAYFSM)	African communities	<i>Community Awareness</i> – Newsletter with HIV information and stories from people living with HIV/AIDS targeting African communities	Metro
Women Light Action Network (WLAN)	Sudanese community	<i>Community Awareness</i> – Educational presentations to various Sudanese communities – Recruit volunteers for Red Cross training and empower them to take on individual community outreach	Metro
Zyombi Project	Cameroon community	<i>Community Awareness</i> – Educational presentation to community leaders – Educational presentations to three tribes and community associations	Metro
<p><b>MDH Public Service Campaigns</b>  <i>Due to funding cuts, most public service campaigns rely on community press and organizations to implement them.</i></p>			
MDH	African American Men and Women	<i>National Black HIV/AIDS Awareness Day (February)</i> – Press kit – Posters	Metro
MDH	African Men and Women	<i>Release of HIV/AIDS Surveillance Data for Minnesota (April)</i> – Press kit – MDH web site – E-mail address books	Statewide
MDH	Young African Men and Women HIV+ Persons MSM MSM of Color Health Care Providers	<i>National STD Awareness Month and Release of STD Surveillance Data for Minnesota (April – May)</i> – Press kit – Radio ads – Bus shelter ads – MDH web site – STD Hotline web site – Internet-based magazines – E-mail address books	Statewide
MDH	General Public Young Adults MSM IDUs	<i>National Hepatitis Month (May)</i> – Press kit – Posters – Outreach	Statewide
MDH	General Public Greater Minnesota	<i>National HIV Testing Day (June)</i> – Press kit – Posters	Statewide

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
MDH	MSM MSM of Color	<i>GLBT Twin Cities Pride/GLBT Black Pride (June and August)</i> – Print media ads – Posters – Outreach at events – Community events	Statewide
MDH	Latino Men and Women	<i>National Latino AIDS Awareness Day (October)</i> – Press release – Proclamation – Community events – Internet magazines, bulletins – MDH web site – MAP AIDSLine website – E-mail address books	Statewide
MDH	Women	<i>World AIDS Day (December)</i> – Press release – Proclamation – Community events – Internet magazines, bulletins – MDH web site – MAP AIDSLine website – E-mail address books	Statewide
<p><b>MDH Supported Counseling, Testing and Referral (CTR) Programs</b></p> <p><i>Note: MDH HERR Grantees that receive OraSure tests for use during HERR interventions are included in the MDH-Funded HERR Programs portion of this table. CTR programs listed here are those that receive funding from MDH for staff to conduct CTR, or are agencies not currently funded by MDH who receive test kits and/or lab processing.</i></p>			
African American AIDS Task Force (AAATF)	At-risk Individuals (African Americans)	<i>Counseling, Testing and Referral</i> – OraSure testing provided in the context of outreach services targeting African Americans	Metro
Hennepin County Red Door Clinic	At-risk Individuals	<i>Counseling, Testing and Referral</i> – HIV counseling and testing provided in an STD clinic (serum and OraSure tests)	Mostly Hennepin County, but can serve clients statewide
Minnesota AIDS Project (MAP)	At-risk Individuals (MSM and African American IDU)	<i>Counseling, Testing and Referral</i> – OraSure testing provided on-site and through outreach	Metro
North Memorial – University Family Physicians	At-risk Individuals (African Americans)	<i>Counseling, Testing and Referral</i> – OraSure testing provided in the context of outreach services	Metro

<b>AGENCY</b>	<b>TARGET POPULATION</b>	<b>INTERVENTIONS</b>	<b>TARGET AREA</b>
St. Paul-Ramsey County Public Health Room 111	At-risk Individuals	<i>Counseling, Testing and Referral</i> – HIV counseling and testing provided in an STD clinic (serum tests)	Mostly Ramsey County, but can serve clients statewide
West Side Community Health Services	At-risk Individuals (Latinos)	<i>Counseling, Testing and Referral</i> – HIV counseling and testing offered in a community clinic predominantly serving Latinos (serum tests)	Metro
<b>CDC Directly Funded Community Based Organizations (CBOs)</b>			
AIDS Information Duluth	Runaway, Homeless and Street-Involved Youth	<i>Street Smart Intervention</i> – Eight group sessions with role playing and a focus on HIV/STDs, risk, condoms/dental dams, substance use, coping with feelings, negotiation, self talk, staying safe over time – One individual session – Group visit to community health resource – Includes free HIV testing – 12 youth	Duluth and surrounding area
Indigenous Peoples Task Force	Native Americans	<i>Counseling, Testing and Referral</i> – Outreach and rapid testing targeting high-risk Native Americans – 500 persons <i>Peer Opinion Leader Intervention</i> – Training Pow Wow officials, drummers and singers to promote testing and provide risk reduction education to the community – 330 persons	Metro and reservations in Greater MN
Minneapolis Urban League	African American MSM and their partners African American MSM/IDU	<i>Community PROMISE Intervention</i> – Including individual level, group level, outreach, and role model stories – 1,000 interventions per year – 500 risk assessments – 50 HIV tests of very high risk AAMSM – 20 peer advocates trained	Metro

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
<b><i>MDH Eliminating Health Disparities Initiative Funded Programs</i></b>			
Council on Crime and Justice	African American	Planning Grant - Community dialogue and needs assessment to address connection between high rate of incarcerated African American males and the disparities in HIV infection.	Hennepin and Ramsey Counties
Hope International Health and Social Services	African (Sierra Leone, Liberia, Nigeria, West Africa)	Planning Grant – Needs assessment to develop a plan to improve the use of and access to culturally appropriate preventive health services.	Metro
Indian Health Board	Native American	Planning Grant – Conduct survey to assess health care needs, assess community strengths and weaknesses. Host urban forum to share results of survey and gather additional best practices information.	Metro
African American AIDS Task Force	African American and African	<ul style="list-style-type: none"> <li>– Staff to serve as HIV service coordinators at HCMC</li> <li>– Outreach to patients' family and social circle</li> <li>– Collect HIV/STD data</li> <li>– Sexual health education</li> <li>– Community capacity building</li> </ul>	Metro
Agape House for Mothers	African American and African Youth	<ul style="list-style-type: none"> <li>– Training and health education for youth</li> <li>– Conferences for youth about leadership</li> <li>– Workshops to identify positive behaviors</li> <li>– Create network of community and faith-based organizations</li> </ul>	Minneapolis (Northside, Phillips, and South Central) St. Paul (Summit-University, and Frogtown)
Centro Campesino	Latino	<ul style="list-style-type: none"> <li>– Promotores de Salud health education project targeting migrant workers</li> <li>– Collaboration with health professionals and organizations</li> </ul>	Steele and LeSeuer Counties

<b>AGENCY</b>	<b>TARGET POPULATION</b>	<b>INTERVENTIONS</b>	<b>TARGET AREA</b>
Children's Health Care	African American, African, and Latino Youth	<ul style="list-style-type: none"> <li>- Teen Age Medical Service (TAMS) will hire additional Spanish-speaking staff</li> <li>- Create materials in Spanish</li> <li>- TAMS will hire bilingual outreach worker</li> <li>- Work with partner agencies to offer youth development for African American youth not reached by TAMS</li> <li>- Provide mother and daughter classes for African American families to promote healthy communication</li> </ul>	Hennepin County
Parents in Community Action	African American, African, Native American, Asian, Latino	<ul style="list-style-type: none"> <li>- Parent education workshops</li> <li>- Family festivals, health fairs</li> <li>- Encourage utilization of existing community programs, services and resources</li> </ul>	Hennepin County
Park Avenue Family Practice	Asian American (Hmong)	<ul style="list-style-type: none"> <li>- Abstinence based individual and group counseling to youth</li> <li>- Discussion groups</li> <li>- Abstinence based video</li> <li>- Abstinence based power point presentation</li> </ul>	Metro
Turning Point, Inc.	African American and African	<ul style="list-style-type: none"> <li>- Health forums and seminars about HIV for youth</li> <li>- Develop culturally appropriate materials that support holistic care</li> <li>- Augment current HIV education programs</li> <li>- Outreach</li> <li>- Support community in its combat of drug use</li> </ul>	Minneapolis
Youth Link	African American, African, Native American, Asian, and Latino Youth	<ul style="list-style-type: none"> <li>- Small group educational sessions</li> <li>- Individual counseling</li> </ul>	Metro

AGENCY	TARGET POPULATION	INTERVENTIONS	TARGET AREA
<b>Other Sources of Funding for Prevention Programs</b>			
AIDS Information Duluth	At-risk Individuals	<i>Outreach</i> – Outreach in soup kitchens, drop-in centers, etc.  <i>Community Awareness</i> – HIV/AIDS prevention education in homeless shelters, transitional housing projects, halfway houses, schools, correctional facilities, youth, homeless persons, GLBT community – 2000 persons	Duluth and surrounding area
Access Works	IDUs	<i>Needle Exchange</i> – Needle exchange provided at the storefront – 180,000 needles exchanged – 1400 persons	Metro
Minnesota AIDS Project	IDUs	<i>Needle Exchange</i> – Mobile van providing needle exchange – 6000 needles exchanged – 90 exchanges with 46 people	Metro
<b>Ryan White CARE Act Funded Services</b>			
Abbott Northwestern Hospital – Clinic 42	HIV+ Individuals	– Medication Adherence – Case Management – Primary Health Care	Statewide Metro Metro
Access Works	HIV+ IDUs	– Outreach	Metro
African American AIDS Task Force	HIV+ African Americans and Africans	– Emotional Support – Health Education/Risk Reduction – Outreach	Metro
The Aliveness Project	HIV+ Individuals	– Care Advocacy – Complementary Care – Congregate Meals – Food Shelf – Health Education/Risk Reduction	Metro
Chicanos Latinos Unidos en Servicio (CLUES)	HIV+ Latinos	– Emotional Support – Mental Health – Outreach	Metro
Community Fitness Today	HIV+ African Americans	– Care Advocacy – Emotional Support – Outreach	Metro
Family and Children's Services	HIV+ Individuals	– Home Health Care – Mental Health	Metro

<b>AGENCY</b>	<b>TARGET POPULATION</b>	<b>INTERVENTIONS</b>	<b>TARGET AREA</b>
Hennepin County Homecare For the Homeless	Homeless HIV+ Individuals	– Outreach	Metro
Hennepin County Medical Center	HIV+ Individuals	– Case Management – Medication Adherence – Mental Health – Primary Health Care – Transportation	Metro
Hennepin County Medical Center (Title III)	HIV+ Individuals	– Primary Health Care	Metro
Hennepin County Medical Center Dental Clinic (Part F)	HIV+ Individuals	– Dental Care	Metro
Hennepin County Red Door Clinic	HIV+ Individuals	– Short Term Intervention	Metro
Indigenous Peoples Task Force (IPTF)	HIV+ Native Americans	– Case Management – Emotional Support – Health Education/Risk Reduction – Mental Health	Metro and Reservations in Greater MN
Mayo Clinic	HIV+ Individuals	– Care Advocacy – Case Management – Health Education/Risk Reduction – Transportation	Southeast and South Central Minnesota
Midwest AIDS Education and Training Center (MATEC) (Part F)	Clinicians, health care providers	– Training related to quality care in treating HIV+ individuals	Statewide
Minneapolis Urban League (MUL)	HIV+ African Americans and Africans	– Case Management – Emotional Support	Metro
Minnesota Department of Human Services	HIV+ Individuals	– Dental Program – Drug Program – Health Insurance Program – Nutritional Supplements	Statewide

<b>AGENCY</b>	<b>TARGET POPULATION</b>	<b>INTERVENTIONS</b>	<b>TARGET AREA</b>
Minnesota AIDS Project	HIV+ Individuals	<ul style="list-style-type: none"> <li>- Benefits Counseling</li> <li>- Case Management</li> <li>- Corrections Systems Development</li> <li>- Emergency Financial Assistance (EFA)</li> <li>- Emergency Housing Assistance (EHA)</li> <li>- Emotional Support</li> <li>- Health Education/Risk Reduction</li> <li>- Housing Systems Development</li> <li>- Individualized Assistance (AIDSLine and QuickConnect)</li> <li>- Legal Services</li> <li>- Substance Use Services</li> <li>- Substance Use Systems Development</li> <li>- Transportation</li> <li>- Women and Families Systems Development</li> </ul>	<p>Metro for all services</p> <p>Case Management and Transpo also in Duluth and St. Cloud areas</p> <p>Statewide Services: AIDSLine, Benefits Counseling, EFA, EHA</p>
Minnkota Health Project	HIV+ Individuals	<ul style="list-style-type: none"> <li>- Care Advocacy</li> <li>- Emotional Support</li> <li>- Transportation</li> </ul>	Western Greater MN
Neighborhood Involvement Program	HIV+ Individuals	<ul style="list-style-type: none"> <li>- Emotional Support</li> <li>- Mental Health</li> </ul>	Metro
NorthPoint Health and Wellness Center (formerly Pilot City Health Center)	HIV+ Individuals	<ul style="list-style-type: none"> <li>- Primary Health Care</li> </ul>	Metro
Open Arms of Minnesota	HIV+ Individuals	<ul style="list-style-type: none"> <li>- Home Delivered Meals</li> </ul>	Metro
Program in Human Sexuality	HIV+ Individuals	<ul style="list-style-type: none"> <li>- Mental Health</li> </ul>	Metro
Regions Hospital HIV/AIDS Program	HIV+ Individuals	<ul style="list-style-type: none"> <li>- Case Management</li> <li>- Primary Health Care</li> <li>- Transportation</li> </ul>	East Metro
Regions Hospital HIV/AIDS Program (Title III)	HIV+ Individuals	<ul style="list-style-type: none"> <li>- Primary Health Care</li> </ul>	East Metro
Rural AIDS Action Network (RAAN)	HIV+ Individuals	<ul style="list-style-type: none"> <li>- Emotional Support</li> </ul>	Greater MN
Rural AIDS Action Network (Title III)	HIV+ Individuals	<ul style="list-style-type: none"> <li>- Early Intervention Services, including primary care, dental care, case management, mental health and substance use treatment, counseling and testing</li> </ul>	Greater MN

<b>AGENCY</b>	<b>TARGET POPULATION</b>	<b>INTERVENTIONS</b>	<b>TARGET AREA</b>
St. Joseph's Medical Center	HIV+ Individuals	<ul style="list-style-type: none"> <li>- Care Advocacy</li> <li>- Emergency Financial Assistance</li> <li>- Emotional Support</li> <li>- Health Education/Risk Reduction</li> <li>- Transportation</li> </ul>	Brainerd area
St. Paul Ramsey County Dept. of Public Health – Room 111	HIV+ Individuals	<ul style="list-style-type: none"> <li>- Short Term Intervention</li> </ul>	East Metro
Sub-Saharan African Youth and Family Services in Minnesota (SAYFSM)	HIV+ Africans	<ul style="list-style-type: none"> <li>- Capacity Building</li> <li>- Emotional Support</li> </ul>	Metro
Turning Point, Inc.	HIV+ African Americans	<ul style="list-style-type: none"> <li>- Case Management</li> </ul>	Metro
West Side Community Health Services	HIV+ Latinos	<ul style="list-style-type: none"> <li>- Case Management</li> <li>- Emotional Support</li> <li>- Health Education/Risk Reduction</li> <li>- Primary Health Care</li> </ul>	Metro
West Side Community Health Services (Title IV)	HIV+ Latina Women and Families	<ul style="list-style-type: none"> <li>- Outreach</li> <li>- Primary Health Care</li> </ul>	Metro
Various Providers	HIV+ Individuals	<ul style="list-style-type: none"> <li>- Interpretation and Translation</li> </ul>	Statewide Metro

## Gap Analysis to Determine Unmet HIV Prevention Needs

*This section of the Community Services Assessment describes gaps in HIV prevention programming for the state of Minnesota. This chapter provides information on what is not currently being done to address prevention needs among various populations.*

### Gap Analysis

Gap analysis is a process used to determine what the *met* and *unmet* prevention needs are in Minnesota. The unmet needs that are identified through conducting a gap analysis can be used in several ways. Entities that are not funded through MDH, but are interested in providing prevention activities, can refer to the results of the gap analysis to see what types of activities are not currently funded and have been identified as unmet need. An organization interested in implementing any of those activities would be helping to meet a need in the community.

One method of performing a gap analysis is to define the components of a comprehensive HIV prevention program, and then determine which components are being implemented to a satisfactory extent, are incomplete, or are missing all together.

The CDC has defined the nine components of a comprehensive HIV prevention program:

1. HIV prevention community planning
2. HIV prevention activities, including:
  - HIV prevention counseling, testing, and referral services (CTR)
  - Partner notification, including partner counseling and referral services (PCRS) with strong linkages to prevention and care services
  - Prevention with positive persons
  - Health education and risk reduction (HERR) activities
  - Public information programs
  - Perinatal transmission prevention
3. Quality assurance

4. Evaluation of major program activities, interventions, and services; including data collection on interventions and clients served
5. Capacity building activities
6. Sexually Transmitted Diseases (STD) prevention activities
7. Collaboration and coordination with other related programs
8. Laboratory support
9. HIV/AIDS epidemiological and behavioral surveillance

### Gap Analysis Plan

While the role of the CCCHAP is primarily to identify met and unmet HIV prevention needs in priority target populations, it is clear that gaps in other areas of the comprehensive HIV prevention program will impact the scope and effectiveness of such efforts. For example, without quality assurance, technical assistance, and capacity building activities, health education and risk reduction activities targeting high-risk populations may not be implemented well, or at all. Thus, the CCCHAP determined that gap analysis should be performed in the following areas in order to accurately describe met and unmet HIV prevention needs:

- Emerging Populations
- Priority Target Populations
- CTR
- PCRS
- Public Information
- Provider Capacity
- Needs Assessment
- Evaluation
- MDH Capacity/Infrastructure

## CHALLENGES TO GAP ANALYSIS

In 2002, the now-defunct Assessment and Evaluation (A&E) Committee developed a gap analysis plan, with steps and a timeline for assessing met and unmet needs in each of the nine categories above. 2003 marked the first time the CCCHAP implemented the plan. It proved to be very challenging, both for MDH staff and the A&E Committee, to determine what a *met* need is. For example, when looking at HERR activities within the priority target populations, information was provided on the types of activities being implemented, as well as the number and demographics of people being targeted. However, it was difficult to say, within each category of intervention type (i.e., outreach, community awareness), whether the interventions being implemented for each target population were enough. Some of the unknowns were: 1) population size for all of the priority target populations; 2) an estimate of how many people within each target population are at high risk; 3) numbers of people actually reached (numbers provided were proposed numbers); and 4) whether the members of each target population being reached through the interventions are really at high risk.

Given that it was the first time that the CCCHAP had really gone through an in-depth process to conduct gap analysis, and they were working on a short timeline, everyone felt that it made sense to continue without yet having a well-defined process for identifying *met* need.

The CCCHAP and MDH staff were not at a stage, either, to identify how much of an *unmet* need would have to be implemented in order for it to become a *met* need. For example, if outreach were identified as an unmet need for MSM of Color, we were not able to say how many more people we would need to reach in order for it to no longer be an unmet need. We hope that as we continue to refine the process, we will also develop a method to quantify how much should be done to change an identified *unmet* need to a *met* need.

## ADDRESSING THE CHALLENGES IN 2004

According to the newly restructured planning cycle, 2004 was supposed to be a year to conduct gap analysis. However, in order to facilitate upcoming planning activities under the new structure, the CCCHAP focused its work in 2004 on developing and refining processes, such as prioritization and gap analysis, that will be used in the future. As a result, most of the unmet needs discussed in following sections of this chapter were identified in 2003.

In 2004, the CCCHAP decided on several ways to assist in determining *met* need in future gap analysis processes. MDH and the CCCHAP have developed crude estimates of the number of people who are at high risk within a given population. These population estimates will be compared to the number of people within that population who have been reached through various types of interventions in order to help assess what the gaps are. We will not be collecting data about risk behaviors of people served in prevention programs, so whether programs are reaching people who are really at high risk will remain an unknown.

In addition to considering the number of people served in prevention programs, CCCHAP members will meet with community groups to get their feedback about whether prevention interventions are adequately meeting the needs of each target population. MDH will also conduct a survey of prevention providers to gather the same type of feedback.

This combination of quantitative and qualitative data will assist the CCCHAP in determining whether needs are being met, and what the remaining unmet needs are. However, it will still be a very rough estimate of unmet need.

The remainder of this chapter provides a description of the process used to identify unmet needs within each category, and an explanation of how the state has responded unmet needs to date. A summary of all identified unmet needs begins on page 210.

## **Process to Identify Unmet Needs in Emerging Populations**

### **EMERGING POPULATIONS**

Emerging populations are groups of people that, in most cases, were not prioritized as being one of the target populations most at risk, but in which we have seen an increase in new HIV infections, or other concerning trends, since the time that the last major prioritization process occurred in 2000.

In 2002 and 2003, the three populations that demonstrated concerning trends were African-born individuals, Latino men, and MSM. As noted in Chapter One, there has been a steadily increasing number of new infections among the African-born residents of Minnesota over the last few years. Among new infections diagnosed in 2003, African persons accounted for 21 percent of cases, but well under 1 percent of the statewide population. More cases of HIV infection were diagnosed among African-born females (28 cases) than any other female racial/ethnic group in 2003. The number of cases among African-born females has increased nine-fold between 1996 (3) and 2003 (28).

Although we did not see an increase in new infections among Latino men in 2003, we have noted some other concerning trends. Latino men have a higher proportion of cases that were AIDS at first diagnosis (40%) than all men (30%) in the past three years. In fact, Latino men have the highest proportion of cases that were AIDS at first diagnosis compared to any other racial/ethnic group. Latino men have a higher proportion of living cases (15%) that are under 30 years old than the total male population (6%). In addition, Latino men also have a higher proportion of AIDS cases (50%) compared to all males (42%).

Finally, although MSM are included among the priority target populations, we have noticed a re-emerging trend within this population. There was a 40 percent increase in new HIV infections among White MSM in 2001, as well as an outbreak of syphilis cases

in MSM in 2002 and 2003. During 2003, there were 70 syphilis cases diagnosed among MSM; with 43 percent of the MSM diagnosed with syphilis being co-infected with HIV. Although we experienced a 9 percent decrease in new HIV cases among MSM in 2003, given the pattern we have seen in other U.S. cities that first experienced an increase in syphilis among MSM followed by an increase in HIV, we realize that the same could occur here.

### **IDENTIFYING UNMET NEEDS IN EMERGING POPULATIONS**

To assess unmet needs within emerging populations, the A&E Committee first reviewed existing needs assessment data on these populations to determine whether there was a need to do needs assessment. In all three populations, needs assessment was the first unmet need identified in order to better understand what the prevention priorities should be within each population.

## **Process to Identify Unmet Need In Priority Target Populations**

The A&E Committee was also responsible for assessing unmet needs within the priority target populations that were identified by the CCCHAP. Basically, the process consisted of comparing prevention interventions that are currently available in the community with those that were recommended by the CCCHAP as being most effective for each target population.

MDH released a competitive Request for Proposals (RFP) in the spring of 2002, for the purpose of identifying organizations to deliver prevention interventions reaching the target populations identified by the CCCHAP. The organizations were chosen through a review process that consisted of a committee of community reviewers who scored the proposals and made funding recommendations. Following the community review, MDH also had an internal review process to ensure that a comprehensive set of prevention services would be in place as a

result of the community review committee's funding recommendations.

The resource inventory (page 177) contains information regarding the interventions that were implemented in January 2003 as a result of the RFP process. In the spring of 2003, the A&E Committee compared the resource inventory to the recommended interventions for each target population that are included in Chapter Five. Intervention categories that were not funded through MDH, or were not available through other sources, were identified as unmet needs.

### **CATEGORIES OF INTERVENTIONS**

The A&E Committee identified categories of interventions as being unmet needs instead of identifying specific interventions for two reasons:

- 1) The individual interventions identified in Chapter Five were not prioritized by the CCCHAP during the last prioritization process; and
- 2) The interventions were included in the RFP as examples of interventions that could be proposed, but applicants were not required to propose the interventions identified by the CCCHAP.

So, for example, there were several different models of group level interventions identified by the CCCHAP for African American Male IDUs. However, no group level interventions were funded for that population. As a result, group level intervention was identified as an unmet need, but none of the intervention models were specifically identified.

There are six basic categories of interventions that are referred to in the gap analysis summary, which starts on page 210:

**Outreach:** Interventions that are designed to identify individuals who are at high risk for being infected with HIV in their neighborhoods or places they normally congregate; give them condoms, bleach, sexual responsibility kits, and educational materials; and refer them to services that can help them reduce or change their risk behaviors. Outreach activities can also include field based testing.

**Individual Level Interventions (ILI):** Health education and risk reduction counseling provided to one individual at a time. ILI assists clients in making plans for individual behavior change and ongoing assessment of their behavior. ILI includes skills building components. These services can also facilitate linkages to other services that support the reduction of risk, such as substance use treatment.

**Group Level Interventions (GLI):** Health education and risk reduction counseling with groups of different sizes. GLI models can either be led by peers or by professionals. As with ILI, group interventions contain a skills building component, and assist clients in making plans for behavior change and assessing their progress.

**Prevention Case Management (PCM):** Client-centered prevention activity focused on assisting clients with multiple, complex issues to adopt HIV risk reduction behaviors. PCM provides intensive, ongoing, and individualized prevention counseling, support, and assistance in accessing other needed services.

**Community Awareness:** The delivery of planned HIV prevention messages through one or more mediums to target audiences. The focus of the messages are to build general support for safe behavior, support for personal risk reduction efforts, and/or inform persons at risk how to obtain specific services. Community awareness interventions may be delivered through: electronic media, print media, telephone hotline, information clearinghouse, presentations or lectures, community events, and web sites and chat rooms.

**Multilevel:** Programs that include a number of interventions designed to achieve multiple purposes with the intention of moving individuals through a continuum of HIV prevention care. They may include outreach and behavioral interventions, as well as activities to raise awareness in the community. The multilevel intervention is designed so that the component interventions support one another and create a "whole" effect that is greater than the sum of the "parts."

## **Process to Identify Other Types of Unmet Need**

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Beyond identifying unmet need in specific populations, there are other types of unmet need that must be taken into consideration. These include unmet needs in Counseling, Testing and Referral, Partner Counseling and Referral Services, and Public Information; as well as gaps related to needs assessment and evaluation activities; capacity building needs of providing agencies; and capacity and infrastructure needs of the health department. The A&E Committee also included activities to assess unmet needs in these areas in the gap analysis plan included at the end of this chapter.

### **COUNSELING, TESTING AND REFERRAL**

MDH determined the unmet needs in the Counseling, Testing and Referral (CTR) system, based on the results of the planning process undertaken in the spring of 2003. Priorities for the CTR system were identified and ranked by an ad hoc community advisory group. MDH then determined how its resources would be used to support CTR activities within those priorities (refer to page 167 for more information). Due to the nature of the priorities that were set and insufficient funding to implement all components, there are some gaps that have been identified, and are included in the gap analysis summary.

### **PARTNER COUNSELING AND REFERRAL SERVICES**

The manager of the Partner Counseling and Referral Services (PCRS) program identified the unmet needs within the program. He attended an A&E Committee meeting to share his findings and concerns and engaged in a dialogue with the committee.

### **PUBLIC INFORMATION**

The gaps in public information (media) were identified by the A&E Committee, after discussion with the MDH staff person who oversees public information efforts. There

were two components taken into consideration when identifying the unmet need in this area. Firstly, due to budget cuts, the MDH can no longer afford to place paid media spots in newspapers, or on the radio, or TV. The A&E Committee considered the loss of paid media placements for the specific campaigns that MDH typically develops on an annual basis an unmet need. Secondly, the committee compared media efforts that had been implemented by community based organizations within each of the priority target populations to media interventions identified in Chapter Five of this plan. Activities identified in the plan that had not been implemented were considered an unmet need.

### **CAPACITY BUILDING OF PROVIDERS**

In 2002, a consultant was hired to conduct an assessment of provider's capacity building needs. He interviewed staff from half of the funded agencies at that time, and developed a report that summarizes their needs in several areas: HIV 101, STDs, Interventions, Contract Support and Monitoring, and Additional Needs. Although the report was incomplete, it was the best source of information for this area of the gap analysis. The A&E Committee compared the needs identified in the report with training and technical assistance opportunities currently being provided in order to identify unmet needs.

### **NEEDS ASSESSMENT**

In 2002, a Request for Proposals (RFP) was released seeking consultants who were interested in performing needs assessment activities. Respondents to the RFP had the opportunity to propose conducting needs assessments in the following populations:

- MSM/IDU
- Young MSM of Color
- Non-Gay/Bi Identified MSM of Color
- Deaf and Hard of Hearing
- MSM Who Engage in Ongoing High Risk Behavior (barebacking)

Initially, as a result of the RFP process, a need assessment was going to be funded for

Young MSM of Color. However, due to state prevention budget cuts experienced in 2003, the needs assessment had to be cancelled.

The A&E Committee reviewed summaries of national needs assessment for each of the above populations in order to determine whether there was a need to perform a local needs assessment. For each population, the committee felt it would be valuable to have more local data.

## **EVALUATION**

In determining unmet evaluation needs, the A&E Committee considered two questions:

- 1) Do the current evaluation activities meet requirements of the Guidance for Evaluating CDC Funded Health Department HIV Prevention Programs?
- 2) Are there additional evaluation activities that MDH, CCCHAP, and grantees would like to implement beyond what CDC requires?

At the time the original gap analysis was conducted, both the committee and MDH staff felt that all evaluation needs are being met, especially given that a client level reporting system was just being implemented in 2003 (although it was later discontinued in 2004). However, at a later date, MDH staff identified the need to increase system capacity and the need for technical assistance from CDC in order to assist the health department in responding to some of the performance indicators included in the grant application, and to evaluate the impact of MDH-funded prevention programs.

## **HEALTH DEPARTMENT CAPACITY / INFRASTRUCTURE**

MDH identified unmet needs related to health department capacity and infrastructure based on priorities that have been established by the STD and HIV Section's management team. There were certain priority activities MDH was unable to do because of insufficient funding.

## **Responding to Unmet Needs**

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In the case that additional funds become available, MDH refers to the unmet needs identified by the CCCHAP for guidance on how to use the dollars. In order to provide a further guidance to MDH about how best to respond to the identified unmet needs, the CCCHAP underwent an exercise to prioritize the nine categories of unmet need in July 2003. They first reviewed a summary of the unmet needs that had been identified in each category, and then were asked to perform a dots exercise to identify the rank order of the unmet need categories. They were asked to consider how they would prioritize the unmet need categories in terms of what they would want to use additional dollars for, should they become available. The results of the prioritization of unmet need categories were as follows:

1. Public Information
2. Priority Target Populations
3. CTR
4. PCRS
5. Emerging Populations
6. Capacity Building
7. Needs Assessment
8. Evaluation
9. MDH Capacity/Infrastructure

## **RESPONDING TO UNMET NEEDS IN 2003 AND 2004**

Needs assessment activities occurred within the African communities and with Latino men during 2003. Planning and implementation of these activities began before the CCCHAP prioritized the categories of unmet need. Needs assessment remains an unmet need for MSM, although MDH collaborated with CDC to conduct a men's health survey at Twin Cities Pride in June 2004. The results of the survey provide some behavioral data.

The needs assessment activities in the African communities revealed widespread stigma, fear and denial related to HIV, as well as a lack of accurate basic knowledge about

HIV transmission and risk reduction. Many community based organizations exist within African communities, and show an increasing need and desire for capacity building and technical assistance in the area of HIV prevention and care.

The needs assessment project in the Latino community also found a high level of stigma and denial. Barriers to Latino men accessing testing included not knowing where to go, particularly not knowing where to find free or low cost testing available in Spanish. Transportation was an issue, as well as not wanting to know if they were HIV positive. Men were concerned about their names and addresses being reported, and did not want to be recognized if they went to be tested.

In the 2004 grant application to CDC, MDH did not follow the guidance of the CCCHAP regarding the priority of unmet needs. Although the CCCHAP identified public information as the top unmet need, MDH proposed using additional funds to support prevention activities in the African and Latino communities (emerging populations), which ranked fifth. MDH felt strongly that the concerning trends within these two communities, as documented in the epi profile, justified the use of these additional funds instead of using them to support broad based public information campaigns.

In response to the needs identified in African communities, MDH utilized funds in 2004 to implement short-term HIV prevention community awareness activities through 15 African organizations targeting a wide range of African communities. Types of activities being implemented include educational presentations, TV and radio shows, newspaper ads and articles, and drama (refer to Resource Inventory for detail), many of which are public information activities.

A one-year temporary community outreach coordinator position was created at MDH in the summer of 2004 to address some of the issues identified in the Latino community. This position will be responsible for assessing the capacity and interest of organizations serving the Latino community and working with

interested agencies to identify solutions to testing barriers. The coordinator will build capacity of organizations to provide testing or appropriate referrals to testing, and to deliver culturally appropriate services and risk assessments to MSM and other high-risk individuals.

The coordinator will also work with community leaders to promote HIV testing through existing HIV prevention programs, health fairs, Spanish-language media, and by making information available in places such as churches, grocery stores, laundry mats, restaurants, dance clubs, etc. These efforts are particularly targeted to reaching Latino MSM, immigrants, and migrant workers.

In June 2004, some unspent funds were used to support a paid public information campaign about syphilis among MSM to correspond with Twin Cities Pride month. The campaign included media ads in newspapers, restrooms, bus shelters, and chat rooms. Posters were also developed.

### **Supplemental Funds**

In the case that supplemental dollars from CDC become available again in the future, which is less likely to happen during these financially constrained times, MDH will first consider the guidelines provided by the CDC regarding the use of the funds. This will help determine which priority unmet needs categories are eligible for consideration. Further prioritization of specific activities within a category may be required. The CCCHAP will also be asked to provide concurrence on activities to be funded through supplemental dollars. If time constraints do not allow the full CCCHAP to respond, the Executive Team will be responsible for prioritizing activities within unmet need categories and providing concurrence.

The now-defunct Prioritization Committee developed criteria to assist MDH and the CCCHAP in determining which of the activities that meet CDC guidelines for supplemental funds should be selected for funding. The criteria were developed with a focus on helping the CCCHAP identify activities that

should be funded to reach emerging populations and/or priority target populations. The CCCHAP should also consider whether these criteria apply to unmet needs in the areas of the general population, needs assessment and evaluation, capacity building for providers, and health department capacity, or whether additional criteria should be developed.

**Criteria for Unmet Need Activities to be Supported through CDC Supplemental Funding:**

- The project is accomplishable within the given time frame of the funding.
- The project will build capacity.
- There is promise of sustaining the project over time (if applicable).
- Consider the short and long-term impact of the project. The project should have high impact.
- The supplemental projects should contribute to existing programs.
- Consider how many people could potentially be reached through the project (or how many HIV cases potentially averted)
- The project should be able to be evaluated.

## **Gap Analysis Summary**

The gap analysis summary beginning on the following page presents unmet needs that were identified in 2003 through the process described earlier in this chapter.

Because of limited funding, the primary unmet needs that have been addressed since 2003 are those that were identified in the African and Latino communities. Minimal paid public information efforts were also implemented in 2004 in response to that being identified as an unmet need.

The emerging population portion of the gap analysis has been updated to reflect activities occurring in 2004. The section related to unmet needs among priority target populations has been updated to reflect any changes in programming that were implemented in 2004. MDH staff identified possible unmet needs as a result of these programming changes, which were then discussed and agreed upon by the subgroup of the CCCHAP responsible for reviewing this chapter of the plan. The same process was used for the Public Information category.

The gap analysis summary is divided into the various categories of unmet need:

- Emerging Populations
- Priority Target Populations
- CTR
- PCRS
- Public Information
- Capacity Building for Providers
- Needs Assessment
- Evaluation
- MDH Capacity/Infrastructure

A description of current activities as well as the identified unmet need within each category. This is a summarized version of more detailed worksheets that the A&E Committee used when conducting the gap analysis.

## Gap Analysis Summary

Emerging Populations		
<b>Populations</b>	<b>Current Activities 2004</b>	<b>Identified Unmet Need 2004</b>
<b>African Individuals</b>	Needs assessment activities were completed in 2003. Based on needs assessment findings, short-term community awareness interventions are being implemented in 2004/2005 for the purpose of increasing awareness of HIV and decreasing stigma within African communities.	Needs assessment was identified as unmet need in 2003 During the term of the community awareness activities, MDH, through the grantees, will continue to informally assess unmet needs in the community as well as the grantees' unmet capacity building needs
<b>Latino Men</b>	Survey and community forums in Latino community completed in 2003. Based on needs assessment findings, a one-year community outreach coordinator was hired at MDH in summer of 2004.	Needs assessment was identified as unmet need in 2003 Towards the end of the one-year position, MDH will assess continuing gaps in information and testing for the Latino community, particularly men.
<b>MSM</b>	Needs assessment has not been implemented in this population Men's Health Survey was conducted at 2004 Twin Cities Pride, and provides some behavioral data, but is not as in-depth as needed.	Needs assessment to better understand risk behaviors in the current social context, and how to address them

**Note:** Current Activities column includes: 1) number of agencies funded through MDH STD & HIV Section with federal and state HIV prevention dollars; 2) programs funded through other sources of funding; and 3) categories of interventions provided through all of the funded agencies, in the order the interventions were prioritized for each target population.

Priority Target Populations		
<b>Populations</b>	<b>Current Activities 2004</b>	<b>Identified Unmet Need 2004</b>
<b>Men of Color Who Have Sex with Men (MCSM)</b>	4 agencies funded by MDH 2 agencies directly funded by CDC Multilevel, Outreach, ILI, GLI, Community Awareness <i>Note:</i> PCM was not identified as a priority intervention and was not funded	All types of interventions targeting Asian MSM All types of interventions in Greater MN Community events targeting African American and Latino MSM <i>Program offering outreach, ILI, and GLI to MCSM due to 2003 funding cuts</i>
<b>Young MSM (YMSM)</b>	3 agencies funded by MDH Multilevel, ILI, GLI, PCM, Outreach, Community Awareness	Multilevel, GLI, PCM, and Community Awareness in Greater MN Outreach by Internet Media campaigns targeting White, African American, Native American, Latino, and Asian YMSM Program offering outreach, ILI, GLI, and PCM to YMSM due to funding cuts <i>ILI will reach fewer young African American MSM due to 2003 funding cuts</i>
<b>Adult MSM (MSM)</b>	4 agencies funded by MDH Multilevel, Community Awareness, ILI, GLI, PCM, Outreach	Multilevel, Community Awareness, GLI, PCM, and Outreach in Greater MN More Community Awareness in metro area More PCM in metro area Outreach to specific populations, such as non-gay identified MSM and deaf MSM
<b>HIV+ MSM</b>	3 agencies funded by MDH Multilevel, ILI, GLI, Community Awareness	All types of interventions in Greater MN Outreach in metro area (no outreach funded) PCM in metro area (no PCM funded) More Community Awareness in metro area
<b>HIV Positive Adults</b>	2 agencies funded by MDH Outreach, ILI, GLI, Community Awareness, Multilevel <i>Note:</i> During the 2003 unallotment process, a new target population of HIV+ adults was created.	Since this was not a specific target population identified through the prioritization process, no interventions were identified.
ILI - Individual Level Interventions (individual counseling) GLI - Group Level Interventions (group counseling, support groups, discussion groups) PCM - Prevention Case Management EHDI = Eliminating Health Disparities Initiative funded through the Office of Minority and Multicultural Health at MDH		

Priority Target Populations		
<b>Populations</b>	<b>Current Activities 2004</b>	<b>Identified Unmet Need 2004</b>
<b>Adult African American Heterosexual Women</b>	2 agencies funded by MDH 1 agency funded by EHDI Multilevel, GLI, Outreach, Community Awareness <i>Note:</i> PCM was not identified as a priority intervention and was not funded	All types of interventions in Greater MN ILI in the metro area
<b>Young African American Heterosexual Women</b>	3 agencies funded by MDH 2 agencies funded by EHDI Multilevel, Community Awareness, Outreach, ILI, GLI, <i>Note:</i> ILI was not identified as a priority intervention, but 2 programs were funded	All types of interventions in Greater MN PCM in metro area
<b>Young Heterosexual Women of All Races</b>	3 agencies funded by MDH 3 agencies funded by EHDI 1 agency directly funded by CDC Community Awareness, Multilevel, Outreach, ILI, GLI <i>Note:</i> ILI was not identified as a priority intervention, but 4 programs are providing ILI	All types of interventions in Greater MN (less need for ILI and GLI in Duluth area due to new CDC direct funded CBO) Non-abstinence based multilevel program for Hmong youth Broader outreach to all young women in metro area PCM in metro <i>Community awareness for Native American youth due to loss of CDC direct funding targeting NA youth</i>
<b>Adult Heterosexual Women of All Races</b>	1 agency funded by MDH 15 agencies funded by MDH to do one-year community awareness activities in African communities 1 agency funded by EHDI 1 agency directly funded by CDC Community Awareness, Multilevel, GLI, and Outreach	All types of interventions in metro Greater MN targeting African, Asian, Latina, Native American and White women White women are not targeted by any of the programs being funded. Latina and Asian women are only targeted through the EHDI funded agency <i>Program offering GLI to White women in Greater MN due to 2003 funding cuts</i>
<b>African American Male IDUs</b>	2 agencies funded by MDH Multilevel programs including Outreach, Community Awareness, ILI Needle exchange programs exist, but not funded through MDH	All types of interventions in Greater MN GLI in metro area PCM in metro area
ILI - Individual Level Interventions (individual counseling) GLI - Group Level Interventions (group counseling, support groups, discussion groups) PCM - Prevention Case Management EHDI = Eliminating Health Disparities Initiative funded through the Office of Minority and Multicultural Health at MDH		

Priority Target Populations		
<b>Populations</b>	<b>Current Activities 2004</b>	<b>Identified Unmet Need 2004</b>
<b>African American Female IDUs</b>	1 agency funded by MDH Multilevel program that includes ILI, Outreach, Community Awareness Needle exchange programs exist, but not funded through MDH	All types of interventions in Greater MN GLI in metro area PCM in metro area
<b>Male IDUs of All Races</b>	1 agency funded by MDH Multilevel program including ILI, GLI, PCM (combined with program at this agency for Female IDUs All Races) Needle exchange programs exist, but not funded through MDH <i>Note: PCM was not identified as a priority interventions, but one program was funded</i>	All types of interventions in Greater MN Community Awareness and Outreach in metro area <i>Community Awareness to maintain current information for pharmacies participating in the Syringe Access Initiative, to assist them in developing more welcoming services for IDUs, and to provide Fitpak disposal kits due to funding cuts</i>
<b>Female IDUs of All Races</b>	2 agencies funded by MDH Multilevel, ILI, GLI, PCM, Community Awareness (one agency combined programs for Male and Female IDUs) Needle exchange programs exist, but not funded through MDH	All types of interventions in Greater MN (one program is funded to reach Native American female IDUs, but targets only the area around one reservation) Outreach in metro area Community Awareness in metro area
<b>Young IDUs</b>	1 agency funded by MDH to target young Native American IDUs in area around one reservation Multilevel program including ILI, and Community Awareness Needle exchange programs exist, but not funded through MDH	All types of interventions in Greater MN All types of interventions in metro area
<b>MSM/IDU</b>	1 agency directly funded through CDC to target African American MSM/IDU (along with AA MSM) Multilevel program including outreach, ILI, GLI and community awareness <i>Note: the only activity prioritized for MSM/IDU by the CCCHAP was needs assessment</i>	Needs assessment
ILI - Individual Level Interventions (individual counseling) GLI - Group Level Interventions (group counseling, support groups, discussion groups) PCM - Prevention Case Management EHDI = Eliminating Health Disparities Initiative funded through the Office of Minority and Multicultural Health at MDH		

Counseling, Testing and Referral (CTR)		
<b>CTR Priority Goals</b>	<b>Implementation Plan Identified 2003</b>	<b>Identified Unmet Need 2003</b>
<p><b>1. To prevent infection by: 1) identifying people at increased risk for HIV; 2) creating a client centered, risk reducing, sexual health promoting behavior strategy during the CTR session(s); and 3) providing referrals to ongoing prevention programs.</b></p>	<p>CTR with a focus on a risk reduction behavioral intervention will be funded within the following contexts:</p> <ol style="list-style-type: none"> <li>1) PCRS program</li> <li>2) Two major STD clinics</li> <li>3) Community clinics/organizations eligible to compete in an RFP process that will give priority to linking the CTR program with behavioral interventions. Applications will also be evaluated on evidence of past experience in one or more of the following: HIV testing, positivity rate, demonstrated ability to reach emerging or target populations</li> <li>4) Media will be developed or identified to encourage testing and knowledge of HIV status</li> </ol>	<p>Availability of publicly funded CTR sites in low prevalence areas, such as Greater Minnesota</p>
<p><b>2. To prevent transmission of HIV by: identifying and notifying individuals who are infected with HIV; 2) creating a client centered, risk reducing, sexual health promoting behavior strategy during the CTR session(s); and 3) providing referrals to ongoing prevention programs.</b></p>	<p>CTR with a focus on a risk reduction behavioral intervention will be funded within the following contexts:</p> <ol style="list-style-type: none"> <li>1) PCRS program</li> <li>2) Two major STD clinics</li> <li>3) Community clinics/organizations eligible to compete in an RFP process that will give priority to linking the CTR program with behavioral interventions. Applications will also be evaluated on evidence of past experience in one or more of the following: HIV testing, positivity rate, demonstrated ability to reach emerging or target populations</li> <li>4) Media will be developed or identified to encourage testing and knowledge of HIV status</li> </ol>	<p>Availability of publicly funded CTR sites in low prevalence areas, such as Greater Minnesota</p>
<p><b>3. To identify HIV infected individuals in order to get them into medical care and support services</b></p>	<p>CTR provided through Goal 2 will also have as a priority getting HIV positive people into medical care and support services.</p>	<p>Funding of points of entry (i.e., substance use and mental health treatment centers, homeless shelters, etc.) sites to do CTR in order to find HIV infected individuals and get them into care (These sites may respond to the RFP, but there will not be specific effort to implement CTR in points of entry sites. Testing in points of entry may occur through collaboration with CBOs or clinics funded to do CTR.) Availability of publicly funded CTR sites in low prevalence areas</p>

<b>Partner Counseling and Referral Services (PCRS)</b>		
<b>Area of Unmet Need</b>	<b>Current Issues 2003</b>	<b>Identified Unmet Need 2003</b>
<b>Providers (CTR sites, doctors, nurses, etc.)</b>	<p>Providers often do not have a clear understanding of the PCRS program and thus are not able to explain it well to their clients/patients. DHS, along with MDH staff, will be providing trainings to providers in Greater MN that will include a piece on PCRS.</p> <p>Providers not always comfortable or do not know how to talk about notifying partners and preventing transmission</p> <p>MDH doesn't know how much time elapses on average between the date the HIV test is done and the date the report is received by MDH, but anecdotally know that there are providers who delay reporting. This affects the time between a person being diagnosed and when a Disease Intervention Specialist (DIS) is able to contact them</p>	<p>Training/information to providers to increase: 1) their understanding of the PCRS program and its benefits to clients; and 2) their ability to explain the program and its benefits to clients</p> <p>Training/information to providers to increase ability to counsel HIV positive patients about the importance of notifying partners and how to prevent further transmission</p> <p>Assess how rapidly reports are received by MDH. Identify providers who are consistently late and work with them to improve speed of reporting</p>
<b>Disease Intervention Specialists</b>	Skills and strengths of individual DIS vary	Improve individual DIS performance, as needed

Public Information (Media)		
<b>Populations</b>	<b>Current Activities 2004</b>	<b>Identified Unmet Need 2004</b>
<b>Men of Color Who Have Sex with Men (MCSM)</b>	National STD Awareness Month and Release of STD Surveillance Data (April – May) news release, media kits, radio ads, MDH web site, ads in phone directories, Internet-based magazines, e-mail address books GLBT Black Pride (August) information provided at community events	MDH-developed media campaigns must rely on agencies' willingness to use media kits and PSAs due to funding cuts Ongoing use of media, and especially electronic media, to spread prevention messages
<b>Young MSM (YMSM)</b>	No activities targeting YMSM	Media campaigns targeting all YMSM Ads in <i>Lavender</i> and <i>City Pages</i> to publicize statistics of infection
<b>Adult MSM</b>	Syphilis Awareness Campaign (January) news release, bulletins and newsletters, e-mail address books National STD Awareness Month and Release of STD Surveillance Data (April – May) news release, media kits, radio ads, MDH web site, ads in phone directories, Internet-based magazines, e-mail address books National Hepatitis Month (May) media kit, posters, outreach GLBT Twin Cities Pride (June) <b>paid</b> campaign with print, restroom, bus shelter and chat room media ads, posters, outreach at events 1 agency conducting outreach to MSM on the Internet 1 agency conducting community awareness on the Internet	MDH-developed media campaigns must rely on agencies' willingness to use media kits and PSAs due to funding cuts Ongoing media campaign to eroticize safe sex MSM video about safe sex using deaf actors and captioning
<b>HIV+ MSM HIV+ Adults</b>	Syphilis Awareness Campaign (January) news release, bulletins and newsletters, e-mail address books National STD Awareness Month and Release of STD Surveillance Data (April – May) news release, media kits, radio ads, MDH web site, ads in phone directories, Internet-based magazines, e-mail address books GLBT Twin Cities Pride (June) <b>paid</b> campaign with print, restroom, bus shelter and chat room media ads, posters, outreach at events One agency implementing a website with information and resources for HIV+ adults	MDH-developed media campaigns must rely on agencies' willingness to use media kits and PSAs due to funding cuts Use focus groups to develop media campaign Campaign about HIV prevention targeting HIV+ individuals using TV, newspapers, posters, radio, magazines

\*Media kits have been developed by MDH and include ready-made materials (posters, flyers, etc), tip sheets, strategies, radio scripts, and resource references. Sent to county and city public health, prevention grantees, community partners.

Public Information (Media)		
<b>Populations</b>	<b>Current Activities 2004</b>	<b>Identified Unmet Need 2004</b>
<b>African American Men and Women</b>	2004 Activities National Black HIV/AIDS Awareness Day media kit and posters	Work with churches to raise awareness Confidential community newspaper column where people can write in anonymously with questions and get responses
<b>Young African American Men and Women</b>	National STD Awareness Month and Release of STD Surveillance Data (April – May) news release, media kits, radio ads, MDH web site, ads in phone directories, Internet-based magazines, e-mail address books STD Hotline targeting young AA women Website with updated HIV information for African American young women and their partners	MDH-developed media campaigns must rely on agencies' willingness to use media kits and PSAs due to funding cuts Use billboards, radio, and call-in shows to promote prevention Incorporate prevention messages into music videos Prevention messages on KMOJ and TV channels such as Fox, the WB
<b>Young Adults</b>	National Hepatitis Month (May) media kit, posters, outreach Website with updated HIV information for all young women and their sexual partners	MDH-developed media campaigns must rely on agencies' willingness to use media kits and PSAs due to funding cuts Use billboards, radio, and call-in shows to promote prevention Conduct a Target Market-type campaign, developing a special message for small towns, including local infection statistics. Use billboards and bathrooms
<b>Adult Heterosexual Women</b>	World AIDS Day (Nov – Dec) press release, proclamation, community events, Internet magazines and bulletins, MDH web site, MAP AIDSLine web site, e-mail address books Every April, mainstream coverage of updated HIV epi data and data can be accessed on MDH website	MDH-developed media campaigns must rely on agencies' willingness to use media kits and PSAs due to funding cuts Flyers, brochures, posters, and newsletters that tell stories of women in the community and how they learned about using condoms and progressed to always using them Radio ads with women's stories are developed, but no funding is available to release rights to use or pay to place ads <i>Consistently</i> remind public of number of new HIV infections and number of people living with HIV/AIDS
<b>African Men and Women</b>	Release of Updated HIV/AIDS surveillance news release, MDH web site, e-mail address books, bulletins and newsletters Prevention Awards to African Agencies news release, community newsletters	2004 Update: MDH-developed media campaigns must rely on agencies' willingness to use media kits and PSAs due to funding cuts This was not a CCCHAP specific prioritized target population, so no specific interventions were identified

Public Information (Media)		
<b>Populations</b>	<b>Current Activities 2004</b>	<b>Identified Unmet Need 2004</b>
<b>Latino Men and Women</b>	National Latino AIDS Awareness Day (October) press release, proclamation, information provided at community events, Internet magazines and bulletins, MDH web site, MAP AIDSLine web site, e-mail address books	MDH-developed media campaigns must rely on agencies' willingness to use media kits and PSAs due to funding cuts This was not a CCCHAP specific prioritized target population, so no specific interventions were identified
<b>IDUs</b>	National Hepatitis Month (May) media kit, posters, outreach	MDH-developed media campaigns must rely on agencies' willingness to use media kits and PSAs due to funding cuts Publicity campaign targeting women and youth who may be injecting (working in sex industry, professional women) Education to general public, pharmacies about how to safely dispose of needles Guerilla-style media to target young IDUs
<b>General Public</b>	National Hepatitis Month (May) media kit, posters, outreach National HIV Testing Day (June) media kit, posters, e-mail address books, direct mail	MDH-developed media campaigns must rely on agencies' willingness to use media kits and PSAs due to funding cuts Educate the general public about the risks associated with tattooing, body piercing, and injectable hormones
<b>Greater Minnesota</b>	National HIV Testing Day (June) media kit, posters, e-mail address books, direct mail	MDH-developed media campaigns must rely on agencies' willingness to use media kits and PSAs due to funding cuts
<b>Health Care Providers</b>	National STD Awareness Month and Release of STD Surveillance Data (April – May) news release, media kits, radio ads, MDH web site, ads in phone directories, Internet-based magazines, e-mail address books	MDH-developed media campaigns must rely on agencies' willingness to use media kits and PSAs due to funding cuts

Capacity Building / Technical Assistance		<i>Needs identified thru capacity assessment</i>
<b>Area of Capacity Bldg</b>	<b>Current Activities 2003</b>	<b>Identified Unmet Need 2003</b>
<b>HIV 101</b> - Understanding HIV - Counseling & Testing - Prevention for Positives	<i>Training provided by MDH:</i> HIV Test Results Fundamentals of HIV Prevention HIV/STD 101	Prevention for HIV+ More in-depth training on doing counseling with different cultures
<b>STDs</b> - Understanding bacterial and viral infections - Treatment - Interplay of STDs and HIV	HIV/STD 101 training by MDH which covers the basics of bacterial and viral infections, treatment, interplay of STDs and HIV	More in-depth training on STDs – bacterial and viral, treatment, interplay of STDs and HIV
<b>Interventions</b> - Behavioral theories - Risk assessments - Monitoring staff and time management - Motivating clients - Mental illness and HIV - Drugs and HIV - Best practices - Data collection	<i>MDH offers:</i> Intervention work plans training Fundamentals of HIV Counseling training Client Level Evaluation training Behavior theory training in 2002 Prevention Case Managers Network MSM Outreach Network	Individual/group behavioral theories Risk assessment and sexual histories Monitoring staff and time management Motivating clients Mental illness and HIV Drugs and HIV Best practices More on data collection
<b>Contract Support and Monitoring</b> - Narrative report writing - Grant finding & writing - Interpreting epi and assessment data - Dissemination of needs assessment data - TA for specific activities common across programs - Staff retention, motivation and reward - Program evaluation - Ethics	<i>MDH offers:</i> Intervention work plans training Individual TA on developing work plans and completing reports Client Level Evaluation training HIV/STD epi data and explanation EOC TA with evaluation PCM Network MSM Outreach Network  <i>Hennepin County offered training:</i> Grant writing Program development Staff retention and supervision	Data collection and analysis, negotiation skills, grant management Additional grant writing and finding Dissemination of needs assessment Interpreting assessment data More TA for specific prevention activities across programs Additional TA related to staff retention, motivation and reward Additional TA related to program evaluation – documenting behavioral change, formative evaluation Ethics
<b>Additional Needs</b> - Skills building for effective prevention in outreach - Advanced STD and Hep C - Help in supporting clients' psychosocial needs - Yearly training schedule - One-on-one TA - Generalist to trouble shoot, respond to changing needs, provide theory and learn about practice - Exchange between MDH and agencies on TA needs	Pillsbury United Communities offers skills building on outreach for African American women only  <i>MDH offers:</i> Hepatitis training HIV/STD 101 New training schedule being developed One-on-one TA by contract managers on specific issues Training on STD and HIV Section Feedback to and from contract managers	Skills building for delivering effective outreach Advanced workshop on STDs/Hep C Formative evaluation, and using the evaluation to “test out” interventions and how to best access community Help in supporting clients' psychosocial issues One-on-one TA Generalist to trouble shoot, respond to changing needs, provide theory and listen and learn about practice Better exchange of information

Needs Assessment		
<b>Population</b>	<b>Current Activities 2003</b>	<b>Identified Unmet Need 2003</b>
<b>MSM/IDU</b>	Was included in the needs assessment RFP in 2002, but no vendor identified. MDH planned to award a sole-source contract but was not able to due to funding cuts	Needs assessment of MSM/IDU
<b>Young Men of Color Who Have Sex with Men (YMCSM)</b>	Was included in the needs assessment RFP in 2002. A contract with a vendor was being developed but was cancelled due to funding cuts	Needs assessment of YMCSM
<b>Non-gay/bi Identified MSM</b>	Was included in the needs assessment RFP in 2002, but no vendor identified	Needs assessment of non gay/bi identified MSM
<b>MSM Who Engage in Ongoing High Risk Behaviors</b>	Was included in the needs assessment RFP in 2002, but no vendor identified	Needs assessment of MSM who engage in ongoing high risk behavior
<b>Deaf and Hard of Hearing</b>	Was included in the needs assessment RFP in 2002, but no vendor identified	Needs assessment of the deaf and hard of hearing community, particularly focusing on determining prevalence and high-risk sub populations
<b>Assessment of Need for an Umbrella System of Access Services – Transportation, Child Care, Interpretation/Translation, etc.</b>	Recommendation from the Linkages Report Currently these services are provided by grantees if they have identified a need within their agency and have included a line item for it in their budget.	Assessment of the needs of clients for an umbrella system of access services such as transportation, child care, interpretation/ translation in order to assist clients in getting to prevention services.

Evaluation		
<b>Area of Unmet Need</b>	<b>Current Activities 2003</b>	<b>Identified Unmet Need 2003</b>
<b>Evaluation of Impact of HIV Prevention Programs</b>	Implementation of client level scannable forms HERR process evaluation Limited amount of outcome monitoring and outcome evaluation Evaluation of section activities	TA from CDC and increased systems capacity to evaluate the impact of HIV prevention programs
<b>CDC Indicators</b>	Numerous MDH staff working on addressing indicators related to their programs for the grant application. Evaluator assisting them and developing an overall plan.	TA from CDC and increased systems capacity to evaluate some of the CDC required indicators

<b>MDH Capacity / Infrastructure (STD and HIV Section)</b>		
<b><i>Area of Unmet Need</i></b>	<b><i>Current Activities 2003</i></b>	<b><i>Identified Unmet Need 2003</i></b>
<b>Personnel</b>	Contract management, planning, evaluation, PCRS, public information, surveillance, information technology, administrative support	
<b>Travel</b>	Travel to out of state conferences relevant to the work of the STD and HIV Section if paid for by hosting organization	Travel to out of state conferences related to HIV and STD prevention, as necessary to the work of the STD and HIV Section, paid with section funds
<b>STDs</b>	Very limited funding for STD testing HIV prevention grantees are asked to integrate STD prevention in their work	Increased funding for STD testing and prevention activities
<b>Surveillance</b>	Basic STD and HIV surveillance activities	Enhanced incidence and behavioral surveillance projects

## Chapter Three

# Prioritization of Populations and Interventions

*This chapter describes the process that was used by the CCCHAP to prioritize target populations and interventions for each of those populations.*

### Prioritization Process

This chapter describes the processes used by the CCCHAP, which was known as the Task Force at the time, to prioritize target populations and interventions during the most recent major prioritization process, which was in 2000/2001. The next major prioritization process will occur in 2005.

The process of prioritization is used by the CCCHAP to determine which populations in Minnesota are at the highest risk of HIV infection or transmission. Once the target populations were identified and prioritized in order of greatest risk, the CCCHAP went through another process to identify and prioritize the prevention interventions thought to be most effective in preventing HIV within each of the target populations.

### Prioritization of Target Populations

In October of 1999, the Comprehensive Prevention Planning (CPP) Committee began the discussion to determine what process would be used to prioritize populations and interventions. (Note: In 2002, the CPP Committee was divided into the Assessment and Evaluation Committee and the Prioritization Committee, which were then both eliminated in 2003 as part of the restructuring process). The first step in the discussion was a recommendation that the prioritization process be separate from the allocations process. The CCCHAP would be responsible for prioritization and MDH would be responsible for determining allocations based on the results of the prioritization. The

CCCHAP approved the recommendation at the October meeting.

The next step was to agree on the model to be used to prioritize target populations. The group reviewed several different models that have been used in other states, as well as the model that was used locally during the last process. Borrowing elements from various models, the CPP Committee designed a new model for prioritizing target populations.

#### STEP ONE: DETERMINING TARGET POPULATION VARIABLES

There was much discussion about how to describe target populations. The factors regarded as most important were identifying risk behaviors, having the same data available across target populations, and following the CDC classification of target populations. Although members of the CPP Committee preferred to describe populations by behaviors (i.e., anal sex, vaginal sex, oral sex, sharing of needles, etc.), it was recognized that other information to be considered, such as HIV surveillance data and needs assessment information, is not categorized by all of those behaviors. It was agreed, then, that the target populations would be initially divided into four behaviorally defined categories based on mode of transmission: Men Who Have Sex with Men (MSM), Heterosexual Transmission (women only), Injecting Drug Use (IDU), and Men Who Have Sex with Men and Inject Drugs (MSM/IDU).

## **STEP TWO: IDENTIFYING SUBPOPULATIONS**

The CPP Committee reviewed surveillance data related to HIV/AIDS and STDs, needs assessment information, as well as data related to pregnancy, substance use/abuse, and socioeconomic status as available for each of the four population categories. The needs assessment data was provided from the most recent comprehensive HIV prevention plan, as well as from literature search and review. Taking each of the four population categories at a time, each member of the committee was asked to present three recommendations for subpopulations most at risk for HIV infection, as well as a justification for their choices based on the data they reviewed and their experience. Subpopulations were to be defined by their need for qualitatively different interventions. Members were asked to put their three choices in rank order. From the resulting list of subpopulations, the top four to five were chosen under each of the broad population categories. It was determined there were no subpopulations under MSM/IDU.

Issues that came up during the process to identify and rank the subpopulations included the importance of primary versus secondary prevention, where to address partners of those at high risk, and whether populations should be defined by behaviors or demographics. The group recognized that behaviorally defined populations ensure that individuals who are most at risk for HIV transmission are identified and reached. They also acknowledged that demographically defined populations allow interventions to be developed and delivered in a culturally and developmentally appropriate manner. The subpopulations that were prioritized resulted in a combination of both.

## **STEP THREE: RANKING TARGET POPULATIONS**

After subpopulations had been identified and prioritized, the CPP Committee prioritized the four major behaviorally defined categories based on first report of HIV/AIDS cases for

each population over time. This process resulted in the following rank order of populations as being considered at high risk for HIV infection:

- Men Who Have Sex with Men (MSM)
- Heterosexual Women
- Injecting Drug Users (IDU)
- Men Who Have Sex with Men and Use Injecting Drugs (MSM/IDU)

## **STEP FOUR: REFINING TARGET POPULATIONS**

The CPP Committee identified additional risk factors that should be taken into consideration when targeting the four broad categories. They varied by target population, but included factors such as HIV infection; STD diagnosis; sex partner of MSM, IDU, MSM/IDU, or HIV positive individual; engaging in survival sex; substance use; mental health issues; and incarceration. Factors were limited to those that are most proximate to the risk of HIV infection. For example, not speaking English is a barrier to services but does not in itself put a person at risk of infection; however, having an STD diagnosis does. It was agreed these additional risk factors would be incorporated into the RFP process, as possible.

## **STEP FIVE: REACHING CONSENSUS ON TARGET POPULATIONS**

The CPP Committee presented their recommendations for the prioritization of target populations to the full CCCHAP for approval in May 2000. After much discussion, there were several changes made in the ranking of the subpopulations under MSM and Heterosexual Women. The final results are presented on the following page.

The final results of the target population prioritization process in rank order are as follows:

**Men Who Have Sex with Men (MSM)**

- Men of Color Who Have Sex with Men
- Young MSM
- Adult MSM of All Races
- HIV + MSM

**Heterosexual Women**

- Adult African American Women
- Young African American Women
- Young Women of All Races
- Adult Women All Races

**Injecting Drug Users (IDU)**

- IDU African American Men
- IDU African American Women
- IDU Men All Races
- IDU Women All Races
- Young IDU

**Men Who Have Sex with Men and Use Injecting Drugs (MSM/IDU)**

- No subpopulations

**CONCERNS RAISED REGARDING TARGET POPULATIONS**

During the process to prioritize target populations, there were concerns raised that youth were not included as a separate target population. It was generally agreed, however, that youth were adequately addressed as subpopulations of the broader categories. Several other concerns were raised later in the process as the community became involved in the prioritization of interventions. One was the fact that heterosexual men were not included as a target population.

There was also a great deal of concern voiced from some members of the CCCHAP, as well as the Minnesota HIV Services Planning Council, that HIV positive individuals were not included as a separate target population. The fact that only HIV Positive MSM were named as a target population was perceived to further stigmatize that group. The exclusion of a broader HIV positive target population was perceived as ignoring the fact that every infection involves an HIV positive

person. These concerns were reviewed and discussed by the CPP Committee, the Executive Committee and the full CCCHAP.

Heterosexual men comprise a small percentage of people infected with HIV/AIDS in Minnesota, as well as a small percentage of newly diagnosed cases in 2000. It was generally agreed that limited prevention funds are most effectively targeted at populations most at risk of becoming infected, as they were defined during the prioritization process.

While many CCCHAP members, however, were in agreement that the omission of HIV positive individuals as a target population was an oversight; the consensus of the group was to not go back and change the results of the prioritization process.

It was the decision of the CCCHAP to allow the concerns related to reaching HIV positive individuals and heterosexual men to be addressed through the RFP that was released in 2002. Interventions that target sexual partners as well as the intended target population were encouraged so as to allow heterosexual men to be reached, as well as sexual partners in general. Interventions targeting HIV positive members of any subpopulation, or HIV positive sexual partners of the subpopulation, were also considered. Programs funded through this RFP process were implemented as of January 1, 2003.

**Prioritization of Interventions**

Immediately following the prioritization of target populations, the CPP Committee began the work of developing and guiding the process to prioritize interventions. The first step was to define youth. Youth Council representatives presented a recommendation that youth sub-populations be considered as two categories: teens, ages 13 – 19, and young adults, ages 20 – 24. The recommendation acknowledges that youth at different ages face very different social and environmental challenges, have access to different kinds of services and education, and are at different developmental stages that help to define their behaviors. Interventions should

be designed accordingly. The full CCCHAP approved this definition at the June 2000 meeting.

After discussing several different prioritization models, the CPP Committee recommended and the CCCHAP agreed to the following process:

**STEP ONE:  
DETERMINING INTERVENTION  
CATEGORIES**

Four intervention categories were developed for each target population:

- **Outreach** – Interventions that are designed to identify at-risk individuals, provide them with risk reduction information and referrals to behavioral interventions. Outreach may also include field-based testing.
- **Single Behavioral** – Interventions that are designed to change high-risk behaviors.
- **Community Awareness** – Interventions designed to provide information and change community norms, but not necessarily designed to make individuals or communities change their behavior.
- **Multilevel** – Programs that include a number of interventions designed to achieve multiple purposes with the intention of moving individuals through a continuum of HIV prevention care. They may include outreach and behavioral interventions, as well as activities to raise awareness in the community. The multilevel intervention is designed so that the component interventions support one another and create a "whole" effect that is greater than the sum of the "parts."

**STEP TWO:  
REVIEWING RESEARCH AND SELECTING  
INTERVENTIONS**

During the months of October through December of 2000, CPP Committee members reviewed research about existing HIV prevention interventions on the local and

national level for each target population, including sub-populations. The research they reviewed is presented in Chapter Four. The research was evaluated as to whether it reflected the norms and values of local communities, theories of behavioral science, and included measures of outcome effectiveness and cost effectiveness. For each subpopulation, the committee broke into small groups to identify the interventions they felt could most effectively be implemented in Minnesota based on the research they had reviewed. The small groups then reconvened and the larger committee chose interventions to fit into each of the four intervention categories based on the results of discussions in the smaller groups. The results of this process were reported back to the full CCCHAP at each of their monthly meetings.

**STEP THREE:  
COLLECTING COMMUNITY INPUT**

In December 2000, CCCHAP and interested community members received a training on how to facilitate community forums. Each CCCHAP member, and some community members, signed up in pairs to facilitate community forums during February and March of 2001. A total of 26 community forums were conducted with the various target populations. While the majority of the forums were held in the metropolitan area, five were held in Greater Minnesota. The format of the community forums was to first give an overview of the CCCHAP and its role in planning for HIV prevention. Participants were asked what they thought would work in their community to prevent HIV infection. They were then asked to review the recommendations from the CPP Committee related to their specific community and give their feedback.

Chapter Five describes the interventions that were identified by the CPP Committee as well as the ideas that were generated from the community forums.

**STEP FOUR:  
PRIORITIZING INTERVENTIONS**

CCCHAP members were given the following information to consider in preparation for prioritizing interventions: a summary of the recommended interventions developed by the CPP Committee, summary feedback from each of the community forums, a summary of needs assessment data available for each target population, and a current resource inventory. A presentation at the April 2001 CCCHAP meeting included an overview of the materials, instructions for completing the ranking of interventions, and discussion of the feedback received in community forums.

CCCHAP members were then given three weeks to complete and return the prioritization. They were asked to rank the four intervention categories (outreach, single behavioral, multilevel, and community awareness) in order from highest to lowest priority for each of the target populations, including sub-populations. A score of one (1) indicated the highest priority and a score of four (4) indicated the lowest priority. They were not asked to rank the individual interventions within the categories.

Twenty-one of the 22 CCCHAP members completed the ranking. One person declined to participate due to his frustration that heterosexual men were not included as a target population. Another member only ranked the MSM and the IDU/MSM target populations, feeling that he did not have the expertise to rank the others.

**Prioritization Results**

The results of the priority setting process are summarized here. Intervention categories were ranked on a scale of 1 to 4. A score of 1 indicates the highest priority and a score of 4 indicates the lowest priority. The rank orders were determined by averaging the scores assigned by the CCCHAP members. The N indicates the number of CCCHAP members who ranked each target population.

An asterisk (\*) indicates that the intervention ranked statistically significantly higher than the next ranked category at a level of  $p < 0.05$ . A number sign (#) indicates that the intervention ranked statistically significantly higher than the next ranked intervention category at a level of  $p \leq 0.10$ .

**MEN WHO HAVE SEX WITH MEN N = 21**

<i>Men of Color</i>	<u>Average</u>
<u>2</u> Outreach	2.62
<u>3</u> Single Behavioral	2.71
<u>1*</u> Multilevel	1.76
<u>4</u> Community Awareness	2.90

<i>Young MSM</i>	<u>Average</u>
<u>3</u> Outreach	2.81
<u>2</u> Single Behavioral	2.48
<u>1*</u> Multilevel	1.62
<u>4</u> Community Awareness	3.10

<i>Adult MSM All Races</i>	<u>Average</u>
<u>4</u> Outreach	2.86
<u>3</u> Single Behavioral	2.76
<u>1#</u> Multilevel	2.19
<u>1#</u> Community Awareness	2.19

<i>HIV+ MSM</i>	<u>Average</u>
<u>2</u> Outreach	2.29
<u>3#</u> Single Behavioral	2.43
<u>1</u> Multilevel	2.24
<u>4</u> Community Awareness	3.05

**HETEROSEXUAL WOMEN N = 20**

<b>Adult African American Women</b>		<u>Average</u>
<u>3</u> Outreach		2.75
<u>2</u> Single Behavioral		2.65
<u>1*</u> Multilevel		1.85
<u>3</u> Community Awareness		2.75

<b>Young African American Women</b>		<u>Average</u>
<u>3</u> Outreach		2.85
<u>4</u> Single Behavioral		3.10
<u>1</u> Multilevel		1.80
<u>2*</u> Community Awareness		2.25

<b>Young Women All Races</b>		<u>Average</u>
<u>3*</u> Outreach		2.65
<u>4</u> Single Behavioral		3.45
<u>2</u> Multilevel		2.25
<u>1#</u> Community Awareness		1.65

<b>Heterosexual Women All Races</b>		<u>Average</u>
<u>4</u> Outreach		3.35
<u>3</u> Single Behavioral		2.90
<u>2*</u> Multilevel		2.05
<u>1</u> Community Awareness		1.70

**INJECTING DRUG USERS (IDU) N = 20**

<b>African American Male IDU</b>		<u>Average</u>
<u>2</u> Outreach		2.50
<u>4</u> Single Behavioral		3.00
<u>1</u> Multilevel		1.95
<u>3</u> Community Awareness		2.55

<b>African American Female IDU</b>		<u>Average</u>
<u>3</u> Outreach		2.70
<u>2</u> Single Behavioral		2.40
<u>1#</u> Multilevel		1.85
<u>4</u> Community Awareness		3.05

<b>Male IDU All Races</b>		<u>Average</u>
<u>4</u> Outreach		2.75
<u>2</u> Single Behavioral		2.50
<u>1</u> Multilevel		2.10
<u>3</u> Community Awareness		2.65

<b>Female IDU All Races</b>		<u>Average</u>
<u>2*</u> Outreach		2.15
<u>3</u> Single Behavioral		2.98
<u>1</u> Multilevel		1.85
<u>4</u> Community Awareness		3.03

<b>Young IDU</b>		<u>Average</u>
<u>3</u> Outreach		2.60
<u>2</u> Single Behavioral		2.45
<u>1</u> Multilevel		2.05
<u>4</u> Community Awareness		2.90

For the MSM/IDU population, the intervention categories were ranked on a scale of 1 through 5. A score of 1 indicates the most important intervention category and a score of 5 is the least important.

**MSM / IDU N = 21**

<b>MSM / IDU</b>		<u>Average</u>
<u>3</u> Outreach		3.05
<u>4</u> Single Behavioral		3.33
<u>2</u> Multilevel		2.86
<u>5</u> Community Awareness		3.62
<u>1</u> Needs Assessment		2.14

## Allocation of Funds

It is the responsibility of MDH to allocate public funds to implement a comprehensive statewide HIV prevention program. MDH uses both state and federal funds to support this program. MDH uses the prevention plan to guide its allocation to all components of this program, including HIV prevention community planning, surveillance activities, HIV testing and counseling, partner counseling and referral services, promoting access to STD testing and treatment, media and other public education activities, lab support, technical assistance and capacity building activities, and needs assessment, quality assurance, and evaluation activities. The plan is most useful to MDH in guiding its allocations to community-based grantees to support health education and risk reduction (HERR) activities.

In order to disburse funds into the community to support the interventions recommended by the CCCHAP for the priority target populations, an RFP was released asking organizations to submit proposals describing which target population(s) they intended to reach and what interventions(s) they would use to reach them.

The proportion of funding available to each broad population category (MSM, Heterosexual Women, and IDU) was determined by the epi data. Sixty-two percent (62%) was allocated to Men Who Have Sex with Men, 22 percent to Heterosexual Women, and 12 percent to IDUs. The remaining 4 percent was allocated to MSM/IDU. However, since the recommended intervention for MSM/IDU was a needs assessment, that funding was included in a separate RFP released later in 2002 for needs assessment activities.

### RFP REVIEW PROCESS

A community proposal review committee was established. The full committee of 30 community members and 5 MDH staff was divided into five groups. Each group was assigned a portion of the proposals, and each

member individually reviewed and scored the proposals assigned to their group. The proposals were scored according to criteria developed by MDH. The criteria were related to agency capacity and ability to provide the proposed interventions. The individual review committee members also made initial recommendations as to whether each proposal should be funded or not.

The community review committee then convened in the five smaller groups. They discussed the proposals as a group, and arrived at final funding recommendations.

Once the community review process was completed, an internal review committee of MDH staff was then convened. The main purpose of this committee was to ensure that a comprehensive set of prevention services was available within each of the target populations. The internal review committee also ensured that the intervention category within each target population that was highest ranked by the CCCHAP would be funded.

The internal review committee reviewed the funding recommendations for the proposals within each of the subpopulations, reviewed budgets for accuracy and feasibility, and made final recommendations as to which agencies would be funded. The resulting grant awards reflect the most comprehensive prevention service system within each of the target subpopulations based on the proposals that were recommended for funding by the community review committee, and on the availability of resources to implement them.

### UNALLOTMENT OF STATE FUNDS

In February 2003, MDH unexpectedly received an unallotment of state HIV prevention funds in the amount of \$1,198,000. The unallotment represented approximately 16 percent of the total budget for the STD and HIV Section at MDH and 50 percent of the funding used for community-based HERR programs and counseling and testing.

Department and section management staff worked quickly to develop a plan to respond to the announcement. The first step was to

identify activities within MDH that could be eliminated in order to lessen the impact of the budget cut on community-based programs. The MDH activities that were suspended were: 1) lab support for testing sites with low positivity rates; 2) media campaigns; 3) out of state travel; 4) food for meetings sponsored by the STD and HIV Section, including CCCHAP meetings; and 5) needs assessment activities. These internal reductions accounted for approximately one third of the total unallotment.

Another third of the budget cut was alleviated when MDH reallocated dollars internally. Funds were moved from the Community Health Services Subsidy and reallocated into HIV prevention.

In determining cuts to be made to community-based programs, the primary goal was to preserve public health resources for the most critical populations. There were several criteria used in the process:

1. Utilize results of the CCCHAP prioritization and RFP review committee recommendation processes;
2. Consider behavioral science and current epi data;
3. Assure capacity for communities of color to do HIV prevention;
4. Assure capacity to do prevention with HIV positive individuals;
5. Maintain a comprehensive mix of populations targeted and interventions implemented;
6. Fund agencies at sufficient levels to run programs; and
7. Maintain the proportion of funding allocated to each target population.

After considering all of the criteria, the decision was made to cut three programs completely, and to maintain the other programs as close to their original funding levels as possible. The three programs that were cut served MSM of Color, Young MSM of All Races, and inmates in the state corrections system.

## Chapter Four

# Potential Interventions and Strategies for Priority Target Populations

*This chapter describes research about the effectiveness of some HIV prevention interventions among various target populations. For the purposes of this plan, an intervention is defined as "what is done to prevent HIV within a target population," while a strategy is defined as "how an intervention is implemented."*

### Review of Research

During the months of October through December of 2000, members of the Comprehensive Prevention Planning (CPP) Committee of the CCCHAP reviewed research about existing HIV prevention interventions on the local and national level for each of the prioritized target populations, including subpopulations. (Note: In 2002, the CPP Committee was divided into the A&E Committee and the Prioritization Committee, which were then eliminated in 2003 as part of the restructuring process).

For each subpopulation, the committee broke into small groups to discuss which interventions they felt would be most effective in Minnesota based on the research. The small groups then reconvened and the larger committee as a whole determined which interventions should be recommended for each target subpopulation based on the discussions held in the smaller groups.

The research literature did not provide the committee with information about the effectiveness of ALL of the interventions in ALL of the target populations, let alone give any indication within a target population as to which intervention might be more effective than the next. However, at least one study suggests that an HIV prevention program can be cost effective, even if the effects on behavior are partial and short term.<sup>198</sup>

Previously evaluated interventions were judged based on review article authors' comments as well as the professional scrutiny

of MDH staff and CPP committee members when methodological details were available. Unless noted, the interventions discussed under each target population assessed change in behavior, not knowledge or attitudes. Although changes in knowledge and attitudes are important in HIV prevention, they do not necessarily lead to behavior change. The absence of a particular type of program does NOT indicate that it is not effective – just that there is little information available to discuss effectiveness of that approach.

The rest of this chapter describes the research that the CPP Committee reviewed to assist them in determining the most effective interventions for the priority target populations. MDH has also added more recent research in order to keep this chapter current. Please note that the research studies are not grouped exactly by the target populations that were prioritized by the CCCHAP. Instead they are grouped according to broader population categories.

### DEBI PROJECT

The CDC is currently coordinating the Diffusion of Effective Behavioral Interventions (DEBI) Project, which is a national-level strategy to provide high quality training and on-going technical assistance on selected evidence-based HIV/STD prevention interventions to state and community HIV/STD program staff.

The evidence-based interventions included as a part of this project have been proven effective through research studies that showed positive behavioral (i.e., use of

<sup>198</sup> NIH, 1997

condoms; reduction in number of partners) and/or health outcomes (i.e., reduction in the number of new STD infections). Studies employed rigorous research designs, with both intervention and control groups, so that the positive outcomes could be attributed to the interventions. Interventions included in this chapter that are part of the DEBI Project are denoted by a "DEBI" in parentheses. (Note: MDH-funded organizations providing prevention services in Minnesota are not required to use interventions included in the DEBI Project.)

The DEBI Project emphasizes community- and group-level interventions over individual-level interventions because CDC feels they have the potential to reach large numbers of the population and reach individuals at high risk who might not voluntarily seek prevention information or services. They are also more cost-effective.

## **INTERVENTION CATEGORIES**

In general, within each population category, the interventions and strategies are discussed under five broad intervention categories: Outreach, Counseling and Testing, Single Behavioral, Multilevel, and Community Awareness.

### ***Outreach***

Outreach interventions are designed to identify at-risk individuals, provide them with risk reduction information and referrals to behavioral interventions. Outreach may also include field-based testing.

Outreach is generally conducted by peer or para-professional educators and are designed to identify individuals who are at risk for becoming infected with HIV. The outreach activities take place in neighborhoods and other places that high-risk individuals usually congregate. Outreach workers hand out condoms, sexual responsibility kits, bleach, and educational materials about how to reduce risk. They also provide referrals to services that can help people reduce or change their risk behaviors.

### ***Counseling and Testing***

HIV testing includes counseling before and after the test is given. High-risk individuals who test negative are referred to prevention programs and other support services, and individuals who test positive are referred to medical care and other support services, as well as to prevention programs.

### ***Single Behavioral***

Single behavioral interventions help people change or avoid behaviors that put them at risk for being infected with HIV. They include individual and group level interventions, and prevention case management.

### ***Community Awareness***

Community awareness interventions are designed to provide information and change community norms, but not necessarily designed to make individuals or communities change their behavior. Examples of mediums used to provide community awareness interventions include: electronic media, print media, hotlines, chat rooms and websites, clearinghouses, presentations/lectures, and community events. Community awareness activities include the interventions that CDC defines as Health Communication/Public Information and Other.

### ***Multilevel***

Multilevel programs include a number of interventions designed to achieve multiple purposes with the intention of moving individuals through a continuum of HIV prevention care. They may include outreach and behavioral interventions, as well as activities to raise awareness in the community. The multilevel intervention is designed so that the component interventions support one another and create a "whole" effect that is greater than the sum of the "parts."

## HIV Positive Individuals

Although only HIV Positive MSM were identified as a priority target population by the CCCHAP, this section addresses all HIV positive individuals in recognition of the greater emphasis that CDC is placing on this population.

We all have the collective responsibility to create the conditions in which both seropositive and seronegative people can make healthy choices.<sup>199</sup> This means that it is essential to engage HIV positive persons, as well as those who are HIV negative, in prevention interventions. However, until recently, prevention efforts in this country have been mostly focused on people who are at risk for becoming infected. The prevention needs of HIV positive individuals have often been overlooked, as have the significant efforts on the part of many to avoid infecting others. Although one HIV positive person is involved in each case of transmission, the world of prevention has shied away from focusing on prevention with positives because of the justifiable fear of stigmatizing people who are living with HIV/AIDS and a concern about creating a divide between HIV positive and negative individuals. In addition, the federal funding streams created two separate systems; one to provide prevention to at-risk individuals and the other to provide care and support to those who are positive.<sup>200</sup>

As HIV positive persons are living longer, they are healthier and are enjoying sexual lives. Recent evidence indicates that risk behaviors among both HIV positive and negative persons are increasing. There is more discussion about issues of intimacy and sex. In addition, many people living with HIV and AIDS face problems that may contribute to risk behavior, such as poverty, racism, homophobia, threat of violence, substance use, and mental health issues.<sup>201</sup>

Behavioral interventions can make a significant contribution to the lasting behavior change among people living with HIV and may be enhanced with the integration of messages of personal responsibility. However, a subpopulation exists among people living with HIV who recognize that they have infected others and within that subpopulation is a very small group who appear to have infected *many* others. This subgroup needs and warrants intensive intervention.<sup>202</sup>

### ADVANCING HIV PREVENTION

In 2003, CDC released its new Advancing HIV Prevention (AHP) strategies.<sup>203</sup> One of the key strategies of AHP is to prevent new infections by working with persons diagnosed with HIV and their partners. According to AHP, CDC will work with professional associations to disseminate guidelines regarding the incorporation of HIV prevention into the medical care of persons with HIV to primary care providers and infectious disease specialists. CDC will work closely with the Health Resources and Services Administration (HRSA) to reach persons who are HIV positive but are not in ongoing medical care or prevention services. CDC has also funded some demonstration projects to provide prevention case management for HIV positive persons. Finally, CDC will support new models of partner counseling and referral services, including offering rapid testing and using peers to conduct PCRS.

### RECOMMENDATIONS REGARDING PREVENTION WITH POSITIVES PROGRAMS

The AIDS Policy and Research Center and Center for AIDS Prevention Studies at the AIDS Research Institute, University of California San Francisco, recommends that people living with HIV, and the groups that represent their interests, must provide the leadership in designing effective prevention

<sup>199</sup> Marks et al, *AIDS*, 1999

<sup>200</sup> Collins et al, AIDS Research Institute, 2000

<sup>201</sup> Ibid

<sup>202</sup> *Journal of Sex Ed and Therapy*, Aug 1999

<sup>203</sup> CDC, *MMWR*, 2003

for positive programs. They note that not enough attention has been paid to the many efforts of HIV positive persons to change behavior and avoid infecting others. The challenge is to design prevention programs for HIV positive individuals about accountability and responsibility without causing feelings of shame or encouraging stigma.<sup>204</sup>

Because there is so much diversity among people living with HIV, different kinds of interventions must be developed in order to effectively reach various populations.

There are a number of factors that can affect risk behavior and should be taken into account in the development of programs:

- *Personal* – current health status, length of time living with disease, success of HIV treatments
- *Partner* – attractiveness, power dynamics within the couple, desire to please
- *Race* – power dynamics, assumptions about roles and HIV status
- *Community* – urban or rural setting, presence or absence of HIV positive peers, communal beliefs about the origins of HIV, the degree to which HIV infection stigmatized a person, ability to feel accepted in the community and discuss challenges with practicing safer sex
- *Substances* – physical or emotional dependence on alcohol and/or drugs
- *Economic situations* – homelessness, economic crisis, dependence on sex for money
- *History* – memory of the Tuskegee syphilis study where treatment was withheld from African American men
- *Availability of health care and prevention* – supportive education campaigns, condoms<sup>205</sup>

**NAPWA’s Principles of HIV Prevention with Positives**

The National Association of People with AIDS (NAPWA) developed 14 principles of HIV prevention with positives<sup>206</sup> to help shape these efforts. The principles were developed through a series of meeting with diverse groups of HIV positive persons across the country, and represent the perspective of those who will be most directly impacted by prevention with positives interventions.

**1. Prevention must be a shared responsibility.**

Developing prevention programs for positive people must not become an excuse for shifting all responsibility for prevention (or blame for new infections) onto the shoulders of people living with HIV/AIDS. A culture of shared responsibility that encourages communication and equality in relationships should be a goal of our prevention programming.

**2. Don’t assume serostatus.**

HIV prevention programs should deliver messages that are inclusive, understanding that HIV positive people are in the audience for these programs. It needs to be assumed that any HIV prevention effort will reach some people living with HIV/AIDS. Messages that are meant to apply only to uninfected people (“Stay negative,” “Don’t have sex with a person with AIDS,” etc) will be heard and understood differently by different people). Think about how these messages shape the way people living with HIV/AIDS think about prevention, and the way others think about us.

**3. HIV positive people have unique needs and concerns that require targeted approaches to reach us.**

It isn’t the same for positive and people of unknown or negative status.

<sup>204</sup> Ibid  
<sup>205</sup> Ibid

<sup>206</sup> NAPWA

**4. People living with HIV/AIDS are extremely heterogeneous and programs need to address the different needs of such a diverse group.**

It simply isn't the same for everyone, and we need culturally competent interventions for diverse populations: race, gender, sexual orientation, age, language, geography, addiction, etc. all impact the type of programming needed. One size does not fit all.

**5. Effective programs must fully accept the right of people living with HIV/AIDS to intimacy and sexual health.**

Few issues are as emotionally charged as sexual activity by people living with HIV/AIDS. Providers must learn to be truly non-judgmental and support the human right to a fulfilling sexual life, while working with people to decrease potential risk to others and themselves.

**6. Behavior change is tough for everyone...including people living with HIV/AIDS.**

Expecting 100% perfection from people who are HIV+ is as unrealistic as expecting it from the uninfected. Creating and sustaining behavior change is rarely instantaneous.

**7. Knowledge of serostatus is important, but isn't enough.**

Knowing is the first step, but it still requires support and skills. Most people who know they are HIV positive will take steps to avoid infecting others – but it is unrealistic to expect people to make and maintain change solely based on knowledge of status.

**8. There is no magic bullet, no single type of intervention that will work for everyone.**

Just like every other population, people living with HIV/AIDS need a variety of interventions delivered in a variety of settings, and sustained over time. While medical settings offer one important venue for interventions, there are many drawbacks to relying on them for positive

prevention. A diverse range of interventions, delivered in diverse settings, is required.

**9. Disclosure isn't always the answer.**

Disclosure doesn't guarantee safe behavior. Disclosure may produce severe and negative consequences. Helping people assess their readiness to disclose and developing the skills to do so is different than telling people they must disclose.

**10. Stigma, discrimination, shame and fear drive people underground and make prevention harder for everyone, especially positive people.**

Programs must function with an acute understanding of the centrality of these issues in the experience of people living with HIV/AIDS, must help people cope with their impact, and should challenge these harmful attitudes in communities.

**11. Coercion/criminalization is not the answer – and certainly shouldn't be the first answer.**

It is impossible to retain the trust and honest engagement of people if our prevention strategies are predicated on the threat of criminal prosecution for engaging in consensual activities.

**12. Programs must be anchored in the real needs and concerns of people living with HIV/AIDS.**

If it is driven solely by a prevention agenda without considering the priorities of people living with HIV/AIDS, it will fail. Listen to what is important to your population. Addressing relationships, housing, economic security, personal safety, etc are all important in engaging people in prevention.

**13. People living with HIV/AIDS need to be involved in the planning, design, delivery and evaluation of these programs.**

Things that are "done to us" won't work as well as things that are "done with us."

**14. Resources and capacity building efforts must support the development of HIV positive-run programs to respond to this need.**

There is an important role for PWA coalitions and other organizations run by and for positive people in these programs. We must invest in the capacity of organizations to do this work, creating sustainable PLWHA-led prevention efforts.

***Recommendations from Empowering Heroes Conference***

In March 2003, MDH and DHS co-sponsored a conference for HIV positive persons, their caregivers, and providers. The purpose of the conference was to provide health education information to participants, and to gather feedback on how to design effective prevention with positives programs.

Three focus group discussions were held. Twelve (12) persons participated in the group with service providers and caregivers, 7 persons in the group with HIV positive individuals, and 4 in the one with negative partners of HIV positive persons, for a total of 23 participants. Three questions were asked of participants:

1. What is a really helpful prevention message?
2. What is an unhelpful prevention message?
3. What prevention activities should be encouraged?

The comments were then analyzed and seven common themes emerged. They are presented below in the order of frequency with which they were mentioned.

*Theme 1: Accurate information:* Participants emphasized the need for accurate information to be repeatedly disseminated at different times, venues, and communities. The information should address transmission routes and levels of risk for different behaviors. Based on their experiences, the participants felt that this type of information does not appear in the community anymore.

*Theme 2: Alternatives to penetrative sex:* Prevention messages should include information about types of sexual behavior other than penetration. Examples given include masturbation, safe use of toys, physical touching, and other types of intimate contact.

*Theme 3: Use condoms:* Participants stressed the need for access to condoms (including non-latex and female condoms), education about how to use condoms. They also mentioned outreach in public sex areas, bars and other places where sex might occur or be negotiated.

*Theme 4: Directed to a specific community:* It is important that information and prevention messages are adapted for reaching specific communities. Some of the communities mentioned by participants were African Americans, deaf and hard of hearing, and youth.

*Theme 5: Negative sexuality and disempowerment:* Participants recommended not using fear, shame, shock or revulsion to educate about HIV/AIDS. Negative sexual self-image and disempowerment occurs when these types of messages are used, and could lead to increased unsafe behavior.

*Theme 6: Positive sexuality and empowerment:* As opposed to the previous theme, participants stressed the need to emphasize sex as a positive and empowering aspect of a person's life and something to be celebrated. Positive sexuality affirms the strength and desires of the individual and builds on those strengths to reduce transmission.

*Theme 7: Miscellaneous:* Other comments provided did not fit into the other categories and included specific examples of prevention activities and advertising campaigns, and the need for outreach.

## HIV COUNSELING AND TESTING

A meta-analysis of 27 published studies involving 19,957 participants was conducted to see whether HIV counseling and testing leads to a reduction in sexual risk behavior.<sup>207</sup> This analysis found that after counseling and testing, HIV positive individuals and persons in serodiscordant couples reduced unprotected intercourse and increased condom use more than people who received HIV negative results or those who did not test.

Some specific outcomes of HIV counseling and testing should include identifying the HIV positive individuals most at risk for transmitting the disease to others and referring them to specialized behavioral interventions and support. Asking a client at the time of testing about the number of persons he or she may have infected may identify those clients at greatest risk of transmitting HIV to others. The number of persons infected between time of infection and diagnosis significantly predicts the number of persons infected post-diagnosis.

## PARTNER COUNSELING AND REFERRAL

Even though this intervention is targeted toward those who are sex and needle sharing partners of HIV positive individuals, the outcome of the intervention depends on successfully reaching and counseling HIV positive people. Partner notification can be performed in two ways: by patient referral and by provider referral. With patient referral, infected persons are asked to notify their partners of the risk of infection and refer them to counseling and assessment. However, according to the CDC, HIV-infected men may need assistance in determining how to communicate their infection status to their partners.<sup>208</sup>

With provider referral, counselors locate partners using names, descriptions, and addresses provided by the patient. The anonymity of the index patient is always maintained. Once contacts are located, the counselor provides an initial 45 – 60 minute

session about HIV and risk reduction, and offers a free HIV test. Post-test counseling is also provided. In several studies, provider referral has been shown to be the more effective of the two approaches in locating partners,<sup>209</sup> as well as bringing about change.<sup>210</sup> Additional studies have shown that partner notification strategies are cost effective.<sup>211, 212</sup>

## HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART)

The use of highly active antiretroviral therapy (HAART) can significantly reduce the levels of virus in the blood, often to the point of being undetectable by current tests. Lower viral load in the blood tends to correlate with lower levels of the virus in genital fluids, but it is not an exact correlation.<sup>213, 214</sup>

One study in Uganda found that low blood viral load resulted in decreased transmission of HIV. No transmission was observed among the 51 serodiscordant couples whose infected partner's blood viral load was under 1500 copies per ml.<sup>215</sup> Another study in Taiwan found that after implementing a policy of providing free access to HAART in 1997, the estimated rate of HIV transmission was reduced by 53 percent by the end of 2002.<sup>216</sup>

It must be noted, however, that even for HIV positive persons on HAART, virus remains in many tissues of the body, inside cells, and in the blood despite being undetectable to tests. Viral loads can also fluctuate over time due to changes in adherence to treatment, the development of drug resistance, or the natural history of disease progression.<sup>217</sup>

As noted in the Needs Assessment chapter of this plan, optimism about treatment has been associated in some studies to an increase in risky behavior.

<sup>207</sup> Weinhardt et al, *American Journal of Public Health*, 1999

<sup>208</sup> CDC Update, January 2000

<sup>209</sup> Landis et al, *New England Journal of Medicine*, 1992

<sup>210</sup> Wykoff et al, *Sexually Transmitted Diseases*, 1991

<sup>211</sup> Rahman et al, *Journal of Epidemiology*, 1998

<sup>212</sup> Varghese et al, XII Int'l Conference on AIDS, 1998

<sup>213</sup> Barroso et al, *Journal of Acquired Immunodeficiency Syndromes*, 2003

<sup>214</sup> Goulston et al, *Journal of Infectious Diseases*, 1998

<sup>215</sup> Quinn et al, *New England Journal of Medicine*, 2000

<sup>216</sup> Fang et al, *Journal of Infectious Diseases*, 2004

<sup>217</sup> Center for AIDS Prevention Studies, 2003

## SINGLE BEHAVIORAL INTERVENTIONS

### ***Serodiscordant Couples Counseling***

Couples counseling was offered to serodiscordant heterosexual couples. On the first visit, couples were counseled together regarding purchase, storage, and use of condoms; how to refrain from anal sex; how to choose abstinence; and how to remain monogamous. In follow up sessions, couples were counseled separately. Counseling sessions included role plays, and discussion of social, financial and legal issues around HIV. The intervention was shown to be effective in improving safer sex behaviors. Eighty-five (85) percent of participants who did not use condoms at enrollment did so by the most recent follow-up.<sup>218</sup>

In another study, couple counseling was offered to serodiscordant couples every six months, and the seronegative person was tested for HIV. Forty-eight percent (48%) of couples used condoms consistently, and they experienced no seroconversions. However, among the couples that did not use condoms consistently, 9.9 percent seroconverted. Condom use was directly linked to fewer seroconversions.<sup>219</sup>

### ***Healthy Relationships (DEBI)***

This group session intervention is based on a study involving HIV positive men and women (52% African American, 22% White, 4% other). Participants self-identified as gay (52%), heterosexual (39%), and bisexual (9%).<sup>220</sup>

Participants in the study reported greater self-efficacy for suggesting condom use with new partners, as well as reporting less unprotected sex, more protected sex, and fewer sexual contacts at the 6 month follow-up. Participants were also significantly more likely to refuse to engage in unsafe sex at the 6 month follow-up.

Healthy Relationships is a five-session, small group intervention for HIV positive men and women. Core elements of the intervention include:

- Defining stress and coping skills in relation to disclosing to family and friends, disclosing to sexual partners, and building healthier and safer relationships.
- Using modeling, role-play, and feedback to teach and practice skills related to coping with stress.
- Teaching decision making skills about disclosure of HIV status.
- Providing personal feedback reports to motivate change of risk behaviors and maintenance of protective behaviors.
- Using movie clips to set up scenarios about disclosure and risk reduction to stimulate discussions and role-play.

### ***Stress Management***

Another study evaluated the impact of stress management training on sexual behavior and immune functioning. HIV positive gay men in San Francisco were recruited after a newspaper article appeared. The intervention consisted of eight two-hour sessions, and included instruction on systematic relaxation techniques, health habit change promotion by creating contracts focusing on healthy behaviors, and skills to manage stress through discussion, teaching and modeling. At follow-up, the participants had significantly fewer sex partners in the previous month than did people who were part of the control group.<sup>221</sup>

## PREVENTION CASE MANAGEMENT

The CDC promotes prevention case management (PCM) as a priority for HIV positive persons. PCM is defined by the CDC as being “client centered HIV prevention activities with the goal of promoting the adoption or maintenance of reduced HIV [transmission] behaviors.”

<sup>218</sup> Padian et al, *Journal of Acquired Immunodeficiency Syndromes*, 1993

<sup>219</sup> de Vincenzi, *New England Journal of Medicine*, 1994

<sup>220</sup> Kalichman et al, *American Journal of Preventive Medicine*, 2001

<sup>221</sup> Coates et al, *American Journal of Public Health*, 1989

CDC has also defined the primary goals and essential components of PCM. Goals include the provision of specialized assistance to people with multiple and complex needs, offering individual multiple sessions of HIV risk reduction counseling, and assessing whether individuals have other STDs and making sure they get proper treatment, as needed.

The seven essential components of PCM are: client recruitment, screening, risk reduction counseling development of client plan, coordination of services, follow-up monitoring, and discharge.

Upon looking at PCM programs across the nation, CDC found that they are being implemented very differently. They also identified some barriers to successful PCM programs, which include a lack of interest by clients, lack of clear definition of PCM, lack of referral resources in the community, and difficulty evaluating the outcome of the program.<sup>222</sup> CDC is funding several demonstration projects of PCM with persons living with HIV over the next couple years in order to provide better guidance on what works.

## **HIV PREVENTION IN MEDICAL CARE SETTINGS**

In July 2003, CDC, the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the HIV Medicine Association of the Infectious Disease Society of America released recommendations regarding the incorporation of HIV prevention into the medical care of persons living with HIV and AIDS.<sup>223</sup> The recommendations are general and apply to all HIV positive adolescents and adults, regardless of age, sex or race/ethnicity. They are intended for all professionals that provide medical care, such as physicians, nurse practitioners, nurses and physician assistants. They might also be useful to other such as case managers, social workers, and health educators.

<sup>222</sup> Collins et al, AIDS Research Institute, 2000

<sup>223</sup> CDC, *MMWR*, 2003

### **Summary of Recommendations**

Basically, the recommendations say that clinicians can greatly affect their patients' risk for HIV transmission by doing the following:

- Performing a brief screening for HIV transmission risk behaviors.
- Communicating prevention messages, both verbally and with literature/posters.
- Providing condoms.
- Discussing sexual and drug use behavior.
- Positively reinforcing changes to safer behavior.
- Referring patients to services such as substance abuse treatment.
- Facilitating partner notification.
- Counseling and testing.
- Identifying and treating other STDs.

## Men Who Have Sex with Men and Men of Color Who Have Sex with Men

In general, the evaluation of programs for gay men has been of high quality, based on sound theory and has been successful in targeting specific behaviors.<sup>224,225,226,227</sup> We need more data on long-term behavioral change. In addition, we are sorely lacking any evaluated interventions that focus on men of color who have sex with men, gay and bisexual youth, men who have sex with men who do not identify themselves as gay, and non-urban men who have sex with men.

Also, some more basic research needs to be done among gay men to describe attitudes and motivations, including development of good scales to measure these constructs. The wider spectrum of sexuality needs to be considered in order to affect maintenance of safer sex over time. For example, according to the CDC, research has shown that some men make false assumptions about the HIV status of their partners, assuming that partners who do not insist on a condom must not be infected, or believing that they have communicated their status by leaving their HIV medications in visible locations. Programs must be designed to address these and other factors influencing behavior, and must ensure that messages are reinforced and adapted as needed over time.<sup>228</sup>

### COUNSELING AND TESTING

A meta-analysis of 27 published studies involving 19,957 participants, including MSM, was conducted to see whether HIV counseling and testing leads to a reduction in sexual risk behavior.<sup>229</sup> The results indicate that people who receive negative test results and those who do not test are less likely to reduce risky sexual behavior than persons who test

positive or are in a serodiscordant couple. HIV negative participants did not reduce risk behavior any more than participants who did not test. This study suggests that counseling and testing is not effective as a primary prevention strategy.

### SINGLE BEHAVIORAL INTERVENTIONS

Most group education programs have been effective, particularly if sexually explicit materials were used and if behavioral skills were an important part of the intervention. No long-term behavioral impact was measured. These interventions involved highly motivated men who were self-identified as gay or bisexual, and may not be as effective for other men having sex with men.

#### *Group Sessions Targeting African American Gay and Bisexual Men*

African American gay and bisexual men in the San Francisco Bay Area were recruited from bars, bathhouses, erotic bookstores, and through African American organizations, street networks, newspaper advertisements, and personal referrals. The intervention consisted of three three-hour group sessions, and included the following four components: promotion of self-identity and self-pride; HIV/AIDS risk reduction education, assertiveness training (discussion and role play), and verbal commitments to reduce high-risk behavior. The sessions were effective in reducing frequency of unprotected anal intercourse.<sup>230</sup>

#### *Many Men, Many Voices (DEBI)*

This group level intervention is focused on behavioral self-management and assertion skills, and is based on a study conducted with 104 gay men (87% White, 13% African American or Latino). Twelve group sessions addressed HIV and prevention, improving behavioral self management, self-identification

<sup>224</sup> Fisher and Fisher, *Psychological Bulletin*, 1992

<sup>225</sup> Choi and Coates, *AIDS*, 1994

<sup>226</sup> NASTAD, 1994

<sup>227</sup> Academy for Educational Development, 1994

<sup>228</sup> CDC Update, January 2000

<sup>229</sup> Weinhardt et al, *American Journal of Public Health*, 1999

<sup>230</sup> Peterson et al, *American Journal of Community Psychology*, 1996

of risk behaviors and personal risk reduction strategies, assertiveness training, relationship building and social support. The intervention was effective in improving safer sex behaviors and at maintaining this improvement over an eight-month period, and in improving assertiveness skills and HIV/AIDS knowledge.<sup>231</sup>

The intervention has been adapted to target gay men of color, and is a six- or seven-session intervention addressing factors specific to gay men of color that influence behavior. The sessions address the following topics:

- Dual identify of gay men of color
- STD/HIV prevention for gay men of color – sexual roles and risks
- STD/HIV risk assessment and prevention options
- Intentions to act and capacity to change
- Sexual relationship dynamics – partner selection, communication and negotiation
- Social support and problem solving to maintain change
- (Optional) Building a healthy community

**Small Group Lecture Plus Skills Training**

A lecture-only intervention with mostly White gay men covered HIV transmission, HIV infection, relative risk for specific sexual practices, condom use, interpretation of HIV test results, and importance of reducing risk. A second intervention added a skills building component that incorporated role play, psychodrama, and group process. Both groups showed trends toward behavior change, and the skills building intervention was effective at increasing the use of condoms during insertive anal sex at six and twelve month follow-ups.<sup>232</sup> Additional studies have shown that not only is the incorporation of a skills building component into HIV prevention education effective in changing behavior, it is also cost effective.<sup>233</sup>

**Research in Minnesota**

The **Man-to-Man Seminar** is a two-day sexual health seminar that is designed to provide comprehensive sexual health education to MSM. The seminar focuses on participants’ knowledge, attitudes, and behaviors as they relate to HIV prevention, risk behavior, and sexual health.

The seminar provides basic information on sexual health issues including sexual identity, HIV and STD prevention techniques, relationships, intimacy and sexual behavior. The curriculum includes multi-media, multi sensory experiences with large group discussions, small group discussions, behavioral modeling, storytelling, video, music, and PowerPoint slide presentations.

Participants in the seminar participate in the following: Complete voluntary pre-and post-test surveys, small group and large group exercises, breakout groups, and discussions with other participants of the seminar. The surveys include questions about sexual and drug experience, attitudes, beliefs, mood, and any abuse experienced and related issues. In 1997 an evaluation study funded by the CDC indicated the effectiveness of the seminar in maintaining consistent protected anal sex.<sup>234</sup>

**The EXPLORE Study**

The EXPLORE behavioral intervention assumes that different MSM will have different risk factors and that interventions need to be tailored to each individual.<sup>235</sup> The first three sessions of the EXPLORE model are designed to build rapport between the counselor and the individual. They focus on identifying the factors most important for the individual in relation to unsafe sex and self-protection. Based on the information gathered in the first three sessions, the counselor designs the following sessions to focus on issues that are most pertinent to the individual.

<sup>231</sup> Kelly et al, *Journal of Consulting and Clinical Psychology*, 1989

<sup>232</sup> Valdiserri et al, *AIDS*, 1989

<sup>233</sup> Pinkerton et al, *AIDS*, 1997

<sup>234</sup> Rosser et al, 2002

<sup>235</sup> Chesney et al, *American Journal of Public Health*, 2003

The EXPLORE model is based on 10 counseling modules. The counselor individualizes intervention by choosing the modules that best fit the needs of each person. The counseling modules have the following core themes:

**Module 1** – Being HIV negative and participating in EXPLORE.

*Session Focus:*

- Participant states why he wants to stay HIV negative.
- Mixed feelings about sex and risk are examined and normalized.

**Modules 2 and 3** – Risk: What's acceptable to me? Crossing acceptable limits.

*Session Focus:*

- Knowledge of risk factors assessed.
- Personal meaning of risk reduction is explored through talking about recent sexual experiences and personal attitudes regarding acceptable risk.
- Discussion about pleasure of unprotected sex.

**Modules 4 and 5** – Sexual Communication: HIV status, spoken and unspoken messages.

*Session Focus:*

- Attitudes and skills that help or impair clear communication of risk limits.
- Communication of serostatus.
- Being part of a couple that negotiates safety arrangements or risk limits.

**Modules 6, 7, 8 and 9** – Sex, drinking, and drugs. Places and events as triggers. Feelings and thoughts as triggers. Partners as triggers.

*Session Focus:*

- Impact of substance use on risk behavior.
- How personal, social, and environmental factors may trigger either risky sex or safer behavior.
- Examination and skills training to manage risk when faced with: settings where risky sex may occur, life and social events that may encourage risk, emotions and self-talk that cue risk taking, partner characteristics that trigger risky sex.

**Module 10 and Maintenance** – Planning for maintenance and staying HIV negative.

*Session Focus:*

- Planning for how to maintain personal risk reduction efforts, including training on how to prevent relapses, applying lessons to changing life situations.

The study found that the most common factor reported by 75 percent of participants was enjoyment of unprotected anal sex, which presents a challenge to motivating behavior change. This model employs motivational interviewing, which is used to identify feelings of ambivalence towards reducing risk. The focus of counseling is on identifying and vocalizing pros and cons of change and reasons to engage in safer behaviors.

Thirty-five percent (35%) of the participants exhibited weak communication skills, which were addressed through strategies to provide information and build skills for engaging in safer behaviors.

The baseline data from the EXPLORE study seem to support the use of a prevention intervention that is individually tailored. A benefit of this type of intervention is that it allows counselors to reinforce current risk reduction efforts while working with clients to anticipate changes in life circumstances and relationships that could be associated with greater risk.

## **MULTILEVEL INTERVENTIONS**

### ***Foundation SIDA de Puerto Rico***

The Foundation SIDA de Puerto Rico developed a four session workshop series for gay/bisexual men in Puerto Rico. Outreach promoting the workshops was performed at areas where men socialize, and small educational sessions promoting the workshops were held in private homes prior to the workshops. At the conclusion of the series, support groups were formed to empower men, and help men assume responsibility for reducing their risk of HIV. Pre-post results suggest that men adopted safer sexual behaviors, reduced consumption

of alcohol and drugs, and reported increased self-esteem following the workshops.<sup>236</sup>

### **Popular Opinion Leader (POL) (DEBI)**

Bartenders from gay bars in three small southern cities identified individuals who they considered to be popular opinion leaders. The opinion leaders were trained as outreach workers in four ninety-minute sessions. They learned the social skills necessary to deliver effective health promotion messages, how to correct peer misconceptions regarding AIDS risk, how to recommend strategies to reduce risk, and how to personally endorse the benefits of behavior change. Each peer opinion leader was contracted to have at least 14 conversations with peers. The intervention was effective at reducing unprotected insertive and receptive anal intercourse, and in increasing the use of condoms during anal intercourse, and at improving norms for safer sex perceived from peers.<sup>237</sup>

In a similar intervention in two west coast cities, in addition to the peer education risk reduction workshops, social events that included AIDS prevention messages, and print and graphics AIDS education materials were distributed in venues frequented by young gay men. The proportion of men engaging in unprotected anal intercourse in the previous two months decreased from 41 percent to 30 percent at the one-year follow-up.

According to the CDC, the use of peer opinion leaders has been found to be an effective strategy in the MSM community. Surveys of nearly 1,300 gay men in cities with and without a popular opinion leader program found that men in the intervention communities were 34 percent less likely to have unprotected sex compared to men from other control communities three to six months after intervention.<sup>238</sup> In addition, such interventions have also been determined to be cost effective.<sup>239</sup>

<sup>236</sup> U.S. Conference of Mayors, 1996

<sup>237</sup> Kelly et al, *American Journal of Public Health*, 1991

<sup>238</sup> CDC Update, January 2000

<sup>239</sup> Pinkerton et al, *AIDS*, 1997

### **Stonewall Health Project**

The Stonewall Health Project (Idaho) is a peer-to-peer education, awareness, and esteem development model for gay men. It consists of weekly meetings (movie, guest speaker, and discussion groups), potlucks, external activity trips, topic based discussion, a website, and a "warm-line." The project networks with many community programs in the region to help provide comprehensive services.

### **Cara a Cara, Hombre a Hombre**

Cara a Cara, Hombre a Hombre is a five-day sexual health seminar targeting the Latino community. The first, fourth and fifth days are for health providers alone, reviewing the history of HIV/STD prevention and presenting a sexual health model as a means of preventing transmission of HIV. The second and third days are for health providers and community members, and consist of a culturally appropriate sexual health seminar for Latino gay men, modeled after the Man-to-Man seminar developed by the University of Minnesota's Program in Human Sexuality.<sup>240</sup>

### **Keeping It Up**

Keeping It Up is a relapse prevention program developed by the AIDS Resource Center in Dallas. Its basic purpose is to promote safer sex by helping gay and bisexual men develop a positive, life-protecting self image. Its objectives are to provide safer and erotic alternatives to intercourse; to reinforce safer sex as a permanent life change that is both necessary and desirable; and to establish and reinforce safer sex as a community norm.

Keeping It Up has five components:

- *Trade Patrol*: An outreach program targeting African American gay/bisexual men that includes condom distribution, weekly meetings and forums.
- *Foreplay*: An in-depth safer sex and issues workshop.

<sup>240</sup> Rosser et al, 1999

- *Condom Guerrillas*: Bar outreach, bath-house presentations, and distribution of information packets.
- *Latex Support Group*: Support group that meets twice a week to discuss issues around safer sex and the community.
- *Slipping and Sliding*: An eight hour workshop on issues concerning relapse prevention which stresses behavior change and provides regular follow-up for nine months after attendance.

**COMMUNITY AWARENESS INTERVENTIONS**

***Community PROMISE (DEBI)***

Community PROMISE is based on the AIDS Community Demonstration Projects,<sup>241</sup> which took place over three years in Dallas, Denver, Long Beach, New York City, and Seattle. Target communities included non-gay-identified men who have sex with men, among others. Each intervention site used peer volunteers to distribute kits featuring role model stories, brochures, condoms, and bleach kits. Significantly greater achievement in consistent condom use, and maintenance of consistent condom use with non-main partners was found in the intervention communities.<sup>242</sup>

The first core element of Community PROMISE is the community identification process, which involves interviewing and holding focus groups with stakeholders in the community to identify why people engage in risk behaviors, what barriers exist to changing behavior, what will encourage them to change behaviors, and locations where they engage in risk behaviors.

The second core element is role model stories, which are brief publications with personal stories from members of the community who have made or are planning to make a risk-reducing behavioral change. The third element is peer advocates, who are volunteers from the community who help

distribute the role model stories and other materials. The final core element is evaluation of the intervention in order to provide evidence of its effectiveness.

***Stop AIDS***

The Stop AIDS project was initiated in San Francisco in the early 1980s. Its goal was to produce a shift in community norms. During two and a half years, 7,000 men participated in a one-time discussion group intervention. During that time period, seroconversion among gay men dropped from 18 percent to virtually zero.

The STOP AIDS sessions lasted three and a half hours and covered the following topics:

- History, background and objectives of Stop AIDS;
- Ground rules for discussion and introduction of outline;
- Introduction of participants;
- Discussion of the impact of the epidemic on each participant's life;
- Discussion of virus transmission through sexual behavior vs. safe sex;
- Discussion of alcohol and drug use as they relate to unsafe sex;
- Discussion of intravenous drug use and virus transmission;
- Discussion of HIV antibody testing;
- Discussion of changes taking place in the gay community because of the epidemic;
- Discussion of participants' visions for the community in the future;
- Discussion of personal power in ending the epidemic and personal involvement in the effort;
- Completion of personal commitment cards and verbal declarations of that commitment; and
- Acknowledgement of the group by the leader.

<sup>241</sup> No author listed, *American Journal of Public Health*, 1999

<sup>242</sup> CDC, 1999

***B-Boy Blues Festival***

The B-Boy Blues Festival is a successful program designed to recognize that a significant portion of African American men who have sex with men may not self-identify as gay or bisexual. HIV prevention information is provided in a more acceptable setting. The festival, held in St. Louis, Missouri, does not advertise or identify as an HIV/AIDS event and includes entertainment and cultural programs that accompany HIV workshops, HIV counseling and testing, and distribution of condoms and HIV prevention literature. Surveys disseminated at the festival in 1996, 1997, and 1998 have shown significant improvements in attitudes about and knowledge of HIV and AIDS by attendants, illustrating that outreach activities not promoted as HIV/AIDS programs are useful in serving these usually hard to reach men.<sup>243</sup>

***Project NEON***

Project NEON is a community level intervention targeting MSM/IDUs. Based in urban Seattle, the program publishes a short harm reduction magazine developed with input and articles from the MSM/IDU community. Project NEON also provides individual and group level counseling and HIV prevention peer education.

**RECOMMENDATIONS FROM MSM IN MINNESOTA**

A total of 61 men participated in a series of five community forums that were held with MSM in 2001 for the purpose of gathering input on appropriate prevention interventions for the MSM target population. Overall, 93 percent of the participants in these forums were White. Three of the forums occurred in Minneapolis. Two were held in Greater Minnesota, and were attended by a total of 27 men. Some common themes emerged from the forums.

***Access to Condoms***

The men stated that there is a need for greater access to free condoms and lubricant,

along with information about how to use the condoms, and HIV/STD risk reduction information. In addition to having bowls of condoms available in places like bars, restrooms, parks, and beaches, several groups talked about the importance of having outreach workers available to distribute the condoms and build up trust with the people they are reaching.

It was noted that condoms are particularly difficult to access in rural areas, and that married, older or younger men may be inhibited from buying condoms in a store because of the fear of being judged or that their partner, spouse or parent may see the receipt.

***Information on the Internet***

Men from both the metro area and Greater Minnesota emphasized the use of the Internet as a prevention tool. Suggestions for the type of information to post included: HIV and risk reduction information, resources for testing and safer sex supplies, banner ads in MSM chat rooms, and a list of GLBT friendly health care providers.

***Free and Anonymous HIV Testing***

All groups except one talked about the importance of having free and anonymous testing accessible, and the need for being able to easily access test results. One group from Greater Minnesota suggested the option of having test results available over the Internet, and a metro group discussed the possibility of providing test results and counseling over the phone.

***Images of MSM***

The group of married men who have sex with men (10 participants) talked about the need for images in public of men showing affection and loving each other, including married men. They talked about the lack of validation they feel as MSM, particularly being married, and that this leads to a sense of isolation. The isolation can lead to denial and mental stress, which may also lead to risky behavior such as anonymous, unprotected sex.

<sup>243</sup> CDC Update, January 2000

***Peer Group Educational Opportunities***

Both rural and metro groups talked about the need for small peer group events that provide the opportunity to share factual information about HIV, and to discuss issues such as coming out and drug use, which impact risk behavior. One group talked about the importance of providing the opportunity for MSM to meet people and dialogue about sexuality in a setting that does not involve drinking or drugs. Several groups also mentioned the need for a safe space for MSM to come together.

***Discussing HIV and Sexuality with Doctors***

Two groups talked about the need to educate health care providers about the need to be sensitive to MSM and to talk about safer sex and HIV/STDs with all patients. They also suggested educating MSM about how to talk to their doctors about HIV and risk behavior.

## Heterosexuals and Heterosexuals of Color

In 2003, heterosexual contact accounted for 12 percent of living HIV/AIDS cases in Minnesota, with women making up the majority of heterosexually acquired cases (78%). Forty-five percent of all living heterosexually acquired cases reported having unsafe sexual contact with a person known to be HIV-infected.

In Minnesota, it is particularly important to implement effective prevention interventions targeting heterosexual men and women of color. Of the 79 heterosexually acquired new infections among females in the past three years, women of color account for 73 percent. Men of color account for 62 percent of the 26 heterosexually acquired new infections among males in the past three years.

### COUNSELING AND TESTING

A meta-analysis of 27 published studies involving 19,957 participants, including heterosexuals, was conducted to see whether HIV counseling and testing leads to a reduction in sexual risk behavior.<sup>244</sup> The results indicate that people who receive negative test results and those who do not test are less likely to reduce risky sexual behavior than persons who test positive or are in a serodiscordant couple. HIV negative participants did not reduce risk behavior any more than participants who did not test. This study suggests that counseling and testing is not effective as a primary prevention strategy.

### Cost Benefit Analysis

Counseling and testing does appear to have substantial benefit given its cost, as averting even one HIV infection yields a net savings to society. In a cost benefit analysis of public counseling and testing services, Holtgrave et al determined that the benefit cost ratio is 20.09, and that such services result in a net economic gain to society.<sup>245</sup> The cost

effectiveness of rapid screening tests have also been demonstrated when HIV negative clients are provided their test results during the same visit in which the test is performed.<sup>246</sup> In particular, screening of pregnant women has been shown to be cost effective,<sup>247,248</sup> as has the treatment of HIV positive pregnant women and their newborns with AZT.<sup>249, 250</sup>

### HIV Education, Testing and Counseling

In another study, men and women (85% African American) at an STD clinic were offered HIV counseling and testing. The counseling consisted of a pamphlet discussing safer and unsafe sexual acts and how to use condoms, a 15-minute video examining risk behavior and promoting condom use, as well as discussing risk with sex partners, and a ten-minute one-on-one counseling session with a physician. Participants reported significantly fewer occurrences of unprotected intercourse than did those in the comparison condition.<sup>251</sup>

### Communication Around Sexual Risks

Two studies found that counseling and testing was effective in having people communicate sexual risks to their partners before sex. One of these programs targeted African American clients. Another program for high-risk heterosexual couples in San Francisco found that a counseling program had no effect on safer sex practices after five months.<sup>252</sup>

<sup>244</sup> Weinhardt et al, *American Journal of Public Health*, 1999

<sup>245</sup> Holtgrave et al, *Archives of Internal Medicine*, 1993

<sup>246</sup> Farnham et al, *Public Health Reports*, 1996

<sup>247</sup> Ecker, *American Journal of Obstetrics and Gynecology*, 1996

<sup>248</sup> Gorsky et al, *Public Health Reports*, 1996

<sup>249</sup> Mauskopf et al, *JAMA*, 1996

<sup>250</sup> Stringer et al, *American Journal of Obstetrics and Gynecology*, 1999

<sup>251</sup> Wenger, *American Journal of Public Health*, 1991

<sup>252</sup> Choi, *AIDS*, 1994

## SINGLE BEHAVIORAL INTERVENTIONS

### *Project Respect (DEBI)*

Project Respect examined the efficacy of HIV/STD prevention counseling. It enrolled 5,801 STD patients (59% African American, 19% Latino, 16% White, 6% other) from five inner-city clinics into an enhanced counseling arm (4x60 minutes), an HIV prevention counseling arm (2x20 minutes), and an HIV education message arm (2x5 minutes), all of which were followed up at 3 and 12 months. All three interventions were face to face, and used a structured format to encourage consistent condom use with all sex partners. A \$15 stipend was offered per intervention session.

Condom use increased in all intervention arms, with enhanced counseling showing the highest condom use. Both the enhanced counseling, and the prevention counseling reduced the incidence of STDs in women and men. The authors conclude that high-risk STD clinic patients will participate in multi-session, clinic based HIV counseling, that theory based behavioral interventions can change high risk behaviors, and can prevent STDs, that counseling interventions can change high-risk behaviors and can prevent STDs, and that benefits of counseling remain at six months.<sup>253</sup>

The findings from Project Respect indicate that, if well designed, brief interventions can make a significant impact. The length of an intervention appears not to be the most important factor. The way prevention messages are delivered and the client's personal involvement in the process can have an important impact.

### *VOICES/VOCES (DEBI)*

A clinic-based intervention consisting of a sixty-minute session started with the viewing of a culturally appropriate video. One video, "Love Exchange," was designed for African Americans and another, "Porque Sí," for Latinos. Both videos provide accurate risk

information and corrected misinformation, portrayed positive attitudes about condom use, and modeled gender- and culturally-specific strategies for encouraging condom use. A facilitated interactive discussion followed the video, and participants received free condoms at the clinic, as well as a coupon for free condoms at an area pharmacy. The intervention was effective in lowering the rate of new STD infections among the men who participated.<sup>254</sup>

### *Other Clinic-based Interventions*

Men and women (67% African American, 15% Latino, 19% other) received a 10 to 15 minute presentation while waiting for appointments at an STD clinic. The presentation emphasized the three important points for effective condom use: condoms should be made of latex, condoms should have a reservoir tip or space left at the end, and condoms should be lubricated with a spermicide. The session included group discussion and a demonstration of how to put on a condom. Another 10 to 15 minutes were allowed for questions and answers. Men and women who participated were significantly less likely to return to the STD clinic within the next 12 months with a new STD.<sup>255</sup>

This single session group intervention with men and women (92% African American) waiting for appointments in an STD clinic began with a video, "Let's Do Something Different," followed by group discussion about methods of prevention STDs, promotion of condom use, and reasons why people like or don't like using condoms. Role-playing allowed the participants the opportunity to practice condom negotiation. Finally, participants were given 10 free condoms. Men who participated in this intervention had a significantly lower STD reinfection rate. There was no evidence of change for women.<sup>256</sup>

This clinic-based intervention consisted of 4 weekly group sessions lasting 90 minutes with 8 to 10 women in each group (87% African

<sup>253</sup> Kamb et al, XI International Conference on AIDS, 1996

<sup>254</sup> O'Donnel et al, *Sexually Transmitted Diseases*, 1998

<sup>255</sup> Cohen et al, *Journal of Sex Research*, 1991

<sup>256</sup> Cohen, *Public Health Report*, 1992

American, 3% Latina, 4% Native American, 6% White). The sessions provided detailed information about HIV risk and focused on behaviors that increase risk, common misconceptions, and how to reduce risk. Exercises emphasized cognitive-attitudinal areas, behavioral skills and social factors. Role-plays were used to practice initiating conversations about HIV and condom use, and how to resist sexual pressure. Condom demonstration and practice was also included. The women also learned how to recognize, understand and manage personal triggers for risk behavior. Women participating in this intervention significantly increased condom use and decreased frequency of unprotected sex.<sup>257</sup>

### **Group Sessions for Pregnant Women**

One intervention, led by female psychologists and health educators, consisted of four sessions, for groups of two to eight single, pregnant women (57% African American, 40% White, 3% other). Women learned negotiation and assertiveness skills, created health plans, reviewed videos, and role-played risk scenarios. Incentives included cash, partial reimbursement for transportation, childcare, and participation in a lottery for a color TV. Women who participated in the intervention increased their use of condoms with partners significantly more than women in the comparison condition.<sup>258</sup>

### **Collaborative Group Counseling**

One study noted the value of a group counseling model that aimed at changing high-risk behaviors through collaborative counseling, and focusing on incentives for positive change, rather than on negative consequences.<sup>259</sup>

### **Group Sessions Targeting University Students**

A series of four ninety-minute sessions were held over one month targeting mostly White

heterosexual women recruited through classes, social groups, and the health service at a Midwestern university. Only 13 percent of women approached participated. Topics included risk behavior education; assertiveness, decision making, problem solving, and negotiation skills; condom use; maintenance of healthy behavior; and rehearsal and role-playing. The intervention improved self-efficacy, sexual assertiveness and communication skills. There was modest reduction in sex without a condom, and drug use.<sup>260</sup>

Another intervention involving an HIV education session consisting of videotape, lecture, role-play, brochures, discussion of transmission, safer sex behaviors, condom use, and information about HIV testing, was held with students attending a student health outpatient clinic (mostly female, mostly White). The students also received HIV tests. There was no impact on sexual risk behaviors. However, those in the intervention group were more likely to ask their partners if they had been tested. Only 20 percent of students approached agreed to participate in the intervention.<sup>261</sup>

### **SISTA (DEBI)**

SISTA is based on an intervention that was demonstrated to be effective in increasing consistent condom use, and in improving skills and perceived norms from partners among African American women in a low income community in San Francisco.<sup>262</sup> The intervention consists of a series of five two-hour sessions facilitated by two peer health educators in a community based setting, which include behavioral skills practice, group discussions, lectures, role-play, a prevention video, and take home exercises.

The curriculum emphasizes gender and ethnic pride and enhancement of self-worth, sexual assertion skills, proper condom use, cultural and gender triggers that may make it challenging for women to negotiate safer sex.

<sup>257</sup> Kelly et al, *American Journal of Public Health*, 1994

<sup>258</sup> Hobfall et al, *Health Psychology*, 1994

<sup>259</sup> Kavanagh et al, *Archives of Psychiatric Nursing*, 1992

<sup>260</sup> Sikkema et al, *AIDS Education and Prevention*, 1995

<sup>261</sup> Wenger et al, *Annals of Internal Medicine*, 1992

<sup>262</sup> DiClemente and Wingood, *JAMA*, 1995

The importance of partner involvement in safer sex is also emphasized, and the take home exercises involve the male partner.

**Sister to Sister**

Sister to Sister is a program funded by the Mississippi Department of Health to provide basic HIV prevention education to African American women at risk for HIV. The Sister to Sister program has its own curriculum. The Rape Crisis Services of Northwest Mississippi combines the Sister to Sister curriculum with its rape counseling services for African American women, teens, and youth.

**Group Sessions Targeting Women from Homeless Shelters and Drug Recovery Programs**

Women were recruited through homeless shelters and drug recovery programs to participate in single one- and two-hour group education sessions. The study shows that the sessions were effective in improving potential determinants of risk behavior, such as knowledge, a decrease in distress scores, and an increase in measures of coping strategies. The sessions may also be effective in facilitating short-term change in risk behavior. The interventions consisted of education, referral, HIV counseling and testing, provision of condoms, brochures, culturally appropriate video presentation (one-hour session), condom use and needle cleaning skills, discussion of problem-focused coping responses; and self-esteem and self control enhancement (two-hour session).<sup>263</sup>

**Institutional Education Interventions**

A course of 16 two-hour group sessions was given to incarcerated women with a history of drug use. The study shows that it is possible to implement a skills building and social support intervention in a jail setting. The intervention did impact on coping skills and social support, but did not change behavior. At the one month follow up there was no significant difference in perceived vulnerability to HIV, sexual self-efficacy, or

HIV/AIDS knowledge from the control group.<sup>264</sup>

The efficacy of cocaine abuse counseling alone as a strategy to reduce HIV-related sexual risk behaviors was evaluated through a study where 232 cocaine abusing or dependent individuals received up to 26 weeks of Matrix counseling, but no formal HIV prevention interventions. Matrix counseling uses a manual-driven format for teaching cognitive and behavioral skills to initiate abstinence and prevent relapse. Participants who completed counseling were more likely to change to safer sex or maintain safer sex over the six months than those who terminated counseling prematurely. Safer sex changes included decreases in numbers of partners.<sup>265</sup>

**Group Education for Women**

Studies have found that improvements in condom use and safer sex knowledge can be obtained for women from a variety of backgrounds through group education sessions that address:

- Assertiveness
- Negotiation skills
- Planning skills
- Skill training in condom use

Participants in these studies were recruited through obstetrical clinics, primary health care clinics, and methadone maintenance clinics.  
266, 267

**MULTILEVEL INTERVENTIONS**

**Project Save** programs principally serve African American females in a mentor/peer oriented multifaceted prevention risk reduction program through a series of class sessions. Efforts emphasize grassroots approaches to identify and recruit the population to assess, educate and involve in rural HIV prevention activities and to conduct local provider needs assessments (Alabama).

<sup>263</sup> Nyamathi et al, *AIDS Education and Prevention*, 1994

<sup>264</sup> El Bassel et al, *Social Work Research*, 1995

<sup>265</sup> Shoptaw et al, *AIDS Education and Prevention*, 1997

<sup>266</sup> Academy for Educational Development, 1996

<sup>267</sup> CDC, 1999

**AIDS Counseling and Education (ACE)** is an inmate peer education model in correctional facilities. The program provides a set of comprehensive services, including educational materials, a buddy program, and support services. ACE is inmate-designed and inmate-established. It began in 1988 at Bedford Hills Correctional Facility, New York.

**COMMUNITY AWARENESS INTERVENTIONS**

**Community PROMISE (DEBI)**

Community PROMISE is based on the AIDS Community Demonstration Projects, which targeted high-risk, hard to reach populations in five large cities. Interventions were developed for female sex partners of male IDUs, women who trade sex for money or drugs, IDUs recruited off the streets, MSM who do not identify as gay, street youths, and residents of areas with high rates of STDs and injection drug use. Each intervention site used peer volunteers to distribute kits featuring role model stories, brochures, condoms, and bleach kits. Significantly greater achievement in consistent condom use, and maintenance of condom use was found in the intervention communities.<sup>268</sup>

The first core element of Community PROMISE is the community identification process, which involves interviewing and holding focus groups with stakeholders in the community to identify why people engage in risk behaviors, what barriers exist to changing behavior, what will encourage them to change behaviors, and locations where they engage in risk behaviors.

The second core element is role model stories, which are brief publications with personal stories from members of the community who have made or are planning to make a risk-reducing behavioral change. The third element is peer advocates, who are volunteers from the community who help distribute the role model stories and other materials. The final core element is evaluation of the intervention in order to provide evidence of its effectiveness.

**Real AIDS Prevention Project (RAPP) (DEBI)**

The Real AIDS Prevention Project (RAPP) intervention is based on the Women and Infants Demonstration Trial, which targeted women in four inner city communities. The intervention was based on the Transtheoretical Model of Behavior Change, which recognizes that change occurs in stages. The intervention included a media campaign, outreach, and community mobilization. Women in the intervention communities reported a greater increase in consistent condom use with non-main partners than women in the comparison communities.<sup>269</sup>

- RAPP involves the following five core elements:
- **Peer Network** - Made up of people from the community who volunteer several hours a week to talk to men and women about HIV prevention and related issues. They also distribute condoms, role model stories, and educational materials.
  - **Stage-Based Encounters** – One on one conversations led by trained peer volunteers who ask questions about attitudes and condom use to find out the person's stage of change. Based on the response, they provide a message to encourage them to begin or continue condom use.
  - **Role Model Stories** – Printed short stories from people in various stages of change telling about what made them think about, start or continue using condoms.
  - **Community Network** – Local businesses, organizations/agencies that support the project by displaying and/or distributing role model stories and other educational materials, and sponsoring project activities.
  - **Small Group Activities** – Safer sex parties in houses and HIV/AIDS presentations. At parties people develop communication and condom use skills. Presentations educate larger groups about HIV prevention.

<sup>268</sup> CDC, 1999

<sup>269</sup> Lauby et al, 1998

## Injecting Drug Users

Unless otherwise noted, when describing interventions targeting injecting drug users (IDUs), behavior change refers to drug-using behavior: sharing needles, cleaning needles, etc. and not sexual behavior.<sup>270, 271, 272, 273</sup>

The interventions targeting IDUs that were reviewed by the CPP Committee lacked a strong behavioral or social science basis. The behavioral interventions were mixed with medical and service needs so it was difficult to attribute positive change to a behavioral intervention. The interventions often lacked formative evaluation and basic needs assessment in order to properly target interventions. The lack of consistency in results may be due to variations in settings, theoretical bases and methodology.

Basic ethnographic research is needed to understand the IDU culture, including subgroups (i.e., IDUs of color, women, etc.). Long-term data are needed to assess sustained behavioral change. More information is needed about sexual behaviors and sustained safer sex among IDUs.

### COUNSELING AND TESTING

A meta-analysis of 27 published studies, which found that people who receive negative test results and those who do not test are less likely to reduce risky sexual behavior than persons who test positive or are in a serodiscordant couple, also found that IDU participants in treatment centers did not demonstrate behavioral changes related to sexual risk.<sup>274</sup> The study recommends focusing on sexual risk behaviors in addition to needle sharing behaviors during HIV counseling and testing delivered in treatment centers.

<sup>270</sup> Fisher and Fisher, *Psychological Bulletin*, 1992

<sup>271</sup> Choi and Coates, *AIDS*, 1994

<sup>272</sup> NASTAD, 1994

<sup>273</sup> Academy of Educational Development, 1994

<sup>274</sup> Weinhardt et al, *American Journal of Public Health*, 1999

### OUTREACH INTERVENTIONS

Behavioral change is consistently positive in these outreach programs described. Some have measured long-term behavioral change.

#### *Peer Outreach Models*

A four-year study in Chicago reported a reduction in the sharing of injection equipment from 100 percent in 1988 to 14 percent at follow-up in 1992. Outreach workers who were recovering addicts provided the intervention. Seroprevalence among the study population went from 5 percent to less than 1 percent during the time frame of the study.<sup>275</sup>

Peer and non-peer volunteers discussed and distributed intervention kits (including brochures, pamphlets, flyers, etc.), bleach kits, and condoms to high-risk individuals in Denver over the course of 2.5 years. The intervention was effective at increasing both needle cleaning and consistent condom use over the time of the study. Consistent bleach use increased from 20 percent to 29 percent, and condom use during vaginal sex from 2 percent to 24 percent.<sup>276</sup>

A series of programs funded by the CDC used an intervention where outreach workers indigenous to the community act as credible messengers, provide risk reduction materials and education, and arrange for free HIV testing and counseling. Counselors distribute bleach and condoms and teach their proper use. Each site developed interventions to promote harm reduction.

Twenty studies from these CDC-funded programs show:

- Decreased frequency of injection, ranging from 10 to 30 fewer injection events per month (14 studies)
- Decreased sharing of injection equipment ranging from 6.7 percent to 42.9 percent fewer (10 studies)

<sup>275</sup> Wiebel, 1993

<sup>276</sup> Rietmeijer et al, *AIDS*, 1996

- Decreased use of shooting galleries (6 studies)
- Decreased number of sex partners (3 studies)
- Decreased risky sex (7 studies)
- Increased disinfection of needles (7 studies)
- Increased entry into drug treatment (4 studies)
- Increased use of condoms (5 studies)
- Declines in prevalence of risk behavior and in HIV incidence (1 study)<sup>277</sup>

**The NADR Project**

The NADR Project assessed longitudinal data from 28 sites delivering street outreach services to a total of 13,475 IDUs and 1,637 sex partners of IDUs. Participants were randomly assigned to standard and enhanced interventions. The standard outreach interventions, delivered by indigenous outreach workers consisted of risk reduction information, referral, condom and bleach distribution, HIV testing and counseling, and demonstration and rehearsal of risk reduction skills. Enhancements to these interventions were site specific and designed to promote the adoption of risk reduction strategies.

At six-month follow-up, statistically significant reductions in the number of IDUs engaging in the following high-risk behaviors were found for both intervention assignments: frequency of injecting drugs, (28% reduction) use of non injected drugs, use of borrowed injection equipment, (24% reduction) and number of sex partners (8% reduction).<sup>278</sup>

**SINGLE BEHAVIORAL INTERVENTIONS**

**Group Sessions Targeting Intranasal Heroin Users**

Adult drug users (26% African American, 23% Latino, 51% White) who used heroin intranasally were recruited to a four session intervention covering HIV information, risks of drug use and drug injection, and how to seek

entry into drug abuse treatment programs. Presentation, group discussion, and role play were used. People who participated in the intervention were significantly less likely to inject drugs than those in the comparison condition.<sup>279</sup>

**Group Education Targeting Participants of Outpatient Treatment Programs**

Some studies have examined the impact of multi-session group education and counseling interventions, which include information on HIV transmission, demonstration of condom use and needle cleaning, and discussion of safer sexual behaviors.

Two interventions showed improvement in needle practices,<sup>280</sup> and a third showed improvement in determinants of risky behavior, but did not demonstrate behavior change.<sup>281</sup> The studies recruited participants from outpatient treatment programs by using opportunistic and chain-referral techniques.

When condoms were made available to male injection drug users receiving outpatient drug abuse treatment, a small increase occurred in condom use during vaginal intercourse. Most participants also attended an AIDS education class in which the correct use of condoms was demonstrated.<sup>282</sup>

**The Personalized Nursing LIGHT Model**

The Personalized Nursing LIGHT Model, a counseling approach to decreasing high risk behaviors for HIV, has two tracks - the first is Personalized Care, where actions are taken by the nurse, and the second is Personalized Action, where actions are taken by the client.

**LIGHT** is an acronym for both tracks of the program.

For the *nurse*, the acronym stands for:

- L**ove the client
- I**ntend to help
- G**ive care gently
- H**elp the client improve his/her well-being
- T**each the Personalized Action process to the client

<sup>277</sup> NIH, 1997  
<sup>278</sup> NIH, 1999

<sup>279</sup> Des Jarlais et al, *British Journal of Addiction*, 1992  
<sup>280</sup> Stephens, 1991; Siegal, 1995  
<sup>281</sup> Sorenson, 1994  
<sup>282</sup> Calsyn, 1992

For the *client*, it stands for:

- Love themselves
- Identify a focal concern
- Give themselves a goal
- Have confidence
- Take Action

The model is premised on the theory that actions taken by the client to improve themselves improve their sense of well being which leads to healthier behaviors. The role of the nurse is to bond with each client by demonstrating sincere value for each one, and to help each client develop plans and take action.

The Personalized Nursing LIGHT Model was evaluated for its efficacy. A total of 2,033 emergency room patients who were IDUs participated in the evaluation. At the three-month follow-up, the IDUs reported significant increases in well being, as well as significant decreases in frequency of injecting drug use.<sup>283</sup>

#### **Programs Targeting Methadone Patients**

Magura et al examined the effect of a prevention program for methadone patients that included didactic AIDS education, HIV antibody counseling and testing, and facilitated peer support groups, and found increased knowledge of HIV risk, and improved attitudes toward and use of condoms. Participation in the prevention program was disappointing.<sup>284</sup>

Five two-hour sessions were delivered to groups of women (36% African American, 64% Latina) in methadone maintenance clinics. The sessions provided information on HIV transmission and prevention; condom use; assertiveness training; problem solving; and communication skills using videos, visual presentation, didactic exercises, and role playing. Participants received modest incentives for attending the sessions. Women who participated in the intervention

significantly increased in frequency of condom use with their partners, as compared with women in the comparison condition.<sup>285</sup>

#### **Group Education in Inpatient Drug Abuse Treatment Centers**

An informational education intervention was compared with an enhanced intervention among adult drug users (82% White, 67% men, 33% women) in an inpatient drug detox and rehabilitation center. The information intervention provided essential HIV information, using primarily didactic methods, including video, lecture, discussion, homework, and demonstration of condom use and cleaning of drug works.

The enhanced intervention focused on personal susceptibility, situation analysis and skills building. Participants engaged in group discussion, and practiced skills. Additional strategies included role playing, peer feedback, tension-release exercises and an emphasis on experiential learning techniques to enhance self-efficacy regarding ability to initiate and maintain HIV harm reduction behaviors. After exit from the program, participants in both interventions reported significant reduction in drug and sex related risk behaviors compared with baseline of risk. However, the enhanced education intervention had significantly greater effects than the informational intervention.<sup>286</sup>

A course of three two-hour sessions was given to African American men in inpatient drug abuse treatment. The intervention decreased the proportion of participants who reported having more than one partner, and improved communication skills, and condom use skills. The first session developed rapport with patients; provided information about, and personalized the threat of HIV; and demonstrated proper needle sterilization procedures. The second session focused on safer sex practices, condom use, condom use negotiation, and skills building. The final

<sup>283</sup> Andersen et al, *American Journal of Drug and Alcohol Abuse*, 1993

<sup>284</sup> Magura et al, *International Journal of Addictions*, 1991

<sup>285</sup> El Bassel et al, *Social Work Research*, 1992

<sup>286</sup> McCusker et al, *American Journal of Public Health*, 1992

session was review, and discussion of HIV testing.<sup>287</sup>

**Holistic Harm Reduction Program (DEBI)**

The Holistic Harm Reduction Program (HHRP) is based on a study done with HIV positive injection drug users which found that participants demonstrated a decrease in addiction severity after three months, decreased risk behavior after three months, and significant improvement in behavioral skills, harm reduction knowledge and behaviors, motivation and quality of life.<sup>288</sup>

HHRP is a 12 session, manual-guided, group level intervention for HIV positive IDUS to reduce harm, promote health, and improve quality of life. The core elements of HHRP are:

- Focus on reducing drug use and high-risk behaviors.
- Address medical, emotional, and social problems that may be associated with the progression of HIV.
- Respect client’s spiritual and religious beliefs, help clients cope with stigma and grief, teach stress management techniques, and address/acknowledge fears of death and dying.
- Follow the Information, Motivation, Behavior (IMB) model to ensure that clients gain the skills to reach treatment goals. Use multiple presentation strategies, such as slides and games, to increase understanding and retention.

**Group Intervention Targeting Male Adolescents in a Correctional Facility**

A group intervention was delivered to male adolescent drug users (65% African American, 33% Latino, 2% White) in a correctional facility. It consisted of four one-hour sessions focusing on health education issues, including general health knowledge, and HIV knowledge. Counselors were guided by a written curriculum. Counselors used techniques based on the problem solving

therapy model, where participants identified the problem, generated solutions, decided on alternatives, and used role play and rehearsal to practice alternative solutions. Participants received \$5.00 for each session they attended. After release from jail, youth who participated in the intervention were significantly more likely to use condoms during sex and had fewer high-risk sex partners than youth in the comparison condition.<sup>289</sup>

**MULTI LEVEL INTERVENTIONS**

**The UFO Study**

The UFO study, which began in San Francisco in 1997, measures the seroprevalence of Hepatitis B, Hepatitis C, and HIV in injection drug users under the age of 30. In addition to pre- and post-test counseling, the project provides vaccinations, as well as outreach and peer counseling.<sup>290</sup>

**ENCORE**

ENCORE is an innovative needle exchange program in Rhode Island that incorporates a full continuum of services. Using a low threshold model of enrollment and participation, clients are not forced into treatment or referral. Instead, ENCORE volunteers build relationships with clients such that over 45 percent of the participants are eventually referred to some treatment modality. ENCORE has incorporated Hepatitis C prevention and treatment referral into its program.

ENCORE has developed a women’s only site, which includes:

- Clothing distribution center
- Medical/clinic based needle exchange where clients can get free medical care
- Physician-based needle exchange program
- One-to-one substance abuse counselor/ advocate and referral program

<sup>287</sup> Malow et al, *AIDS Education and Prevention*, 1994

<sup>288</sup> Margolin et al, *Health Psychology*, 2003.

<sup>289</sup> Magura, *Journal of Adolescent Health*, 1994

<sup>290</sup> www.ufostudy.org

## COMMUNITY LEVEL INTERVENTIONS

### *Political Mobilization of IDUs*

An intervention in Brooklyn, New York, sought to organize drug users to develop a political voice and to reduce high-risk behavior. One strategy emphasized therapeutic casework using group process to identify individuals; a second strategy aimed at changing the subculture through identification and promotion of leaders. Subjects were recruited from a neighborhood storefront drop-in center, and from street locations.

The percentage of subjects who refrained from using shooting galleries increased from 53 percent to 66 percent. The proportion of users who cleaned equipment increased from 10 percent to 18 percent. The use of condoms increased from 23 percent to 33 percent, the proportion of subjects using bleach rose from 10 percent to 19 percent, and 47 percent of subjects entered treatment. It was thought that the political mobilization of this community contributed to a significant change in social and peer norms regarding drug injection and the sharing of injection equipment.

### *Community PROMISE (DEBI)*

Community PROMISE is based on the AIDS Community Demonstration Projects, which targeted high-risk, hard to reach populations in five large cities. Interventions were developed for female sex partners of male IDUs, women who trade sex for money or drugs, IDUs recruited off the streets, MSM who do not identify as gay, street youths, and residents of areas with high rates of STDs and injection drug use. Each intervention site used peer volunteers to distribute kits featuring role model stories, brochures, condoms, and bleach kits. Significantly greater achievement in consistent condom use, and maintenance of condom use was found in the intervention communities.<sup>291</sup>

<sup>291</sup> CDC AIDS Community Demonstration Projects Research Team, 1999

The first core element of Community PROMISE is the community identification process, which involves interviewing and holding focus groups with stakeholders in the community to identify why people engage in risk behaviors, what barriers exist to changing behavior, what will encourage them to change behaviors, and locations where they engage in risk behaviors.

The second core element is role model stories, which are brief publications with personal stories from members of the community who have made or are planning to make a risk-reducing behavioral change. The third element is peer advocates, who are volunteers from the community who help distribute the role model stories and other materials.

The final core element is evaluation of the intervention in order to provide evidence of its effectiveness.

### *Legal Sale of Syringes*

A Connecticut repeal of a state law banning needle sales resulted in decreased needle sharing and decreased street buys among IDUs.<sup>292</sup>

After legislation was passed in Minnesota to legalize the sale of up to ten syringes without a prescription by a pharmacist, pharmacies replaced other sources as the primary source from which IDUs obtained syringes. A significant decrease in the percentage of IDUs who shared syringes was observed. This decrease did not hold true, however, for IDUs who were speedball users, or had a history of incarceration.

## NEEDLE EXCHANGE PROGRAMS

There have been no randomized, controlled studies of needle exchange programs; however, behavior change from these programs is mostly positive in reducing needle sharing and other behaviors. How needle exchange programs impact on sexual risk behavior among IDUs is not clear.

<sup>292</sup> Valleroy et al, *Journal of Acquired Immune Deficiency Syndromes and Human Retroviruses*, 1995

Although the following studies contain a preponderance of evidence demonstrating the effectiveness of needle exchange as an HIV prevention intervention among injecting drug users, state and federal governments prohibit the use of public funds to support such interventions. Thus, a prior public policy intervention is necessary before needle exchange activities can be comprehensively implemented.

### **Impact on Needle Sharing**

Of 16 studies that have examined impact of needle exchange programs, ten noted a decrease in needle sharing, and four found no significant change in behavior.<sup>293</sup>

### **Impact on Drug Use**

Of eight studies that presented data on reported injection frequency, three found reductions in drug use, four found mixed or no effects, and only one found an increase in injection. This study also found reduced needle sharing.<sup>294</sup>

### **Impact on HIV Seroincidence**

An analysis from a New York City needle exchange program concluded that there is a protective effect of needle exchange programs on HIV seroincidence.<sup>295</sup> Another study was conducted to evaluate the effects of an all-volunteer syringe exchange program on risky injection drug use.<sup>296</sup> Both studies reported a stabilization of HIV seroprevalence rates that coincided with increased reporting of risk reduction activities.

### **Cost Effectiveness**

Holtgrave et al found that a policy of funding syringe exchange programs, pharmacy sales, and syringe disposal to cover all illicit drug injections would cost \$34,278 per HIV infection averted.<sup>297</sup> The current estimate of the cost of lifetime treatment for HIV is

\$154,402.<sup>298</sup> Cost effectiveness studies of specific needle exchange programs have consistently been found to be cost effective, and an efficient use of financial resources.<sup>299, 300, 301</sup>

## **DRUG ABUSE TREATMENT AS AIDS PREVENTION PROGRAMS**

Most programs only measured declines in drug use, rather than declines in HIV risk behavior. The results are mostly, but not completely, positive in reducing drug use among clients who are in treatment. Numerous studies have documented that significantly lower rates of risk behaviors are practiced by drug users who are in treatment. Awareness is growing that individuals who are in treatment provide access to a much larger community of drug users who are not in treatment. Significant preventive impact is possible through the effective treatment of drug users who are in treatment, even though they represent only a minority of all active drug users. In addition, HIV prevention activities, including HIV counseling and testing, in methadone treatment clinics have also been shown to be cost effective - particularly if activities can impact risky sexual behaviors, as well as drug use behaviors.<sup>302, 303</sup>

### **Methadone Treatment Programs**

In a prospective evaluation of 952 HIV negative IDUs, an analysis was performed comparing 40 HIV positive IDUs who became positive over time with 40 who remained negative. Methadone treatment and methadone dosage were found to have dramatic protective effects. For every three months spent out of treatment, the risk of getting infected with HIV increased by 70

<sup>293</sup> Lurie et al, 1993

<sup>294</sup> Ibid

<sup>295</sup> Des Jarlais et al, *Lancet*, 1996

<sup>296</sup> Watters et al, *JAMA*, 1994

<sup>297</sup> Holtgrave and Kelly, XI International Conference on AIDS, 1998

<sup>298</sup> Holtgrave and Pinkerton, *Journal of Acquired Immune Deficiency Syndromes*, 2003

<sup>299</sup> Gold et al, *Canadian Medical Association Journal*, 1997

<sup>300</sup> Jacobs et al, *Canadian Journal of Public Health*, 1999

<sup>301</sup> Lurie et al, *Journal of Acquired Immune Deficiency Syndromes and Human Retroviruses*

<sup>302</sup> Cole et al, IX International Conference on AIDS, 1993

<sup>303</sup> Gorsky et al, *Public Health Reports*, 1996

percent. The higher the methadone dosage, the lower the risk of infection.<sup>304</sup>

In another study in Philadelphia, 152 IDUs were randomly selected from a methadone treatment center, and 103 out of treatment IDUs were recruited using a snowball technique. At entry, 18 percent of the out of treatment participants, and 11 percent of the methadone participants were HIV positive. After 18 months of study, 33 percent of the out of treatment group were infected with HIV while 15 percent of the methadone participants were HIV positive.<sup>305</sup>

### ***Relapse Prevention Program***

One study examined the effectiveness of a relapse prevention program, which was designed to prevent relapse back to injecting drug use behaviors, in decreasing HIV risk behaviors among IDUs. Participants were recruited from methadone programs to participate in a series of six 60-90 minute sessions. The first session was a one-on-one motivational interview conducted by a therapist. The second session focused on assisting subjects to identify their high-risk situations for injecting and unsafe sex, the third addressed coping with craving, the fourth addressed decision making and lifestyle, the fifth focused on coping with lapses, and the final session reviewed progress and encouraged continued use of coping skills. At six-month follow-up, researchers found evidence of a lower rate of needle risk behavior - but not sexual risk behavior - during the heaviest risk-taking month since pre-intervention assessment. They cautiously concluded that individual relapse prevention programs can decrease needle risk behavior.<sup>306</sup>

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<sup>304</sup> Serpelloni et al, *AIDS Care*, 1994

<sup>305</sup> Metzger et al, *Journal of Acquired Immune Deficiency Syndromes*, 1993

<sup>306</sup> Baker et al, *AIDS*, 1993

## Gay/Bisexual Youth and Youth at Risk

Adolescence and young adulthood can be a difficult and confusing time as youth are struggling to establish their identities and values in the face of peer pressure, parents' expectations, and conflicting messages from the surrounding environment. This is a time when many begin to experiment with sex, drugs, and alcohol, without necessarily having the skills to make wise decisions about their behavior. It is important to reach youth with HIV information and risk reduction skills that they can continue to use throughout their lives.

### SINGLE BEHAVIORAL INTERVENTIONS

#### *Individual Counseling*

Recent studies demonstrate the positive impact of communication between parents and adolescents on teen sexual behavior. One study found that mother-adolescent discussions about condoms before first sexual intercourse greatly increased the percentage of young people who use condoms, both for their first intercourse and for subsequent acts.<sup>307</sup> Key findings are:

- *Less Risky Sexual Behavior Among Teens*  
Parental communication can influence two primary public health strategies for preventing HIV infection among adolescents. First, parent-adolescent communication can encourage delay of sexual initiation. Second, it can promote condom use among sexually active youth.
- *Less Conformity to Peer Norms By Teens*  
Parental discussions about sex and condoms can impact behavior by moderating the extent to which peer norms guide sexual behavior and condom use. Conversely, teens who do not discuss sexual issues with a parent may be influenced by peer norms to guide their sexual behavior.

- *Greater Belief that Parents Provide the Most Useful Information About Sex*  
Teens who discuss sexual issues with their parents see them as the most useful source of information and norms about sex.<sup>308</sup>

#### **Street Smart (DEBI)**

The Street Smart is based on research conducted of small group sessions at a recreational/social service agency for gay/bisexual youth. Protected sex acts rose from 60 percent at baseline to 78 percent at twelve-month follow-up for anal sex, and from 28 percent to 45 percent for oral sex. The intervention had no effect on those gay/bisexual youth who engaged in commercial sex; instead, their level of high-risk sex increased over time.<sup>309</sup>

The resulting Street Smart program is designed for runaway or homeless youth, but can easily be adapted for youth in other settings. The intervention consists of eight two-hour group sessions, one individual session after the group sessions are completed, and then a group trip to a community resource. It is preferred that teens attend all sessions, but the program is designed so that each session stands alone.

Each group session has a specific topic:

*Session 1: Getting the language of HIV/AIDS and STDs*

*Session 2: Personalized risk*

*Session 3: Condoms and dams*

*Session 4: Drugs and alcohol*

*Session 5: Recognizing and coping with feelings*

*Session 6: Negotiating safer sex*

*Session 7: Self talk*

*Session 8: Staying safe over time*

<sup>307</sup> Miller et al, *American Journal of Public Health*, 1998

<sup>308</sup> Whitaker et al, *Journal of Adolescent Research*, 2000

<sup>309</sup> StreetSmart, Rotherum, Borus, 1994

The program utilizes role-plays to act out typical situations. Quick role-plays are short and usually scripted, and are mainly used to introduce a session or topic. Longer role-plays may or may not be scripted, and are videotaped so that participants can see themselves as others see them. Other participants also fill out feedback forms on the role-plays.

### **Group Education for Runaway Youth**

Another program targeting runaway youth involved ten small group sessions conducted with runaway youth at residential runaway shelters. There were four components to the intervention: 1) knowledge was addressed through video and art workshops, and HIV prevention videos; 2) training in coping skills; 3) private individualized counseling; and 4) access to health care. The intervention was effective in decreasing the number of unprotected sexual acts and substance use. The study also suggests that a sizeable number of intervention sessions are required.<sup>310</sup> Additional analysis suggests that this intervention is also cost effective.<sup>311</sup>

### **Group Education Targeting African American Youth**

One five-hour small group session targeted African American male adolescents. It was led by African American men and women and included culturally and developmentally appropriate materials, including a video, and an "AIDS Basketball" activity in which participants formed into teams to earn points for correctly answering questions about HIV. A condom exercise focused on the correct use of condoms, and role play activities confronted participants with potential problems in trying to implement safer sex practices. Adolescents who participated in the intervention reported more frequent use of condoms and fewer sex partners than adolescents in a comparison condition.<sup>312</sup>

<sup>310</sup> Rotherum-Borus, 1997

<sup>311</sup> Rotherum-Borus et al, XII International Conference on AIDS, 1998

<sup>312</sup> Jemmot, Making Proud Choices - Making a Difference, 2002

The **Focus on Kids** intervention is an eight-session group intervention delivered to low-income African American pre- and early adolescents in peer groups that consisted of three to ten same-gender friends within three years of age of each other. The sessions were led by two African American men or women recruited from the community, at least one of whom was gender-matched to the group.

The sessions emphasized values clarification and goal setting; presented facts about AIDS, STDs, contraception, and human development; and provided condoms. Multiple delivery formats were used include videos, games, acting, role playing, storytelling, and arts and crafts. In the seventh session, participants developed community projects with specific target audiences and intervention messages. Beginning in the first session and integrated throughout, a family genogram was used to illustrate the application of concepts to real life situations. Sexually active youth who participated in the intervention reported significantly greater condom use than sexually active youth in the comparison condition.<sup>313</sup>

The **Becoming a Responsible Teen (BART)** intervention involved eight small group sessions were delivered to African American youth at a public health clinic serving low-income families. Incentives included \$5.00 an hour for participating, a project T-shirt, and a personalized certificate of completion. The sessions provided HIV/AIDS information, addressed sexual decisions and values, condom use, communication skills and assertiveness, behavioral self-management and problem solving, and social support and empowerment. Videos, games, discussion, role plays, and peer education were some of the media used to deliver the educational messages. Youth who participated in the intervention reported significantly greater condom use and significantly lower frequency of unprotected intercourse than youth in the

<sup>313</sup> Stanton et al, *Archives of Pediatric and Adolescent Medicine*, 1996

comparison condition. Abstinent youth who participated in the intervention significantly delayed sexual onset to a greater extent than abstinent youth in the comparison condition.<sup>314</sup>

**School-based Programs**

A number of sex education curricula have been designed, some of which address HIV prevention. No evidence exists that educational programs increase sexual activity, and some programs are effective in postponing onset of intercourse or increasing contraceptive usage if students are sexually active.

- Successful school-based programs had the following characteristics:
- Narrow focus only addressing sexuality.
  - Based on social learning theories.
  - Personalized information acquired via active learning methods.
  - Address social and media influences on sexual behavior.
  - Give clear statements of facts, norms, and expectations about behavior.

Decision-making strategies and behavioral skills were generally not effective without the context of clear statements of norms. These norms should be age-appropriate (i.e., younger kids would get more abstinence messages, while older kids might get more clear messages about safe sex). Abstinence only curricula have not been effective in postponing age of intercourse onset. Longer programs were not more effective than shorter programs.

Studies of education programs offered in conjunction with school-based clinics seemed to indicate that the strong educational component was more important than the reproductive services in reducing risk behavior. A study on the effects of peer based programming vs. adult led programming suggests that when education is presented by peer counselors, adolescents

may be more likely to see HIV as a personal danger.<sup>315</sup>

**Reducing the Risk** was implemented in 13 high schools in California through 15 sessions in health education classes. The curriculum included instruction on developing social skills to reduce sexual risk behavior and used role-play to model and practice the skills. It also emphasized decision making and assertive communication skills, encouraged students to go to stores and clinics to get relevant health information, and required students to ask their parents about their views on abstinence and birth control.<sup>316</sup>

**Get Real About AIDS** was implemented in 10 high schools in Colorado. The intervention consisted of 15 sessions covering HIV knowledge that can be used to reduce risk, teen vulnerability to HIV, normative determinants of risky behavior, condom use, and skills to help students recognize, manage, avoid, or leave risky situations.<sup>317</sup>

**Gay Sensitive HIV Education**

A random sample was conducted of 3,647 high school students in Massachusetts.<sup>318</sup> Four percent of the sample was considered to be gay, lesbian or bisexual (GLB) based on self-identification of sexual orientation and/or self-report of same-sex behavior.

The study found that GLB students were significantly more likely than heterosexual students to report lifetime and recent (last 30 days) drug use, as well as lifetime and recent sexual intercourse (86% vs. 48%), and to report using drugs or alcohol before last sexual intercourse (44% vs. 28%). Among sexually active youth, GLB students reported an earlier age of first intercourse, more lifetime and recent sexual partners, and a higher frequency of either being or getting someone pregnant in comparison to heterosexual students.

The study compared risk factors for GLB youth in schools that did not offer gay

<sup>314</sup> St. Lawrence et al, *Journal of Consulting and Clinical Psychology*, 1995

<sup>315</sup> Rickert et al, *Journal of Adolescent Health*, 1991

<sup>316</sup> Kirby et al, *Family Planning Perspectives*, 1991

<sup>317</sup> Main et al, *Preventive Medicine*, 1994

<sup>318</sup> Blake et al, *American Journal of Public Health*, 2001

sensitive HIV education with those in schools that did offer gay sensitive HIV education. A drawback of the study is that gay sensitive HIV education was not clearly defined. It was determined by teachers reporting the use of gay sensitive HIV education curricula and confidence that they could meet the needs of gay/bisexual students.

GLB students in schools with no or minimal levels of gay sensitive HIV education were more likely than their heterosexual classmates, and more likely than GLB or heterosexual students in schools with gay sensitive education to:

- Become or get someone pregnant.
- Have a higher number of recent sex partners.
- Make a plan to commit suicide.
- Miss school for personal safety reasons.
- Have property damaged or stolen.

**University/College-based Interventions**

Several college-based interventions have been implemented, but rarely have they measured behavioral change. These interventions have generally not been based on sound behavioral theory and have been primarily information-based. A couple of studies demonstrated positive behavior change due to education,<sup>319,320</sup> but more detailed work needs to be done.

One of these studies involved a series of four ninety-minute sessions held over one month targeting mostly White heterosexual women recruited through classes, social groups, and the health service at a Midwestern university. Only 13 percent of women approached participated. Topics included risk behavior education; assertiveness, decision making, problem solving, and negotiation skills; condom use; maintenance of healthy behavior; and rehearsal and role-playing. The intervention improved self-efficacy, sexual assertiveness and communication skills. There was modest

reduction in sex without a condom, and drug use.<sup>321</sup>

Another intervention involving an HIV education session consisting of videotape, lecture, role-play, brochures, discussion of transmission, safer sex behaviors, condom use, and information about HIV testing, was held with students attending a student health outpatient clinic (mostly female, mostly White). The students also received HIV tests. There was no impact on sexual risk behaviors. However, those in the intervention group were more likely to ask their partners if they had been tested. Only 20 percent of students approached agreed to participate in the intervention.<sup>322</sup>

One program seemed to indicate that eroticizing condom use and instruction is effective in promoting condom use during sex. Another randomized study of a workshop for college students found that skills practice was no better than general education in promoting positive behavior change. In addition, change was modest for condom use but not for other behavioral intentions.

**Group Intervention Targeting Male Adolescent Drug Users in Correctional Facility**

A group intervention was delivered to male adolescent drug users in a correctional facility. It consisted of four one-hour sessions focusing on health education issues, including general health knowledge, and HIV knowledge. Counselors were guided by a written curriculum. Counselors used techniques based on the problem-solving therapy model, where participants identified the problem, generated solutions, decided on alternatives, and used role play and rehearsal to practice alternative solutions. Participants received \$5.00 for each session they attended. After release from jail, youth who participated in the intervention were significantly more likely to use condoms during sex and had fewer high-risk sex partners than youth in the comparison condition.<sup>323</sup>

<sup>319</sup> Shulkin et al, *Journal of the American College of Health*, 1991

<sup>320</sup> Sikkema et al, *AIDS Education and Prevention*, 1995

<sup>321</sup> Ibid

<sup>322</sup> Wenger et al, *Annals of Internal Medicine*, 1992

<sup>323</sup> Magura et al, *Journal of Adolescent Health*, 1994

**Teens Linked to Care (DEBI)**

Teens Linked to Care is based on research with HIV positive youth by Rotheram-Borus et al which found that all participants reported fewer sexual partners, including fewer HIV-negative partners, and fewer unprotected behaviors. The youth also reported a decrease in alcohol, and drug use, as well as decreases in feelings of distress and anxiety, and in physical symptoms of the disease.<sup>324</sup>

Teens Linked to Care is a small group intervention for HIV positive youth. There are 8 to 12 sessions focused on providing social support, learning and practicing new skills. The participants set goals regarding their health, sexual relationships, drug use, and daily peace.

The intervention is based on Social Action Theory, and consists of three modules:

Module 1: Staying Healthy targets health care and health behaviors

Module 2: Acting Safe addresses sexual and drug-use related transmission risks

Module 3: Being Together focuses on improving quality of life.

**MULTILEVEL INTERVENTIONS****The Mpowerment Project (DEBI)**

The Mpowerment Project is based on an intervention conducted over eight months to reach young gay men ages 18 to 29 in a Eugene, Oregon community. A core group of young gay men designed and ran the intervention with input from a community advisory board of “elders” from the AIDS, public health, gay and lesbian, and university communities. Men who participated in the project reduced their frequency of unprotected anal intercourse significantly more than the men in the comparison community did.<sup>325</sup>

The Mpowerment Project includes four integrated activities:

- *Formal Outreach:* Teams of young gay men go to locations frequented by young gay men to discuss and promote safer sex, distribute condoms, and hand out HIV risk reduction literature. The teams also create special events to promote risk reduction to young gay men (i.e., dances, picnics, video parties, discussion groups).
- *M-groups:* Peer-led, 2-3 hour meetings of 8-10 young gay men. The meetings include discussion of factors contributing to unsafe sex, skills building exercises regarding safer sex negotiation and condom use, training on how to conduct informal outreach. Participants receive free condoms and lubricant.
- *Informal Outreach:* Young gay men talk about safer sex with their friends.
- *Ongoing Publicity Campaign:* Promotion of the project through word of mouth, and articles and ads in gay newspapers.

**AQU<sup>25</sup>A**

Asian and Pacific Islander Queer and Questioning, 25 and Under, All Together (AQU<sup>25</sup>A) is a group for and run by young queer and questioning Asians and Pacific Islanders (APIs) in San Francisco. AQU<sup>25</sup>A uses a youth development model to maximize the strengths and assets of API queer and questioning youth and to address their broad range of emotional, health, social/interactive, and educational/vocational needs.

The program supports young API MSM in making positive changes in their lives, developing essential skills related to personal growth, and provide information to enable them to make well-informed decisions about their health and well-being through outreach, groups, individual counseling, and a peer leadership program. AQU<sup>25</sup>A also serves as a safe space for young people to just hang out, through drop-ins, gatherings, picnics, workshops, scholarships, socials, parties, dances, trips, retreats and other fun activities throughout the year.

<sup>324</sup> Rotheram-Borus et al, *American Journal of Public Health*, 2001

<sup>325</sup> Kegeles et al, *American Journal of Public Health*, 1996

### **Research in Minnesota for Gay/Bi Youth**

An intervention which includes individual risk assessment, risk reduction counseling, peer education, optional HIV antibody testing and counseling, referral to medical and psychosocial services as needed, and longitudinal follow-up has contributed to short-term risk reduction in HIV transmission among gay/bisexual youth, measured by reductions in the number of sex partners and their frequency of unprotected anal intercourse among the participants.<sup>326</sup>

This intervention has also been shown to be cost effective in societal terms of averting 13 HIV infections, and saving 180 Quality Adjusted Life Years over a ten-year period, at a cost of \$1.1 million dollars.<sup>327</sup>

### **Youth Drop In Center**

A model program in California provides a convenient drop in center for youth, using a storefront-style building on an active pedestrian thoroughfare and near public transportation. The center provides access to low-income youth at high risk for HIV infection to harm reduction-based prevention services. Services include HIV testing, counseling, education, harm reduction, and health referral in a coordinated manner. Also support sessions, support groups, and incentives are available. The storefront has developed partnerships with other service providers, including mental health, STD programs, substance abuse treatment, etc.<sup>328</sup>

### **Peer Education for Rural Teens**

**STAND** is a peer education training program designed for rural teens. It is based on the diffusion of innovations theory and the stages of change model. It is consistent with the developmental characteristics of teens, including perceived unique invulnerability, limited abstract reasoning ability, and focus on present rewards over long-term consequences. STAND is an “abstinence-

plus curriculum”, promoting both sexual abstinence and risk reduction strategies.

It is delivered in 28 one-hour sessions, held twice per week, and can be school or community-based. The training prepares teens to initiate one-on-one conversations with their peers about sexual risk reduction. Teens are taught to determine a person’s stage of change, and recommend the use of appropriate change supporting processes. Peer leaders are selected by a peer- and self-nomination technique, and this process usually results in a very diverse group of teens.

After completion of the training, STAND peer educators plan and participate in whatever formal and informal educational activities are feasible in their community setting. They also participate in the STAND club, which meets once a month to provide peer educators with peer support. STAND peer educators self report positive changes in knowledge, condom use self-efficacy, consistent use of condoms, and incidence of unprotected intercourse - though most of these changes were more pronounced at the beginning of follow up than at the eight month follow-up. STAND teens also reported significantly more conversations with friends about birth control or condoms.<sup>329</sup>

## **COMMUNITY AWARENESS INTERVENTIONS**

### **Community PROMISE (DEBI)**

Community PROMISE is based on the AIDS Community Demonstration Projects, which targeted high-risk, hard to reach populations in five large cities, including high-risk youth. Each intervention site used peer volunteers to distribute kits featuring role model stories, brochures, condoms, and bleach kits. Significantly greater achievement in consistent condom use, and maintenance of condom use was found in the intervention communities.<sup>330</sup>

<sup>326</sup> Remafedi, *Journal of Adolescent Health*, 1994

<sup>327</sup> Tao et al, *Journal of Acquired Immune Deficiency Syndromes and Human Retroviruses*, 1998

<sup>328</sup> California Dept of Health Services, Office of AIDS

<sup>329</sup> Smith and DiClemente, *Preventive Medicine*, 2000

<sup>330</sup> CDC, 1999

The first core element of Community PROMISE is the community identification process, which involves interviewing and holding focus groups with stakeholders in the community to identify why people engage in risk behaviors, what barriers exist to changing behavior, what will encourage them to change behaviors, and locations where they engage in risk behaviors.

The second core element is role model stories, which are brief publications with personal stories from members of the community who have made or are planning to make a risk-reducing behavioral change. The third element is peer advocates, who are volunteers from the community who help distribute the role model stories and other materials.

The final core element is evaluation of the intervention in order to provide evidence of its effectiveness.

### **Q Action**

Q Action is the young MSM program (for men 25 years old and younger) of the Stop AIDS Project. Created in 1994, this program has been successful in serving young MSM in San Francisco. Q Action has a meeting space as its Q&A Lounge, an accessible and safe space for participants to use and the only place for young MSM to congregate in the Castro away from the club and bar scene.

The focus of Q Action is to assist young MSM organize and mobilize to find creative and innovative ways to address their unique needs and concerns and build a healthy community beyond the epidemic. Q Action accomplishes this by leading young men in community building and organizing activities, as well as in single and multiple sessions. Q Action is led by a group of highly trained core group of volunteers who coordinate all program activities.

Q Action partners with other programs SAP and other agencies to create community forums and social opportunities to promote community and positive peer modeling. Q Action is based on the philosophy that the personal is political and helps participants

understand that others share the same stressors they experience in their lives and that there are steps they can take together to overcome these challenges.

Q Action also has a formal outreach component led by Q Action volunteers and the Q Action Outreach Coordinator. Formal outreach is conducted at venues where young men congregate. All outreach efforts promote safer sex behavior and work to create public interest for Q Action.

### ***Video Education Targeting African American Youth***

In this program, 194 African American teenagers were assigned to either a culturally sensitive or culturally dissimilar video education intervention. Results indicated that both interventions were effective in increasing AIDS knowledge scores. However, only the culturally sensitive video was effective with youth who were in a group defined as "Know It All" - that is, youth who claimed to "know a lot" about AIDS but actually knew less than youth who claimed to have moderate knowledge.

The authors suggest that culturally sensitive materials are most particularly effective with youth who like to project an attitude of security, confidence and resistance ("cool pose"). The cool pose African American youth may be less likely to reject new information if it is culturally relevant. Conversely, culturally dissimilar information may be perceived as "irrelevant," "acting white," or "corny."<sup>331</sup>

<sup>331</sup> Stevenson et al, *AIDS Education and Prevention*, 1995

## Greater Minnesota

Although Greater Minnesota was not identified as a target population and specific interventions were not identified by the CPP Committee for Greater Minnesota in the most recent prioritization process, information regarding strategies for rural areas is included here as a reference for individuals and organizations that may be interested in implementing prevention interventions to reach members of the priority target populations residing in Greater Minnesota. Greater Minnesota is defined as all counties outside of the eleven-county eligible metropolitan area (EMA). Rural areas refer to non-urban areas in Greater Minnesota.

There has been no rigorous reported evaluation of HIV prevention programs targeting individuals in Greater Minnesota. What follows is a summary of information about the perceived need and acceptability of specific interventions in Greater Minnesota that was collected through community meetings and surveys conducted as needs assessment activities in various regions outside the metro area.

### OUTREACH INTERVENTIONS

In a 1996-1997 survey of people of color,<sup>332</sup> 51 comments were made supporting the distribution and promotion of condoms. Three people specified that condoms should be distributed in STD clinics. Two comments were made to support the distribution of clean needles. Focus group participants requested increased accessibility to free condoms. They also mentioned the development of home parties for the purpose of providing HIV and risk reduction information.

In a 1996/1997 survey of men who have sex with men,<sup>333</sup> the use of opinion leaders, key informants, and influential persons was overwhelmingly identified as the most effective method of reaching individuals at risk. Twenty-nine percent (29%) reported a

need for AIDS outreach workers as a method of choice for education - they felt that having a peer in the environment where the activities are occurring would be more likely to get people's attention. Respondents felt that condoms should be made available in multiple locations: bars, public sex environments, counseling and testing sites, schools, clinics, community based organizations (CBOs), the Salvation Army, farmers coops/elevators, etc.

Youth reported a need for street outreach programs. They stated that STD/HIV prevention information, as well as safer sex materials (condoms, dental dams) should be available wherever youth meet; for example, skateboard parks, in youth recreation centers, and dance halls.

### COUNSELING AND TESTING

In 1996, several regional surveys asked the question, "Where would you go to be tested for STDs?"

Thirty-two percent (32%) of Native Americans preferred a Tribal Health Clinic, 21 percent a private clinic, 18 percent a free community clinic, 18 percent county public health, 2 percent Planned Parenthood, and 9 percent said they would go out of town. When asked specifically about HIV testing, 4 percent said they would donate plasma or blood to discover their HIV status.<sup>334, 335</sup>

Youth in Greater Minnesota preferred to visit a doctor, clinic, or local public health for testing because those locations were most accessible. Sixty-five percent (65%) of youth respondents reported a need for information on availability of testing.<sup>336</sup>

Most immigrant participants said they would visit a private healthcare provider, or Migrant Health Services office to be tested for STDs. The choice would be made depending on cost and confidentiality.<sup>337</sup>

<sup>332</sup> Fond du Lac Human Services, 1996

<sup>333</sup> Rural AIDS Action Network, 1995

<sup>334</sup> Fond du Lac Human Services, 1996

<sup>335</sup> Clay County Public Health, 1997

<sup>336</sup> Fond du Lac Human Services, RAAN, 1996

<sup>337</sup> Clay County Public Health, 1997

Men who have sex with men preferred metro clinic settings, or state funded testing sites in order to maintain anonymity. Thirty-eight percent (38%) reported a need for information on where testing is available.<sup>338</sup>

Women and men who have sex with men would often choose to visit a private doctor, since they were perceived to be safe people to discuss HIV/STDs with. However, physician's offices were not perceived to be well versed in how to attend to counseling needs. Respondents felt that physicians need to be more open, even aggressive, in sharing information about HIV/STDs with clients. Both women and MSM indicated a need for more information on testing locations for HIV and STDs.<sup>339</sup>

## **SINGLE BEHAVIORAL INTERVENTIONS**

### ***Peer Education***

In the surveys of men who have sex with men, respondents reported that they would like to learn more about safer behaviors, how to change behavior, non-risk sexual behaviors, one-on-one counseling and support, condom use, and help with alcohol or substance use. Participants consistently preferred education to be presented to them by peers.

In surveys of youth, respondents reported the following educational needs: signs and symptoms of STDs, needle cleaning and resources for IDUs, condom use, testing and treatment of STDs and HIV, and using latex condoms. Participants consistently preferred education to be presented to them by peers.

In a 1996 survey of Latino immigrants, 25 percent of respondents indicated a need for abstinence education for their children, delivered through a peer group presentation.<sup>340</sup>

Over half of the key informants interviewed in the 1996-1997 survey of people of color felt that their clients would prefer access to peer

led counseling, because peers are less threatening, less judgmental, and are culturally competent when counseling teens, and immigrants. Interventions that address self-esteem were considered important.<sup>341</sup>

### ***Education from a Professional***

In the 1996-1997 survey of people of color, respondents reported a need for education on condom use, negotiation skills, self-esteem, communication skills, and honesty in relationships. Thirty-seven percent (37%) of Latinos surveyed in 1996 indicated a need for education regarding condom use. They indicated that condom use should be taught by a professional educator, on a one-to-one basis, as it would be uncomfortable to practice in a group.

Women noted that they regularly attended family planning or doctor's clinics, and that they would prefer to receive education from a doctor or trusted health practitioner, "It would be nice to get a 'total' health package from the doctor when you are in for a yearly physical."

### ***Group Support***

In the survey of people of color, 54 comments were made suggesting that HIV/STD prevention education community meetings/forums/seminars be frequently offered to the public.

In the survey of men who have sex with men respondents reported a need for support from other men, and 43 percent of youth reported a need for support from other youth.

Focus group participants indicated that women like to have social support, and that with group support feel safe in discussing HIV/STD related concerns.

### ***School-based Programs***

Youth ages 13-15 reported being confused by comprehensive health education programs. It was difficult for them to combine multiple ideas presented at the same time. This is the result of their natural cognitive development at this age. Materials should be developed that are cognitively appropriate, and

<sup>338</sup> RAAN, 1995

<sup>339</sup> RAAN, 1995; RAAN and Clay County, 1998

<sup>340</sup> Clay County Public Health, 1997

<sup>341</sup> Fond du Lac Human Services, 1996

comprehensive health education programs should be seriously evaluated prior to implementation.

Youth also reported a desire for peer education. Peer educators provide role models for younger youth, can provide information in informal settings, and diminish the fear of discipline in educational settings. Youth also felt that teachers are significant role models for youth, and need to show common sense, honesty and comfort with the topic, and be willing to push the system on behalf of youth to be effective educators.

Youth requested that condoms be made available in schools, and promoted as “proving we are practicing safer sex” and not that access to condoms promotes sexual activity. However, many youth in focus groups held in 1998 also felt abstinence messages should be taught.

In a 1996-1997 survey of people of color, 37 statements were made supporting HIV/STD prevention education in schools. Two comments were made supporting condom distribution in schools. Focus groups participants suggested that, “Schools should be forced to follow through on mandated HIV/STD education; penalize schools that don’t follow policy.” Two statements were made to support education offered in the workplace. Inservice education should be available in both small and large businesses.

In needs assessments of women, participants felt that school systems should work more extensively with parents to develop a curriculum that is effective and meets parents' approval, that community education sessions should be developed for parents to promote sexuality education in school settings, and that comfort levels of teachers responsible for sexuality education should be raised through teacher training.

### **MULTILEVEL INTERVENTIONS**

In recommendations from the 1996-1997 survey of men who have sex with men, it was determined that a bigger picture education program is needed for rural communities. In

addition to basic information about the transmission of the diseases, such a program needs to include diversity education and communication skills. It needs to address perceptions that “rural sex is safer than metro sex.”

### **COMMUNITY AWARENESS INTERVENTIONS**

In surveys of youth, it was recommended that the issue of denial that youth are sexually active needs to be addressed at a community level. Parents need to be educated about this. Youth felt that parents also need general HIV/STD information since youth report knowing more than their parents. The youth often indicated a strong need for alternative activities (e.g., street dances, skate parks, organized non-competitive sports).

#### **Media**

In all populations surveyed, television and radio were identified as media by which Greater Minnesotans can be reached. Several respondents noted that, especially in winter months, rural Minnesotans watch a lot of TV. Latino respondents encouraged distribution of Spanish language messages through culturally specific programming on cable TV and Latino radio shows.

Responses by Latino immigrants to the question, “In your community, what kinds of HIV/STD information could there be more of?”

- Information about HIV and STD testing site locations and protocols (41%).
- Information about signs/symptoms of STDs (33%).
- Information regarding risky behaviors (29%).
- Information about the treatment of STDs (26%).
- Information about talking to family and friends about prevention (25%).
- Information about women and HIV/STDs (22%).
- Information concerning injectable drugs (21%).

In surveys of men who have sex with men, it was recommended that print media should include a variety of formats and topics, (e.g., stark and dark messages, and erotic and explicit safer sex pamphlets). Men need information on specific behaviors such as oral sex, rimming, anal sex, mutual masturbation, etc. Local TV stations are a safe method of reaching men, and are not being utilized. Confidentiality and anonymity are key. The visibility and availability of information should be increased by distributing rural sensitive flyers through: public libraries by placing in books at check out; grocery stores by placing in bags at check out; and business cards in bars. Key influential people, such as professionals, people living with HIV/AIDS, family members, members of the GLBT community, as well as peers, can communicate education and prevention ideas. Men also reported that AIDS service organizations (ASOs) in Greater Minnesota are not open when they visit for information and that public health nurses are not interested in the issues. Hotlines may address these gaps if they are publicized and easily accessible.

People of color surveyed in 1996-1997 felt that brochures, posters, TV, radio, movies and videos were effective means of education and risk reduction. Focus group participants felt that a list of available resources should be posted or distributed in the community, and that public TV should address HIV/STDs. Focus group interviews also supported HIV/STD positive volunteers speaking about their experiences.

Youth surveyed in 1996-1997 said that messages must be relevant. They should include more than basic information, and stress both abstinence and condom use. Printed materials should be made available at coffee shops, safety centers, probation officers' offices, school, and police stations. Comic books and the Internet were both mentioned as effective mass media. A youth HIV/STD hotline was also promoted as an effective intervention.

Women felt that printed information should be made available to them in public settings, "Places where lots of brochures are displayed so it is not obvious what you are picking up." - for example, daycare centers, gyms, libraries, clinics, and health fairs where booths are not staffed. Women also felt that information hotlines should be better promoted.

**CAPACITY BUILDING INTERVENTIONS**

The following capacity building measures were recommended from the 1996-1997 survey of people of color:

- Staff training.
- Host regional conferences to educate staff.
- Continued education for agencies.
- Help develop collaboration between the community and agencies, as well as inter-agency collaboration.
- Notify tribal health programs of programs that teach negotiation skills.
- Encourage reservations to incorporate negotiation skills in their community education.
- Conduct research or studies to evaluate efficacy of behavioral interventions.
- Continue to identify high-risk people in population through community needs assessment.
- Conduct migration surveys and surveillance research so statistics will reflect actual number of cases in rural areas, since funding hinges on actual numbers.
- Improve and gather statistics more accurately. There is a need for socioeconomic statistics, not racial statistics.

## Chapter Five

# Prioritized Interventions and Strategies

*This chapter describes the interventions and strategies that were identified as being the most effective in reducing HIV infection in each of the prioritized target populations.*

### Interventions and Strategies

This chapter presents the interventions that were recommended through the work of the CPP Committee and approved by the full CCCHAP. As described in Chapter Three, the committee reviewed research to identify which interventions would be the most effective for each of the prioritized target population. In addition, the CCCHAP held a number of community forums in order to gather feedback on the recommended interventions from members of the various target populations.

Descriptions of the prevention interventions and ideas for strategies to implement them are provided in this chapter. Comments and recommended interventions that evolved out of the community forums are also included. Similar documentation was included in the RFP released in the spring of 2002 for providers to refer to as they developed proposals for HIV prevention programming for specific target populations.

### INTERVENTION CATEGORIES

The interventions are presented according to target population. Within the target populations, the individual interventions are grouped by the four intervention categories identified by the CCCHAP: Outreach, Single Behavioral, Multilevel, and Community Awareness. All interventions may include field based testing (OraSure) as a component. Definitions for each of the intervention categories were developed by MDH based on understanding of the intent of the CCCHAP and CDC definitions.

#### **Outreach**

Outreach interventions are generally conducted by peer or para-professional

educators and are designed to identify individuals who are at risk for becoming infected with HIV. The outreach activities take place in neighborhoods and other places that high-risk individuals usually congregate. Outreach workers hand out condoms, sexual responsibility kits, bleach, and educational materials about how to reduce risk. They also provide referrals to services that can help people reduce or change their risk behaviors.

#### **Single Behavioral Interventions**

Single behavioral interventions help people change or avoid behaviors that put them at risk for being infected with HIV. They include individual and group level interventions and prevention case management.

Individual level interventions (ILI) assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. They include a skills building component. Group level interventions (GLI) also contain skills building exercises, as well as education, information and support, and are provided to groups of varying sizes. Prevention case management (PCM) provides intensive, ongoing, and individualized prevention counseling, as well as support and assistance in accessing other services.

#### **Community Awareness Interventions**

Community awareness interventions are designed to provide information and change the way a community *thinks* about something. These interventions are not necessarily designed to make individual people or communities change the way they *behave*. Community awareness activities include interventions defined by CDC as Health Communication/Public Information and Other.

Community awareness activities involve the delivery of planned HIV/AIDS prevention

messages through one or more channels to target audiences in order to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk of infection how to obtain specific services.

Examples of mediums used to provide community awareness interventions include: electronic media, print media, hotlines, clearinghouses, presentations or lectures, community events, and websites and chat rooms.

### **Multilevel Interventions**

Multilevel interventions include some combination of one or more of the other types of interventions that move people through different states of health education and risk reduction. The component interventions support one another and create a “whole” effect that is greater than the sum of the “parts”.

In many instances, particular component interventions from the multilevel category were also included as appropriate in the outreach, single behavioral, or community awareness intervention categories.

During the RFP process, providers had the opportunity to design their own multilevel programs by combining interventions from the outreach, single behavioral, and community awareness categories in a way that made sense for them. These multilevel programs could be designed to be located in one agency or as a collaborative effort between agencies.

### **Format**

The recommended interventions are grouped by intervention category for each target population. For each subpopulation, the intervention categories are presented in the order in which they were prioritized by the CCCHAP. Under each individual intervention, strategies or components of the intervention are presented. Comments, feedback, and suggestions for interventions that originated from the community forum participants are noted in *italics*.

The charts presented in this plan include some activities, such as needle exchange, that are not eligible for funding using federal or state dollars; however, there may be organizations in the community who are interested in pursuing other funding sources to implement such interventions.

## **Goals of the Interventions**

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Goals for the interventions funded through the RFP process for each target population were developed during contract negotiations. The goals tell us what impact we expect the intervention to have on the target population, how the intervention will be implemented, and how many people will be reached through the intervention.

The goals for the prevention interventions that were implemented in 2003 are included in the Resource Inventory section of Chapter Two, starting on page 177.

## MEN OF COLOR WHO HAVE SEX WITH MEN

### **MULTILEVEL INTERVENTIONS**

#### ***Outreach and Workshops***

- Environmental outreach
- Social events, such as potlucks or cultural events
- Peer education
- Discussion groups
- Esteem development for gay men

#### ***Sexual Health Seminar***

- Five-day seminar targeting men of specific race/ethnicity
- Days 1, 4, and 5 are for health providers only to discuss HIV/STD prevention
- Days 2 and 3 are a culturally appropriate sexual health seminar for providers and community members

#### ***Comprehensive Program***

- Formal outreach in community and informal outreach through peers/friends
- Individual level counseling about risk behavior
- Peer led small groups focused on safer sex, building relationships, intimacy, anonymous sex
- Small publicity efforts to reinforce safer sex

### **OUTREACH INTERVENTIONS**

#### ***Phone Card Program***

- Free long distance calling cards that play a 15 second HIV prevention message each time the card is used

*Local community forum participants recommended that the phone card program be integrated into a comprehensive program.*

#### ***Environmental Outreach***

- Talk to people in parks, bars, etc., and identify those who are at high risk
- Give out condoms, HIV information
- Do HIV field based testing in parks, bars, etc.
- Refer people to other prevention services if needed

*Local community forum participants recommended that more people of color should be doing environmental outreach. They recommended doing outreach through peer networks, and doing education and outreach in substance use treatment centers, with youth, and with athletes that may be injecting steroids.*

## MEN OF COLOR WHO HAVE SEX WITH MEN

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### ***Individual Level Counseling***

- Culturally appropriate
- Assess individual's risk for contracting HIV
- Peers provide risk reduction education
- Referral to HIV testing

#### ***STD Testing and Counseling***

- One-on-one counseling
- Stipend for attending sessions
- Multiple tests for STDs
- Clinic based

#### ***Peer Support Groups***

- Recruit people through bars, erotic bookstores, culturally specific organizations, street networks, personal referrals
- Three 3-hour group sessions to promote self-identity and pride, provide assertiveness training, HIV risk reduction education, and get verbal commitments to reduce high-risk behavior

#### ***Group Level Interventions***

- Group sessions focused on building skills and self-esteem

*Community forum participants suggested the following group level interventions:*

- 1. Develop a web-based support network online.*
- 2. Hold a relationship workshop for men of color. Discuss esteem and healthy relationships, dynamics involved in interracial relationships, power dynamics in relationships, intimacy issues, and building communication skills.*

### **COMMUNITY AWARENESS INTERVENTIONS**

#### ***Community Events***

- Provide information about HIV prevention for gay men at community events/festivals for general Latino, Asian, African American or Native American community

*Forum participants recommended developing community events that are multicultural.*

#### ***Media***

- Use of media, and especially electronic media, to get across HIV prevention messages

#### ***Low Rider Intervention***

- Donated low rider is refurbished and painted with safer sex messages
- Car is entered in low rider shows and displayed at Latino community events

## YOUNG MEN WHO HAVE SEX WITH MEN (AGES 13 – 24)

### **MULTILEVEL INTERVENTIONS**

#### ***Outreach, Counseling and Media***

- Outreach to young MSM
- Group level counseling and skills building related to reducing risk behaviors
- Provided by peers or mentors
- Media campaign targeted at young MSM

#### ***Outreach, Small Groups and Peer Support***

- Outreach to young MSM
- Small group support and discussion activities
- Peer to peer counseling
- Build self-esteem

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### ***Prevention Case Management***

- Ongoing risk assessment
- Multiple individual counseling sessions
- Development of a care plan
- Made to fit the individual, with varying levels of intensity according to need
- Help address other issues in clients' lives

#### ***School-based Activities***

- School based prevention activities led by peers

*Young MSM who participated in community forums suggested the following group level interventions:*

1. *School based activities should include education for teachers regarding HIV and GLBT issues. HIV+ speakers should be brought into the schools because they have a greater impact. Schools should be made safe for GLBT, especially in Greater MN.*
2. *Parent education would help get parents more involved and teach them how to talk to their kids.*

#### ***Peer Counseling***

- Group or individual skills building sessions
- Build self-esteem
- Provided by peers

## YOUNG MEN WHO HAVE SEX WITH MEN (AGES 13 – 24)

### OUTREACH INTERVENTIONS

#### ***HIV Testing Party***

- Informal outreach by peers
- Bring young MSM who are at high risk into community organizations or homes of peer educators
- Provide educational materials and information about HIV, supplies
- OraSure testing for HIV
- Peer based and confidential

#### ***Outreach***

- Conduct outreach in areas where young MSM hang out
- Conduct outreach by Internet, radio, TV and phone

### COMMUNITY AWARENESS INTERVENTIONS

#### ***Community Capacity Building***

- Build skills/capacity among professionals and community that work with youth in order to create a safe and supportive environment

#### ***Media Campaign***

- Media campaign targeted at young MSM

*Community forum participants suggested running ads in Lavender and City Pages. They felt it was important to get the statistics out about HIV infection.*

## ADULT MEN ALL RACES WHO HAVE SEX WITH MEN

### **MULTILEVEL INTERVENTIONS**

#### ***Outreach, Media and Peer Groups***

- Outreach
- Media campaign
- Small peer-led groups that focus on social activities as well as discussion, support and skills building
- Program has a membership continuum, and an individual may move through different interventions that are part of the program

#### ***Intensive Multisession Activities***

- Media outreach
- Small group activities including discussion about risk behaviors, testing, how gay community has been impacted by HIV, personal power in prevention
- Individual counseling

### **COMMUNITY AWARENESS INTERVENTIONS**

#### ***Community Events***

- Attend non-HIV specific community events to deliver HIV prevention messages

*Community forum participants suggested having HIV information and images of MSM showing affection at large community events, such as auto shows, state fair, etc. They also suggested having a catchy website name under a large image of MSM that is easy to remember without writing it down.*

#### ***Community Awareness through Internet***

- Provide prevention messages through the Internet

*The following recommendations were provided related to web-based community awareness:*

1. *Young people, married men and closeted people can use the web to find information and resources for testing and safer sex supplies.*
2. *Have key words associated with cruising and chat rooms also associated with safer sex pages.*
3. *Have a list of where to get free condoms available on the web.*
4. *Demonstrate how to put on a condom on the web.*
5. *Provide a list of GLBT friendly health providers on the web.*
6. *Provide an appropriate link for deaf people to find information.*

*Community Awareness Interventions continued on next page*

## ADULT MEN ALL RACES WHO HAVE SEX WITH MEN

### **COMMUNITY AWARENESS INTERVENTIONS**

#### **Mass Media**

- Media campaign with the goal of eroticizing safer sex

*Community forum participants noted that images in public places of men loving men, including married men, help reduce a sense of isolation and increase sense of validation. They wanted to see "in your face" advertising. They also wanted the messages to be broad-based and continued on a consistent level.*

#### **Peer Opinion Leaders**

- Peer opinion leaders provide opportunities for informal conversations, counseling and discussion in order to strengthen community support of safer sex

*Other suggestions that were given for community awareness activities:*

1. *Placing safer sex literature in non-traditional places like grocery stores, community centers, book stores, libraries, churches, restaurants, laundromats, restrooms, and coffee shops.*
2. *Videos targeting deaf MSM should be produced using deaf actors and captioning. The videos could focus on different topics such as substance use and HIV, MSM and HIV, and men who don't identify as gay and HIV.*
3. *Training to doctors about how to talk about safer sex and HIV/STD transmission with all patients, including MSM.*

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### **Short Term Intensive Group Sessions**

- Small group activities including discussion about risk behaviors, testing, how gay community has been impacted by HIV, and personal power in prevention

#### **Peer Groups**

- Small groups led by peers that focus on social activities as well as discussion, support, and skills building

#### **Prevention Case Management**

- Ongoing risk assessment
- Multiple individual counseling sessions
- Development of a care plan
- Made to fit the individual, with varying levels of intensity according to need
- Address other issues in clients' lives
- Especially important for people who are underprivileged or those who don't speak English

*Community forum participants noted that persons providing PCM to deaf people should be culturally competent. It's more effective than using an interpreter.*

#### **Group Counseling Seminars**

- All day seminars
- A mix of large and small group counseling and skills building sessions
- Messages in different forms of media

#### **Group Counseling – Peer Opinion Leaders**

- Peer opinion leaders (people considered to be leaders in their community) are identified by community members
- Peer opinion leaders are trained to do HIV prevention education and skills building around how to change risky behavior

## ADULT MEN ALL RACES WHO HAVE SEX WITH MEN

### **OUTREACH INTERVENTIONS**

#### ***Outreach to Non-Gay Identified MSM***

- Outreach efforts focus specifically on MSM who don't identify themselves as gay
- Outreach done through venues such as house parties, friendship networks, Internet, media, churches, and correctional facilities

#### ***Post Exposure Prophylaxis (PEP)***

- Consider using PEP at time of test to reduce possibility of infection

#### ***Electronic Outreach***

- Internet outreach

*Community forum participants felt that outreach activities to non-gay identified MSM should include the free distribution of a wide variety of condoms and lube at places such as support groups, parks, beaches, bathrooms. Information about condom use and risks for contracting HIV/STDs should be given out with the condoms and lube.*

*They also recommended having outreach targeted at deaf men. Condoms should be handed out with a brochure that uses simple vocabulary and pictures. Outreach and condom distribution should be conducted at deaf clubs, Minnesota Rainbow Alliance of the Deaf (MNRAD) meetings, and bars.*

## HIV POSITIVE MEN WHO HAVE SEX WITH MEN

### **MULTILEVEL INTERVENTIONS**

#### ***Self Care/Advocacy***

- Integrate prevention messages and skills building into programs promoting self care and self advocacy for HIV+ persons

### **OUTREACH INTERVENTIONS**

#### ***Prevention Services & Referral***

- Provide outreach and HIV services referrals in places where HIV+ individuals currently meet

#### ***Outreach to Professionals***

- Educate HIV doctors, care case managers, and Disease Intervention Specialists about HIV prevention resources for HIV+ individuals, so they can effectively refer clients to those programs

*Community forum participants felt that all physicians, not just HIV specialists, should learn where HIV+ people should be referred for prevention and care.*

*Participants also recommended that peers be used to do outreach in Greater Minnesota.*

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### ***Individual Counseling***

- A number of individual counseling sessions provided over a period of time
- May range from occasional counseling as needed to intensive therapy

*Community forum participants felt that individual counseling should focus on prevention and reinfection. It should also build on support and social networks available to the individual.*

#### ***Couples Counseling and Testing***

- Counseling for partners where at least one partner is positive
- Testing of partners of positive persons

#### ***Group Counseling***

- For serodiscordant couples
- Sexual health seminars
- Time limited support group focusing on sexuality and sexual behavior

*Community forum participants suggested a support group for HIV+ MSM that offers the opportunity to touch or be held in a non-sexual way. HIV+ MSM need touch and to feel valued because there is a sense of being "damaged goods".*

*Single Behavioral continued on next page*

## HIV POSITIVE MEN WHO HAVE SEX WITH MEN

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### ***Coordination with Care Case Managers***

- Train care case managers to recognize HIV transmission prevention needs of clients they are working with
- Provide care case managers with information about where clients should be referred for intensive behavior change interventions

#### ***Prevention Case Management***

- Ongoing risk assessment
- Multiple individual counseling sessions
- Development of a care plan
- Made to fit the individual, with varying levels of intensity according to need
- Help address other issues in clients' lives
- Most helpful for HIV+ persons who are also diagnosed with chemical dependency and/or mental health problems, those who have other recurrent STDs, and/or who say they have a hard time using safer sex techniques

### **COMMUNITY AWARENESS INTERVENTIONS**

#### ***Social Marketing***

- Hold focus groups with specific populations to develop prevention interventions for that population
- Use focus groups to also develop a media campaign to promote the prevention intervention

#### ***Website***

- Develop a website with prevention resources for HIV+ individuals, showcasing upcoming events. An example of such a website is <stopaids.org>

*It was recommended that a website have multiple entries through erotica and safer sex sites. They wanted to see a Minnesota specific bulletin board and/or on line discussion group, with links to other sites.*

#### ***Media Campaign***

- Campaign about HIV prevention targeting HIV+ individuals. Use various types of media, such as newspapers, TV, magazines, posters, radio, etc.

## ADULT AFRICAN AMERICAN HETEROSEXUAL WOMEN

### **MULTILEVEL INTERVENTIONS**

#### ***Storefront Program***

- Provide a safe place for prostituted women to meet, put on make-up, etc.
- Services such as group support, individual counseling, and/or prevention case management would be available for women as needed

#### ***Peer Opinion Leader***

- Peer opinion leaders are identified by members of their community
- Peer opinion leaders are trained to do outreach, informal health education and counseling, group counseling and referral to HIV testing
- This model will work better in places such as small towns or housing projects

#### ***Comprehensive Program***

- Outreach in churches, beauty salons, jails
- Targeted media campaign using radio, print, TV
- Time limited support and discussion group focusing on healthy sexuality. Different aspects discussed at each session
- Couples group in which men and women meet separately for part of the time, and together for part of the time
- Group specifically for women affected by incarceration (either they or their partners are, or have been, incarcerated)
- Individuals from groups are referred to individual counseling

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### ***Individual Counseling***

- Individual counseling at STD clinics that encourages and discusses ways for women to protect themselves from being infected with HIV and/or STDs
- Women are encouraged to design their own prevention plan

#### ***HIV Education***

- Incorporate HIV education into city and county mandated classes, such as domestic abuse classes, back to work programs, DWI classes, etc.

#### ***Support Group***

- Time limited support and discussion group focused on healthy sexuality. Different aspects discussed at each session

#### ***Couples Group***

- Men and women meet together for part of the time and separately for part of the time
- Focus on building relationships and healthy sexuality

#### ***Group For Women Affected by Incarceration***

- Support group for women affected by incarceration (either they or their partners have been, or are, incarcerated)

#### ***Counseling and Testing***

- HIV testing for women and their partners that includes counseling about risks

## ADULT AFRICAN AMERICAN HETEROSEXUAL WOMEN

### OUTREACH INTERVENTIONS

#### ***Targeted Outreach***

- Start conversations, hand out information, give referral to services, and do field based testing for women most at risk
- Those considered most at risk include women living with HIV and/or STDs, prostituted, chemically dependent, homeless, suffering domestic abuse, having an unplanned pregnancy
- Do outreach in churches, beauty shops, day care centers, community events, and civic organizations

#### ***Outreach to Pimps***

- Do outreach, provide information about HIV and STDS, and hand out condoms to pimps

*Community forum participants felt that outreach should be targeted at the youngest members of the families since adults are already set in their ways. Outreach should be performed in the neighborhoods, and the Mall of America. Outreach to drug users should continue.*

### COMMUNITY AWARENESS INTERVENTIONS

#### ***Church Initiative***

- Work with churches to raise awareness and teach the congregations about HIV
- People at risk are referred to programs that can help them change/reduce their risky behavior

*Community forum participants recommended the development of a confidential column in a community newspaper where people can write in anonymously with questions related to HIV prevention and get responses.*

## YOUNG AFRICAN AMERICAN HETEROSEXUAL WOMEN (AGES 13 – 24)

### **MULTILEVEL INTERVENTIONS**

#### ***Mentorship***

- Done individually or in small groups
- Mentors provide role-modeling, one-on-one counseling, and social events

#### ***AIDS Counseling and Education***

- Young women inmates provide education, buddy program, and support to other young women in correctional facilities

#### ***Youth Drop-in Center***

- Provide outreach, testing, one-on-one counseling, referrals
- Have the center in an area where youth hang out

#### ***Presentations and Referrals***

- Presentations to at-risk young women in correctional facilities and alternative schools
- Combine presentations with tours of HIV service organizations
- Give referrals to one-on-one counseling and skills building

#### ***Peer Opinion Leader***

- Train peer leaders to do outreach and education to friends and acquaintances
- Peer leaders provide workshops in the community
- Involve parents

#### ***Comprehensive Program***

- Outreach targeting young African American women
- HIV testing
- Group educational presentations about HIV and how to reduce risky behavior
- Prevention case management
- Stipends given for participation

### **COMMUNITY AWARENESS INTERVENTIONS**

#### ***Integrated Community Services***

- Bring HIV/STD prevention services into other services that already exist, such as family planning, school, recreational programs, and other activities that focus on youth

#### ***Media Campaign***

- Use billboards, radio, call-in shows, and Internet to promote prevention

*Community forum participants suggested having prevention messages on KMOJ, B96, Fox, Channel 9, and the WB. They also suggested incorporating prevention messages into music videos. They mentioned that they needed to have someone on the radio telling them how good they're doing; i.e., praising abstinence and good grades.*

#### ***Church Initiative***

- Work with ministers to put prevention messages into their sermons and other church activities

## YOUNG AFRICAN AMERICAN HETEROSEXUAL WOMEN (AGES 13 – 24)

### **OUTREACH INTERVENTIONS**

#### ***Environmental Outreach***

- Talk briefly, give HIV info and condoms to young women in correctional facilities, foster care, chemical dependency programs and mental health programs

#### ***STD Screening***

- Test for STDs and treat those who are infected. Provides opportunity to teach about HIV infection and offer HIV testing
- Train doctors how to do counseling before and after testing

#### ***Targeted Outreach and Testing***

- Do outreach and field based testing targeted at young African American women

*Community forum participants gave the following recommendations regarding outreach targeted at young African American women:*

- 1. Do outreach at parks, the YWCA and YMCA, Boys and Girls Clubs, roller rinks, movie theaters, and on buses.*
- 2. Have posters with prevention messages in the bathrooms of these places.*
- 3. Offer free HIV field based testing in the parks during the summer.*

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### ***Small Group Counseling***

- Led by peers
- Focus is on having fun
- Skills building activities about how to reduce risky behavior

#### ***Prevention Case Management***

- Ongoing risk assessment
- Multiple individual counseling sessions
- Development of a care plan
- Made to fit the individual, with varying levels of intensity according to need
- Help address other issues in clients' lives
- Targeted at young women who have recurrent STDs, have children, unplanned pregnancy, or are being prostituted

## YOUNG HETEROSEXUAL WOMEN ALL RACES (AGES 13 – 24)

### **COMMUNITY AWARENESS INTERVENTIONS**

#### ***Integrated Community Services***

- Bring HIV/STD prevention services into other services that already exist, such as family planning, school, recreational programs, and other activities that focus on youth

#### ***Media Campaign***

- Use billboards, radio, call-in shows, and Internet to promote prevention

#### ***Train the Doctor/Nurse***

- Train health care professionals about adolescent issues

#### ***Technical Assistance and Capacity Building***

- Provide training about HIV prevention to organizations that already serve youth (drop-in centers, shelters, etc.)
- Training focuses on teaching harm reduction, outreach, testing and referral to services
- Provide capacity building to these organizations to help them learn how to deal with issues related to HIV prevention

*Community forum participants had the following recommendations regarding community awareness activities:*

1. *Conduct a Target Market-type campaign, developing a special message for small towns including the local infection statistics. Use billboards and bathrooms.*
2. *Have speakers who are HIV+ talk about their personal stories.*
3. *Bring together community groups of peer educators and parents working together.*

### **MULTILEVEL INTERVENTIONS**

#### ***Mentorship***

- Done individually or in small groups.
- Mentors provide role-modeling, one-on-one counseling, and social events

#### ***AIDS Counseling and Education***

- Young women inmates provide education, buddy program, and support to other young women in correctional facilities

#### ***Youth Drop-in Center***

- Provide outreach, testing, one-on-one counseling, referrals
- Have the center in an area where youth hang out

#### ***Presentations and Referrals***

- Presentations to at-risk young women in correctional facilities and alternative schools
- Combine presentations with tours of HIV service organizations
- Give referrals to one-on-one counseling and skills building

#### ***Peer Opinion Leader***

- Train peer leaders to do outreach and education to friends and acquaintances
- Peer leaders provide workshops in the community
- Involve parents

#### ***Outreach and Prevention Case Mgmt***

- Outreach targeting young women
- Provide ongoing risk assessment and prevention education on individual basis
- Based at STD clinics or drop-in centers
- Targeting young women most at risk, such as those who are prostituted or have recurring STDs

## YOUNG HETEROSEXUAL WOMEN ALL RACES (AGES 13 – 24)

### OUTREACH INTERVENTIONS

#### **Age Specific Outreach**

- Outreach for young women between the ages of 20 –24
- Done at bars, colleges, beauty salons, etc.

#### **Environmental Outreach**

- Talk briefly, give HIV info and condoms to young women in correctional facilities, foster care, chemical dependency programs and mental health programs

#### **STD Screening**

- Test for STDs and treat those who are infected. Provides opportunity to teach about HIV infection and offer HIV testing
- Train doctors how to do counseling before and after testing

#### **Mobile Services**

- Have testing vans at bars, clubs, and on the street where youth hang out

*Community forum participants had the following recommendations regarding outreach activities:*

1. *Outreach workers should target younger girls ages 13 – 18. They agreed that more outreach and program information should be available in bars.*
2. *Free condoms should be available in various places across college campuses – residential halls, mailboxes, bathrooms, and at enrollment. They suggested having a condom butler to deliver condoms to student dormitories.*

### SINGLE BEHAVIORAL INTERVENTIONS

#### **Group Counseling**

- Time limited group sessions
- Teach young women how to be assertive and skills related to protecting themselves from HIV/STDs

#### **Peer Education Training**

- Peer educational training program that teaches teens to talk with their peers about reducing sexual risks
- 28 one-hour sessions, held twice a week
- School or community based

#### **Small Group Counseling**

- Led by peers
- Focus is on having fun
- Skills building activities about how to reduce risky behavior

#### **Prevention Case Management**

- Ongoing risk assessment
- Multiple individual counseling sessions
- Development of a care plan
- Made to fit the individual, with varying levels of intensity according to need
- Help address other issues in clients' lives
- Targeted at young women who have recurrent STDs, have children, unplanned pregnancy, or are being prostituted

#### **Rape Counseling**

- Build HIV prevention education into rape counseling services

*The following school-based activities were recommended:*

1. *Peer education*
2. *Plays focused on HIV prevention*
3. *Increased HIV education starting in elementary school*

## ADULT HETEROSEXUAL WOMEN OF ALL RACES

### **COMMUNITY AWARENESS INTERVENTIONS**

#### ***Single Mothers***

- Target single mothers for HIV prevention through parents/family events at school

#### ***Over 50***

- Activities to raise awareness and understanding about HIV among women over 50 years old

#### ***Syringe Access***

- Increase awareness among women about the availability of clean syringes through pharmacies

#### ***Capacity Building***

- Teach existing agencies that serve women (domestic abuse programs, shelters, services for prostitutes, etc.) about HIV prevention

#### ***Community Mobilization***

- Hand out flyers, brochures, posters, and newsletters that tell stories about women in the community, focusing on how they first learned about using condoms and then progressed to always using them
- Individual outreach done by women from the community. HIV information, referrals and condoms given out
- Small businesses and neighborhood agencies donate services or products. Also allow their space to be used to distribute flyers, etc.

*Forum participants felt it was important for the public to be constantly reminded of the number of cases of new HIV infections, and the number of people living with HIV/AIDS.*

### **MULTILEVEL INTERVENTIONS**

#### ***Outreach and Counseling***

- Outreach to high-risk women in institutions such as corrections or substance abuse programs
- Risk assessment
- Tailored individual counseling

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### ***Group Counseling***

Types of groups could include:

- Couples program to focus on building communication, attitudinal and negotiation skills about safer sex behaviors
- Parent groups for women with children
- Women only groups using entertainment and recreation to introduce safer sex messages

#### ***Prevention Case Management***

- Ongoing risk assessment
- Multiple individual counseling sessions
- Development of a care plan
- Made to fit the individual, with varying levels of intensity according to need
- Help address other issues in clients' lives
- Targeted at high-risk women who have recurrent STDs, are in substance abuse treatment, or are being prostituted, etc.

#### ***Group Counseling***

- Teach women to be assertive and other skills related to protecting themselves from HIV/STDs
- Time limited sessions

*Single Behavioral continued on next page*

## ADULT HETEROSEXUAL WOMEN OF ALL RACES

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### ***Pre-release Program***

- Program for men in prison and their female partners when the man is going to be released
- Communication about unsafe behavior that may have happened in prison and how to implement and maintain safe behaviors upon release
- Referrals to services in the community

*Forum participants felt that the program should also be offered to women leaving prison and their partners.*

#### ***Individual Counseling***

- Risk assessment
- Individual counseling according to person's need, including skills building around reducing risk behaviors
- Could be time limited, with stipends offered

#### ***Prevention for Positives***

- Multi-session group workshops for HIV+ women and their partners
- Discuss how to prevent transmission of HIV between serodiscordant couples
- Discuss how to avoid reinfection among couples where both partners are positive

#### ***Testing and Counseling***

- Testing for HIV
- Counseling about risk behavior before and after the test
- Referral into prevention services for high-risk negatives, and into care for women who test positive

### **OUTREACH INTERVENTIONS**

#### ***Annual Exams***

- Incorporate HIV risk assessment and testing into annual reproductive health exams (pap smears)

*Community forum participants had the following recommendations regarding outreach activities:*

1. *Outreach and field based testing should be targeted at the deaf community, using a deaf advocate or doing the testing in an agency for deaf persons.*
2. *Conduct outreach and field based testing in substance abuse treatment centers.*
3. *Conduct outreach and field based testing on college campuses.*
4. *Conduct outreach activities targeting women working in strip clubs or adult entertainment centers.*

## MALE AFRICAN AMERICAN INJECTION DRUG USERS

### **MULTILEVEL INTERVENTIONS**

#### ***Discharge and Release Planning***

- Peer education and materials to inmates about HIV and drug use
- Refer inmates to services in community
- Collaborate with public health agencies and community organizations to work with inmates upon their release

#### ***Syringe Access Initiative***

- Outreach to IDUs to let them know they can buy up to 10 clean syringes at pharmacies
- Encourage pharmacies to promote the program
- Encourage social service agencies to inform IDUs about the program

#### ***Outreach and Testing/Vaccinations***

- Outreach to IDUs
- Testing for HIV, Hep A, B, C
- Counseling before and after about risks for infection
- Vaccinations for Hep A and B
- Peer counseling about drug use, risk for HIV infection, and how to reduce risky behavior

#### ***Group Sessions and Needle Exchange***

- Drug users recruited to attend several educational sessions on HIV, risks of drug use and drug injection
- Distribute Fitpaks at the sessions and demonstrate and do role plays of cleaning needles
- Needle exchange provided to attendees

#### ***Outreach, Counseling and Prevention Case Management***

- Outreach workers make referrals
- Individual counseling on drug use and HIV
- Prevention case management provides ongoing risk assessment and counseling

### **OUTREACH INTERVENTIONS**

#### ***Peer Outreach***

- Recovering addicts give out information, materials, referrals and do HIV testing with IDUs
- Possible target populations include: IDUs on the streets, female sex partners of IDUs, MSM who do not identify as gay, residents of areas with high rates of STDs and injection drug use

## MALE AFRICAN AMERICAN INJECTING DRUG USERS

### **COMMUNITY AWARENESS INTERVENTIONS**

#### ***Harm Reduction Education***

- Educate community about harm reduction
- Recognize that change happens in stages over time
- Education that also addresses racism

#### ***Community Outreach***

- Peers attend community events to tell their stories, hand out flyers, distribute bleach kits

#### ***African American Churches***

- Involve churches by speaking at pastors' breakfasts and to advisory boards

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### ***Group Sessions***

- Limited number of sessions that provide information to IDUs about HIV, risks of drug use and drug injection, and how to enter a drug rehab program
- Distribute Fitpaks at the sessions and demonstrate and do role plays of cleaning needles

#### ***Prevention Case Management***

- Ongoing risk assessment
- Multiple individual counseling sessions
- Development of a care plan
- Made to fit the individual, with varying levels of intensity according to need
- Help address other issues in clients' lives

#### ***Individual Counseling***

- One-on-one counseling sessions focused on HIV transmission and prevention, how substance use and injecting drug use contribute to transmission, and how to reduce risky behaviors

#### ***Needle Exchange in Corrections***

- Needle exchange programs in correctional facilities

## FEMALE AFRICAN AMERICAN INJECTING DRUG USERS

### **MULTILEVEL INTERVENTIONS**

#### ***Innovative Needle Exchange***

- Women only site
- Clothing distribution center
- Clinic/physician based needle exchange  
Program also offers medical care
- Substance abuse counseling
- Referrals to treatment
- Hep C prevention

#### ***Needle Exchange***

- Provide needle exchange where needed:  
drop-in centers, street, shelters, homes
- Provide field based HIV testing
- Referrals for clothing, food, counseling,  
medical services, etc.

#### ***Outreach, Testing and Group Counseling***

- Outreach to IDUs
- Testing for HIV, STDs, Hepatitis, and  
pregnancy
- Group counseling
- Referrals to prevention and other services

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### ***Group Counseling at Methadone Clinics***

- Teach communication and negotiation  
skills
- Teach women how to use a condom

#### ***Individual Counseling at Clinics/ Emergency Rooms***

- Nurses work with clients to learn to value  
themselves, develop plans and take action
- Clients learn to take actions to improve  
their well-being and sense of self

#### ***Prevention Case Management***

- Ongoing risk assessment
- Multiple individual counseling sessions
- Development of a care plan
- Made to fit the individual, with varying  
levels of intensity according to need
- Help address other issues in clients' lives

#### ***Group Counseling***

- Time limited group counseling sessions  
focused on HIV transmission and  
prevention, how substance use and  
injecting drug use contribute to  
transmission, and how to reduce risky  
behavior

## FEMALE AFRICAN AMERICAN INJECTING DRUG USERS

### **OUTREACH INTERVENTIONS**

#### ***Outreach***

- Give out HIV info, condoms, bleach kits in churches, homeless shelters, on the street, clinics, domestic abuse shelters, neighborhood and community centers

#### ***Outreach and Referral***

- Outreach conducted by peers
- Distribute information about HIV and injection drug use
- Referrals to groups for users and provide incentives for attendance at the groups

### **COMMUNITY AWARENESS INTERVENTIONS**

#### ***Publicity Campaign***

- Targeted at specific types of women who may be injecting drug users; i.e., women in the sex industry or professional women

#### ***Systems Change for Substance Abuse Treatment Programs***

- Allow children to attend inpatient treatment with their mothers and/or provide intensive childcare
- Allow for return to programs without penalty after relapse

## MALE INJECTING DRUG USERS OF ALL RACES

### **MULTILEVEL INTERVENTIONS**

#### ***Syringe Access Initiative***

- Do outreach to IDUs to let them know they can buy up to 10 clean syringes at pharmacies
- Encourage pharmacies to promote the program
- Encourage social service agencies to inform IDUs about the program

#### ***Outreach and Counseling***

- Outreach activities conducted by peers to give out information, bleach kits, and condoms
- Recruit individuals to participate in individual and group level counseling sessions, according to their needs
- Counseling session will focus on HIV transmission and prevention, and how substance use and injecting drug use contribute to transmission

*Community forum participants recommended the following HIV prevention education program for inmates:*

- 1. Inmates receive a certificate for completing an HIV prevention education program, which provides a sense of accomplishment.*
- 2. Inmates then do HIV prevention education in the community. Other such tutor training courses are already in place and have been well received in the community.*

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### ***Enhanced AIDS Education Program***

- Six one-hour sessions focusing on drug use and HIV harm reduction behaviors
- Sessions include group discussion and practicing skills through role playing, tension relaxing exercises, etc.
- Sessions held in drug detox and rehab centers

*Community forum participants recommended having mandatory classes about HIV/STDs in prison. They noted that inmates are often afraid to come to voluntary sessions because of the stigma attached to HIV. They said they would like to have speakers with HIV come to the classes. The education should be given at time of intake and discharge.*

#### ***Individual Counseling***

- One-on-one counseling sessions focused on HIV transmission and prevention, how substance use and injecting drug use contribute to transmission, and how to reduce risky behavior

#### ***Group Counseling***

- Time limited group counseling sessions focused on HIV transmission and prevention, how substance use and injecting drug use contribute to transmission, and how to reduce risky behavior

#### ***Syringe Exchange***

- Programs where people can exchange their dirty needles for clean ones
- Located on the streets or in storefronts

## MALE INJECTING DRUG USERS OF ALL RACES

### **COMMUNITY AWARENESS INTERVENTIONS**

#### ***Peer Opinion Leader***

- Use peer opinion leaders and peer role models to tell their personal stories to help change behaviors and ways of thinking that are common among IDUs
- Also include street and environmental outreach

#### ***Systems Advocacy***

- Systems advocacy efforts to encourage treatment centers to promote the inclusion of harm reduction models and education about other blood-borne diseases like Hep C

#### ***Syringe Disposal Education***

- Education to general public, pharmacies, etc. about how to safely throw away needles

#### ***Media Campaign Using PSAs***

- Use public service announcements to talk about the risks associated with injection drug use and how to prevent getting HIV

*The following recommendations were made regarding community awareness activities:*

- 1. Education should be provided to the police so they know that it is legal to carry up to 10 clean syringes.*
- 2. Media campaigns with images of people before they had HIV and when they become ill in order to show the effects of the disease on the body.*

### **OUTREACH INTERVENTIONS**

#### ***Outreach***

- Give out HIV information, condoms, bleach kits, referrals to services to people on the streets, in shelters, prisons, colleges, etc.

#### ***Syringe Distribution***

- Distribute clean needles to people who are injecting

*Community forum participants made the following suggestions related to outreach activities:*

- 1. Conduct outreach activities in the suburbs since much of the injecting drug activity is happening there.*
- 2. Train parole/probation officers to speak to their clients about HIV and to have condoms available.*

## FEMALE INJECTING DRUG USERS OF ALL RACES

### **MULTILEVEL INTERVENTIONS**

#### ***Harm Reduction Services***

- Prevention case management
- Group counseling sessions that focus on harm reduction
- Support groups for women to talk about their experiences and give support to each other
- All services located at the same place

#### ***Outreach and Prevention Case Management***

- Outreach provided at points where IDUs access services, such as emergency rooms, clinics, treatment centers, etc.
- Provide prevention case management in those locations

#### ***Outreach and Counseling***

- Outreach activities conducted by peers to give out information, bleach kits, and condoms
- Recruit individuals to participate in individual and group level counseling sessions, according to their needs
- Counseling session will focus on HIV transmission and prevention, and how substance use and injecting drug use contribute to transmission

### **OUTREACH INTERVENTIONS**

#### ***Outreach to Lesbians***

- Give out information about HIV, dental dams, and bleach kits to lesbians and women who have sex with women
- Conduct the outreach in such places as bars, shelters, substance abuse treatment centers, and the streets

#### ***Environmental Outreach***

- Give out information on HIV, condoms, bleach kits, dental dams
- Provide in places that IDUs come in for help – clinics, emergency rooms, treatment centers, etc.

#### ***Peer Outreach***

- Peer opinion leaders give out information about HIV, condoms, bleach kits
- Referrals to prevention services

*Community forum participants noted that outreach is usually done where lower class and homeless people are. Outreach should also be done where the general public is reached, in places like the convention center.*

## FEMALE INJECTING DRUG USERS OF ALL RACES

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### ***Prevention Case Management***

- Ongoing risk assessment
- Multiple individual counseling sessions
- Development of a care plan
- Made to fit the individual, with varying levels of intensity according to need
- Help address other issues in clients' lives

#### ***Group Counseling***

- Time limited group counseling sessions focused on HIV transmission and prevention, how substance use and injecting drug use contribute to transmission, and how to reduce risky behavior
- Teach communication and negotiation skills, and condom use skills

#### ***Individual Counseling***

- One-on-one counseling sessions focused on HIV transmission and prevention, how substance use and injecting drug use contribute to transmission, and how to reduce risky behavior

### **COMMUNITY AWARENESS INTERVENTIONS**

#### ***Media Campaigns***

- Educate the general public about the risks associated with tattooing, body piercing, and injectable hormones

*Community forum participants had the following recommendations regarding community awareness activities:*

1. *Pharmacies, particularly those participating in the syringe access initiative, should have a way and place to dispose of used needles on site.*
2. *Media campaign showing before and after pictures of the effects that HIV has on the body.*
3. *Presentations to the community about HIV from people that community can relate to; i.e., from the same neighborhood.*
4. *Media campaigns focusing on HIV being spread from woman to infant. Have kids talk about their experiences living with HIV. This type of campaign should be particularly effective with women.*

## YOUNG INJECTING DRUG USERS (AGES 13 – 24)

### **MULTILEVEL INTERVENTIONS**

#### ***Counseling, Testing and Follow-up***

- Outreach to young IDUs to get them interested in participating
- Take them to a community agency for an interview, counseling and testing for HIV
- At second visit, young IDUs are given results of test and post-test counseling
- Referrals are given for any needed services
- There is follow-up with youth who participated to see how they're doing

#### ***Treatment, Shelter, Prostitution Diversion***

- Drug treatment program
- Shelter for youth who don't have anywhere to live
- Services to help young women get out of prostitution

#### ***Drop-in Center***

- Safe place for youth
- Assist young IDUs with issues such as homelessness and basic needs
- Incorporate substance abuse treatment program
- HIV testing, counseling, education and harm reduction
- Support groups with incentives for attending

#### ***Peer Outreach and Counseling***

- Peers give out information, condoms, bleach kits, referrals to counseling programs
- Individual counseling focused on drug use and preventing HIV infection
- Group counseling focused on drug use and prevention HIV infection

### **MULTILEVEL INTERVENTIONS**

#### ***Outreach, Testing and Counseling***

- Street outreach to youth
- Provide testing for HIV/STDs, Hep, and pregnancy
- Group counseling on drug use and HIV
- Referral to other services

#### ***Syringe Access Initiative***

- Outreach to young IDUs to let them know they can buy up to 10 clean syringes at pharmacies
- Encourage pharmacies to promote the program
- Encourage social service agencies to inform IDUs about the program

#### ***Outreach and Counseling***

- Outreach activities conducted by peers to give out information, bleach kits, and condoms
- Recruit individuals to participate in individual and group level counseling sessions, according to their needs
- Counseling session will focus on HIV transmission and prevention, and how substance use and injecting drug use contribute to transmission

#### ***Needle Exchange***

- Provide needle exchange where needed: drop-in centers, street, shelters, homes
- Provide field based HIV testing
- Referrals for clothing, food, counseling, medical services, etc.

#### ***Group Sessions and Needle Exchange***

- Drug users recruited to attend several educational sessions on HIV, risks of drug use and drug injection
- Distribute Fitpaks at the sessions and demonstrate and do role plays of cleaning needles
- Needle exchange provided to attendees

## YOUNG INJECTING DRUG USERS (AGES 13 – 24)

### **SINGLE BEHAVIORAL INTERVENTIONS**

#### ***Group Counseling in Corrections***

- Group counseling for incarcerated youth focused on preventing HIV infection and the risks associated with injection drug use

#### ***Group Counseling***

- Group counseling for young IDU focused on injection drug use and how it contributes to the risk of HIV infection
- Teach communication and negotiation skills
- Teach youth how to use condoms

#### ***Individual Counseling***

- One-on-one counseling sessions focused on HIV transmission and prevention, how substance use and injecting drug use contribute to transmission, and how to reduce risky behavior

#### ***Enhanced AIDS Education Program***

- Six one-hour sessions focusing on drug use and HIV harm reduction behaviors
- Sessions include group discussion and practicing skills through role playing, tension relaxing exercises, etc.
- Sessions held in drug detox and rehab centers

#### ***Prevention Case Management***

- Ongoing risk assessment
- Multiple individual counseling sessions
- Development of a care plan
- Made to fit the individual, with varying levels of intensity according to need
- Help address other issues in clients' lives

### **OUTREACH INTERVENTIONS**

#### ***Peer Outreach***

- Use peers to provide outreach and give out information, condoms, and bleach kits
- Peers talk to young IDUs about HIV and the risks associated with injection drug use

#### ***Outreach***

- Outreach to young IDUs on the streets, in shelters, prisons, colleges, etc.
- Give out information, condoms, bleach kits, referrals to services, do field based testing (OraSure)

#### ***Prevention Supplies***

- Outreach activities that provide access for young IDUs to supplies that help prevent the spread of HIV, such as condoms, bleach kits, information regarding pharmacies participating in the syringe access initiative

### **COMMUNITY AWARENESS INTERVENTIONS**

#### ***Media Campaign***

- Media campaign targeting specific types of youth who may be involved in injecting drugs; i.e., those involved in the sex industry

#### ***Guerilla Based Media***

- Use guerilla-style media (flyers, posters) to promote prevention messages targeted at young IDUs

## Chapter Six Coordination and Collaboration

*This chapter describes how governmental and non-governmental agencies coordinate to provide comprehensive HIV prevention services and programs. In addition, this chapter describes coordination between HIV prevention and care, STD testing and treatment, hepatitis efforts, tuberculosis, and family planning.*

### Coordination of HIV Prevention Activities

One of the primary responsibilities of the STD and HIV Section is to coordinate HIV prevention activities that occur among public and non-governmental agencies. Most such activities in Minnesota are funded through MDH, so that coordination occurs through grant contract management and management of those staff that provide direct services (i.e., the disease intervention specialists). Coordination occurs through regular unit, management team, and section meetings and is directed by the goals and priorities set in the Plan.

#### COORDINATION WITH STATE AGENCIES

For those few agencies that provide HIV prevention services and activities beyond the jurisdiction of MDH, coordination occurs in part by maintaining voting seats on the CCCHAP for representatives from such agencies. For example, state agencies that provide HIV prevention education in some form, including the Minnesota Department of Corrections (DOC); Minnesota Department of Human Services (DHS); and Minnesota Department of Education (MDE) have historically had representatives participate as voting members on the CCCHAP, although there is currently no DOC representative.

Coordinated School Health Approach, a collaboration between MDE and MDH, addresses school-related health policy development, instruction, counseling, support, and community education. Staff assist school districts to implement comprehensive

curriculum and programs to prevent and reduce the risk of HIV/AIDS and remain in compliance with the state STD statute.

Although, as a result of the state budget cuts in 2003, MDH is no longer able to provide direct financial support to state correctional facilities to implement HIV prevention interventions, MDH will still provide technical assistance to the DOC as they continue to provide some health education and risk reduction activities within the prison system.

#### COORDINATION WITH THE OFFICE OF MINORITY AND MULTICULTURAL HEALTH

In 2001, the Minnesota Department of Health Office of Minority and Multicultural Health (OMMH) was successful in securing a significant amount of state funds to support the Eliminating Health Disparities Initiative (EHDI). In 2002, a number of minority organizations were funded through this initiative to develop planning and/or implementation activities related to eliminating racial and ethnic disparities in STD and HIV infection rates. Additionally, in 2003, the OMMH received funding to assess need and provide capacity building support to community based organizations providing HIV-related services in the communities of color. Two representatives from the STD and HIV Section sit on an interdepartmental EHDI Technical Assistance Team to ensure coordination between the EHDI activities and the activities of the STD and HIV Section.

## **COORDINATION WITH COMMUNITY ORGANIZATIONS**

### ***Latino Assessment Project***

In 2003, staff from MDH worked very closely with staff from three community based organizations in the planning and development of the survey and community forums targeting Latino men. The purpose of the survey was to learn whether Latino men have access to information about HIV/AIDS, what the barriers are to testing, and what can be done to make it easier to test. The community forums were focused on learning more specifically about the barriers to testing and how to address them.

Staff members from Chicanos Latinos Unidos en Servicio (CLUES), United Migrant Opportunity Service (UMOS), Inc., and West Side Community Health Services provided their time, expertise, and knowledge of the community in collaborating with MDH staff to develop the questions to be asked, and planning for implementation. They also assisted in administering the survey, and CLUES and UMOS staff moderated all of the five community forums, while MDH provided logistical support.

### ***MDH Engagement with Community Networks***

In addition, staff from the MDH engage with the following networks in the community: Community AIDS Network; African HIV Collaborative, Gay/Lesbian Support Network; Community Educators Network; AIDS Substance Abuse Partnership; African American Health Workers Network; Comprehensive Adolescent School Health Planning Project; Hispanic Health Network; Peer Education Network, Minnesota Prevention Network; and Men Who Have Sex With Men Outreach Worker Network.

## **COMMUNITY BASED COLLABORATIVES**

### ***African HIV Collaborative***

The African HIV Collaborative began as an advisory body to the DHS in the development of a request for Office of Refugee

Resettlement (ORR) funds. The group also advised MDH in convening a community meeting to talk about concerns with the increasing new HIV infections within African communities in Minnesota. Since then, the group has gone through a process to establish its own identity and purpose.

The new mission of the African HIV Collaborative is to build the capacity of, and coordinate efforts between, existing organizations serving African immigrants in the area of HIV, and increase participation of African immigrant community members in HIV decision making entities. The goals of the African HIV Collaborative are to: (1) build the capacity of the African immigrant community to decrease the stigma of HIV through community building and leadership; (2) bring African immigrant communities together around the common problem of HIV, while recognizing cultural differences; (3) strengthen and make the system of services more available to African immigrants with HIV; and (4) provide support, education, and networking for HIV organizations that serve African immigrants.

### ***African American Health Workers Network***

This group meets on a monthly basis and is comprised of African Americans, including HIV positive individuals, who provide HIV outreach services, sexual health and prevention education, including risk assessments and risk reduction counseling for African Americans in the Twin Cities metro area. The group focuses on HIV/STDs and other diseases affecting the African American community, developing a proactive response to African American health care issues, and providing networking opportunities.

### ***AIDS Substance Abuse Partnership***

The AIDS Substance Abuse Partnership (ASAP) is a network of professionals and affected members of the community that focuses on HIV prevention in the context of substance abuse. They worked closely with DHS to revise and update the guidelines for HIV prevention education in chemical dependency treatment centers.

### ***Community AIDS Network***

The Community AIDS Network (CAN) is a network of over 200 professionals and community members working with youth and HIV/AIDS. Facilitated by the Youth and AIDS Projects (YAP), this group meets quarterly and invites speakers to spend time in sharing resources, etc. Invitations are extended to all areas of the HIV prevention community, however, since youth are often present at these meetings, YAP asks that adults wishing to attend be sponsored by an organization in the AIDS/ Health/ GLBT/ Social Service fields.

### ***Hispanic Health Network***

The Hispanic Health Network consists of Hispanics and non-Hispanics addressing HIV/STDs and other community health issues. Their mission is to promote the health and well being of Hispanics/Latinos by enhancing the effectiveness and quality of services for Hispanics/Latinos in Minnesota. This is achieved by: (1) providing a forum for networking among health educators, health and human service providers, and community members in Minnesota; (2) promoting access to support and health services for Hispanic/Latino clients and patients and advocating to ensure that these services are provided in a culturally competent manner and are also available in Spanish; and, (3) providing network members with opportunities for information sharing in the areas of research, referrals, and culturally specific materials.

### ***Latino Initiative***

The Latino Initiative was started in 2004 by the Minnesota HIV Services Planning Council in an effort to increase Latino participation in the community planning process for HIV/AIDS services. The focus of the initiative to date has been to involve community people from other health related initiatives, as well as business owners, religious leaders, and community members, in efforts to promote health services, awareness and education to the Latino community. Representatives from the STD and HIV Section and OMMH participate in this initiative, as well as a

number of representatives from organizations serving Latinos. The group sponsored a health tent at Mercado Central's fifth anniversary event in July 2004, providing resources and information about various health issues, including HIV. MDH staff also provided OraSure testing at the event.

### ***Men Who Have Sex With Men Outreach Workers' Network***

The MSM Outreach Workers' Network is a group of staff from organizations that receive HIV prevention funds from MDH to provide outreach to men who have sex with men. This group meets once each quarter to discuss issues and topics related to indoor and outdoor environmental outreach and general street outreach in various targeted communities. Members of the network have developed collaborative outreach efforts that have reduced the amount of duplicated outreach services and have increased the amount of referrals to each other's services. The members also discuss safety issues and community visibility. The network plans to continue meeting and will address their role in the developing outreach effort in Minnesota to men of color who have sex with men. Also, the network will be one resource for the HIV community prevention planning project's focus on men who have sex with men.

In 2002, following an increase in the number of MSM becoming infected with syphilis, including a number of people co-infected with HIV, the MSM Outreach Workers' Network was brought together to strategize and implement the integration of syphilis prevention messages into their work.

### ***Minnesota AIDS Project's Public Policy Committee***

The Minnesota AIDS Project (MAP), Minnesota's largest and oldest AIDS service organization, has an active public policy program. MAP, a private non-profit and a registered 501(h), has assembled AIDS activists from both the public and private sectors throughout the state. Their Board of Directors has established a Public Policy Committee that currently meets three times

per year. The committee is charged with developing an action agenda of policy issues to research and subsequently educate the public about. Where needed, this action plan includes the recommendation for legislative or policy action. Over the years, MAP's Public Policy Committee has recommended and worked to achieve statewide syringe access, regulation of viatical companies, establishment of regional HIV training sites and maintaining the statewide mandate for school-based HIV education.

### ***Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting***

The Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting (MOAPPP) works to strengthen policies and programs related to adolescent pregnancy prevention, adolescent pregnancy care and adolescent parenting in Minnesota. MOAPPP provides resources for parents, teens, educators, health care providers, youth workers, media professionals and policy makers.

MOAPPP collaborates with a number of partners in many of its efforts. Sexuality for Life – Minnesota is a coalition of educational, religious, health, social service and advocacy organizations that promote lifelong healthy sexuality by advocating for legislative policies comprehensive sexuality education and access to confidential health care services. The Minnesota Sexuality Education Resource Review Panel, made up of 40 members representing community based and statewide organizations, reviews and recommends sexuality education and HIV prevention curricula and resources for use in schools and communities.

MOAPP coordinates an Adolescent Parent Network, which is a group of social service, health and education professionals who work with, or on behalf of, teen parents. The network provides the opportunity for members to share strategies, resources and support, to discuss solutions to common issues, and receive training. MOAPPP also has a Latino Outreach Project, working with organizations

in the Latino community to address teen pregnancy and parenting.

### ***Sexuality and Family Life Educators***

Sexuality and Family Life Educators (SFLE) acts as an education resource for parents, schools, and the community. Sixty-eight (68) organizations throughout the metropolitan area and surrounding counties offer education on numerous topics related to sexual health: reproductive anatomy and physiology, responsible sexual decision making, sex roles and stereotyping, contraception, STDs, teen pregnancy, HIV/AIDS risk reduction and education, parents as sex educators, parenting issues, relationship/dating issues, sexual orientation, prenatal growth and development, sexual assault, and domestic violence.

### ***Streetworks***

Streetworks is a collaborative of youth-serving agencies that do outreach to homeless youth. The purpose of this effort is to enable outreach workers to team up on the streets with outreach workers in other agencies in a formal way. This enables agencies to more effectively cover the Minneapolis and St. Paul area. Bi-monthly support and supervision sessions are held for interested agencies.

### ***Women and Families Network***

The mission of the Women and Families Network is to address the needs of Minnesota women and families affected by HIV through collaboration, advocacy, training and resource sharing. The network is coordinated by West Side Community Health Services, the Ryan White CARE Act Title IV grantee, in collaboration with the Woman and Families Systems Advocate at the Minnesota AIDS Project (MAP).

The network is comprised of consumers and providers that address the multiple needs of people living with HIV and their families. The network creates the opportunity for formal and informal partnerships to facilitate referrals, avoid duplication of services, and to provide cross-training and support. In order to ensure

that services are meeting the needs of consumers, feedback and input is gathered from consumer network members and Consumer Advisory Boards.

In 2003, the Women and Families Network held an HIV Women's Health Retreat focused on gynecological issues for women with HIV, and learning how to talk with providers and each other about these issues.

The Title IV grant funds a Perinatal HIV Nurse Coordinator. This position is responsible for creating and distributing user-friendly tools that explain the recommendations for care of HIV-infected pregnant women, and offer support and education to OB/GYN providers. The nurse coordinator also provides education and support directly to HIV positive pregnant women, or works closely with their case manager. The nurse coordinator is working to develop a system to help ensure that HIV positive women receive care during and after their pregnancy and their children receive ongoing HIV-related care after birth.

## **Coordination with the Ryan White CARE Act**

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There has been great progress made in recent years towards creating stronger linkages between the CCCHAP and the Minnesota HIV Services Planning Council (Planning Council), the body that is responsible for prioritizing the Title I and II Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funds for the state of Minnesota. Additionally, there is much greater coordination and linkages between the MDH and the governmental entities responsible for administering the CARE Act Title I and II funds.

## **GOVERNMENTAL HIV ADMINISTRATIVE TEAM (GHAT)**

The Governmental HIV Administrative Team (GHAT) is made up of representatives from MDH; the Hennepin County Human Services Department (HSD), the CARE Act Title I

grantee; and the Minnesota Department of Human Services (DHS), the CARE Act Title II grantee.

The GHAT meets on a monthly basis, and discusses issues related to grant administration, data collection, contracting, and community planning. While the group was originally established with a focus on CARE Act-related issues, over time the GHAT has begun to focus more of its attention on issues impacting both prevention and care, and on learning more about the prevention world.

As a result of discussion at the GHAT, the staff from the three government agencies who are responsible for managing contracts with care and prevention providers have started meeting on regular basis. The purpose of these meetings is for the contract managers to share information and learn what the various contracted programs are responsible for, avoid duplication of effort, and share strategies for addressing the various needs of contracted agencies.

Additionally, staff responsible for developing training opportunities are in the process of planning a joint training and networking event for both prevention and care providers to take place in July 2004. A similar event was also held in December 2003. The event will offer providers the opportunity to learn more about each other's programs and to meet staff from other agencies.

## **MINNESOTA DEPARTMENT OF HUMAN SERVICES**

Since 2002, there has been increased coordination between MDH and DHS. Effective April 1, 2002, DHS took over administration of the Ryan White CARE Act Title II grant from MDH. However, DHS contracts with MDH to maintain continued participation in planning for care services for people living with HIV. This has been a priority for MDH in order to maintain the public health perspective in care planning, and to ensure that linkages between prevention and care are in place.

### ***Heroes Conference***

In 2003, MDH and DHS collaborated on the development of a conference targeting HIV positive individuals, their caregivers, and providers, which was held in April 2003. CDC supplemental funds were used to support activities at the conference to gather feedback from persons living with HIV and AIDS about how to most effectively design prevention for positive programs. In addition, separate activities were designed to assess capacity building needs of agencies in providing prevention for positives interventions. The Planning Council contributed Title II carryover funds towards the conference in order to support health education opportunities for the attendees.

In 2004, the DHS sponsored another conference with Title II carryover dollars. Prevention providers presented information about the recent increase in syphilis cases among MSM and increased efforts to promote syphilis testing with this target population.

### ***Working with African Communities***

The MDH staff person hired to conduct an assessment in 2003 of capacity to implement HIV prevention activities within African communities in Minnesota worked very closely staff at the DHS that were assessing and building capacity within African communities to build awareness of HIV and improve access to service for individuals who are HIV positive. The two agencies together planned a meeting with representatives of African communities in late 2003 in order to share findings from the assessment efforts and gather input regarding how to address identified needs.

### ***Training in Greater Minnesota***

Additionally, DHS, in conjunction with the Hennepin County Human Services Department (HSD), Rural AIDS Action Network (RAAN), and the Minnesota AIDS Project (MAP), has developed a plan and curriculum for delivering trainings in rotating regions in Greater Minnesota. The training is targeted at providers in Greater Minnesota and the focus is to provide information about available services, information to assist in

getting people into care, and an opportunity for networking. In addition, two staff persons from MDH deliver a portion of the training, focusing on counseling, testing and referral (CTR) guidelines, Partner Counseling and Referral Services (PCRS), and STDs.

### **CARE SYSTEM ASSESSMENT DEMONSTRATION PROJECT**

The Title I grantee recently received notice that the Minneapolis/ St. Paul eligible metropolitan area (EMA) is one of four EMAs chosen to conduct a CARE System Assessment Demonstration (CSAD) Project.

The CSAD Project will focus on assessing systems barriers to HIV positive African people getting into or staying in care. The project will consist of an assessment of the service system, which includes CTR and prevention with positives services. In addition to the system assessment, the project will use the qualitative Rapid Assessment Response and Evaluation (RARE) methodology, which has been used effectively in prevention studies, to gather information from the target population.

As the African population is of interest to the CCCHAP, as well, staff from MDH and CCCHAP members were invited to work with Title I and II staff, Planning Council members, and the principal investigator of the project in the planning and organizational stages of the process. MDH staff participated in the planning process, and continue to be involved in the advisory committee.

### **JOINT CO-CHAIRS COMMITTEE**

The co-chairs of the two planning bodies have been meeting as the Joint Co-chairs Committee on a regular basis for the past four years, and will continue to meet on a semi-annual basis. The reauthorization of the CARE Act in 2000 opened the door for increased opportunities for coordination. For the first time, Title I and II dollars can be used for HIV counseling, testing and referral activities. The reauthorized CARE Act expanded the language regarding eligible

outreach activities to include referring individuals at high risk for HIV into counseling and testing, although the priority is to find people who know they are infected, but aren't in care. In addition, the definition of health education and risk reduction services has been revised to put more emphasis on providing information to positive individuals about how to reduce transmission of the disease, in addition to providing information about how to improve their health status.

During 2001, the Joint Co-chairs Committee formed an ad hoc workgroup, which included former and current members of the CCCHAP and Planning Council, to develop a plan for increasing collaboration between the two groups. The plan lays out a number of tasks that can be accomplished over the next several years. This plan is reviewed and updated on a regular basis as tasks are accomplished. One task that was completed in 2003 was developing the following joint vision statement that was approved by the two planning bodies, "The CCCHAP and Planning Council share a common vision of a coordinated, comprehensive system of HIV prevention and care for the state of Minnesota."

During 2002, members of the two planning bodies were jointly involved in two workgroups described below. In 2003, recommendations from the two workgroups were brought forward to both planning bodies for discussion and approval. Besides the work of the Joint Co-chairs Committee, these workgroups marked the first time that there have been formal, collaborative planning efforts between the two groups.

**STATEWIDE PLAN WORKGROUP**

The Statewide Plan Workgroup was responsible for the following objectives:

- Identify core levels of prevention and care services that should be available throughout the state.
- Identify barriers and opportunities related to ensuring access to core prevention and care services.

- Develop a plan to improve access to core prevention and care services statewide.
- Develop a structure for regional planning for both prevention and services.
- Develop a plan to monitor access to prevention and care services statewide.

The workgroup primarily focused on developing a regional planning model, as well as a model of service delivery that would better meet the needs of people in Greater Minnesota. Both the proposed regional planning and service delivery models called for the integration of prevention and care services in Greater Minnesota.

The recommendations from the Statewide Workgroup, which were presented in a plan and broken into seven components, were presented to the CCCHAP and Planning Council for discussion over the course of two meetings. Through that process, each of the planning bodies independently arrived at some level of consensus about what they would like to see happen. Then the Executive Committees of the two bodies held a joint meeting, at which they came to agreement on how to proceed with the various components of the plan.

***Components of the Statewide Recommendations***

Following is a description of each of the seven components and the decisions made by the two planning bodies in 2003. Please note that none of these recommendations have been implemented as of September 2004.

**Greater Minnesota Committee:** The CCCHAP and Planning Council agreed to establish a provisional planning group with representation from all of Greater Minnesota to provide input on the development of a regional planning process to the CCCHAP and Planning Council.

Once the model for regional planning is decided, the permanent Greater Minnesota Committee would be established. Each regional planning group would name a representative to the Greater Minnesota Committee, which would be responsible for

communicating the needs of the various regions to the CCCHAP and Planning Council. The committee would elect one representative to serve as a member on the Planning Council and one to serve on the CCCHAP.

**Regional Planning System:** The CCCHAP and Planning Council agreed to work with members of the provisional Greater Minnesota planning group to explore possible entities to convene and provide support to the regional planning bodies. The entity chosen to convene the regional planning bodies would to some extent determine the number of regions to be used.

Once established, the regional bodies would be responsible for planning for both prevention and care services. They would assist with needs assessment and gap analysis, develop a local resource inventory, determine needs for technical assistance in the region, develop a list of priorities for the region, and participate in statewide discussions via representation on the Greater Minnesota Committee.

**Prioritization Process:** The original recommendation from the Statewide Plan was that each of the regional planning bodies would develop a list of prevention and care priorities, which would then be taken into consideration as the CCCHAP and Planning Council developed their statewide priorities.

The CCCHAP felt that each regional planning body should conduct their own local process to prioritize target populations in their region and identify prevention interventions to reach them. The Planning Council decided that they needed to have further conversation about whether to have the regional planning bodies identify their own priorities for care services in their regions, or whether the priorities identified by the regions would be taken into consideration by the Planning Council as it developed one statewide priority list. A decision has not yet been made.

**Allocations:** The Planning Council felt that each region should receive an allocation for planning support and prevention and care services according to a formula that will

include, but not be limited to, a base rate per region and regional population of people living with HIV and AIDS. The CCCHAP agreed to the *principle* of setting aside an allocation. Neither group decided on an exact proportion of the total funding to be set aside for the regions. It was agreed that this would be determined after the GHAT had assessed the feasibility of implementing this component.

**Service Delivery Network:** The CCCHAP and Planning Council both supported the development of an RFP that would require the provision of prevention and care services within each region, and would include a suggested list of types of partners that would enhance collaborative and coordinated service delivery.

**Technical Assistance and Capacity Building:** The two planning bodies agreed that technical assistance and capacity building would occur as needs develop and providers in Greater Minnesota seek assistance. Technical assistance and capacity building would also be provided to the CCCHAP and Planning Council around issues related to service delivery and planning in Greater Minnesota.

**Monitoring and Evaluation:** The CCCHAP and Planning Council agreed that monitoring and evaluation would be done as required, based on the components that are implemented.

### ***Implementation of the Statewide Recommendations***

At this point in time, none of the recommendations have been implemented, although progress was made in determining how to move forward. The GHAT held several meetings during the beginning of 2004 to determine what would be feasible to implement. Following are the decisions that were made:

Minnesota counties outside of the EMA were divided into four regions. The regions are mostly based on Community Health Services (CHS) regions, although some of them have been combined.

MDH determined that it does not have the resources, either human or financial, to support ongoing regional planning. The Planning Council plans to move forward with regional planning for care services.

It was agreed, however, that staff of the two planning bodies would collaborate to convene a statewide meeting on an annual basis. The focus of the annual meeting would vary according to where the two bodies were in their planning processes.

Whether funds were distributed jointly would depend to some extent on target populations identified for prevention. It may not make sense to distribute joint care and prevention funds if the target populations are very different. The GHAT did discuss the possibility of piloting a joint RFP for a service activity, such as outreach, where there is greater overlap. The GHAT also discussed the possibility of developing a joint application form, which would include some questions that would be answered by all applicants, and others that would be specific to organizations applying for prevention funds, and others specific to care funds.

Following the GHAT discussions, in August 2004, the CCCHAP was asked to make a decision about whether or not to allocate funds to Greater Minnesota regions. They decided against the allocation. However, the CCCHAP will provide suggestions to the MDH about how to improve the upcoming RFP process so that providers serving Greater Minnesota will be able to more effectively compete for funding. The Planning Council already has a funding allocation for services in Greater Minnesota, although at this time it is not distributed by region.

With the decision to not allocate prevention funding to Greater Minnesota regions, it is not clear at this point what, if any, collaborative efforts will occur in the future between prevention and care in terms of planning efforts and service delivery in Greater Minnesota. This will be a topic of continuing discussion with the GHAT, the Joint Co-chairs Committee, and the two planning bodies.

## LINKAGES WORKGROUP

The Linkages Workgroup was the second joint planning process implemented in 2002 and was responsible for the following objectives:

- Identify prevention and care services where there should and can be overlap.
- Identify administrative opportunities for grantees to integrate prevention and care services where it increases efficiency and effectiveness.
- Identify specific prevention services that should be considered for integration into the Continuum of Care and care services that should be integrated in the prevention plan.
- Identify additional questions for further investigation.

The first three meetings of the Linkages Workgroup focused on HIV counseling, testing and referral (CTR) given that the Health Resources and Services Administration (HRSA) now allows Title I and II funds to support CTR activities in points of entry, such as emergency rooms, substance abuse treatment programs, mental health treatment programs, correctional facilities, clinics, etc.

A survey was conducted with representatives from various points of entry. The greatest needs that arose from the survey responses were:

- Sites that have the capacity to do testing, but need additional funds to pay for the test and/or staff time to provide the counseling and testing.
- Sites that do not have the capacity themselves to provide testing, but could benefit from community based organizations coming in to provide the counseling, testing and referral services.
- Capacity building and technical assistance needs on the part of many of the points of entry providers to do counseling and provide appropriate referrals.

Given that the survey only involved a small number of providers, and that the CCCHAP

last set its priorities for counseling and testing activities in 1997, it was determined that additional assessment of the current counseling and testing system needed to be undertaken as a joint effort between the CCCHAP and Planning Council before a decision to allocate Title I or II funds could be made. This process was implemented by MDH in 2003, and is described in detail in the resource inventory section of Chapter Two.

Through the remainder of the year, the Linkages Workgroup looked at other prevention and care services where it appears that there is the opportunity for coordination. These service areas included: psychosocial care, case management, outreach, health education and risk reduction, information and referral, interpretation, childcare, discharge planning, transportation, screening for co-infections, and clinical trials.

Final recommendations included in the Linkages Workgroup report were forwarded to the CCCHAP and Planning Council for discussion and approval in early 2003. The two planning bodies agreed to accept the report and forward the recommendations on to the GHAT and Joint Co-chairs Committee for consideration of feasibility and development of a timeline for implementation. That work was completed in July 2003, and the recommendations were taken back to the CCCHAP and Planning Council and approved in October and November 2003.

***Linkages Recommendations***

The Linkages recommendations were divided into four categories: administrative agency activities, administrative agency/service provider joint activities, service provider activities, and planning activities.

**Administrative agency activities** include the following:

- Coordinated RFP and contract management between prevention and care
- Development of a risk assessment guidance and a sample tool to be used by both prevention and care providers

- Review of case management definitions, goals and job descriptions
- Review of CTR goals and activities
- Discuss the possibility of joint activities between the Partner Counseling and Referral Services (PCRS) program and outreach staff
- Collaborative efforts with mental health, chemical health, and corrections

**Joint administrative agency and service provider activities** include the following:

- Development of a joint referral process between prevention and care, tools and follow-up mechanisms, dissemination and training
- Joint trainings and networking opportunities for care and prevention providers
- Discussion of possible alternate funding sources to support HIV-related work
- Discussion of shared resources by providers

**Service provider activities** include the following:

- Shared activities/opportunities for health education and risk reduction
- Improved system of communication between prevention and care providers
- Discussion of shared resources by providers

And, finally, **planning activities** are:

- Assessment of a path to care for newly diagnosed individuals
- Increased representation on the CCCHAP and Planning Council from persons in the mental health and substance use fields
- Assessment of the need for connecting services to prevention programs (transportation, child care, interpretation/translation). If there is a need, then an assessment of the need for an umbrella system of these types of services for clients accessing both prevention and care services.

### ***Implementation of Recommendations***

Work has already begun on some of the Linkages recommendations. Two joint training and networking opportunities for prevention and care providers have been implemented. In addition, the MDH, DHS, HSD and the Office of Minority and Multicultural Health (OMMH) have begun discussions with a consultant about how to optimize available resources for providing capacity building and technical assistance to prevention and care providers. An initial discussion with the manager of the PCRS program took place regarding the possibility of linking activities with outreach workers. The CCCHAP and Planning Council both began the discussion about how to increase representation from the mental health and substance use fields. The recommendation related to assessing the CTR system has already been completed, resulting in the identification of new priority goals and an initial plan for implementation.

In 2005, two other components of the Linkages recommendations will be implemented. A sample behavioral risk assessment tool will be developed for use by both prevention and care providers. The tool will be available to providers to use as an example and they will be able to adapt it so that it fits within the context of their program and the population(s) they work with.

Also in 2005, MDH and HSD will collaborate to implement a joint prevention and care pilot project that will include OraSure and/or OraQuick testing. Three or four agencies will be selected through an RFP process to implement the pilot project. The agencies will be expected to provide outreach activities that include the distribution of prevention literature, safer sex kits, and bleach kits; provision of field based testing; and referral to prevention services. Persons who test positive, or people who already know they are positive but are not in care, will be assisted in accessing care and support services.

### ***Development of Continuum of Prevention and Care***

One of the early recommendations of the Linkages Workgroup was to integrate prevention into the already existing Continuum of Care document that was developed by the Planning Council in 1999. The CCCHAP went through an exercise in the summer of 2002 to identify priority prevention interventions that are needed for the general community, at-risk individuals, and for HIV positive individuals. An ad hoc committee consisting of members from both the CCCHAP and the Planning Council met in 2003 to finish developing the integrated document. The two planning bodies approved the final Continuum of Prevention and Care in the fall of 2003. The Continuum of Prevention and Care provides a model of the ideal prevention and care service system for the state of Minnesota and will be used by the two planning bodies as one of many sources of information to inform their prioritization processes.

## **OTHER LINKAGES**

### ***Short Term Intervention Services***

CARE Act dollars are used to fund short term intervention services, which are located at the two largest metro HIV/STD counseling and testing sites. Short term intervention services enable individuals diagnosed with HIV to access support and health care services early and to discuss transmission prevention behaviors. These programs assist newly diagnosed persons in obtaining an initial medical assessment and referral to ongoing medical care and includes CD4 counts and other lab tests, a physical examination, safer sex and needle use education, and referral to ongoing supportive services.

### ***Case Management Services***

Presently, all care case management grantees are required to provide prevention education to their clients, and all prevention case management grantees are required to refer HIV positive individuals to care case management programs. Care case managers

also receive training about how to talk about risk reduction with their clients.

### ***Jointly Funded Providers***

Approximately 50 percent of community agencies funded by MDH to provide HIV/STD prevention services to priority target populations have also been funded through Ryan White CARE Act and other HIV services funds to provide services to HIV positive individuals. In addition, all HIV prevention and HIV care providers are bound by contractual requirement to make referrals for their clients to STD testing and treatment, drug treatment, and reproductive health care, as appropriate.

## **Coordination Between HIV and Other Diseases**

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### **STD TESTING AND TREATMENT**

HIV and STD prevention and services activities in Minnesota have always been combined within the same section at MDH, namely the STD and HIV Section. This has allowed collaborative efforts to occur naturally, as funding has allowed. MDH currently supports components of a comprehensive STD program, including STD surveillance activities, lab testing for some STDs, and STD outreach and testing activities. Currently, all community based HIV prevention grantees are required to also implement STD prevention activities as feasible and appropriate, particularly those HIV prevention programs targeting youth.

As an immediate example of the need for such an integrated approach, Minnesota has experienced an increase in cases of syphilis infection in 2002 and 2003, primarily among men who have sex with men. Through December 31, 2003, there were 70 new cases among MSM. Of these cases 43 percent were co-infected with HIV.

MDH has worked closely with HIV prevention programs funded to reach MSM in heightening their efforts to prevent further outbreaks of syphilis, and to refer people to syphilis testing and treatment.

Federal STD prevention dollars continue to fund 29 clinics to reach adolescents and

young adults, providing chlamydia and gonorrhea testing and treatment. An additional four agencies with 16 clinic sites in neighborhoods with high STD rates were added in 2004. Clinics are located throughout the state. Ten clinics are in zip codes with the highest STD rates; funding for some of these clinics also pays for outreach workers to go out and talk to youth at parks, community centers, and other places in the neighborhood where youth congregate. They provide education on STDs and HIV to the youth and encourage them to come into the clinics to be tested. Two clinics reach adolescents at local high schools. All clinics also provide HIV testing based on clients' level of risk.

### **VIRAL HEPATITIS INTEGRATION**

The STD and HIV Section of MDH was successful in securing diverse funds to support the integration of viral hepatitis prevention and control activities into existing HIV and STD prevention activities. MDH received a one-year grant from the Council on State and Territorial Epidemiologists (CSTE) to develop a statewide viral hepatitis plan, which was completed in February 2003. In addition, MDH received three years of funding through the Viral Hepatitis Integration Project (VHIP), a cooperative grant agreement with the CDC to support the integration of viral hepatitis prevention activities into existing STD and HIV programs. This funding ended as of March 2004.

The VHIP project supported a number of activities:

- Training and technical assistance for HIV grantees targeting injecting drug users, including the development and distribution of culturally appropriate educational materials.
- Hepatitis C/HIV prevention outreach, and prevention case management activities in a storefront program for IDUs.
- Training in integrated risk assessment and counseling for community clinics serving high-risk populations, including IDUs.
- Hepatitis screening and vaccination in community clinics for high-risk adults, including IDUs.

A new hepatitis coordinator position at MDH is responsible for promoting the integration of viral hepatitis prevention and control into the existing activities of clinical health care providers, public health agencies, and community based health promotion programs. This will be done through the development and implementation of curriculum and materials designed to increase viral hepatitis risk assessment, screening, vaccination, and referrals to prevention and support services.

## **TUBERCULOSIS**

The STD and HIV Section works closely with the Tuberculosis (TB) Program at MDH. Ongoing collaborative activities include visiting HIV medical care providers to raise awareness about recommendations for screening and treatment of HIV positive persons for TB; making presentations to physician groups to inform them of the epidemiological, clinical, and prevention aspects of TB and HIV; and collaboration between the TB and Refugee Health Programs to assure that HIV-infected refugees receive appropriate TB screening, follow-up and treatment.

## **FAMILY PLANNING**

The Family Health Division at MDH has convened two groups in which STD and HIV Section staff is involved. The Adolescent Health Team focuses on coordination of efforts to improve the health of youth. The Women's Health Team focuses on collaborative efforts to improve the health of women and girls.

## **Summary of Coordination**

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A summary table of the various coordinated efforts described in this chapter is provided on the following pages, along with a description of the purpose of each effort. While some past efforts are described in the narrative, only current coordinated efforts are included in the summary table.

<b>COORDINATED EFFORT</b>	<b>ENTITIES INVOLVED</b>	<b>PURPOSE</b>
<b><i>African HIV Collaborative</i></b>	African organizations, Minnesota Department of Humans Services (DHS), MDH, Hennepin County Human Services Department (HSD)	Build capacity of, and ensure collaboration between, organizations serving Africans, and increase participation of Africans in HIV decision making entities.
<b><i>African American Health Workers Network</i></b>	African American HIV professionals and HIV positive persons	Develop a proactive approach to African American health care issues and provide networking opportunities.
<b><i>AIDS Substance Abuse Partnership</i></b>	HIV and substance use professionals	Address issues related to HIV prevention in the context of substance abuse.
<b><i>CARE System Assessment Demonstration (CSAD) Project</i></b>	HSD, DHS, Planning Council, MDH, community members	Identify system, community and personal barriers to HIV+ Africans accessing and/or staying in care
<b><i>Case Management Services</i></b>	Care and prevention case management providers, MDH, DHS	Ensure that HIV positive individuals are receiving the care and prevention services they need.
<b><i>Community AIDS Network</i></b>	YAP, professionals working with youth and HIV/AIDS	Share information and resources related to HIV and youth.
<b><i>Continuum of Prevention and Care</i></b>	CCCHAP and Planning Council	Develop an integrated model of the continuum of prevention and care services for ongoing use in community planning.
<b><i>Coordinated School Health Approach</i></b>	MDE MDH	Assist school districts in implementing comprehensive HIV prevention curriculum.
<b><i>Coordination with Office of Minority and Multicultural Health</i></b>	STD and HIV Section staff sit on Eliminating Health Disparities Initiative (EHDI) Technical Assistance Team	Ensure coordination between STD and HIV Section activities and EHDI activities related to HIV prevention.
<b><i>Family Planning</i></b>	STD and HIV Section, Family Health Division	Develop coordinated efforts to improve the health of youth and women
<b><i>Governmental HIV Administrative Team (GHAT)</i></b>	MDH, DHS, and HSD staff	Ensure communication and coordination between the MDH and Title I and II CARE Act grantees.
<b><i>Hispanic Health Network</i></b>	Latino and non-Latino professionals	Promote the health and well being of Latinos by enhancing the effectiveness and quality of services for Latinos in Minnesota.

<b>COORDINATED EFFORT</b>	<b>ENTITIES INVOLVED</b>	<b>PURPOSE</b>
<b><i>Joint Co-chairs Committee</i></b>	Co-chairs of the CCCHAP and Planning Council, MDH, DHS, and HSD	Ensure communication and coordination between the two planning bodies.
<b><i>Latino Initiative</i></b>	Planning Council, Latino organizations, MDH, Office of Minority and Multicultural Health (OMMH), HSD, DHS	Promote health services, awareness and education related to HIV and other health issues to the Latino community
<b><i>MDH Staff Participation in Community Networks</i></b>	Community AIDS Network, Gay/Lesbian Support Network, Community Educators Network, AIDS Substance Abuse Partnership, African American Health Workers Network, Comprehensive Adolescent School Health Planning Project, Hispanic Health Network, Peer Education Network, Minnesota Prevention Network, MSM Outreach Workers' Network	Ensure ongoing communication and interaction between MDH staff and community-based networks. Provide community networks the opportunity to give feedback to MDH regarding HIV prevention efforts.
<b><i>Men Who Have Sex with Men Outreach Workers' Network</i></b>	MDH, MSM outreach programs	Ensure collaboration and reduce duplication of effort in outreach activities.
<b><i>Minnesota AIDS Project Public Policy Committee</i></b>	MAP, interested organizations and individuals	Develop an action agenda of policy issues, educate the public, and develop recommendations for legislative or policy action.
<b><i>Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting (MOAPPP)</i></b>	MOAPPP, interested organizations and professionals	Strengthen policies and programs related to adolescent pregnancy prevention, adolescent pregnancy care and adolescent parenting in Minnesota.
<b><i>Permanent Seats on CCCHAP</i></b>	Minnesota Department of Education (MDE), Minnesota Department of Corrections (DOC), and DHS	Ensure ongoing participation in the HIV prevention planning process by state agencies that provide some form of HIV education.
<b><i>Sexuality and Family Life Educators</i></b>	Sexual health and related organizations	Provide education resources to parents, schools and the community on subjects related to sexual health.
<b><i>Short Term Intervention Services</i></b>	Red Door Clinic, Room 111, MDH, and CHD	Provide access to short term medical care and referral to ongoing care for newly diagnosed persons who don't have health insurance.

<b>COORDINATED EFFORT</b>	<b>ENTITIES INVOLVED</b>	<b>PURPOSE</b>
<b><i>Streetworks</i></b>	Youth serving organizations	Ensure collaboration and greater coverage of outreach activities.
<b><i>STD Testing and Treatment</i></b>	Prevention grantees, MDH, STD clinics	Ensure that STD prevention messages are available in the community. Ensure access to STD testing and treatment for adolescents and young adults, particularly in the area with highest rates of STDs.
<b><i>Technical Assistance</i></b>	DOC MDH	Ensure that inmates receive effective HIV prevention education.
<b><i>Training in Greater MN</i></b>	DHS, HSD, Rural AIDS Action Network (RAAN), Minnesota AIDS Project (MAP), and MDH	Ensure that providers in Greater MN have necessary information to assist clients in accessing services.
<b><i>Tuberculosis</i></b>	STD and HIV Section, TB Program	Ensure medical providers have knowledge needed to screen and treat HIV/TB co-infected individuals.
<b><i>Women and Families Network</i></b>	West Side Community Health Services, MAP, providers serving HIV+ women and families, consumers	Ensure formal and informal partnerships to facilitate referrals and avoid duplication of effort in services for women living with HIV and their families. Provide cross training and support.
<b><i>Working with African Communities</i></b>	MDH and DHS	Ensure coordination of efforts in assessing and building capacity of African communities to provide prevention and care services.
<b><i>Viral Hepatitis Integration</i></b>	MDH, community clinics, OMMH, tribes	Promote the integration of viral hepatitis prevention and control into the existing activities of clinical health care providers, public health agencies, and community based health promotion programs.

## Glossary

*This glossary provides definitions for acronyms and words that are used throughout the Minnesota Comprehensive HIV Prevention Plan.*

### Glossary of Acronyms

<p><b>A&amp;E</b> Assessment and Evaluation Committee. Former committee of the CCCHAP that was responsible for needs assessment and evaluation activities.</p> <p><b>AIDS</b> Acquired Immunodeficiency Syndrome. A clinical definition of illness caused by HIV, resulting from a CD4 count less than or equal to 200, or one or more diagnosed opportunistic infections.</p> <p><b>ASO</b> AIDS Service Organization. An organization that provides services related to preventing HIV/AIDS, and/or services to people living with HIV/AIDS.</p> <p><b>CBO</b> Community Based Organization (organizations that are not government agencies).</p> <p><b>CDC</b> U.S. Centers for Disease Control and Prevention. The government agency that provides funding for prevention services.</p> <p><b>CCCHAP</b> Community Cooperative Council on HIV/AIDS Prevention. The community planning group in Minnesota.</p> <p><b>CPG</b> Community Planning Group. A generic term for community planning groups across the United States.</p> <p><b>CPP</b> Comprehensive Planning and Priorities Committee. Former committee of the CCCHAP that was responsible for developing recommendations for target populations and prevention interventions.</p>	<p><b>CTR</b> Counseling, Testing, and Referral. Pre- and post-test counseling, HIV testing, and appropriate referrals.</p> <p><b>DEBI</b> Diffusing Effective Behavioral Interventions Project. National-level strategy to provide high quality training and on-going technical assistance on selected evidence-based HIV/STD prevention interventions to state and community HIV/STD program staff.</p> <p><b>DHS</b> Minnesota Department of Human Services</p> <p><b>DOC</b> Minnesota Department of Corrections</p> <p><b>EMA</b> Eligible metropolitan area that is eligible to receive Ryan White CARE Act Title I funds.</p> <p><b>GLI</b> Group Level Interventions that contain a skills building exercises, as well as education, information and support, and are provided to groups of varying sizes.</p> <p><b>HIV</b> Human Immunodeficiency Virus. The virus that damages the immune system and causes AIDS.</p> <p><b>HRSA</b> Health Resources Services Administration. A federal agency under the U.S. Department of Health and Human Services and part of the Public Health Service, which oversees the Ryan White CARE Act.</p> <p><b>IDU</b> Injection drug user/Intravenous drug user. Someone who shoots drugs using a needle.</p>
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- ILI** Individual Level Interventions, which assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior, and include skills building.
- MDE** Minnesota Department of Education
- MDH** Minnesota Department of Health
- MSM** Men Who Have Sex with Men
- PCM** Prevention Case Management, which includes ongoing individual risk assessment and individual counseling services to reduce risk behavior, as well as support in accessing other needed services.
- PCRS** Partner Counseling and Referral Services, which includes counseling infected persons about how to prevent HIV transmission, referring patients for medical care and support services, locating sexual and/or needle sharing partners identified by patient and notifying them of their risk, referring partners for testing, and counseling partners.
- PIR** Parity, Inclusion and Representation. Principles of prevention community planning regarding membership.
- PSA** Public Service Announcement. Free media ads placed on the radio, TV, etc.
- RFP** Request for Proposals. Documents issued by funders to announce that grant funds are available and provide specific instructions about how to apply for the funds.
- STD** Sexually Transmitted Disease, such as gonorrhea, chlamydia, herpes, etc.
- TA** Technical Assistance. Training and information that assist people in doing their jobs or tasks better.
- YMSM** Young Men Who Have Sex with Men

## Glossary of Words

**Behavioral Interventions** Programs that help people change or avoid behaviors that put them at risk for being infected with HIV.

**Behavioral Science** A science, such as psychology or sociology, that seeks to survey and predict the responses (behaviors) of individuals and groups in a given situation; i.e., “find out why people do what they do.” Behavioral science helps HIV prevention planners choose strategies that are known to help people change or avoid HIV risk behaviors.

**Community Awareness** Programs that provide information and change the way a community thinks about something. These programs are not necessarily intended to make individual people or communities change their behavior.

**Community Cooperative Council on HIV/AIDS Prevention** The community planning group in Minnesota that is responsible for prioritizing the target populations that are most at risk for HIV infection, and the prevention interventions that are thought to be most effective.

**Comparison or Control Group** A group to which the study or research group are compared. The control group does not receive the intervention that is being researched. The control group is compared to the group who does receive the intervention in order to measure the effectiveness of the intervention.

**Contractor** A person or agency funded directly by MDH (or another funding agency) to perform specific services.

**Convenience Sample** The people who participate in a study are available to the researcher.

**Cultural Competence** The ability of an agency or a person to work well with clients and communities of various cultures. This means more than just being sensitive or aware of a culture or cultures. It is being able to relate to people and provide interventions in a way that fits with their culture.

**Cultural Group** Any group of people who share a worldview, language, history or lifestyle. There are many differences within cultural groups, including factors such as gender, ethnicity, education, occupation, length of time in the United States, residence (rural, urban, suburban), and life experience.

**Culture** Learned behavior patterns that are shared by members of a particular group. Culture includes customs, experiences, beliefs, rituals and practices shared by a group of people. Culture can include things that are visible, like the way people look or dress. Culture also includes things like how people view their relationships with others, as well as their values and priorities.

**Drop-in Center** A place supervised by adults where youth can meet for peer support, prevention programs and other services.

**Environmental Outreach** Doing outreach in places you think the people you are trying to reach will be; for example, in bars or beauty salons.

**Epidemic** A disease that spreads rapidly among a large number of people in a short period of time.

**Epidemiology** The study of epidemics. Epidemiological information shows us which groups of people are being affected by a disease (gender, race, age, etc.)

**Epi** Epi is the shortened version of epidemiology or epidemiological.

**Field Based Testing** Testing for HIV that can be done anywhere – at a bar, in a park, on the street. The test most commonly used is called OraSure, and a swab is taken from the tongue, so you don't have to take any blood.

**Grantee** A person or group receiving funds from an outside source. The term is used to refer to health departments that receive federal funds from the CDC for HIV prevention activities, and to refer to the agencies that receive funding from the MDH to provide prevention services in the community.

**Guidance** The CDC document that provides information and rules for receiving funding for HIV prevention programs, and defines the process of HIV prevention community planning.

**Harm Reduction** An approach to working with clients that is respectful and non-judgmental. It recognizes the skills and power that individuals already have to make changes in their lives, but allows each person to set their own timeline for making changes. Any positive changes are acknowledged.

**Incidence** The rate of new infections in a specific population within a year. For example, the number of new HIV infections among women from January 1, 2000 through December 31, 2000.

**Intervention** An activity used to try to change behaviors that could lead to being infected with HIV. The activity is usually targeted at groups of people who are at especially high risk.

**Jurisdiction** A geographic area that is within the responsibility of a particular government agency, such as a local public health department.

**Morbidity Data** Statistics that show disease or illness, such as HIV infection or AIDS.

**Mortality Data** Statistics that represent deaths that were related to a certain condition, like AIDS.

**Multilevel Interventions** Prevention programs that include a number of interventions designed to achieve different goals. These programs usually move people through different stages of prevention care. They may include outreach, behavioral interventions, as well as activities to raise awareness in the community).

**Needs Assessment** The process of collecting and analyzing information from different sources (research, articles, interviews). The information is used to figure out what the needs of a certain population or community are.

**Objective** A goal that can be measured within a specific time period.

**Outcome Evaluation** An evaluation to determine whether a specific intervention caused the expected outcomes.

**Outcome Monitoring** An evaluation that assesses whether the expected outcomes occur. This type of evaluation does not measure whether the intervention caused the expected outcomes.

**Outreach** Interventions that are designed to identify individuals who are risk for being infected with HIV, giving them information about how they can reduce their risk, and letting them know where they can go for services that can help them change/reduce their risky behaviors. Outreach can also include field based testing.

**Peer Education** Peers educators are members of a target population (for example – IDU, African American males, young women) who have been trained to teach other people from the same population about HIV. Peer educators usually act as role models, demonstrating ways of thinking and acting that reduce the risk of getting HIV.

**Perinatal** The time period during pregnancy and birth (before, after and during delivery).

**Planning Council** The Minnesota HIV Services Planning Council is the community planning group responsible for prioritizing the care and service needs of people living with HIV/AIDS in Minnesota.

**Prevalence** The percentage of people who have a disease at any given time. For example, at the end of 1999, 17% of the people living with HIV/AIDS in Minnesota were women.

**Primary Prevention** Interventions to reduce HIV transmission from person to person or from mother to fetus.

**Prioritize/Prioritization** A process used to decide what populations and interventions are the most important or most at risk. This community forum is part of the prioritization process.

**Process Evaluation** Evaluation designed to document whether programs were conducted according to written intervention plans. Describes content and quality of program services, who and how many were served, and client feedback.

**Qualitative Data** Data that are gathered and analyzed as words.

**Quantitative Data** Data that are gathered and analyzed as numbers.

**Referral** Giving information and assistance to a person in order to help them get a service they need (phone number, name of agency, help make a call, sometimes includes taking client to appointment).

**Resource Inventory** A listing or summary of information about prevention activities and related services provided by agencies to populations in a specific area, such as the state.

**Risk Assessment** Asking people about their life style and behaviors to determine how much risk they are at for getting HIV.

**Risk Behaviors** Behaviors that increase the chance of a person getting HIV; for example, having sex without using a condom, sharing needles, having sex when you're high or drunk, having a lot of sexual partners.

**Risk Reduction** Things that reduce a person's risk for getting HIV. For example, using a condom, cleaning needles.

**Ryan White CARE Act** The federal legislation that provides funding for the health care and services for people living with HIV and AIDS.

**Sample** A subset of people drawn from a larger population to participate in a study.

**Secondary Prevention** Interventions designed to help people with HIV maintain their health and slow the progression of the disease. (Interventions that help HIV+ people avoid transmission of HIV to others are considered to be primary prevention.)

**Seroprevalence** The percentage of people living with HIV/AIDS within a specific target population during a defined period of time (e.g., a month, a year, etc.). Seroprevalence studies test blood samples from at risk populations to find the percentage of sampled persons infected, regardless of when infection occurred. (sero = blood)

**Sex Worker** A person who exchanges sex for money (commercial sex worker, prostitute), drugs, shelter, etc. This word may refer to persons of any gender or sexual orientation.

**Single Behavioral** Specific types of interventions that are designed to change high-risk behaviors. Several examples of a single behavioral interventions are individual counseling, support group, prevention case management, or group counseling.

**Street Outreach** Giving people on the street information about HIV, condoms, bleach kits, information about where they can go for services.

**Surveillance Data** Statistics on the number of people with HIV, AIDS, or other reportable diseases in a given area. The statistics are based on reports to public health departments.

**Survey** A written self-report method to collect data that may be conducted by mail or in person.

**Target Population** Groups of people who are the focus of HIV prevention efforts because of their high rates of HIV infection, risk behaviors, and other factors.

**Task Force** Commissioner's Task Force on HIV/STD Prevention Planning. The former name of the CCCHAP, which is the community planning group in Minnesota responsible for prioritizing the target populations that are most at risk for HIV infection, and the prevention interventions that are thought to be most effective.

**Technical Assistance** Training and information that helps people do their jobs better.

**Transgender** A person who self-identifies as a gender (male or female) that is different from their biological sex. For example, a person who was born a man but identifies herself as a woman. Some transgender people use hormone treatments, have gender reassignment surgery (a sex change), or change their appearance. Others do not.

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